

Scottish Journal of Residential Child Care



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Editorial

Graham Connelly

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@DocCTweets

Welcome to the autumn 2022 issue of the *Scottish Journal of Residential Child Care*, a special issue published in celebration of 20 years since the journal was established.

Introducing the first issue in autumn 2002, then editor, Professor Andy Kendrick of the University of Strathclyde, set the context for a specialist journal about residential child care in a year which had seen the publication of the first **national standards for social care in Scotland, the establishment of Scotland's** care regulator (the Care Commission) and a new professional registration body, the Scottish Social Services Council (SSSC).

Andy hoped that the *SJRCC* would help break down barriers between research and practice: 'Research needs to impact on policy and practice in residential child care and residential workers need to be "research-minded"', he wrote. This aim continues to **govern the journal's mission, exemplified in our explicit** editorial policy to publish both long-form original research papers and shorter accounts of and commentaries on contemporary practice.

The original publisher of the *SJRCC* was the Scottish Institute of Residential Child Care, established in 2000, and now incorporated into CELCIS, the Centre for **Excellence for Children's Care and Protection**. A conference on residential child care is organised by CELCIS annually and in recent years the *SJRCC* has published an autumn issue to coincide with the event, calling in advance for short papers on the conference theme.

An international outlook was also envisaged from the beginning. Andy signalled the desire to have 'contributions from practitioners and researchers in other countries so that we can learn from a wide range of residential contexts, traditions and settings'. In this way, Andy wrote, 'we hope to promote and enhance the development of positive practice in residential child care, both in Scotland and in the wider world'.

In recognition of the *SJRCC*'s increasing international outlook, in 2021 the **strapline: 'an international journal of group and family care experience' was added to the journal's title. An important way in which the *SJRCC*** has developed its international outlook is through membership of the international editorial advisory board. Board members act as advocates for the journal in their own countries, ensuring that the journal has a broader reach and attracts authors from outside Scotland. Editorial board members also provide an essential quality assurance function by reviewing articles submitted to the journal; they are volunteers, and, as editors, we pay tribute to their valuable contribution to the **journal's success.**

The autumn 2022 issue

This **issue's leading article was specially commissioned to celebrate the *SJRCC*'s 20th** year from James Anglin, Emeritus Professor of Child and Youth Care at the University of Victoria, Canada. Describing the *SJRCC* as 'a journal like no other', Jim quotes from an **analysis of the journal's entire back catalogue of more than 400** articles conducted by CELCIS colleagues Gemma Watson and Craig McCreadie, and judges that 'the journal has been highly successful in attracting contributors with diverse backgrounds and allowing them to speak in very personal ways about their learning, their struggles and their engagements with **young people and the complex systems that have evolved to address children's** needs'. The most common theme in articles over the 20 years turns out to be **'staffing issues/practice'**. Jim kindly ends his article with some plaudits for the **journal's editorial team:** 'To everyone who has been even a small part of creating and maintaining this unique and valuable journal, I say on behalf of all your readers, 'Well done, and thank you'.'

Also contributing an article in celebration of the *SJRCC*, Iain Mathieson of Massey University, New Zealand marks the anniversary by discussing '19 other residential child care developments over the last 20 years from across the world and in particular Europe, North American and Oceania', ascribing to the journal **the accolade of being one of the sector's 'collective achievements and strengths'**.

In the first of four long-form, double-blind peer-reviewed papers we publish in this issue, Dan Johnson and Lily Burnard of Kibble Education and Care Centre in Paisley, Scotland review the literature to identify themes for young people and residential care staff in relation to self-harm support and management, finding that positive relationships between staff and young people emerges as a predominant theme.

Lucy Abraham and colleagues of Cardiff University Centre for Human Development Science researched the views and experiences of people working in residential child care based on focus group interviews with 22 workers at five residential centres in England and Wales. They identified three core themes: a rewarding profession but one that is neither well understood nor valued by society; that many factors can be barriers to the residential workers being emotionally available to the children in their care, but other factors help promote resilience; and workers recognise that their confidence and skill impact their ability to successfully manage challenging behaviours.

Katy Ervine of the Institute of Integrated Systemic Therapy in London has investigated the understanding and management of self-harm in a children's residential therapeutic community in England. She found that 'the terms 'risk', 'intent' and 'level' can have different meanings to different individuals and may vary between children and contexts, even within the same context'. She concludes that, 'such fluidity in definition and terms can make self-harm a **challenging subject to understand... compounded by the idea that self-harm** is often seen as a taboo subject, uncomfortable to look at or discuss'.

Martin Power draws on data collected as part of Social Care Ireland's 'recruitment and retention in social care survey' to examine the **professionalisation of children's residential care**. His findings include that 'social

care workers are optimistic and positive registration about the potential benefits registration may bring' such as protection of title and placing social care workers on a more equal footing with other health and social professions. 'On the other hand, registration will likely increase individual costs for social care workers, given registration fees, continue professional development requirements and the need for professional indemnity insurance'.

Earlier in the year we called for short papers related to theme of the 2022 SIRCC conference – **'Resilience and Recovery in Residential Child Care: Supported Adults and Supported Children'**, and had a very good response, so we can now publish six articles on this theme.

Charlotte Wilson who is undertaking doctoral studies in the University of Strathclyde describes a brief history of secure care in Scotland, based on a literature review conducted for her doctoral studies. She notes that the aim of secure care was described in 2004 as providing 'a safe, containing setting by restricting the liberty of children and young people' and finds that this view has not changed much, despite the many changes in the sector, expressing a concern about the lack of research on the specific needs of young people with autism being cared for in secure settings.

The paper by historian Amanda Gavin of the University of Glasgow takes a **historic approach to inspection practices and children's experiences of residential care** in Scotland in the period 1945 to 1980. She says that 'many voluntary **children's homes were not effectively regulated, and the** [government] Inspectorate had little influence over day-to-day caregiving practices and **therefore on children's experiences of care'**, concluding that 'a focus on **children's physical needs by the Inspectorate contributed to the catastrophic failure of many voluntary children's homes to meet the emotional needs of the children in their care'**.

Kayoko Ito, a professor at Osaka Metropolitan University who has been conducting research at the University of Glasgow, contributes a paper which considers 'how to respond to child abuse after the COVID-19 pandemic by identifying the actual situation of child abuse consultations in Japan and how

these consultations were handled’ based on a survey of 39 local authorities in Japan. The paper identifies five issues such as the ‘need to change and devise the nature of the child and family consultation and support system’, including overcoming weak IT infrastructure in social work settings in Japan.

Mary Morris of the Care Inspectorate in Scotland explores the changing experiences of siblings in Scottish residential child care services. She notes that: ‘The Promise [the report of the Independent Care Review in Scotland] outlines that children should as far as possible be supported to live with their families, but if that is not possible children must stay with their brothers and sisters when safe to do so’. Mary says that translating the spirit of the report and related legislation into practice will need ‘huge commitment and energy from everyone working in the [residential child care] sector’ and she highlights the important influence of care experienced children and young people and advocacy groups such as Stand Up for Siblings.

Frank Ainsworth of James Cook University, Queensland, Australia and Paul Mastronardi of the Dunlea Centre, Engadine, New South Wales, Australia consider the claim by the former Central Council in Education and Training for Social Work (CCETSW) in the UK that residential child care work is part of social work and conclude that it is not. Using Great Britain and Australia as their evidence base, they argue that viewing residential care as an aspect of social work has led to a reduction in services available for children with complex needs and ‘held back research efforts to design and tested urgently needed new therapeutic residential care (TRC) models’.

We provide our usual tailpiece of book reviews – ‘**Marginalised Communities in Higher Education**’, edited by Neil Harrison and Graeme Atherton (reviewed by Eavan Brady of Trinity College Dublin), ‘**The Great Pretender**’ by Susan Cahalan (reviewed by Graham Connelly), and ‘**Behind Closed Doors: Why we break up families and how to mend them**’ by Polly Curtis (reviewed by care experienced activist, David Anderson) – while noting that we have recently received some very positive comments about the value of our book reviews. Our book review editor, Leanne McIver, is always on the lookout for books to review – newly

published and classics - **and readers to review them. The offer is there: we'd** love to hear from you.

About the author

Dr Graham Connelly CPsychol is the editor of the *Scottish Journal of Residential Child Care* and an honorary senior research fellow with CELCIS and the School of **Social Work and Social Policy in the University of Strathclyde. Graham's research** interests have ranged over alternative care internationally and more particularly the education of care experienced children and adults. He is a non-executive director of Kibble Education and Care Centre and a trustee of the MCR Pathways school-based mentoring programme.

A journal like no other: Engaging with 20 years of the Scottish Journal of Residential Child Care

James P. Anglin

Abstract

The first 20 years of the SJRCC has offered a rich array of articles, perspectives and experiences from across the full spectrum of the child and youth care field internationally. A thematic analysis reveals the most common theme over the life of the journal to be **'staffing issues/practice'**, with **'international'** second, and the three themes of **'education'**, **'transitions and leaving care'** and **'historical reflections'** in a virtual tie for the bronze medal. Accessibility and a welcoming of authors from diverse backgrounds while maintaining rigour in its selection of peer-reviewed research articles contributes to the SJRCC being indeed 'a journal like no other.'

Keywords

Residential childcare, childcare history, key childcare themes, threshold concepts

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I was asked by Graham Connelly, the editor of the *SJRCC* since 2012, if I would **write a perspective piece in recognition of the journal's 20th** anniversary. Of course, I was pleased to be asked, and eager to use the opportunity to (spoiler alert) read some articles I had not yet read. It is a challenge to keep up with everything published across the seven child and youth care journals with which I am in some way involved. I rationalised this task as an invitation 'to look back to move forward.'

I want to acknowledge that I was aided in this task by Graham himself who answered all my questions about the origins, purposes, logistics and evolution of the *SJRCC*, as well as by Andy Kendrick with some background on the founding of the journal. Also, Gemma Watson and Craig McCreadie sent me their summary analysis of all the articles and book reviews that appeared in the journal over its two decades of existence. Thank you all.

Where does one start to make sense of 417 articles and book reviews? And a few poems; personally, I would like to see more poems. Poems are often the way those with lived experience in care formulate and communicate their meaning making.

The first thing I want to say is how impressed I was in looking through the diversity of material, and reading what I could within my time limit. I learned a great deal, and my passion for CYC was continually renewed and strengthened. The *SJRCC* has attracted such a wide range of contributors, across many dimensions and levels of the child and youth care field, and I credit the editors over the years with creating and maintaining an open, welcoming and supportive approach, especially for those who may not be experienced in publishing in formal journals.

Andy Kendrick, a founder of the journal and Professor of Residential Child Care at the University of Strathclyde, understood this journal as a way to:

engage with the residential child care sector in Scotland. I
thought the journal was an important means of communicating
the latest research and policy and practice developments with

residential child care managers and practitioners. I also wanted to encourage young people (although this probably came later) **and professionals to be writing about their experience...** (personal communication, June 30, 2022)

To my mind, the journal has been highly successful in attracting contributors with diverse backgrounds and allowing them to speak in very personal ways about their learning, their struggles and engagements with young people, and **the complex systems that have evolved to address children's needs. It is not an** easy feat for a journal to be rigorous in its expectations of quality while being personable in its editorial culture. The four editors over the first 20 years, Andy, Irene Stevens, Laura Steckley and Graham, have provided committed, passionate and skilled leadership for the journal, continuing to serve the needs of the residential childcare sector while being open to broader sociological perspectives such as those around poverty and the impacts of capitalism. Perhaps most impressively, they have managed all this with minimal financial resources and a transition to free access to boot.

On the logistics side of things, many people over the years have worked behind the scenes, many of whom were connected with the Scottish Institute for Residential Child Care (SIRCC) and in more recent times, CELCIS (Centre for **Excellence for Children's Care and Protection**) as well. When the journal decided to go online, the webmasters and support staff at CELCIS were instrumental in facilitating this process. I find the *SJRCC* website to be one of the most user-friendly journal websites I know, and accessing articles and journal issues across the decades has been a joy rather than a hassle. As Graham mentioned to me, **accessibility has always been in the journal's DNA.**

I am not familiar with all those who have made the journal work and thrive over so many years, but I do know about the stellar contributions that have been, and continue to be, made by Laura Steckley. Laura has not only overseen the book reviews, now in the capable hands of Leanne McIver, she has been a key part of steering the journal through inevitable dilemmas and challenges. It was she who championed the creation of a 'peer reviewed' component in recognition of the demands placed upon academic researchers, while maintaining the

impressive diversity of overall contributions. Over the years, the *SJRCC* book reviews have been responsible for me ordering a number of texts, with the latest one being thanks to a review by Graham himself on *Labours of Love: The Crisis of Care* by Madeleine Bunting.

I think the *SJRCC* is indeed 'a journal like no other' due to the manner in which it welcomes and displays the diversity of academic, professional and experiential dimensions in such an accessible and respectful way, while retaining a sense of rigour and thoughtfulness (traditional Scottish values).

Over the years, while the journal began with a strong Scottish, UK and European focus, it has grown into a truly international publication. The journal editors and the cadre of reviewers have maintained their welcoming stance by assisting contributors for whom English is not a first language to be published. This can be a time-consuming task, but one highly worthwhile and greatly appreciated by both the authors and the readers who are exposed to a range of cultures, traditions and ways of thinking.

While I cannot (and should not) try to focus on any specific articles, editorials or book reviews, I do feel a need to somehow 'connect the dots' between them. What patterns can we discern from scanning (and sometimes reading) over 5,000 electronic pages of fascinating writing? In addition, I might add, to the over 5,000 pages of other materials already surrounding my beleaguered home office writing space. Each morning I struggle to clear an 8.5 by 11 inch (North American standard) spot on which to place my writing pad.

As an aside, when I submitted my PhD at Leicester University, I needed the written permission of the University Provost to submit my dissertation on North American size paper, as trying to use British A4 paper (an awkward 8.27 by 11.7 inches) in my printer would not have been possible. I am grateful that such permission was graciously granted to this colonial from the backwoods of Canada where paper is plentiful, but apparently of a peculiar size for those in Great Britain. Perhaps the fact that I lived in *British* Columbia helped.

Where was I? Oh yes, trying to find a way to make sense of the thousands of pages of insightful perspectives, wisdom, experiences, emotions, visions and critiques from a great **diversity of authors from all corners of children's services**, and some beyond.

Thanks to the painstaking content analysis done by Craig McCreadie and Gemma Watson, I was handed a list of the 110 identified themes and the number of times they appeared as primary or secondary themes in the 417 articles. I think you will be interested to learn that the most common theme across the 20 years was 'staffing issues/practice.' Clearly, the needs of people charged with doing the work of child and youth care have been central to the commitments and identity of this journal. At the same time, virtually every issue contains vivid threads of the lived experiences of the children and young people in our CYC systems. When I read through some of the issues, I began to feel myself wrapped in a many coloured cloak that was intricately woven from the lived experiences of the adults and young people dancing (as Mark Krueger would say) together through residential and community-based care.

One of my favourite CYC book titles is a little known and almost impossible to find text published by FICE-International in about 1984-85. (I find it terribly annoying when books and reports are undated.) It is actually the sub-title I love – Living with Others as a Profession (Courtioux, Jones, Kalcher, Steinhauser, Tuggener & Waaldijk, undated). To my mind, one of the great strengths of the *SJRCC* as an evolving, organic entity is the pervasive sense throughout the pages of a vital life force at work, and at play. The authors seem to really love living and working with others, holistically, whatever their particular roles might be. In many cases, their sense of passion seems to sing from the pages. And that is a beautiful and somewhat rare thing to find so consistently in a formal journal that also appeals to academic researchers.

The second most common theme across the years was 'international.' This theme is comprised of national accounts from places such as India, Africa, Asia, Australia and North America, practice and policy-related articles by international authors, as well as attempts to formulate global perspectives and understandings.

In a virtual dead heat for the bronze medal are 'education', 'transitions and leaving care' and 'historical reflections.' **I expect the term 'education' covers many forms of learning, teaching, mentoring and pedagogy – all key dimensions of a vibrant professional field. The notions of 'transitions and leaving care' speak** not only to young people moving out of the system, but also to the fluid, lava-lamp nature of modern life, with each of us highly conscious that we are on a journey, morphing, sometimes moving away from things, sometimes moving towards things, and sometimes just wandering. But we need to remember that 'not all who wander are lost' (J.R.R. Tolkien in *Fellowship of the Ring*). All journeying is purposive even if it takes us a lifetime to discern the pattern.

And the many 'historical reflections' interspersed throughout the journal issues keep us aware of the enduring wisdom to be found in the writings of those who understood even 200 years ago the need for a new profession grounded in the realities of residential childcare. Indeed Larry Brendtro and I contributed an article to the *SJRCC* on the importance of a profession knowing and valuing its history in order to find a good way forward (Anglin & Brendtro, 2017).

And the book reviews. I expect many of you love books as I do. I have realised with the push toward a 'paperless society' how much I am in love with paper. When I spent a year doing research and writing in Oxford, England, I could not **go a week without entering Blackwell's bookshop or one of the many used-book stores in the town.** I had to go and 'rub up against the stacks', so to speak, like a cat against the pant leg of its master. Now I have learned also to enjoy the electronic access to material and I do not lament that most journals are no longer in print form. Saving trees while also increasing access for all are important as we strive for equity and environmental sustainability.

At one point, I wondered in an email to Craig and Gemma if they would be able to consider mapping the over 100 themes they had identified on to the set of **'threshold concepts' produced in Laura Steckley's fascinating work** (Steckley, 2013, 2020a, 2020b), but time did not allow for this. Just perusing the two sets of themes and concepts, I realised this might be a challenging task, and my impression was it might not even be a fruitful one. Perhaps some braver soul might give that a try at some later date.

The astute reader of the *SJRCC* may have noticed that although the year 2012 appears in the website access tabs for issues and articles, there were actually no issues published that year. Graham explained that this was the year CELCIS was formed, and the press of start-up activities and organisational changes meant the journal had to hit the pause button until the first issue of 2013 could be assembled and published. But in other years, we have been able to eagerly anticipate and enjoy two or three issues filled with some of the most recent and ground-breaking **ideas in the children's services field**.

To everyone who has been even a small part of creating and maintaining this unique and valuable journal, I say on behalf of all your readers, 'Well done, and thank you.' Scotland continues to lead the CYC world in so many ways, but especially with helping us to understand the need to put love at the heart of everything we do with families and young people.

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About the author

Dr Jim Anglin began his career as a front-line child and youth care counsellor in 1970, working in a mental health centre and then as coordinator of a

community-based group home for adolescents before becoming involved in **social policy development, children's services design and management, and** education, research and training. He is Emeritus Professor and a former Director in the School of Child and Youth Care at the University of Victoria, BC, Canada, is a keen amateur historian of the child and youth care profession, and is a Research Affiliate of the Residential Child Care Project, Bronfenbrenner Centre for Translational Research at Cornell University. He is the author of *Pain, Normality and the Struggle for Congruence: Reinterpreting Residential Care for Children and Youth* (Routledge, 2002) and coordinating editor of *Perspectives in Professional Child and Youth Care* (Haworth, 1990).

Celebrating 20 residential childcare developments from across the world

Iain Matheson

Abstract

This issue celebrates the 20th anniversary of the Scottish Journal of Residential Child Care. While the journal has a very important place in residential childcare in Scotland, its readership and contributors are now increasingly global. As my way of marking this anniversary, and reflecting back, in this article I discuss 19 other residential childcare developments over the last 20 years from across the world. These include developments in policy, practice and research, the establishment of new professional organisations, programmes and services, and some new professional development and learning opportunities. Personal, subjective and, no doubt, eclectic, these developments and others, both large and small, are also worth celebrating. In most countries, the last three years or so have been tough for residential childcare. However, as we look forward to the next 20 years of the journal and the future of residential childcare more broadly, **let's also recognise, acknowledge and celebrate these and other collective** achievements and strengths.

Keywords

Celebrate, residential, world, developments

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Introduction

This issue celebrates the 20th anniversary of the *Scottish Journal of Residential Child Care*. I would still have been living in Scotland when the journal was **launched. Working at Aberdeenshire Council's headquarters in the** Northeast of Scotland, fresh copies probably came to me in a box for distribution. As I recall, the box was expected. However, while there may have been a launch party in **Glasgow, there wasn't much fanfare in Aberdeen** – back then no launch video, no webinar, and no announcement on Twitter. As an ex-residential childcare worker I was certainly intrigued, and particularly so as one of the articles had **been written by a former colleague. However, I'm not sure that back then I** knew quite what to make of it. As it happens, this year is also a 20-year anniversary for me and my family. It is 20 years since we left Aberdeen airport on a flight to London Heathrow, and then others to Los Angeles, Fiji and Auckland, to start a new life in New Zealand. A new adventure for us all and one that would for the next two years also take me back to residential childcare – this time in a national leadership role. As such, writing this is conjuring up many personal as well as professional reflections.

The journal has a very important place in residential childcare in Scotland, but its readership and contributors are now increasingly global. As my way of marking this anniversary and celebrating quality residential childcare, in this article I discuss 19 other residential childcare developments over the last 20 years from across the world, and in particular Europe, North American and Oceania. These include developments in policy, practice and research, the establishment of new organisations, education programmes and services, professional development and learning opportunities. My selections are personal, subjective and, no doubt, eclectic. However, these developments and others, both large and small, are also worth celebrating.

Developments in policy, practice and research

Guidelines for the Alternative Care of Children (International)

The rights conferred on all children under the United Nations Convention on the Rights of the Child (UNCROC) are particularly important for those in residential and foster care. **Furthermore article 20 specifically concerns “the right to special protection and support for children who cannot live with their parents”**, while article 25 also relates to children placed away from home and provides children and young people with the right to have their circumstances regularly reviewed.

Beyond these individual rights, there is also now greater recognition that under UNCROC signatories have a number of broader responsibilities towards those in state care and care leavers (Munro et al., 2011), arising from the 2010 *Guidelines for the Alternative Care of Children* (United Nations General Assembly, 2010). Many or most of the 167 sections are applicable to residential childcare, and sections 123-127 specifically outline the following requirements:

123: Small family-like residential provision and purposeful placements.

124: Separate residential provision for children solely in need of protection, from those involved with the youth justice system.

125: Rigorous screening procedures to avoid unnecessary admissions into residential care.

126: Residential facilities are sufficiently staffed with those able to provide individual, relationship-based, purposeful and safe care.

127: The recruitment and solicitation of children for placement in residential care should be prohibited.

From my perspective the 2010 guidelines were a particularly welcome development. However, not all jurisdictions that I am familiar with yet sufficiently comply with all these requirements.

Consensus Statement of the International Work Group on Therapeutic Residential Care (International)

Established in April 2016, the International Work Group on Therapeutic Residential Care (TRC Work Group) is 'a small invitational association of international researchers, scholars and practitioners dedicated to the continuous improvement of high quality therapeutic residential services through research, cross-national dialogue and dissemination of evidence-based information' (TRC Work Group, n.d., para 1). Their Consensus Statement takes the form of a journal article (Whittaker et al., 2016) in *Residential Treatment for Children and Youth*, and various other publications.

The following definition of therapeutic residential care has been adopted:

Therapeutic residential care involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection to children and youth with identified mental health or behavioral needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources (Whittaker et al., 2014, p. 24).

The Consensus Statement also includes the following five underpinning principles:

1. First, do no harm.
2. Grow partnerships between families and professionals.
3. Get grounded in communities, cultures, and social relationships.
4. Develop a culture that recognises the centrality of deeply personal human relationships.
5. Build evidence-based models or strategies that are effective, replicable, and scalable (Whittaker et al., 2016).

The resulting article was co-authored by 32 founding members from across 16 different countries. It has been translated into Dutch, Spanish, Italian, Hebrew

and Japanese, disseminated through a range of appropriate journals, and endorsed by key international professional bodies (TRC Work Group, n.d.).

Young People from a Public care background: Pathways to Education in Europe project (Denmark, England, Hungary, Spain, and Sweden)

Led by Sonia Jackson at the University of London Institute of Education, the *Young People from a Public care background: Pathways to Education in Europe* (YiPPEE) project was a large multi-national research project (Jackson & Cameron, 2014). With a research team in each of the five countries, this major multi-phased project sought to explore the educational circumstances of young people in care and formerly in care, and to identify how more young people with a care background could be encouraged to remain at school longer and then enabled to access tertiary education.

In the final report, 16 recommendations were made as to how the education of young people in care, and the transition to tertiary education in particular, could be improved. These included:

- governments collecting and publishing more reliable information on the education of children in care;
- social work agencies giving education much more attention in relation to those in care and formerly in care;
- education organisations providing individual tuition and mentoring support to compensate for gaps in schooling; and
- encouraging children and young people to defer entry into the labour market for as long as possible.

Reduced use of large isolated secure facilities

Over recent years, the use of large secure facilities located in isolated rural areas has fallen in many countries, and in some Anglo-American jurisdictions in particular. As such, the numbers of children in secure care in these jurisdictions has fallen, and with some exceptions, residential facilities have become smaller

and located closer to where children ordinarily live (Matheson, in press). In North America in relation to youth justice, while not new, the Missouri Model of Juvenile Rehabilitation continues to be very influential. For example, in New York City, the Taskforce on Transforming Juvenile Justice (2009) found that the previous youth justice system was harming children, wasting money, and endangering the public; The Missouri Model approach and principles are reflected in **New York State's Close to Home initiative (Annie E. Casey Foundation, 2010)**. In non-Anglo-American countries the use of any secure provision appears to be highly variable e.g., Norway has eight secure youth justice beds for the entire country.

The Promise

In my time I've read a lot of review reports on residential and foster care.

However, February 2020 saw the publication of what I would consider to be the most audacious of them all – the seven Scottish *Independent Care Review* reports (2020). The review argues that Scotland needs to:

- acknowledge the lasting pain that removal has caused many children, families and communities;
- fundamentally re-think why, when and how children are removed from their families;
- develop more holistic support for families, spanning both universal services and intensive long-term family support provision, so that far fewer children need to come into care in the first place;
- have the compelling international evidence on poor average outcomes for children in care to-date front-of-mind, and ensure that outcomes are actually improved;
- stop tolerating poor quality care, and redesign for the future;
- **reconceptualise 'care', both in terms of policy and practice, to be caring** through relationships with carers and workers, siblings, family, friends and other supportive networks;

- **also reconceptualise the very notion of ‘professional relationships’; carers and workers must be encouraged ‘not to step back but to step in’;**
- while recognising that qualifications and training continue to be important, place much more emphasis on recruiting people with the right ethos and qualities in the first place;
- ensure that organisational systems and processes fit around children and their families, and not the other way round;
- plan for the majority of current crisis services to in time become obsolete; and
- really listen to children and meaningfully and appropriately involve them in decisions about what they need and want.

Given the timing coincided with COVID it **didn’t get much international attention** then or since. However, for those of us outside of Scotland, in my view its implementation is one to watch.

Growing debate about physical restraint (international)

Over recent years, in Anglo-American jurisdictions in particular, there has been growing debate, both in and outside of the profession, about the place of physical restraint in contemporary residential provision. Despite an absence of international comparative research on this topic, there has nonetheless been an increase in individual studies (Matheson, in press-b).

In Scotland, the Scottish Physical Restraint Action Group (SPRAG) formed out of presentations, conversations and a collective concern at recent Scottish Institute of Residential Child Care conferences. SPRAG is specifically focused on residential childcare organisations and practitioners; this national initiative concentrates on reducing the use of physical restraint (Centre of Excellence for **Children’s Care and Protection**, n.d.). In a similar vein in the US, earlier this year, the **National Association of Children’s Residential and Community Services** (2022) held an event entitled *Relationships First: Committing to the Reduction and Elimination of Restraints* and has committed to hosting a series of follow-up events.

National apologies and professional humility and empathy (international)

A very long time coming, over recent years we have seen a number of historical apologies being issued to those abused and neglected as children in various forms of residential and foster care. Across Anglo-American countries these include:

- The Australian Prime Minister's apology to 'forgotten Australians' and former 'migrant children' (Rudd, 2009).
- The UK Prime Minister's apology to former 'child migrants' (Brown, 2010).
- The Pope's apology for the 'evil' that was perpetrated towards Indigenous children in many of its Canadian residential schools (Winfield & Gillies, 2022).
- The Irish Taoiseach and the Catholic primate of All Ireland apologies for the mother and baby homes that abused and shamed unmarried mothers and their children (Carroll, 2021).
- The New Zealand Public Service Commissioner's apology to survivors at the Royal Commission of Inquiry into Abuse in Care (Tahana & Olley, 2022).

While such apologies are often too late for many or most of those affected, and not necessarily something to celebrate per se, they can be very meaningful for victims and their families. Such events are also part of our professional history, and a prism through which we, residential childcare providers, and power, are still seen today.

Establishment of new professional organisations

International Research Network on Transitions to Adulthood from Care (international)

The International Research Network on Transitions to Adulthood from Care (INTRAC) is an international community of researchers who work together to promote national and international research on transitioning from care. Formed

in 2003 by bringing together a small group of researchers from Europe, the Middle East, Australia, Canada and the US, it was inspired by a belief that a better understanding of transitioning from care had the potential to contribute towards better outcomes for this group (Stein, 2016). Outputs have included three major books on the topic, with contributions from members and others, from around the world (i.e., Mann-Feder & Goyette, 2019; Mendes & Snow, 2016; Stein & Munro, 2008). Now a larger global organisation, as well as three thematic interest groups on disability, higher education, and care leavers as parents, three independent researcher networks are also affiliated to INTRAC as regional chapters i.e. the African Network of Care-leaving Researchers, the UK-Ireland INTRAC Research Network, and the Nordic Research Network on Care Leavers.

Website: <https://globalintrac.com/>

National Therapeutic Residential Care Alliance (Australia)

The National Therapeutic Residential Care Alliance is an Australian collaborative network of non-government residential childcare provider organisations, researchers and other supporters, who develop, share and promote best practices, and advocate for quality residential provision. Recognising that therapeutic residential care models were developing concurrently across Australia, it started in 2012, 'when a group of like-minded colleagues working across States and Territories of Australia opened a discussion about the possibilities of working together to share our collective wisdom and knowledge about best practice in therapeutic residential care for high risk young people' (Bristow, 2018, para. 4). The network provides and supports advocacy, research, workforce development and cross-jurisdiction engagement. Its stated mission is: 'To ensure residential care is a valued element of out of home care, where children and young people feel safe, heal, and reach their full potential' (National Therapeutic Residential Care Alliance, 2021). Outputs have included a number of research reports and articles undertaken by or for the Network or its member organisations (e.g., McLean, 2018; McNamara & McLean, 2017).

Website: <https://ntrca.com.au>

National Network for the Education of Care Leavers (England)

The National Network for the Education of Care Leavers (NNECL) is a community of education and other professionals working together for care experienced people. The aim of NNECL is to transform the opportunities available to care leavers by championing continuous improvement of local practice, multi-agency partnerships and national collaboration. It does this by celebrating and sharing effective practice; advocating with policymakers and other sector organisations in higher and further education; commissioning and disseminating research; providing training, events and guidance materials; and working collaboratively with other relevant charities and sector organisations. One major new initiative has been the development of the NNECL Quality Mark to support further and higher education organisations to achieve the best outcomes for their care experienced students. It builds on the legacy of an earlier quality mark developed by the Buttle UK charity.

Website: <https://www.nnecl.org/>

VOYCE – Whakarongo Mai (New Zealand)

The New Zealand organisation VOYCE – Whakarongo Mai, connects children and young people who have been or are in care, and promotes their individual and **collective voice on the care system. VOYCE stands for 'Voice of the Young and Care Experienced'; Whakarongo Mai is from the Māori language and translates as 'Listen to me'. A long time coming, the establishment of VOYCE in 2017, was a partnership between young people, government, and the philanthropic and non-government sectors, and addressed a major gap in the New Zealand child welfare system (Matheson, 2016). Whether focused on connection and voice, and/or adult advocacy, most Anglo-American jurisdictions in particular have had some form of organisation for children in care in place for years, if not decades; for example, the CREATE Foundation in neighbouring Australia was established in 1993, while Who Cares Scotland? was founded in 1978. With staff across several New Zealand cities, VOYCE also runs local events and experiences. VOYCE is co-funded by government and philanthropy partners.**

Website: <https://voyce.org.nz>

Development of new programmes and services

Transitioning from care developments (international)

A few years ago, when I wrote in my first ever book chapter, I stated that in New Zealand, unlike most other Anglo-American jurisdictions, we effectively had no statutory transitioning from care provision (Matheson, 2016); in contrast Scotland has as I recall had transitioning from care legal duties in place since **1968. Recently we've seen major transitioning from care developments.** In the US, states now have the option to provide accommodation and support for those transitioning from care, with a lot of attention being paid to the CalYOUTH research (Courtney et al., 2020) in California. There have been major developments in other Anglo-American jurisdictions too, for example Victoria Australia and indeed New Zealand, as well as in some other European countries.

A recent key policy and practice focus across many jurisdictions has been extended foster care; this is where young people could be supported to remain with their foster carer beyond the age of 18 and potentially up until the age of 21. In England, a residential variant has emerged that complements their extended foster care programme *Staying Put*. The *Staying Close* programme model (Department for Education, 2022) offers stable move-on accommodation to young people at the age of 18, alongside practical and emotional support **provided by a member of staff from their former children's home or someone else who they know and trust.** Piloted since 2017-18, the programme is now being expanded.

Virtual School Heads (England)

The English Virtual School Heads initiative for children in residential and foster care, was piloted back in 2007-09 across 11 local authorities, evaluated, and subsequently rolled out across all of England. Virtual School Heads are usually senior roles – often former primary or secondary Principals or Deputy Principals. Straddling care and education, they essentially champion and oversee, influence, direct, plan and monitor. They may also provide support and advice to schools and those in residential and foster care. These are also statutory roles. The

English Children and Families Act 2014 requires local authorities in England to **appoint at least one person for the purpose of discharging the local authority's** duty to promote the educational achievement of its looked after children. As such, and usually with little or no additional staffing under their direct control, they complement the role of traditional school heads and senior staff. While not a statutory role, the four LOOKOUT education support centres in Victoria are based on this Virtual School Heads model.

National Association of Virtual School Heads website <https://navsh.org.uk>

Raising Expectations (Australia)

Launched in 2015 the Raising Expectations programme in Victoria is currently supporting approximately 700 care experienced further and higher education students (Victoria Department of Education and Training, 2022). Established with a three-year philanthropic grant, and now funded by the Victorian Department of Education and Training, Raising Expectations is a Victorian cross-sectoral collaboration between the Centre for Excellence in Child and Family **Welfare (Victoria's peak body for Child and Family Services)**, La Trobe University and Federation University Australia. Swinburne University of Technology joined the collaboration in late 2019. Notably, Federation University Australia and Swinburne University of Technology are **two of Australia's six dual**-sector universities i.e. they provide further education vocational courses alongside higher education university courses.

Raising Expectations aims to increase the number of care experienced young people going on to tertiary education by:

- lifting the educational aspirations and expectations of and for young people in care;
- improving the knowledge and skills of carers and professionals to better support the educational needs of young people in care and after care;
- implementing awareness-raising programmes and outreach services for students, carers, educators and other professionals to encourage participation in tertiary education; and

- providing wraparound support at university.

Individually, the three universities may also offer scholarships that are specific to care experienced young people.

Website: <https://www.raisingexpectations.com.au>

Propel website (UK)

The Propel website is developed and maintained by Become (formerly The Who Cares? Trust), the English charity and advocacy organisation for children in care and young care leavers. Propel is a fully searchable website providing children in care and care leavers with comprehensive information on the support available to them from colleges and universities offering higher (undergraduate or postgraduate) education courses. Young people considering applying for a higher education course at college or university – and the professionals supporting them – **can access information about each institution's pastoral and financial** provision for care leavers including:

- whether year-round accommodation is available
- what bursaries and grants are on offer
- what help and support care leavers can expect, and
- who they should get in touch with at each institution.

Most UK colleges and universities, including prestigious traditional research-intensive universities, have chosen to be featured on the website. Propel has been independently evaluated by the University of Northampton (Alexander & Callaghan, 2017). Furthermore, care leavers are recognised as a priority group by the Office for Students, the independent regulator of higher education in England. The Office for Students expects all organisations to provide support to care leavers across all access, retention and progression activities.

Website: <https://propel.org.uk>

Professional development and learning

A better qualified workforce (international)

Increasingly jurisdictions and organisations are requiring their residential childcare workers to hold an academic and/or professional qualification. This is particularly the case in Europe, where for example:

- Finland: Half of any residential care team must have a degree in either social services or health care (James et al., 2021).
- Germany: Most Social Educators (residential care workers) have a Social Work degree, Social Pedagogy degree, or another vocational degree (James et al., 2021).
- Italy: Residential care workers require a degree in Educational Sciences. Continuing education and supervision are mandatory in many regions, and **a new residential care Master's programme was established at Milano Bicocca University in 2020** (James et al., 2021).
- Lithuania: Guardianship teams are comprised of residential care workers with a degree in social work (James et al., 2021).
- Scotland: Residential childcare workers need to be registered with the Scottish Social Services Council; they require both a practice qualification and a knowledge qualification (Scottish Social Services Council, 2022).
- Spain: A degree qualification is required to be a Social Educator (Residential Care Worker) (Matheson, in press-a).

Evidence-based practices

When discussing residential childcare with US and European colleagues I generally find that those from the US frame this around evidence-based programmes, aka Manualised Evidence-supported Treatments (MEST), while those from Europe prefer to frame residential childcare around practice. I love a good quality evidence-based program, and with some I am in awe of the quality of the design thinking, the translation of this into clear systems and processes, and the centrality of research, monitoring and quality assurance. However, I come from the Scottish practice tradition, and in New Zealand we often find that programmes deemed to be evidence-based elsewhere, tend not to *transplant* here particularly well. However, a middle path has emerged in recent years – Empirically Supported Practices (ESPs), aka Evidence-Based Practices, Common Elements, Common Factors or Kernels approach. In the book *From Evidence to Outcomes and Child Welfare*, Mildon et al. (2014, define ESPs as:

effective skills, techniques, and strategies that can be used by an individual practitioner. Such practices describe core intervention components that have been shown to reliably produce desirable effects and can be used individually or in combination to form more complex procedures or programs (p.87).

As well as providing a middle path in relation to being evidence-informed, ESPs can also offer one in relation to the training and professional development of both qualified and unqualified staff.

Residential child and youth care in a developing world (international)

Published by CYC-Net Press, this edited series of four volumes on residential childcare, is in my view an amazing resource. There are other excellent edited books with contributors from different countries on residential childcare (e.g., Courtney & Iwaniec; 2009; Whittaker et al., 2015). While I am maybe a little biased as the editors Leo Fulcher and Tuhinul Islam invited me to write the New

Zealand chapter (Matheson, 2016) I just love the audacity of its much wider range of authors and countries. The four volumes are as follows:

1. Global perspectives (Islam & Fulcher, 2016)
2. European perspectives (Islam & Fulcher, 2017)
3. Middle East and Asia perspectives (Islam & Fulcher, 2018)
4. African perspectives (Islam & Fulcher, 2021).

Easier access to residential childcare reports, books and articles (international)

On my social worker qualifying course in the 1980s at the (now) University of the West of Scotland, the focus was very much on the role of the generic social worker. As far as I can remember we did not really study residential childcare, and certainly no specific residential childcare theories or practice frameworks. I would have graduated and been working in England before I read my first book on the residential care of children: *The Hour of the Wolf and other Short Stories* by Phil Carradice (1985). My first real exposure to residential childcare theory would have been in my third residential role, by now in the Northeast of Scotland – Fritz Redl and his life space interview were regularly discussed in supervision.

However, over the last 20 years there has been an explosion in the availability of, and access to, residential childcare reports, books and articles (and now webinars, online training courses, podcasts and blogs too). *The Scottish Journal of Residential Child Care* has been free and open access since 2011. Today reports are freely available to all, and, with the exception of many academic textbooks, most other books can easily be bought as eBooks. Additionally, despite so many other journals being hidden behind the paywalls of only five international conglomerates, with some effort and creativity residential childcare professionals who are not studying can now access almost as many journal articles as their studying colleagues.

Conclusion

So, there you have it; my personal selection of another 19 developments in residential childcare from the last 20 **years' worth** celebrating. In most countries, the last three years or so have been tough for residential childcare. However, as we look forward to the next 20 years of the journal, and the future of residential **childcare more broadly, let's recognise, acknowledge and celebrate these and** other collective achievements and strengths. I wonder how these, and other new developments, will fare over the next 20 years, and who will be the existing, emerging, and future professional or care experienced leaders to take them forward.

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About the author

Dr Iain Matheson is Director of the New Zealand-based Research Centre for Better Outcomes from Fostering and Residential Care. His 2015 doctorate was on the education of care leavers. A social worker by background, Iain first worked in residential care practice before moving into management, including **the New Zealand government's national leadership role for residential and foster care**. He now helps organisations in New Zealand and internationally, to generate and use evidence and learning on statutory care and its alternatives.

As well as research and consultancy, Iain mentors leaders and teams, facilitates groups, and delivers training workshops and events.

A brief history of secure care in Scotland

Charlotte Wilson

Abstract

In undertaking a doctoral research project looking at the impact of Scottish secure care experience on the identity constructions of autistic young people, I began by carrying out an extensive literature review. This was to inform the research, by understanding what was already known about this topic, and where the gaps were. The literature review covered a number of areas, one of these being the history of secure care. To align with the theme of this special issue considering historical perspectives, the findings of this section of the literature review will be presented here. The paper begins by defining secure care, and the numbers of children this is relevant for. It provides a very brief summary of the history of residential childcare, before moving on to consider in some detail the main policy drivers which have influenced the direction of travel in secure care over the years. The paper concludes by suggesting future considerations for research.

Keywords

Secure care, history, literature review, policy, Scotland

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Introduction

'Looked after children' are defined in the Children (Scotland) Act 1995 as those in the care of their local authority. **Children's Social Work Statistics 2019-2020** (Scottish Government, 2021) show that 14,458 children were looked after on 31 July 2020, which is a 1% increase on the previous year (Scottish Government, 2020a). Around 10% (1436) of these young people were looked after in residential care, with an average of 82 young people in secure care accommodation. Secure care is defined as a service which provides accommodation for the purpose of restricting the liberty of children in residential premises where care services are provided. It is approved by Scottish Ministers for that purpose (Public Services Reform [Scotland] Act, 2010). Secure care is a branch of residential childcare that provides a safe, containing, highly controlled environment through restricting the freedom of children and young people. This is due to the high risk of significant harm they present to themselves or others (Children **and Young People's Centre for Justice** [CYCJ], 2018; Scottish Government, 2018). Emond et al. (2016) define a containing environment as being made up of not only of the physical environment, but also relationships, expectations, rhythms, routines, and responses. This is a concept I explore throughout my thesis.

There are currently five secure care units in Scotland (Care Inspectorate, 2022) with a total of 84 places between them (plus four emergency beds). Due to the restrictions on liberty, young people can only be placed in secure care in very specific circumstances, as defined in The Secure Accommodation (Scotland) Regulations 2013. It must be established both that the placement is in the **young person's best interests, and that the secure unit is able to meet their** needs as determined by their aims and objectives. Additionally, one or more of the following conditions must be met:

- (a) that the child has previously absconded and is likely to abscond again **and, if the child were to abscond, it is likely that the child's physical,** mental or moral welfare would be at risk,
- (b) that the child is likely to engage in self-harming conduct,

(c) that the child is likely to cause injury to another person (The Secure Accommodation [Scotland] Regulations 2013, regulation 8[1][3]).

These conditions are reiterated by Sections 83(6), 87(4) and 88(3) of the **Children's Hearings (Scotland) Act 2011** with respect to a **Children's Hearing** authorising the use of secure accommodation. The conditions offer clarity in understanding that secure care does not exist as a prison for young people who have been involved in criminality, which may be how it has been constructed by society (Gough & Lightowler, 2018). This is largely understandable when considered in the context of secure units having a discourse of control, as by their very nature they **restrict young people's liberty. This could be construed as** young people lacking in self-control and needing adults to provide that control for them, which reinforces perceptions of youth as dangerous and out of control and informs the justice agenda (Smith, 2009).

Residential childcare context

Throughout history, referrals to residential childcare have been influenced by the four major state service delivery systems. The lenses of education, health care, welfare and justice have been used to inform **young people's pathways**. With autistic people being viewed through a medical lens, support has been provided primarily through the health care system. This led to confinement in a variety of institutions such as asylums, locked hospital wards, and forensic units (Gormley, 2021). However, within the latter half of the 20th century there has been increasing recognition of disability as a social issue, with corresponding responses to this reflected in policy decisions (Shah & Priestley, 2011). Neurodiversity has many parallels with the trajectory of residential childcare, with a steadily increasing focus on human rights and deinstitutionalisation. This resulted in a 93% decrease in residential provision between 1976 and 2002 (Emerson, 2004).

The Curtis report (Care of Children Committee, 1946) and Scottish equivalent the Clyde report (Committee on Homeless Children, etc., 1946) criticised large institutions and recommended that care be provided in smaller establishments. **Goffman's (1961) findings on institutionalisation in 1000-bed secure psychiatric**

settings also played a part in the shifting narrative, although his work has often been used out of context (Crimmens & Milligan, 2005). The developing historical abuse discourse of residential childcare following public scandals such as the **'Pindown Inquiry' (Levy & Kahan, 1990), and subsequently** the Utting (1991) and Skinner (1992) reports, resulted in a decline in the use of residential care more widely than just for children with disabilities (Skinner, 1992; Milligan & Stevens, 2006; Smith, 2009). This was further impacted by concerns about cost (Crimmens & Milligan, 2005; Milligan & Stevens, 2006). As Rose (2002, p.18) describes:

There have been a number of serious consequences arising from the persistent and critical attacks on residential care over recent years. In general terms the significantly reduced number of residential homes for young people, and in **recent years the decrease in the number of secure children's homes, has meant** that there is now a limited choice of placements available for young people who, for whatever reason, cannot live at home with their natural family.

An increasing focus on the quality of outcomes for young people has resulted in critics alleging that residential childcare is failing young people, citing examples of poorly resourced large institutions (Francis et al., 2007). As this narrative has played out, residential childcare has become viewed as the last resort for looked after children (McPheat et al., 2007). Foster care became the placement of **choice due to interpretations of Bowlby's (1969) attachment theory and** associated notions of permanence. The Independent Care Review (2020) was a **three year 'root and branch' review of Scotland's care system which consulted** with over 5500 people. It further reinforced this view by repeatedly referring to the importance of family placements. However, it does go some way towards mitigating **this by accounting for young people's voices**, advising that residential care can be the right placement for some young people. Somewhat ironically, inappropriately placing children in foster care can lead to multiple placement breakdowns, decreasing a sense of permanence (Smith, 2009). This can mean **children 'fail their way' into residential childcare** (Whittaker et al., 2015) with additional significant disruptions to their development and attachment.

Secure care context

Secure care however is always considered a last resort due to the restrictions on **young people's liberty**. The conditions set out in The Secure Accommodation (Scotland) Regulations 2013 must be met for the placement to be approved. Whilst necessary, it could be argued that **the language of 'last resort' has an unhelpful impact on young people's lived experience**. They may believe they **have reached 'the end of the road,' with this rhetoric subsequently becoming a self-fulfilling prophecy**. Smith (2009) advises that the steady increase in the use of secure placements since the 1970s is in inverse proportion to the decrease in **'open beds.'** This is reflected in the **Children's Social Work Statistics 2018-2019** (Scottish Government, 2020a) which show a 5% reduction in looked after children from the previous year, and the seventh consecutive year of decrease. The number of young people looked after in secure care accommodation (79), whilst one less than the previous year, was still an 18% increase for Scottish young people than the previous year. Additionally, the average number of young people placed in secure care accommodation during 2017-18 was 81, which was an increase from 76 during the previous year. In 2019-20 this increased further to an average of 82 young people (Scottish Government, 2021).

Smith (2009) argues that rather than being in response to a rise in demand, the growth in the use of secure accommodation has actually generated the demand. This means **limited resources are focused on the 'wrong end' of the childcare spectrum**. In the paper by Francis et al., (2007) comparing the provision of residential childcare in Scotland and Finland, it is noted that Finland does not provide any secure accommodation services (although in two of their residential units they have a provision for locked rooms). This is despite Finland having significantly higher numbers of residential childcare placements (2.5 times more children placed at any one time than Scotland) and offering placements to more **children under the age of 12 (35% to Scotland's 7%)**. Although direct comparison between different countries and cultures is difficult, it could be surmised that the increased residential childcare provision may have a consequential impact on the decreased need for secure accommodation placements.

Unfortunately, the discourse of last resort around residential childcare has had wide reaching implications, with subsequent impact on policy development and morale in the sector (Smith, 2009). Smith (2009) advises that this makes it all the more difficult for these services to achieve positive outcomes for young **people and to effectively manage young people's behaviours in the context of** the current justice agenda. Barclay and Hunter (2008) suggest that rather than **locating problems with children's behaviour within young people's identities,** these should be seen through deficiencies in the welfare system. As explained by Smith (2009, p.57) '**children's homes that are badly managed, poorly resourced or inadequately supported are likely to fuel demand to lock up young people.**'

The 2019 Scottish Secure Care Census (CYCJ, 2019) raw data shows that for 65% of young people living in secure accommodation their previous placement was a residential childcare one. This could be construed as the care system failing young people (Independent Care Review, 2020) or as a reflection of the level of adverse life experiences young people making their way into secure care have encountered. It could also be related to the closer level of monitoring assigned to young people living in care than those living at home (e.g. in relation to drug taking or going missing), as described by Haydon (2018). This is supported by the Independent Care Review (2020) which asserts that care experienced young people are overrepresented in the criminal justice system. However, it advises that 'there is no evidence that care experienced children engage in more offending behaviour than their peers, but the consequences of their behaviour whilst in care are much more likely to result in criminalisation' (Independent Care Review, 2020, p.91). Similar assertions have been made by Gormley (2021) regarding people with learning disabilities, due to the enhanced monitoring of their lives often framed as safeguarding.

Secure care history

There is a limited choice of placements available in the residential childcare sector more widely (Rose, 2002), and austerity has further impacted on this since he published this view. However, it appears that the availability of secure placements in Scotland at least is strongly based on evidence and regular review. To understand the secure estate today, it is necessary for us to explore

the history which has influenced developments in the sector over time. The five secure units in existence today appear largely to have started out life as reformatories or orphan asylums which reflects their purpose at the time (for example, Kibble Reformatory for Boys, Rossie Reformatory for Boys, and **St Mary's Roman Catholic Orphanage and Industrial School for Boys**). Over time these services became more justice-oriented; becoming Industrial Schools, Approved Schools in 1937 (Gough & Lightowler, 2018), and finally List D Schools **following the 1968 Social Work Act (Children's Homes, 2019)**. **Seven secure** facilities opened between 1962 – 2007, five of which are still current provision (see table 1 which I have created below).

Date opened	Name of service	Location	Current number of beds	Date closed
1962	Rossie Secure Accommodation Services	Montrose	18	N/A
1976	St Mary's Kenmure	Bishopbriggs	24	N/A
1983	Kerelaw Residential School (secure unit)	N/A	N/A	2006
1984	Edinburgh Secure Services	Howdenhall	6	N/A
2005	St Philip's Secure Unit	N/A	N/A	2011
2006	Good Shepherd Centre Secure Unit	Bishopton	18	N/A
2007	Kibble Safe Centre	Paisley	18	N/A

Table 1: Scottish secure accommodation service details

I have designed the timeline below (figure 1) to give an overview of the main policy developments in the secure estate since the 1960s, which will be followed by analysis.



Figure 1: Timeline of developments in secure policy

The 1968 Social Work Act was developed following the 1964 report of the **Committee chaired by Lord Kilbrandon. The resulting 'Kilbrandon principles' instigated revolutionary changes to Scotland's welfare and justice systems.** This informed the routes of referral to List D and List G Schools, and later led to the **Children's Hearings System being established in 1971 (Gough & Lightowler, 2018).** An advancing awareness of children's rights in the 1980s resulted in the **release of 'The Code of Practice: The Use of Secure Accommodation for Children'** in 1985 (Social Work Services Group, as cited by the Scottish Institute for Residential Child Care [SIRCC], 2009). Following this, secure care in Scotland has been reviewed several times over the years in response to changing **perceptions and policy directions. In the White Paper 'Scotland's Children' (The Scottish Office, 1993)** it was noted that over the past ten years significant changes had occurred in the secure estate which resulted in the Government calling for a review of secure accommodation. This review was published in the **report 'A Secure Remedy' (Social Work Services Inspectorate for Scotland, 1996)** which noted that at that point in time there were seven units in Scotland registered to provide 89 secure care places, but that since 1994 there had been evidence that there had not been enough places available. Due to the justice focus at that point this report centred around the criminality of young people.

The 1999 report of the National Planning Group for the care and education services for young people with behavioural problems which include offending (Skinner, as cited by Scottish Government, 2001) also focused on the criminality of young people. The Secure Accommodation Advisory Group was set up following this to develop a more strategic approach to the use of secure care **(Scottish Government, 2001).** **'The need for secure accommodation in Scotland,'** an addendum to the interim report, was published at the same time. This led to significant investment in the sector, increasing the number of secure beds by 30% and improving geographical spread and specialist provision, based on perceived need at that time (SIRCC, 2009).

In 2006, 'Secure Accommodation in Scotland: its role and relationship with "alternative" services' (Walker et al., 2006) was published as the result of research carried out into the use and effectiveness of secure care. It details characteristics of the young people, but there is no mention of disability. This is

interesting when considered alongside the publication of the practice guidance **'Secure in the Knowledge,'** from SIRCC in the previous year, in which Stevens (2005) wrote about the issues surrounding young people with learning disabilities and autism who were accommodated in secure settings. It can be surmised that as a minority group, the experiences of autistic young people and those with learning disabilities were overlooked in the review and development **of the secure estate, for example with the absence from 'specialist provision'** noted above.

The **'Securing Our Future Initiative' (SOFI) (SIRCC, 2009)** was commissioned as part of the National Residential Childcare Initiative (NRCCI, 2009) to comprehensively review the secure estate. At this point there were still seven secure units, now with a total of 124 places between them. SOFI noted that the average number of young people resident in secure care had been largely around 102 since 1999, and that this had not changed with the increased provision described above. Therefore, there was to be a planned reduction to 106 beds. More recently, Together (2019) advised that since 2015 the number of secure beds used by Scottish children has gradually reduced year on year. It has been argued that this decrease has been driven by the increase of children from out with Scotland using Scottish secure placements (Gough, 2016). This **argument is further supported by the Children's Social Work Statistics 2018-2019** (Scottish Government, 2020a) which show that when the number of non-Scottish children using Scottish secure placements decreased by 26%, the number of Scottish children rose by 18%.

'Secure Care in Scotland: Looking Ahead' (Gough, 2016) presented the key findings of a further review of secure care in Scotland. It notes that 'some young people may have unrecognised problems which have been missed, particularly those who have experienced multiple home settings' (Gough, 2016, p.20) which could be reflective of a range of neurodiversity. It found that the recording and reporting of information was varied across the key agencies, and noted 'longstanding issues in relation to definitions, terminology, language and meaning' (Gough, 2016, p.22). This is illustrative of the diagnostic and terminological difficulties present across the autistic community. Moodie and Gough (2017) also completed research with Chief Social Work Officers regarding

perceptions of, and approaches to, the use of secure care in Scotland. This highlighted several issues relating to a lack of specialist resources for young people with very complex needs, including autistic children.

Gough's (2016) report resulted in the creation of a Secure Care Strategic Board in 2017. **It's aims were** to review trends and patterns of usage to inform future decisions around commissioning; create a vision for the future purpose of secure care; and develop national standards for secure care. The board reported to ministers (Scottish Government, 2019) with three key recommendations. These being the creation of a governance group; delivery of national secure care standards; and the examination of different commissioning models with clear guidance on the contract specification. The Secure Care Pathway and Standards Scotland (Scottish Government, 2020b) have since been published, with the intention of transforming secure care (Sullivan & Logan, 2021). They are designed to sit alongside the Health and Social Care Standards (Scottish Government, 2017) which were intended to be relevant for all health and social care services. It could be argued however that as the Health and Social Care Standards are so generic, they do not provide the level of detail required for such a specialist service.

The Independent Care Review (2020) reported a variety of recommendations specifically in relation to secure care. It comments on the inappropriateness of the way the current secure estate is structured, which has resulted in a wide variety of cultures, values, and ultimately provision. It recommends the future purpose and delivery of secure care be given further consideration. It recognises the overrepresentation of young people with disabilities in secure care placements and concludes that this is due to the inability of other services to **meet these young people's needs. It advises that young people should be given** comprehensive assessments; that the support they are provided with reflects their range of needs; and that any planning for the future of secure care must ensure that it reflects the needs of young people. For autistic young people this should include the provision of accessible environments, and I am giving consideration to this in my thesis.

Regulations 4 and 5 of the Children's Hearings (Scotland) Act 2011

(Implementation of Secure Accommodation Authorisation) (Scotland)

Regulations 2013 provide that Chief Social Work Officers have a statutory duty to consult with young people, and notify them of decision making, regarding **their placements in secure services. However, the Children and Young People's Commissioner Scotland's (2021) investigation found that there was little** evidence of consultation with young people at the start of their placements **across all 32 Scottish local authorities, and that children's views were often not** recorded. Whilst it makes no mention of neurodivergent young people, or those with communication differences, it can only be assumed that these factors would amplify the lack of consultation on such matters. Berg (2021) reports on the rising numbers of young people being placed on Deprivation of Liberty Orders and referred to secure units, citing examples of autistic young people and other neurodiversity within this.

Conclusion

Allely (2018) and Robertson and McGillivray (2015) note the lack of research around the experiences of autistic people in the prison system and it appears that the same is true for the secure sector. The 2018 Scottish Secure Care **Census (CYCJ, 2020) makes no mention of either autism or 'barriers to learning'** which reflects the hidden nature of how these young people are often overlooked. It could be argued that people who are accommodated in existing secure settings require access to specialist services (Myers, 2004), as they may **not fit the 'remit' and fall between gaps in service provision (Mental Welfare Commission for Scotland, 2016, 2019).**

...people with learning disabilities in general and ASD [autism spectrum disorder] in particular do not fit easily into what is perceived to be the core business of the different secure environments. There is a pervading sense that somehow people with learning disabilities and/or ASD would **have their needs better addressed 'somewhere' else (Myers, 2004, p.83).**

The 'core business' of secure care, as described above, is to provide a safe, containing setting by restricting the liberty of children and young people. Despite

all the changes in the secure sector described above since Myers asserted this in 2004 the primary purpose of secure accommodation services has not changed. Therefore, my research is exploring whether this assertion remains true, or whether sufficient adaptations have been made to ensure the particular needs of autistic young people are met in a way which supports the positive development of their identity.

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About the author

Charlotte Wilson has over twenty **years' experience** working in a variety of residential child care settings. She is currently undertaking her doctoral research at the University of Strathclyde, looking at the impact of secure care experience on the identity constructions of autistic young people.

Historic inspection practices and children's experiences of residential care, 1945-1980

Amanda Gavin

Abstract

In January of 1965 Quarrier's Homes was inspected by the Child Care and Probation Inspectorate. It was one of the most extensive – and damning – inspections of a children's home at that time. Many of the criticisms relating to staff practices and organisational failures were an open secret amongst the civil service in Scotland since at least the 1940s and would continue to be repeated until the 1980s. The testimony of those who were formerly in the care of Quarrier's Homes, heard before the Scottish Child Abuse Inquiry, reveals a considerable gulf between the priorities and perspectives of children and those who delivered and regulated their care. This article reflects on historic inspection practices and the regulation of children's residential care in the decades following the end of the Second World War. Using the 1965 inspection of Quarrier's Homes as an illustrative case study, this article finds that many voluntary children's homes were not effectively regulated, and the Inspectorate had little influence over day-to-day caregiving practices and therefore on children's experiences of care. It finds that a focus on children's physical needs by the Inspectorate contributed to the catastrophic failure of many voluntary children's homes to meet the emotional needs of the children in their care.

Keywords

History, children's homes, orphanages, inspection, regulation, twentieth century, Scotland

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Introduction

In January of 1965 Quarrier's Homes, the largest voluntary children's home in Scotland, was inspected by the Child Care and Probation Inspectorate. It was one of the most extensive – and damning – **inspections of a children's home** at that time. Over the course of two weeks, a team of inspectors observed the children at various times of the day; they interviewed all members of staff who were looking after the children, they ate meals in the cottages, visited the school, the nursery, and the hospital, and consulted with senior members of the organisation. The result was a highly astute and critical inspection report. And yet, the report appears to have had minimal influence on the organisational **culture or caregiving practices at Quarrier's, with some of those same criticisms** continually repeated until the **Homes' closure in the 1980s. The testimony of those who were formerly in the care of Quarrier's Homes, heard before the** Scottish Child Abuse Inquiry (SCIA) (hereafter the Inquiry), reveals a considerable gulf between the priorities and perspectives of children and those who delivered and regulated their care.

Since the 1990s the number of official inquiries into the historic abuse of children in care has proliferated (Sköld & Swain, 2015). Previously, there were few opportunities for survivors of abuse in institutional care to be heard.

Philanthropic institutions such as Quarrier's went to great lengths to cultivate a positive image in the public eye, and governing boards went to great lengths to protect their reputation when scandal did arise (Swain, 2018). The public narrative on institutional care in Scotland was largely dominated by the organisations themselves, who bolstered their profiles through fundraising activities covered by local press and various printed promotional materials. The testimony of those who were formerly in institutional care challenges the narratives of institutions themselves, but also, in some instances, of those who inspected and regulated them.

Using **the 1965 inspection of Quarrier's Homes as an illustrative case study**, this article explores historic inspection practices and the regulation of residential childcare in the decades following the end of the Second World War. It finds that

voluntary children's homes were not effectively regulated, and the Inspectorate had little influence over day-to-day caregiving practices and therefore on children's experiences of care.

A brief history of Quarrier's Homes (1878-1989)

Quarrier's Homes, known until 1958 as the Orphan Homes of Scotland, was a self-contained village of individual cottages in the Bridge of Weir. The Homes were founded by philanthropist William Quarrier, who opened the doors of the **first two cottages in 1878. The establishment of Quarrier's Homes** was part of the wider expansion of residential childcare in Scotland in the late nineteenth century (Kendrick, 2022). Over time, the Village grew to include almost 40 cottages, a school and the Mount Zion Church. The Village was geographically and culturally isolated, with some residents rarely venturing outside its confines. For some children, this was experienced as a feeling of safety, but for others, **this could feel suffocating. For instance, 'Alan' (b.1957), a former resident of Quarrier's, told the Inquiry:**

Everything was self-contained in Quarrier's. You didn't need to go outside the village for anything because everything was there. They had a bakery, a clothes maker, a shop, a church and a hospital. You were part of the world but you weren't part of the world at the same time. (SCAI, witness statement of 'Alan', b.1957, p. 2)

In the early twentieth century, Quarrier's Village was home to 1,500 children. By the time of the 1965 inspection, there were around 500 children under the care of this institution (NRS, ED11/708/1). Many local authorities were heavily reliant on Quarrier's to provide residential care for children under their care. **Indeed, since the end of the Second World War, on average, Quarrier's provided 1 in 7 of all residential childcare places in Scotland. In over 100 years of operation, more than 30,000 children passed through Quarrier's doors. In short, Quarrier's Homes was a significant part of Scotland's care 'system' for much of the twentieth century.**

Quarrier's Homes before the 1965 inspection

Poor practice

Poor practice at Quarrier's was widely known about amongst the civil service and local authorities since at least the 1940s. For instance, one Scottish Home Department internal memo, dated 1951, notes that the County of Renfrew Children's Officer no longer wanted to place his 'families' in the Orphan Homes, as it was known then, as he 'is not satisfied with the progress, educational or otherwise, that his children were making in O.H.S.' (NRS, ED11/288). In response, one civil servant remarked: 'Here is a long history relating to Orphan Homes and much criticism.' (NRS, ED11/288) That same year, a report by the Senior Psychologist of Renfrew, following the examination of children attending the Orphan Homes School, described internally as 'rather a shocker', found that **children's intelligence** – as measured by IQ tests – deteriorated the longer they stayed in the Homes (NRS, ED11/288). The concerns surrounding the adverse **impact of Quarrier's practices on children's development was perhaps best** summarised by the then Headmaster in 1946, who said: 'The dead hand of the past lies too heavy on the Homes' (NRS, ED11/161).

Many practices that were considered outmoded in the 1940s continued at Quarrier's until the 1970s, and perhaps later in some cottages. As the UK witnessed significant legislative, cultural and social shifts in relation to children following 1945 (see Hendrick, 2003), the culture at Quarrier's was marred by complete inertia and suspicion towards 'outsiders'. Its inability to adapt and fundamentally change its original model of care ultimately led to its closure as a voluntary children's home. The significant move away from residential care towards boarding-out or foster care, particularly marked after the 1970s, (see Abrams, 1998) presented an existential crisis for Quarrier's.

Staff training and recruitment

Before the 1960s there was very little formal training available for those looking after children. In 1960, for example, there were fewer than 20 trained childcare staff in all of Scotland's local authorities (Abrams & Fleming, 2019). Many of

those staffing children's homes were drawn from the ranks of ex-military or were former nurses (Abrams & Fleming, 2019). And in Quarrier's, very few houseparents had formal training, with many viewing it as a Christian vocation, rather than a profession. A number of houseparents had grown up in Quarrier's themselves, and for the purposes of recruitment, having grown up in Quarrier's was viewed as adequate experience for the position of houseparent. For instance, 'Alison' (b.1950) told the Inquiry: 'I had no training or qualifications in caring for children. Quarriers said that I had plenty of experience because I had been brought up in Quarriers' (SCAI, witness statement of 'Alison', b.1950, p. 5). Due to a lack of scrutiny of individual cottages, many outmoded and even harmful practices became embedded and transmitted from one generation to the next.

Inspections of voluntary homes

Before 1968, inspections of voluntary homes, such as Quarrier's, were largely carried out by the local authority children's departments, but only with respect to the children whom they had placed there. The Scottish Home Department had overall responsibility for the regulation and inspection of children's homes. Most inspections were carried out over the course of one or two days with what can only be described as a 'light touch'. Children's homes were generally given ample notice of a visit, although the Inspectorate possessed the power to turn up unannounced. 'Finlay', a former resident of Quarrier's, told the Inquiry:

I don't remember seeing inspectors or there being inspections. I think it was like a closed shop. Nobody came in. There was nobody who came in from the outside to ask us how we were getting on. There were visitors from the charity who came to Quarrier's, but they never spoke to us. They were shown about and left with the impression that it was a wonderful place for the children. Nobody ever spoke to us or asked us our opinion. You didn't have an opinion anyway. You were told what your opinion was. (SCAI, witness statement of 'Finlay', p. 6)

It was not uncommon for inspections to take place while the children were attending school, meaning that children were not seen and certainly not spoken to by inspectors.

The hostility towards 'outsiders' was not unique to Quarrier's; other voluntary homes operated in a similar way. For example, Smyllum Park Orphanage, a Catholic voluntary home in Lanark, was remembered by former Children's Officer at Dingwall, James (b.1925) to be discouraging of attempts to build relationships with the children. James told the Inquiry:

...at that time all the Catholic establishments had the same reputation. They felt that you were intruding. It was their job and they didn't want you interfering. The sad thing was that this was accepted by the social work department that they were different from other residential homes.
(SCAI, witness statement of James Murray Haddow, b.1925, p. 4)

There was a reluctance on the part of inspectors to disturb this dynamic as many **local authorities were reliant on voluntary children's homes. For example, Glasgow Children's Department, one of the largest in Britain, was chronically underfunded, understaffed and unable to provide aftercare. An inspection of its childcare service revealed that in May 1965 Glasgow's Children's Department had 2,413 children under its care and a further 3,433 children under supervision in their own homes (NRS, ED11/669/1). The Department was staffed by a total of only 21 professional staff. One Child Care Officer had a case load of 253 (NRS, ED11/669/1). The reliance on Quarrier's as a residential care provider was a barrier to forcing organisational change. Dr Davidson, then Director of Quarrier's Homes, told an inspector in 1965 that he 'is well aware of the disadvantages of the big institution' but referred to the demand for places (NRS, ED11/708/1). In 1964/65 96% of all admissions to Quarrier's were from local authority children's departments (NRS, ED11/708/1).**

The 1965 inspection of Quarrier's Homes

The system of individual cottages, headed up by houseparents, was intended to replicate family relationships. Houseparents were given almost total autonomy in

their individual cottages. 'William', a former resident of Quarrier's, told the Inquiry: 'There were no inspections of Quarriers that I know of and I never had or saw a social worker. Your life was run solely by your house parents.' (SCAI, **witness statement of 'William', p. 8**) The level of autonomy given to houseparents at Quarrier's meant that children could have vastly different experiences of growing up there. When this worked well, children could **experience a relatively stable and happy upbringing at Quarrier's. When this did not work, however, the Quarrier's model of care made children extremely vulnerable to mistreatment, abuse and exploitation.**

The disparity between cottages was explicitly recognised in the 1965 inspection report. **It found that the standards of care ranged from 'exceptional' in some cottages to 'unsatisfactory' in others. The inspectors concluded:**

For the children in care at Quarriers Homes, life in the cottages is determined by their individual capacities, disabilities and needs, by the wide standards of care from one cottage to another, by the overriding conditions of location and general organisation, and by the survival, mitigated in many cases by the common sense, energy and fortitude of individual houseparents, of outmoded traditions and practices. (NRS, ED11/708/1)

One such cottage deemed to be 'exceptional' by inspectors, was Cottage 5, home at that time to 12 children looked after by a housemother and housefather. The houseparents were described by the inspector as being 'a young couple' in their '**early 30's**' with two children of their own. As a couple, they were noted as being 'well suited' and both 'devoted to the children' (NRS, ED11/708/1). The inspector was impressed by their relationship with the children. The housemother of Cottage 5, the inspector said, was 'a gentle warm-hearted woman, and handles the little ones [...] with affectionate care' (NRS, ED11/708/1). And the housefather was described as a 'bright happy person, with a sense of humour, he is very active and hard-working and very acceptable to the children' (NRS, ED11/708/1). The inspector shared a meal with the children and the houseparents in the 'cosy kitchen' and found the children to be 'chatty' and 'the occasion a social one' (NRS, ED11/708/1). Unusually for an

inspection, the quality and the quantity of the food was not the focus, but the dynamics of cottage life.

In the early evening the inspector observed the children 'spread themselves between the playroom and sitting room' where there was 'plenty of play equipment, a record player, a shop, modelling material, games and books.' (NRS, ED11/708/1) Not only that, but the houseparents were 'involved in all that the children were doing' and '[a]ll were happy and relaxed' (NRS, ED11/708/1). This intimate picture of a relaxed, playful evening in Cottage 5 was in stark contrast to what was observed in some of the other cottages. For instance, Cottage 7 was home to 14 children who were looked after by a single **housemother who had been at Quarrier's since 1935. The housemother of** Cottage 7 was described by the inspector as 'a forbidding woman, stern and scrupulously just' (NRS, ED11/708/1). Unlike Cottage 5, this Home was described as 'efficient' and although there was 'real effort to make the children comfortable [...] stimulus, fun, interest and recreation are at a low ebb' (NRS, ED11/708/1). The chatty mealtimes of Cottage 5 stood out in comparison to some of the other cottages where inspectors found that 'the children lined up to have hands inspected before filing in to eat.' (NRS, ED11/708/1)

On the standard of care in Cottage 5, the inspector concluded that:

[the houseparents of Cottage 5] are a good example of a couple, with very ordinary intelligence but with big hearts, hardworking and using to the full every quality and skill they have in being good parents to the children and good members of the community. It was interesting that the school master, the nursery matron and the nursery school staff, all mentioned this couple as providing exceptional standard of care. (NRS, ED11/708/1)

In 2001, some 36 years after this report was written, the housefather of Cottage 5 was found guilty on two charges of rape, nine charges of lewd, indecent and libidinous practices, nine charges of assault and one charge of shameless **indecentcy against a number of girls at Quarrier's Homes between 1961 and 1968. He was a houseparent at Quarrier's from 1961 to 1968. He went on to**

become a senior social worker. However, this is not to suggest that the inspectors should have been alert to potential signs of sexual abuse, as this would be an anachronism and was simply not reflective of practices at the time (see Bingham, 2019; Delap, 2018). It is not a case of holding those in the past to the standards of today, but rather, it highlights the failures of an inspection system that did not seek the perspectives of children. Inspection reports, as with all records authored by child welfare professionals, were written by and for adults.

The testimony of those who were formerly in care can, at times, corroborate or confirm what we find in archival records, but more often than not, it disrupts, undermines and even obliterates the narratives found in the records of child **welfare professionals. The 1965 inspection of Quarrier's Homes was, overall,** highly critical and offered astute observations into the inner workings of an **organisation that was largely hostile to 'outsiders'.** The foresight and perceptiveness of the inspectors lends credibility to its positive analysis that may otherwise have been read with a more critical lens.

An entrenched dynamic between the Inspectorate and voluntary children's homes where inspectors were reluctant to 'interfere' meant that inspections were only able to scratch the surface of an institutional regime. And Quarrier's, which faced increasing criticism of its outmoded model of care after 1965, focused much energy on preventing reputational damage. Ian Brodie (b.1950), a former **in-house social worker at Quarrier's (1977-1985),** told the Inquiry: 'the public image was more important than the private reality.' (SCAI, Witness statement of Ian Brodie, b.1950, p. 5) **It is perhaps unsurprising, therefore, that 'Troy' (b.1951), a former resident of Quarrier's, said:** 'Our meals changed when someone came to visit. A lot of falsifying went on in that place. If someone came we were told by [redacted] say we loved it and to be on our best behaviour.' (SCAI, witness statement of 'Troy', b.1951, p. 8) Again, this was not unique to **Quarrier's,** with one former resident of Nazareth House, Glasgow, a Catholic voluntary home, telling the Inquiry that 'fictional menus' were put out for inspections, alongside 'teddies', 'nice little rugs at the side of the beds' and 'nice pyjamas folded up' which were only brought out for the benefit of inspectors

(SCAI, witness statement of 'Poppy', b.1944, p. 11). The picture painted by the official records does not always reflect what it was really like for children.

The lack of oversight and regulation, both internally by Quarrier's and externally, by the inspectorate, had grave consequences for some of those who were in the care of Quarrier's throughout the twentieth century. Children in the care of Quarrier's Homes suffered emotional, physical and sexual abuse at the hands of those who were meant to look after them (SCAI 2020; Shaw, 2011). There were a number of organisational failures that meant individuals were able to abuse children at Quarrier's; on an organisational rather than individual level, children were exploited in a number of ways by Quarrier's.

In one of the most egregious examples of the failures of the historic inspection system, **Dr Davidson, then Director of Quarrier's, was able to inflict experimental medical treatment on children at Quarrier's over the course of a decade without the knowledge of the Scottish Home Department. And when this did come to their attention, neither Quarrier's nor Dr Davidson faced any consequences. In a 1955 paper, Dr Davidson, alongside the Deputy Council Medical Officer for Renfrew and the Area Supervising Tuberculosis Physician for Renfrewshire, described an ongoing 'investigation' being carried out at the Orphan Homes of Scotland; of the 783 children living in the Homes between the ages of one and 15, every single child was included in the experiment (Frew, Davidson & Reid, 1955). Around half of the children were given the B.C.G. vaccine in the 'routine intradermal manner' and the other half given the vole bacillus vaccine 'by multiple puncture' (Frew, Davidson & Reid, 1955). The latter was described in the paper as being administered by a 'spring-loaded gun which [...] projects 40 needles through a predetermined distance' (Frew, Davidson & Reid, 1955). Although the authors note that the children felt 'little pain' due to this method of administration, 100% of the children given the vole vaccine in the intradermal method developed 'deep ulcers' and 45% went on to develop abscesses which took between 14 and 28 weeks to heal (Frew, Davidson & Reid, 1955). To put it another way, the children suffered from painful pus-filled abscesses for between three and six months. The paper states that there was 'very satisfactory healing which followed the admittedly very severe local reactions' (Frew, Davidson &**

Reid, 1955). **'Finlay', whose date of birth is undisclosed but whose testimony suggests he was part of the tuberculosis vaccine trial in the early 1950s, told the Inquiry:**

I got injections because I had scabs on my arms. I think they were **experimenting on me. It's the only reason I can think of. I remember** these doctors came to Quarriers from Edinburgh to do this. It was outside people. They came every week to measure the size of the scabs with a ruler [...] I think it was something to do with TB. (SCAI, witness statement of **'Finlay', p. 9)**

Following the publication of the paper in *The British Medical Journal*, the front page of *The London Daily Herald* featured a story by *Glasgow Herald* reporter, **Douglas Long, under the headline '600 CHILDREN WERE USED AS GUINEA PIGS'** (Daily Herald, 5 February 1955). It told how 600 children living in what was then known as the Orphan Homes of Scotland had been, for three years, subjected to experiments for the purposes of a new tuberculosis vaccine. The Scottish Home Department told the reporter: 'We were not aware that this experiment was being carried out. There is no question of our allowing children to be used for experimental purposes' (Daily Herald, 5 February 1955). In short, the body **responsible for the oversight, regulation and inspection of Quarrier's was** unaware that for three years over 600 children were subjected to an experimental vaccine that caused severe reactions in several hundred children. Dr Davidson faced no consequences for this. In fact, the following year he would **become the Director of Quarrier's.**

The 1965 inspection report of Quarrier's criticised Dr Davidson as a 'remote' and 'intellectually autocratic' person who has 'failed to give sufficient leadership' or to 'improve organisation' (NRS, ED11/708/1). Neither the 1955 controversy over the vaccine experiments, which were described by a Glasgow MP in the House of Commons as having 'provoked a great deal of disturbance in the public mind in Scotland' (Mr Rankin to Mr Stuart, House of Commons, 15 March 1955), nor the **highly critical 1965 Scottish Home Department report damaged Dr Davidson's position at Quarrier's, where he remained until 1974. Moreover, there is little evidence that the culture at Quarrier's fundamentally altered under new**

leadership after 1974. Ian Brodie, in reference to the 1965 report, told the Inquiry: 'What surprises me is that while I was there nobody mentioned a report which very much questioned the continuation of the village. The village model **was seen as fundamental to Quarrier's...**' (SCAI, witness statement of Ian Brodie, p. 32). **In the 12 years between the 1965 inspection and Ian Brodie's arrival at Quarrier's, he found that** little had changed and many of the fundamental issues identified by the report remained. **This damning report which deemed Quarrier's to be a 'defective organisation' was not only lost to institutional memory but had had no discernible impact on Quarrier's organisational culture or caregiving practices.**

Conclusion

Voluntary children's homes played a significant role in Scotland's care 'system' for much of the twentieth century, with Quarrier's being the largest institution. A significant number of children were abused and exploited while they were in the care of Quarrier's Homes. **As private arrangements, whereby children's families placed and paid for their children's care, became increasingly obsolete by the mid-1960s, local authorities were ultimately responsible for most children in Quarrier's by 1965. Poor practice in Quarrier's was an open secret amongst child welfare professionals since as early as the 1940s, and yet local authorities continued to place children there until the 1980s. Quarrier's Homes was effectively unregulated for most of its operational history. For children, this meant they were subjected to archaic and abusive caregiving practices, an outmoded model of care, a particularly punitive disciplinary regime, and isolation that made them extremely vulnerable to abuse and exploitation as children, and as young people leaving care. Inspectors, and many of the homes in which they inspected, continued to focus solely on children's physical needs. Inspections often looked to the quantifiable, the quality and quantity of food, the number of beds, baths and books. And yet, when we listen to those who were formerly in the care of homes such as Quarrier's we overwhelmingly hear that it is emotional needs that were most important to children. Inspectors were able to record ounces of milk, observe and record how clean the kitchen was or how**

neat the children's clothes were, but being read a bedtime story or a reassuring squeeze of the hand could not easily be counted.

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Scottish Child Abuse Inquiry – witness statements

'Alan', b.1957

'Alison', b.1950

'Finlay'

Ian Brodie, b.1950

James Murray Haddow, b.1925

'Poppy', b.1944

'Troy', 1951

'William'

National Records of Scotland (NRS)

ED11/161, Committee on homeless children, personal memorandum of Mr Galletly, Headteacher of Orphan Homes of Scotland School, 1946

ED11/288, Psychological tests of children in voluntary homes, 1951

ED11/708/1, Voluntary homes, inspection of Quarrier's Homes, 1965

ED11/669/1, Glasgow children's department, inspection of child care service, 1966

About the author

Amanda Gavin is a doctoral researcher in History at the University of Glasgow and a visiting researcher at the University of Edinburgh. Her research looks at **children's experiences of the care 'system' in Scotland since 1945 and seeks to** place the perspectives of children and the memories of Care Experienced people at its centre, rather than those of child welfare professionals in the past. Her research is funded by the Arts and Humanities Research Council.

Report on the actual situation of child abuse and responses to it under the pandemic of COVID-19 in Japan

Kayoko Ito

Abstract

During the COVID-19 pandemic, child-rearing families became more isolated and clandestine, leading to a concern that problems such as child abuse and domestic violence may have become more widespread. In addition, families in need of support prior to the pandemic, such as those suffering from economic distress, domestic violence and child abuse, have found it difficult to receive the necessary support due to restrictions on their behaviour imposed by infection prevention measures. In this article, we would like to introduce how Japanese local authorities and counselling services have responded to child abuse counselling and other issues during the COVID-19 pandemic and to share the challenges that have emerged in the process. This article aims to aid consideration, together and beyond national borders, of how to outreach to problems in the home, such as abuse that has become difficult to detect outside the home, and how support agencies and local authorities should look after families raising children while schools are in lockdown.

Keywords

COVID-19, child abuse, protection social work, Japan

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Introduction

In April 2020, a state of emergency was declared by the Japanese government following the spread of the COVID-19, with requests to close workplaces and refrain from going out. As a result, child-rearing families became more isolated and secluded, while unemployment and insecurity in their lives worsened, and child abuse and domestic violence also became more widespread.

In particular, child abuse increased, and opportunities for its detection outside the home decreased, as a result of school holidays, which increased contact time between parents and children and led to a life of high stress for both. In addition, the parental burden on parents raising children with disabilities increased.

Under these circumstances, support activities such as home visits by local authority advisory services were also restricted, making it difficult to intervene in a timely manner, which in some respects exacerbated the situation.

The purpose of this paper is to examine how to respond to child abuse after the COVID-19 pandemic by identifying the actual situation of child abuse consultations in Japan and how these consultations were handled.

Methods

A questionnaire was conducted with 39 local authority consultation bodies in the Kinki region (Western part) of Japan. The survey period was from March to November 2020. It should be noted that the child and family consultation system in local authorities in Japan is a dual system, with consultation agencies in municipalities and child consultation centres set up in a slightly wider area.

The questionnaire consisted of questions about the number of consultations on child abuse, etc., the nature of the consultations, and the innovations of the consultation and support system during the COVID-19 pandemic.

When requesting survey cooperation, the following points relating to ethical considerations were communicated in advance:

- Cooperation in the study must be voluntary and consent can be withdrawn at any time during the research period.
- The positions, names, etc. of survey respondents shall only be used for the purpose of enquiring about the content of the responses, and not for any other purpose.
- The results of the survey must not be used for any purpose other than research purposes and survey data should be stored securely in a locked locker in the laboratory.

Results

The total number of consultation notifications received in the 39 municipalities surveyed (16 child guidance centres and 26 municipalities) between March and November 2020 was 67,029, a decrease from 72,723 notifications received in the same period the previous year. This is thought to be due to the impact of the school holidays, which led to a decrease in consultation notifications from schools (Figure 1).

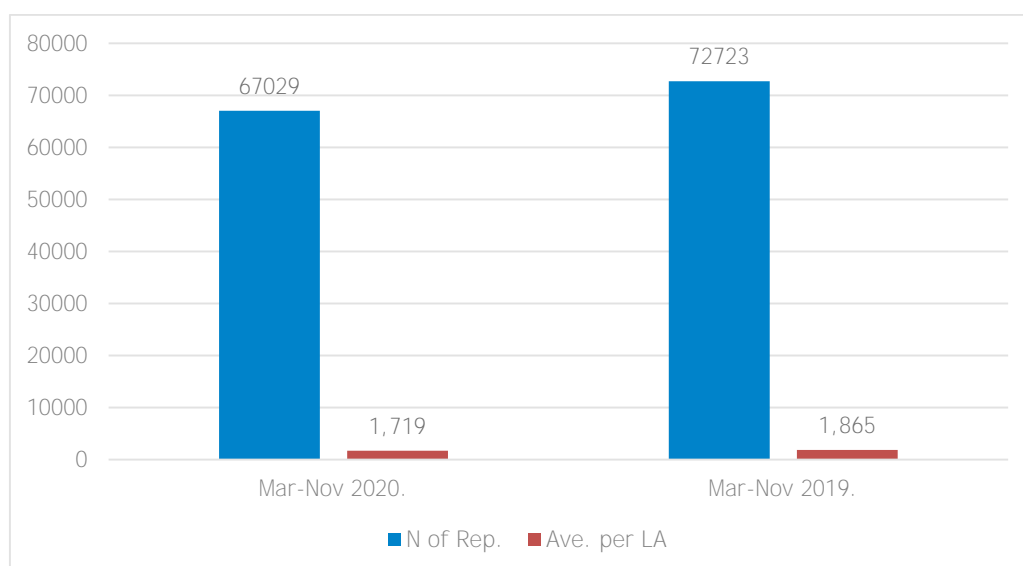


Figure 1: Number of child and family consultations

Looking at the number of consultations by type of consultation, there has been a decline in all types except parenting and abuse consultations. The decrease in

consultations on disability, discipline and truancy is particularly significant (Table 1). The decrease in the number of discipline consultations is thought to be influenced by the decrease in truancy consultations due to the school holiday period. Looking at specific examples of consultations, the most common complaint was that they had become dependent on social networking and smartphone games, followed by a number of consultations to the effect that parent-child relationships had deteriorated. There were also a number of reports that telecommuting had caused marital quarrels, fights between parents and children, and family violence to become more serious.

	Public child guidance centres			Municipalities		
	Mar-Nov 2020.	Mar-Nov. 2019.	Percentage change	Mar-Nov 2020.	Mar-Nov. 2019.	Percentage change
Nursing	24,802	25,512	2.8%.	7,461	7,316	Δ 2.0
Abuse	21,806	22,502	3.2%.	4,567	3,931	Δ 16.2%.
Others	2,996	3,010	0.5%.	2,894	3,385	17.0%.
Delinquency	1,118	1,040	Δ 7.5	3,232	3,206	Δ0.8
Disability	21,004	17,461	Δ 14.6%.	1,534	1,382	Δ 11.0
Discipline	4,694	3,795	Δ23.7	933	716	(30.3%)
Others	1,108	1,114	0.5%.	649	551	Δ 17.8%.

Table 1: Number of consultations by type

Next, regarding abuse consultations, by type of abuse, in municipalities there was a slight increase compared to the previous year, except for sexual abuse, which is a concern for latent abuse. In child guidance centres, there was a slight increase in reports of psychological abuse, which may be due to the increase in face-to-face DV (Figures 2 and 3) child abuse consultations in municipalities.

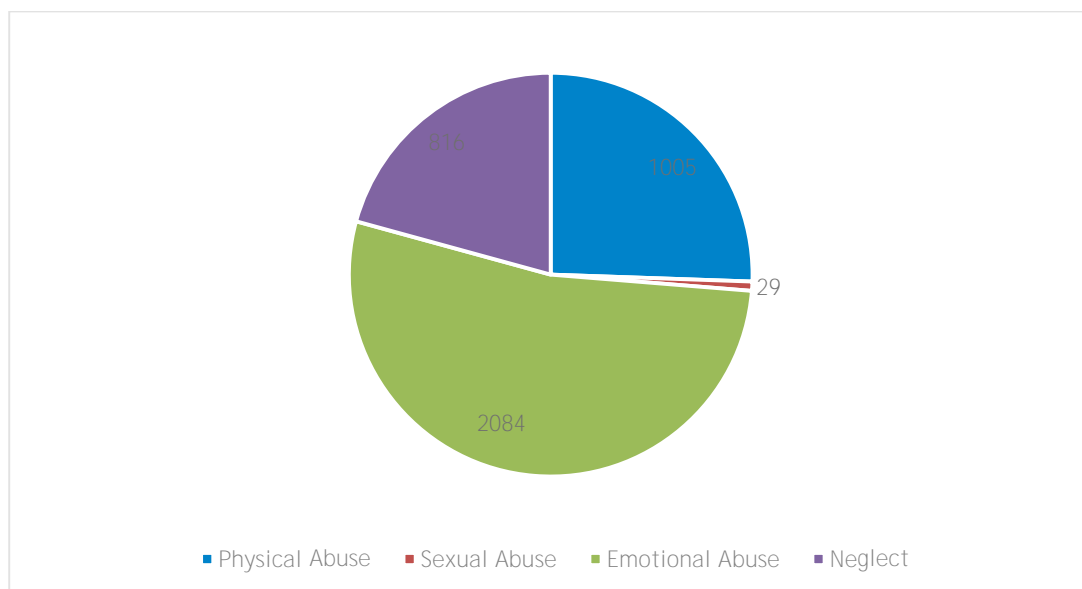


Figure 2: Child abuse consultation in municipalities

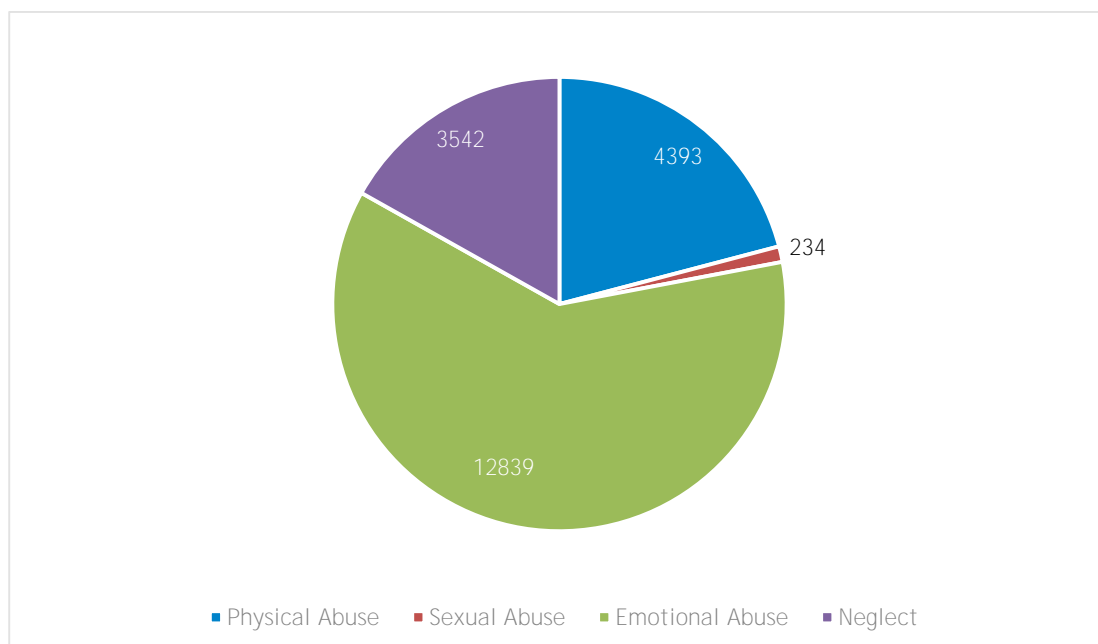


Figure 3: Child abuse counselling in child guidance centres

In Japan, the authorities that issue temporary protection orders and foster care orders for children in need of social care are the public child guidance centres. A comparison of the number of care orders and other legal responses by child guidance centres in the aftermath of the COVID-19 pandemic with those before the pandemic shows that on-site investigations and requests for assistance from police officers have decreased, while applications under Article 28 of the Child Welfare Law in Japan (a procedure to obtain an order from the family court when the biological parents do not agree with placements for parent-child separation such as foster care placement) increased (from 49 to 63). This is thought to be a result of the impact of the pandemic, which made it impossible to conduct home visits and other activities, and to provide careful explanations and social work to persuade parents to consent to a care order.

In terms of the number of temporary protection cases, although the number of protection cases themselves is lower than before the pandemic, the number of temporary protection consignments to foster carers and **children's homes** has decreased, while the number of cases to protection centres attached to child guidance centres has increased. This is thought to be an effect of the refusal or impossibility of each **children's home** or foster family to take action for new children during the COVID-19 pandemic.

The next section deals with the actual systems that were put in place to deal with COVID-19. The most common responses were 'provision of protective clothing to social workers' and 'thorough disinfection at temporary shelters.' Many municipalities also asked private hotels to cooperate, as it was difficult to secure emergency temporary shelter for children for the aforementioned reasons.

Discussion

The results of the survey suggest the following five issues

On the first point, it became clear that there was a need to change and devise the nature of the child and family consultation and support system during the COVID-19 pandemic. Until now, support plans have only been formulated on the

basis of face-to-face consultations and interviews at home visits and in person, but equipment and staff training are needed with a view to actively utilising online, telephone and internet consultations. It has traditionally been pointed out that social work settings in Japan are weak in terms of IT. Overcoming this is an urgent issue.

Second, while home visits are not possible, how to intervene with families in need of outreach should also be carefully considered in the future. For example, it will be important for each municipality to strategically develop home visits under the guise of 'delivering relief supplies' such as masks and food. It will also be essential to provide protective clothing for visiting social workers.

Third, the study suggested the importance of a watchdog system and network for the early detection of child abuse during school closure due to lockdown, as well as cooperation with the independent organisations or NPO and so on. While notifications of abuse consultations from schools decreased during school closures, notifications from children's cafeterias and local learning support agencies for poor families increased. In addition, Japan has volunteer-like watchdog staff called 'child committee members' assigned to each school district. The pandemic has shown that the independent organisations or NPOs play a significant role when schools are unable to fulfil their function of early detection of child abuse.

Fourth, as emergency temporary shelters were in short supply during the pandemic, it is necessary to be prepared, for example, for neighbouring accommodation facilities and local authorities to sign an agreement in advance on the provision of accommodation in the event of an emergency. In this case, the issue of how to secure temporary shelter in municipalities that are not tourist destinations remained to be addressed.

Fifth, the need for publicity and awareness-raising for the prevention of addiction on a daily basis was suggested in response to the acceleration of problems such as gaming and alcohol dependence.

The recent COVID-19 pandemic has had a greater impact on families who are particularly vulnerable and in crisis due to poverty and abuse. By sharing experiences around the innovations and difficulties of child and family counselling and support during the COVID-19 pandemic, both domestically and with other countries, it will be possible to take the necessary measures for child and family social work and social care in possible future crisis situations.

Dominelli (2021) notes, for example, that the UK's Civil Contingencies Act 2004 designates social workers and health professionals as 'key response personnel' and that 'in many countries social workers have a formal role in the emergency response system, with legislation specifying their role and conduct'. She also stated that in the context of this pandemic, the pressure of helping people who are ill has fallen on health professionals, and there is a growing appreciation and respect for them. On the other hand, people are not so aware of what social workers do. People in the field should call on conventional and social media as much as possible to give their work the proper recognition it deserves (p. 3).

The findings from this experience should be consolidated and used for future system development and manual preparation.

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Seldom seen sibling support: exploring the changing experiences of siblings in Scottish residential childcare services

Mary Morris

Abstract

The Promise, published in February 2020, outlined the findings of Scotland's Independent Care Review. The review heard evidence from over 5,500 care experienced children and adults, where being separated from siblings was identified as one of the most serious and negative consequences of going into care. The Promise has called for radical changes in how Scotland supports children and families, with family, scaffolding, voice, and people being integral to moving forward differently. One of the foundations for family is recognising the importance of sibling relationships for care experienced children and young people. The Promise outlines that children should as far as possible be supported to live with their families, but if that is not possible children must stay with their brothers and sisters when safe to do so. If they are not able to live with each other then they must be supported to keep in touch and be a part of each **other's lives. The Scottish Government has committed to implementing the** recommendations of the Promise. The rights of brothers and sisters to grow up together and stay connected throughout their childhood so they have enduring bonds are being recognised through changes in legislation, guidance, and practice. Residential workers are embracing this and making a real difference to **children's experiences with an emphasis on promoting** their sibling relationships. This article outlines some of the work that is happening and explores how residential childcare can continue to support children and young people in their relationships with brothers and sisters.

Keywords

Relationships, **children's rights**, skills, fun, support, the Promise

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Scene setting

The Promise (Independent Care Review, 2020)ⁱ highlighted the importance of relationships between brothers and sisters. The Independent Review heard evidence from care experienced children and adults that being separated from their brothers and sisters had a detrimental impact on their wellbeing and sense of self. Part of the evidence from the discovery phase of the Independent Care Review in the report *1000 Voices* outlines the pain separation caused, compounded by uncertainty about arrangements to spend time with brothers and sisters.

There is a strong commitment in Scotland to acting on these important messages. There has been increasing recognition across the sector of the need to do more to ensure care experienced children and young people in Scotland have enduring relationships with their brothers and sisters. The Looked After Children (Scotland) Amendment Regulations (2021) have strengthened the rights of children regarding these important relationships, and these changes and the heightened awareness are welcomed. This article outlines some of the important work and changes that are quietly taking place across the residential childcare sector in Scotland to support **children's rights and experiences**. While many aspects of this work are not new, there is a renewed energy and commitment across the residential sector to support sibling relationships from the outset. This fits in with some of the re-focusing of residential work and the important difference it makes for some children and young people. While there have been many challenges, this work shows there is also resilience and growth across the sector. The phrase 'seldom seen' is used in the title to draw attention to the work that is happening and to hopefully widen awareness of the role, experience, and skills the residential childcare sector brings.

Support for siblings

Residential workers across Scotland are keen to support the rights of care experienced children and young people to know their brothers and sisters, and to ensure these important relationships are nurtured. There is increasing

recognition that these key sibling connections need to be on the agenda for each child or young person when residential care is considered. Careful reflection on the whole child and what is important in their life is vital. Helen McKenzie, residential childcare manager at Aberdeen City Council, outlines that for them this is now very much part of any matching considerations. A recent example involving a brother and a sister, where initially the discussion regarding a residential placement was only about one of the young people, led to a wider discussion about the needs of both young people. Having a forum where questions can be asked, and assessments widened, is a big part of shifting culture and practice and keeping *The Promise*. Taking the time to consider the needs of both young people, and importantly to involve them in the decision-making process, led to the siblings living together in **one children's house**. For the young people this was their first choice and continuing to live together has huge supportive benefits for them.

Jane Kerr, manager at Pebbles Care, similarly describes the advantages of two brothers aged 15 and 16 remaining together in a small two-bedded **children's house**. Again, they had strongly articulated that this was what they wanted. Ensuring sensitive, individualised support has allowed both young men to enhance their own individual identity while staying together. A robust referral process and having options - for example about sharing bedrooms if siblings prefer this - allows for flexible and responsive care.

Thinking very carefully about the needs of each child and young person and how best their needs can be met, in the shorter and longer term, involves intricate planning. It may not be possible, or at that time the right thing, for brothers and sisters to live together. It is important that these decisions are kept under review. *The Promise* (Independent Care Review, 2020, p.62) emphasised the importance of: 'Robust management processes that facilitate and support good practice relating to sibling relationships and addressing any sibling estrangement.'

There will be advantages for most children and young people coming into residential care in maintaining and building relationships with their brothers and sisters. *The Promise* and the voices of care experienced children and young

people have evidenced that paying attention to these relationships and scaffolding is essential, thereby ensuring that the rights of children regarding these important relationships are integral to planning and decision making. Marcello O'Brien, manager with Curo Salus, identifies this as something that is **part of their company's approach** at the referral stage. They recognise the need to invest in this important aspect of supporting young people. On a practical level this means being well organised and having the right resources in place. Ensuring there are enough staff around, and carefully planned rotas, as outlined in the Care Inspectorate's '**Guidance for providers on the assessment of staffing levels**' (2021), is key. Thinking about suitable transport, enough drivers, and working out where the best venue to meet up might be, must be factored in too. **It won't just** happen. The **Care Review's** report, 'Follow the Money' (2020), advocates investing in what is important in **children and young people's lives**.ⁱⁱ Practical barriers, costs and poor organisation should not **obstruct children's** rights, such that leaders and managers responsible for children and young people in residential care settings need to take a proactive approach. Those responsible for placing children and young people should ensure they have open discussions from the outset about all the practical support that will be needed to make sure the rights of care experienced children and young people are met. The Care Inspectorate's **guidance** 'Matching looked after children and young people: Admissions guidance for residential services' (2022) outlines important considerations for services.

There needs to be real commitment, investment, and energy to make children and young people spending time with their brothers and sisters a reality. There is increasing recognition within residential childcare that time together for brothers and sisters who live apart should be part of fun childhood experiences. Stilted, awkward times spent in social work offices are now much less common. Such experiences are the opposite of having a good childhood. Instead, residential workers are organising fishing trips, outings to the beach, sleepovers, and holidays. Special times that can build sustaining memories are central. Celebrating birthdays and spending time together at Christmas and other important holidays are also seen as part of a good childhood. One of the care experienced Young Inspection Volunteersⁱⁱⁱ at the Care Inspectorate has

articulated some of her feelings about her experience in residential care and powerfully shows how important it is to do better: 'Special times like birthdays and Christmas are important. After coming into care, I never spent Christmas with my sisters. It never happened and I never asked. I now realise we missed out so much.'

Children and young people in residential care may need support and help at these times to maintain or re-establish bonds. They may need help with buying cards and gifts. Sometimes they will ask, but they may not, and if it is part of the culture and on the radar of residential staff this can make a big difference. Lee Robson from Care Visions has found that having visual reminders about important dates such as family birthdays really helps to ensure they are prepared.

Sometimes there can be an element of spontaneity to brothers and sisters spending time together and having a settled and welcoming culture can contribute to this. Sam Whannel, team leader at Angus Council, describes always having a chair at the table for the younger brother of two brothers who live together, all of whom have complex needs. As well as having the right equipment, this approach is informed by recognising that this is the home of these young people, and their rights and wishes are the priority.

Most children and young people coming into residential care settings in Scotland will have experienced trauma and loss, as outlined by Furnivall and Grant (2014). They may associate human contact with stress and anxiety, and struggle to interpret interactions or to understand play. Their sense of self may be poor. Sometimes this can impact on their relationships, including those with brothers and sisters.

Treisman (2017) places emphasis on the importance of working in a trauma informed relational way, recognising the need for sensitivity, safety, and trust, and the need to consider the whole person. Endings may have been difficult both for the children and young people and the adults involved. There may be situations that can lead to disconnections and siblings being split up. Finding a way for brothers and sisters to keep in touch in delicate circumstances requires

diplomacy and sometimes tenacity. There can be resistance from the adults involved, such as family and other carers. They may need help and support to put aside their own sometimes raw feelings of hurt to prioritise the needs, rights and wishes of the children and young people. There needs to be a focus on the immediate situation, as sometimes the easier option is to leave things as they are.

Social workers may not have the time or desire to navigate and negotiate such scenarios. Skilled and knowledgeable residential workers can help find a way forward, helping to repair and restore fractured relationships. They can work alongside families to provide reassurance and support. When children and young people have trusting, attuned, loving relationships with the residential staff who support them lots of things start to become possible. For example, a young person who has not seen siblings for several years may feel they can start to express some of their emotions around this. Residential staff who understand the importance of these relationships and are committed to keeping *The Promise* can work alongside the young person and advocate, if necessary, on their behalf. Ross Buchanan, manager at Care Visions, acknowledges the importance of this aspect of the residential role. Over several years, they have supported brothers who had not spoken for three years to gradually get to re-know each other. **They were helped to understand each other's** perspectives, resolve some of the entrenched difficulties and move on to a better place.

There may well be glitches on the way. Residential staff can help with this, exploring some of the tensions and difficulties with the young people. Skilled residential staff who have an informed understanding of the impact of trauma and a thorough knowledge of child development, as detailed by Daniel, Wassel and Gilligan (1999), can help support children and young people through what can feel like a fragile maze. Knowing what the key child developmental stages are enhances understanding in relation to each child and young person and their unique circumstances. Squabbling and fall outs are very much part of the usual sibling experience, but they can be amplified when children and young people are not living together and have experienced trauma. Residential workers can get underneath some of this messy, complex and at times difficult stuff. They

can help children and young people understand that it is possible to get through things and promote resilience. They are also often able to engage, work alongside, and provide support for families.

Conclusion

It is important that this vital work residential workers do is recognised and valued. For care experienced children and young people in residential care, residential staff can and do make a huge difference to ensuring the rights of these children are upheld. The legislation outlined in the introduction **strengthens children's** rights regarding their rights to family life. Legislation and guidance, especially 'Staying Together and Connected: Getting it Right for Sisters and Brothers: National Practice **Guidance**' (2021), are a great starting point. The voices of care experienced children and young people and groups such as Stand up for Siblings have influenced these. To make the spirit and intent of the legislation and practice guidance the reality of all care experienced children and young people in Scotland is a challenge. It will need huge commitment and energy from everyone working in the sector. The residential sector is very much part of taking this forward and can play a leading role. The innovative and skilled work that is already happening, which has been touched upon in this article, should be acknowledged and valued. Residential work is developing and evolving to ensure that *The Promise* is kept. Work to support the rights of care experienced brothers and sisters is very much part of keeping *The Promise*. It would be great if this work was more fully 'seen', recognised, and understood. Many thanks to the residential childcare managers who have contributed to this article and have given their permission to be included herein.

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ⁱ The Promise-evidence framework: Siblings- A review of the evidence on the circumstances and experiences of siblings in the 'care system', and the factors which promote or inhibit relationships.

ⁱⁱ The Reports, the Money and Follow the Money published as part of the Independent Care Review in February 2020 explain how Scotland can invest better in children and families. Investing money wisely at an early stage can lead to greater financial savings in the longer term.

ⁱⁱⁱ The Care Inspectorate has a group of care experienced Young Inspection Volunteers who work alongside inspectors as part of the scrutiny of **children's care** services. They enhance the work of the Care Inspectorate in a range of ways bringing valuable insight and experience.

From the low status role of residential (care) workers to the high-status role as house mentors

Frank Ainsworth and Paul Mastronardi

Abstract

This article is about the claim that 'residential work is part of social work', and how the subsequent demise of specialist residential qualifications in both Britain and Australia came about. This demise resulted from the British adoption of the CQSW (Certificate of Qualification in Social Work) as a common fieldwork and residential services qualification. Australia, in time, imported US models of residential care and treatment. Two examples are given, firstly, of how the downsizing of residential facilities in NSW has created a demand for residential placements that cannot be satisfied. This is described as a planning and policy failure. The second example is from education. This educational sector programme avoided the rush by community services to reduce the use of residential facilities. In contrast, this programme, for educationally disengaged young people, has maintained a capacity of 32 young people, and can empirically demonstrate effectiveness in returning these young people to mainstream education. The focus in this programme is on 'educational gain and behaviour change', with staff in the four special houses having an educational role as house mentors.

Keywords

Residential workers, low status, house mentors, high status

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Introduction

In Britain, Australia and New Zealand, the job titles of people who staff residential services for children and young people (CYP) have changed over time. This started in the 1970s under the influence of policies of deinstitutionalisation and the downsizing of residential facilities for CYP. This article comments mainly on British and Australian events.

Downsizing heralded the wider emergence of family group homes (FGH) staffed by married couples, whose task was to provide tender, loving care (TLC – nurturing care) to a group of young people for whom TLC was seen as the best response to their ongoing developmental needs. The recruitment of married couples (with no human service type qualifications) to the role of cottage or houseparents, as they were called, was deemed problematic by the 1980s. By that time there was an increased likelihood of married women being employed outside the family home. In addition, young people who only needed TLC were seen as candidates for foster care, and not residential placement.

The response to this view, and to the related staffing dilemma, was to move to a rostered staffing model, for what became known as group homes (GH). A rostered staffing model for GH involved employing a group of workers to cover the 24/7 daily life of a GH. The staff are known as residential (care) workers. These workers had low status in comparison to community-based practitioners. Staff turnover was, and is, high due to the combination of difficult YP who are placed in GH and the anti-social work hours for staff. Importantly, GH simply provide accommodation and some assistance with daily living activities. Other services, such as education or counselling are provided by external agencies.

GH in Australia primarily cater for adolescents with complex emotional and behavioural issues, who are inappropriate for placement in foster care. TLC would not be enough for these YP. This complexity is usually accompanied by a **young person's** history of multiple failed foster care placements.

Despite this by the 1990s the wish list in New South Wales (NSW) was for 'no more residential care', which turned out to be illusory. In fact, the drive to

reduce the use of residential facilities merely moved CYP, who should have continued to be the responsibility of the child welfare system, into homelessness and juvenile justice systems. Ainsworth and Hansen documented this transfer of responsibility for these YP, in a much-cited article (Ainsworth and Hansen, 2005). The limitations of GH were, later, further elaborated by Ainsworth (2017). The current NSW Alternative Care Arrangements (ACWA, 2020) programme illustrates the problems that arise when downsizing becomes the dominant policy imperative, to which we will return later.

Qualifications

Specialised courses in residential work existed in England in the 1960s at Selly Oak College (Birmingham) and Newcastle and London universities (primarily for Approved School staff). In Scotland, similar courses existed at Langside College **(Glasgow)** and **Aberdeen (Robert Gordon's)**. In Australia low level community college initiatives were to be found in Brisbane and Adelaide.

In Britain, these courses all ended when the Central Council in Education and Training for Social Work (CCETSW) in 1974, made the claim that 'residential work is part of social work'. The plan was that in future the existing CQSW (Certificate in Qualification Social Work) courses would be the professional qualification for both fieldworkers and residential workers. CQSW courses were of two years' duration and generally university based.

The extent to which existing CQSW courses were able to integrate teaching about residential work (group work, use of the environment, etc.) into the existing curriculum of CQSW courses is questionable. Up to this point CQSW courses were staffed by social workers committed to an individual casework model of social work practice. Some courses added a residential services practitioner to their staff, but this had a marginal impact on course content (Ainsworth, 2021).

Reflecting the above orientation, two recent Australian articles illustrate how, to this day, an individualised relationship-based model of practice is inappropriately

imposed on residential programmes, in the belief that this will make these programmes therapeutic (Kor, Fernandez & Spangaro, 2021a, 2021b).

In Britain most residential staff who acquired the CQSW qualification did not return to practice in residential facilities for CYP. Instead, they preferred to take a position in field social work. Thus, the idea that making the CQSW the main professional qualification for residential work would professionalise this area of practice was never achieved.

One contribution to the debate about CQSW courses and residential work was **the publication in 1983 by CCETSW of 'A Practice Curriculum for Group Care'** (CCETSW paper 14.2). This curriculum was never embraced as a practice model by any of the CQSW qualifying programmes, even those that proclaimed to be educating residential workers.

The exceptions to the above were a number of initiatives in Scotland. In 2000 the Scottish Institute for Residential Child Care (SIRCC) was established. Prior to that, in 1995, the Centre for Residential Child Care (CRCC) was set up. In 2011 this organisation morphed into CELCIS (Centre for Excellence in Child Care), based at the University of Strathclyde. Today, CELCIS is at the forefront of the drive to establish a degree level qualification for residential childcare staff. To this end the Centre offers an MSc in Advanced Residential Child Care as well as an MSc in Child and Youth Care studies. No similar organisation exists in any of the three other nation states that make up the former UK (United Kingdom).

Developments in Australia were undoubtedly influenced by the British claim that 'residential work is part of social work'. The eventual demise of Australian community college residential work certificate courses was however more associated with the downsizing of residential facilities for CYP. The downsizing meant that courses of this kind could no longer attract sufficient student numbers to be economic for the named colleges. The state-based Residential Care Associations in Western Australia and Queensland were also made redundant.

Today, Victoria is the only Australian State to specify minimum qualification for residential care workers (VDHHS, 2018). There are three mandatory community college level units. These units are to work effectively in trauma informed care, provide primary residential care, and facilitate responsible behaviour. This should, following further study, result in a Certificate V, in Child, Youth and Family Intervention. This is a vocational rather than a professional level qualification.

In contrast, Australian social work courses are accredited by the Australian Association of Social Workers (AASW), not by a semi-autonomous government body like CCETSW. To qualify as social worker, you complete a generic 4-year degree. The courses do not offer specialisations by field of practice e.g., mental health. As a result, the debate surrounding the notion that 'residential work is part of social work' had little if any impact on qualifying course content.

Importing therapeutic programmes into Australia

International therapeutic platforms or specific models of care have been implemented in some agencies in Australia (e.g. Children and Residential Experiences, CARE [Holden, 2009]; Sanctuary [Bloom, 2013]; the Family Home Programme, TFM [Thompson and Daly, 2015]). Outcome data from the Australian editions of these programmes, other than TFM, is not readily available.

Other models have been developed by local organisations and specialists, including the *Keep Embracing Your Success* (KEYS) model, Anglicare Victoria, (www.anglicarevic.org.au); *The Lighthouse Model* (Barton et al., 2012); the ***Mercy Family Services' Therapeutic Model of Care*** (Wall et al., 2013); and the *Spiral to Recovery Model* (Downey et al., 2015) (Ainsworth & Bath, forthcoming).

For more about the importance of programmes see Ainsworth (2015). Unlike *CARE*, *Sanctuary* or *TFM* the above programmes have not been empirically tested.

Ainsworth and Bath (forthcoming) also identify organisations such as the Australian Childhood Foundation (www.childhood.org.au) and Knightlamp Consulting (www.knightlamp.org) that support other services to develop context-specific therapeutic residential care. The National Therapeutic Residential Care Alliance (www.ntrca.com.au), which has been operating for close to 10 years, is made up of managerial personnel who share their 'collective knowledge' about TRC and seek to play a leadership role in the development of policy and practice.

In addition, all funded GH residential services in NSW must now implement a questionable therapeutic framework developed by Verso consultants (NSW DCJ, 2020), although there is one exception in NSW that will be discussed later. Similarly, in Queensland, all funded GH residential services must adhere to a therapeutic framework called *Hope and Healing* (PeakCare and Encompass, 2015).

Australian examples: Planning and policy failure and service effectiveness

Example 1: Community services

The current NSW *Alternative Care Arrangements* (ACWA, 2020), referred to earlier, illustrate the point that a mature child welfare system will always need some residential provision. Indeed, at any one time, over 100 CYP in NSW are accommodated in motel and hotel rooms, where they are looked after by youth workers, while they wait for a GH placement. These placements are, on average, more costly than any standard GH placement. The shortage of GH placements is the result of the NSW child protection authority reducing the number of GH services they are willing to fund. In that respect the ACA programme is a resounding planning and policy failure.

Example 2: Education and community services

The residential education programme at the Dunlea Centre (DC) (the original Australian Boy's Town) in suburban NSW is an example of service effectiveness.

As an accredited school it has never been subject, unlike other residential services, to the therapeutic framework developed by Verso Consulting (2016).

The centre is a 5 day/4 night (Monday-Thursday) and is a programme that is an accredited residential school for male and female young people. The enrolment age ranges from 12 to 16 years. The centre is a campus-based facility consisting of a modern school, extensive recreational facilities, and four special residential houses (three male and one female) with a capacity of eight young persons in each house (32 YP in total). These houses are in part financially supported by the NSW Department of Community Services and Justice (DCJ). A further house for females is expected to be opened in 2023, giving DC a capacity of 40 young people. The expected period of attendance at DC is a minimum of 12 months. The aim is to return a young person to either mainstream school, college, or employment following completion of their time at the DC.

In the 1990s there was an attempt to cast DC as a family preservation (FP) programme with the addition of family counselling (FC) to the services they provided. This in some way made DC into a hybrid programme, which straddled the education and social work systems. Unfortunately, in 2016 the collection of demographic data showed that 70% of parents who had agreed to attend every two weeks for FC did not do so. Today, DC does not present as a FP programme. Families are now engaged through a time-limited, skills focused Common Sense Parenting (CSP) programme, which has been well received by parents.

Programme change at Dunlea

Following a 2018 review by an expert panel, changes **were made to the agency's** organisational structures and day-to-day educational and care practices in 2019 (Humphreys, Urquhart & Sydes, 2018). As part of the change process the agency adopted the Teaching Family Model (TFM), **as used at Boy's Town in** Omaha, Nebraska (Fixsen & Blase, 2019; Thompson & Daly, 2015). The agency selected the TFM after an extensive review of US and UK residential programmes. TFM has evolved over 50 years (Fixsen & Blase, 2019) and has outstanding outcome evidence, about the productivity and well-being of young

people who have completed the Boy's Town programme (Huefner et al. , 2007; Kingsley et al. , 2008).

The TFM is a cognitive-behavioural intervention characterised by family-style living, integrated support systems, and clearly defined individualised goals (James, 2011). The TFM has been researched and widely replicated. It is identified as a promising best practice model (Fixsen et al. , 2007; James, 2011; The California Evidence-Based Clearinghouse for Child Welfare, 2012).

Evidence of the DC programme's effectiveness was published as, '**Demonstrating the effectiveness of a residential education programme for disengaged young people**' (Mastronardi, Ainsworth & Huefner, 2020). The objectives of the DC programme are 'educational gain and behaviour change', and it is these empirical results that are reported in the above article. The empirical data to support this claim was obtained using multiple administrations of SDQ (Strengths and Difficulties Questionnaire) which was used to measure behaviour change and PAT (Progressive Achievement Test) that was used to measure educational gain.

This programme is unique and is the only non-group home facility in NSW. In Australia it should be noted that the dominant form of residential services is group homes, of which it is estimated there are around 800. The norm is four places per group home, with Victoria moving to two places (Ainsworth and Bath, forthcoming; CCYP, 2019).

In this respect, the DC has successfully defied the move to downsize or move away from the use of a residential facility, as the most suitable form of service when efforts are needed to reengage youth in mainstream education. In fact, the DC demonstrates that, contrary to much of the current negative appraisal, residential programmes professionally designed and staffed can be effective.

Moving the TFM model on – the next step

Boy's Town in Omaha (BTO) in implementing the TFM employ married couples as Teaching Parents (TP) in each campus house, to act as mentors and show young people (YP) how to act in new prosocial ways. BTO does not call TP residential

workers or residential (care) workers, as this is uncommon American terminology. TP do of course also assist YP with daily living activities, when necessary. Importantly, the use of TP as job title confirms that the endeavour is educational, not just TLC (nurturing care).

At Boy's Town Engadine (BTE) the term teaching parent (TP) cannot be used as BTE employ two unrelated staff per special house (not married couples). As a result, it is suggested that the term residential worker, or residential (care) worker be made redundant, in favour of the job title, *House Mentor* (HM). This job title more accurately describes the duties that HM must undertake.

The standing of people employed in residential services as care workers for children and young people (CYP) is acknowledged by social work and child welfare agencies as attracting low status. There are many reasons for this, not least the negative image of this work, as portrayed by federal, state and territory authorities, whose long-term aim has been, and continues to be, to build a child welfare system that contains no 24/7 residential services (Ainsworth and Bath, forthcoming). A job title like House Mentor has the capacity to increase the status of these staff and their level of remuneration. GH staff could reshape their role and adopt the same job title.

Conclusion

The concluding disclaimer is that residential work is *not* part of social work. Neither GH nor DC fit that claim. The eight curriculum content areas for direct care workers as contained in the CCETSW's *Practice Curriculum for Group Care* (CCETSW paper 14.2, 1983) vividly demonstrates this fact. Only item five, on the spot counselling, has a remotely social work flavour.

In fact, the claim by CCETSW that 'residential work is part of social work' was both misleading and harmful. It compounded the drive to reduce the use of residential facilities for CYP with complex emotional and behavioural problems, for which no community-based services are adequate. It has also held back research efforts to design and tested urgently needed new therapeutic residential care (TRC) models (Ainsworth, 2015).

Of course, it might be argued that the drive to create a child welfare system that contains no residential provision means that the benign neglect of these services and their workforce is justified. Why invest in a service you want to see disappear? But closer examination of state and territory services in Australia shows that despite every effort to achieve this aim, residential services, in the form of GH, continue to proliferate while DC is likely in 2023 to increase its female student capacity.

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About the authors

Frank Ainsworth was a CCETSW Social Work Adviser when the council held the **view that 'residential work is part of social work.'** **He no longer shares that view.**

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Self-Harm in Residential Care: A consideration of the evidence and the implications for practice

Lily Burnand and Dan Johnson

Abstract

Young people in residential care settings are disproportionately affected by self-harm. This has an impact on other residents and care staff as well as the young people engaging in self-harming behaviours. Research into the efficacy of care strategies in these contexts is scarce, which makes developing and implementing effective practice challenging. This paper reviews the existing literature to identify important themes for young people and residential care staff in relation to self-harm support and management, and to outline potential areas for further research and policy development.

Keywords

Self-harm, young people, staff, interventions, relational supports, practical support, talking support, professional support

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Introduction

Self-harm is a growing healthcare concern in the U.K. generally, exacerbated by the COVID-19 pandemic and subsequent lockdowns (Farooq, Tunmore, Ali & Ayub, 2021). Although estimates of its prevalence vary, children and young people in residential care are known to be substantially more at risk than the general population (Johnson, Ferguson & Copley, 2017). Adverse childhood experiences and trauma are strongly associated with the development of self-harm and suicidal behaviours (Huntley et al., 2019), and many young people in care have experienced neglect, abuse, and other forms of maltreatment (Wadman et al., 2017).

Within care settings, incidents of self-harm have practical and emotional repercussions for the individual engaging in self-harm, and for the staff and other residents who work and live with the individual (Mendes, 2020). At the same time, staff attitudes and responses play an important part in the experience of the self-harming young person. A comprehensive framework of care that takes into account the needs of everyone impacted by self-harm is therefore crucial.

Definitions and scope

Self-harm is defined in the U.K. as an act of deliberate self-injury, regardless of intent (NICE, 2013). This reflects the fact that while self-harm is a strong predictor of suicidal ideation and suicide attempts, it is not always a precursor to suicide. The most common form of self-harm is cutting; other methods include burning, self-hitting, swallowing or inserting objects, and self-poisoning (NICE, 2013).

For the purposes of this study, the term **'young people'** has been defined as people aged 11-21. This is because the development of self-harming behaviours largely begins in adolescence, and most young people leave residential care between 18 and 21 years of age (Wadman et al., 2017). Outside of the care setting, there is evidence that the experience and prevalence of self-harm differs

within and between groups, according to, for instance, race, gender, neurodivergence, cultural background, LGBTQI+ identification and socioeconomic status (for examples, see Cawley et al., 2019; Sharifi, Krynicki, & Upthegrove, 2015). Existing studies generally treat care-experienced young people as a homogenous group, limiting this **article's ability to comment on** differences between groups. How these differences manifest within residential care settings is undoubtedly an area in need of further research.

Much of the research regarding self-harm in young people focuses on the reasons, motivations, and functions behind self-harm, which are numerous and complex. While it is important for those supporting young people in residential care environments to remain up to date on this understanding, the implications for practice are essential if children are to receive quality care. The focus therefore of this review is on the practical support and organisational processes that can be implemented in a residential care setting.

Residential care encompasses the accommodation services provided to young people when they are unable to live in their own home. This includes care settings for young people whose parents are deemed unable to look after them, secure settings for young offenders, and residential schools.

Method

A literature search was conducted, and articles were included based on their relevance to the purpose of this review. Articles were deemed relevant based on the following criteria: young people with residential care experience in the UK; young people with experience of self-harm; care staff in the UK with experience of caring for young people who engage or have engaged with self-harm; published between 2000 and 2021.

Articles with relevant titles were read and included or excluded based on overall quality and relevance. The initial literature search identified five studies that had care-experienced young people as participants, two that had residential care staff as participants and one with both young people and care staff. Four reviews of the literature were identified as relevant and included in this review.

The initial search criteria were then expanded to include articles that would give useful context and comparison points to the main body of literature. Relevant articles that included young people in other care placements, such as kinship care and foster care, have been included; articles that looked at experiences of older people in residential care, and care staff experiences with older people in residential care were also included as a point of comparison.

Key findings

Research into the impact of supports for young people who self-harm in residential care settings is scarce. Across the studies that do exist, ambivalent and contradictory findings make it difficult to draw meaningful conclusions that can be used to inform effective care strategies. There is a lack of consistent findings in the evidence at individual, group, and institutional levels. These inconsistencies relate to both the processes surrounding incidents of self-harm and the responses to these processes. This perhaps demonstrates that the needs of those who engage in self-harm are nuanced and varied and therefore so must be the responses.

The types of effective supports that emerge most frequently from the existing literature can be grouped according to four key themes: relational, practical, discursive, and professional. This review will examine these themes from the perspectives of both young people and residential care staff, thereby suggesting potential courses of action and areas for further research.

Relational supports

The importance of interpersonal relationships as a protective factor and source of support for young people experiencing self-harm is a predominant theme in the existing literature. This coincides with the established understanding that social isolation is a risk factor for self-harm and suicide, and developing trusting relationships is an important means of reducing self-harm (Epstein & Ougrin, 2020). Strong personal relationships established in a care setting are a crucial element of effective support.

In a recent study that explored what young people who self-harm find most useful, care-experienced young people named friends and pets as two of the most useful sources of support, while A&E and social services were two of the least useful (Holland et al., 2020). In the same study, non-care-experienced young people identified siblings as a useful source of support and expressed a desire for support from people who have been through similar experiences. Interestingly, Child and Adolescent Mental Health Services (CAMHS) were cited as both the most and the least useful service. Free-text responses allowed the authors to draw some limited inferences about the reasons behind these results, and they suggest that the range of services provided by such a large organisation leads to differing experiences for service users. They also attribute positive experiences to positive interactions with individuals, rather than the organisation or service itself. In keeping with this interpretation, their findings indicate that for young people, the most useful sources of support are the individuals who immediately surround them, and who are not associated with professional organisations. This is an important finding for residential care staff, whose role within the care setting is both immediate and professional.

These findings resonate with earlier evidence that young people find positive relationships with staff to be a more significant source of support than interactions with healthcare professionals. Piggot, Williams, McLeod and Barton (2004) found that young people identified internal members of staff who listened, empathised, and got to know the young person and their history of self-harm as the basis for effective support. One young person from this study explicitly credits the perseverance of a particular member of staff with helping to reduce her self-harm, and others mention talking, listening, and demonstrating genuine care – for instance, staying on beyond the end of a shift to talk – as helpful and supportive. By contrast, medical professionals, external psychologists, and social services were associated with inappropriate responses and negative experiences, such as jargonistic language, a lack of compassion or understanding of the emotional needs of the young person and feeling judged. Piggot and colleagues infer that the emotional distress that arises from negative interactions can increase the secrecy of self-harming behaviours, which inhibits **the young person's ability to access and receive the right support, therefore**

making further self-harm more likely. A more recent study on self-harm **disclosure describes this cycle as 'help negation'** (Haskings, Rees, Martin & Quigley, 2015). The authors suggest that when self-harm disclosure is met with fear, discomfort or misinterpretation, this reinforces the avoidance of support services. The study also found that adolescents who self-harm are more likely to confide in a friend (67%) than an adult (32%), reiterating the importance of social connectedness as a feature of engaging with support networks. The authors conclude that informal support such as family and friends can act as a pathway to seeking help from formal sources of psychological support, which suggests that help-seeking is an incremental process that begins with reaching out to people who are socially important but have low professional or psychological expertise.

Social connectedness often exists between peers in the care setting, as well as between staff and young people, and seeking support from friends can be a stepping-stone in the process of seeking professional psychological help. When developing a self-harm care plan, it is therefore important to include support for both staff and young people in their knowledge and understanding of self-harming behaviours in others. Providing all young people with knowledge about self-harm and how to seek support for this may help those who harm themselves, those who do not but are exposed to it, and those who are in relationships with these young people.

The positive outcomes of social connectedness are complicated by the potential for contagion of self-harming behaviours in care settings. There is amassed evidence that having family or close friends who have self-harmed increases the likelihood of young people engaging in self-harm (see Hasking et al., 2015). The same study also indicates that exposure to self-harm content can increase assumptions about its prevalence in others. Over-estimating the prevalence of a behaviour within your social group is a known factor for increasing the likelihood and frequency of a type of behaviour within that group (Bicchieri, 2005). Studies that looked at residential groups and close-knit communities demonstrated that similar methods of self-harm (and suicide) exist within groups, suggesting that **these methods are 'transmitted'** (see Cheng, Li, Silenzio

& Caine, 2014). Though causal factors are almost impossible to delineate, greater understanding of what contagion constitutes within a care setting would help practitioners and staff support groups of young people living with an individual or individuals who self-harm. For instance, contagion is often framed as the result of social influence (Insel & Gould, 2008). In such cases, identifying socially influential individuals within a group and addressing their behaviour can be a useful means of addressing group behaviour. On the other hand, self-harm behaviours **'spreading' in a care setting could be indicative of compounding** factors such as the heightened stress on all residents of living with traumatised young people, combined with reduced inhibitions (Wadman et al., 2017). In these cases, the supports and interventions discussed in this article all apply.

Practitioners and care staff should also be wary of using terminology associated with disease, as this promotes the idea that self-harm is something which young people need to be **'cured' of** (Cheng et al., 2014). As discussed later in this article, indicating to young people that they need to stop self-harming can result in greater emotional distress and increased self-harm.

Research into the experiences of residential care staff similarly highlights the importance of building strong **personal relationships**. Piggot and colleagues' (2004) study found that moving staff between houses within a care setting was regarded as detrimental to providing effective care, as it inhibited staff from developing their knowledge of individual young people. A more recent study corroborates these findings, indicating that staff attribute their ability to provide effective care to knowing individuals on a personal level, and being familiar with aspects of their behaviour and experiences (Evans, 2018). Staff in this study perceive self-harm to be a method of communication, and their understanding of the individual engaging in self-harm contributes to their ability to interpret what is being communicated. By contrast, the insights of external healthcare professionals can be seen as limited in this respect. Likewise, care staff reflected that self-harm can be a means to influence relationships, regarding this as operating on an individual interpersonal level within the care setting, rather than on a systemic level. An example of this is that staff reported individuals only engaging in self-harm when a particular member of staff was on duty, which was

interpreted as a sign that they felt they would get the desired care from that person (Evans, 2018).

Building on these findings, Jennings and Evans (2019) found that the emotional investment of their work is an important aspect of how residential care staff self-identify in the context of their job. The authors noted a contrast between staff depictions of their own role, which emphasised the importance of experiential expertise and the complex understanding they have of the young people they work with, and the role of clinicians and psychiatrists, which was perceived to be founded on academic expertise, but empathetically limited and impersonal.

Nonetheless, establishing and maintaining personal relationships is a challenging **aspect of care workers' roles. There is a growing body of research supporting the** anecdotal evidence that managing self-harm in residential care settings is extremely emotionally demanding for staff, with consequences that impact their work and their personal lives. Asarnow and Mehlum (2019) hypothesise that practitioners may experience secondary traumatic stress when working with children and young people at risk of self-harm and suicide, and that a trauma-informed approach to supporting staff (as well as young people) is essential. Similarly, Brown and colleagues (2019) identify aspects of staff experiences that mirror the isolation and coping difficulties experienced by those they are caring for. Their study indicates that staff experience primary traumatic stress following self-harm incidents, as they report invasive thoughts and flash-back memories that are characteristic of post-traumatic stress disorder. In addition to this, staff describe the difficulty of engaging with young people on an emotional level, instead adopting automated responses to help them comply with self-harm **protocol. At the same time, coping strategies that include 'switching off'** emotionally or distancing oneself from the reality of the event inhibit care **workers' long-term** ability to provide compassionate support in the care setting.

Research into strategies for supporting staff is limited, and the existing literature is filled with contradictions. In residential settings for adults, emotional debriefing for staff after an incident of self-harm is often negatively received, as it brings unpleasant emotions to the surface (Mendes, 2020). Some researchers suggest that time off for staff in response to the increased strain of managing a

young person's self-harm is essential to avoid burn out and maladaptive coping mechanisms (Mendes, 2020). Conversely, there is also evidence to suggest that care workers find the intimacy of the care setting, where other staff have similar experiences, offers better emotional support than going home. For example, in **Brown and colleagues' (2014, p.13) study, one participant described the team of social workers as 'like a family', with switching back to normal life being seen as challenging.**

The evidence above has numerous implications for practice. It is important that residential care staff can identify who is socially significant for individuals experiencing self-harm and to nurture the social (over the professional) nature of these relationships. This lends support to the key carer or key worker model seen in many residential care settings where a named carer who is a good **personal match for the individual leads the child's care and attempts** to build a particularly strong relationship.

Given the similarities between the experiences and demands on both staff and young people, support structures that employ similar mechanisms may be beneficial to both groups. As suggested by Asarnow and Mehlum (2019), a person-centred and trauma-informed approach to staff support plans is a potentially fruitful means of improving their ability to cope in a high-stress work environment. Increased support for individuals who are working closely with at-risk young people needs to occur at three levels: practical, to reduce the strain of working at or beyond capacity; psychological, to help them process emotional stress and traumatic events; and continuous, to avoid crisis development and to create a proactive rather than reactive care structure for both young person and staff member. Support processes that are adaptable to the needs of the individual, and simultaneously consider the impact of their work on colleagues and residents, are likely to be most effective. For instance, it is important to prioritise care responses that encourage engagement and processing of events, and empathy between care staff and young people. For some, this might entail taking time off, whereas others might benefit from being around their colleagues and continuing to engage with their work.

There is a clear need for further research into the impact on residential staff of caring for someone who engages with self-harm. Several studies exist on this topic as it applies to parents and nurses and indicate that it takes a significant toll on their jobs, marriages, families, and their own resilience (see Brown et al., 2019). Greater understanding of how to support residential staff would be hugely beneficial.

Talking supports

A distinctive feature of the research into what young people would find helpful as a means of managing self-harm is the opportunity to discuss their needs with the carers and psychologists who interact with them. Experiences of self-harm are known to be varied and complex, and both young people and residential care staff indicate that they would benefit from talking about the historic and present experiences of the young person engaging in self-harm. Open and non-judgemental discussion is likely to strengthen relationships and improve engagement with support services.

In a study into the efficacy of care strategies in a residential setting, young people identified that staff who showed an interest and understanding in their lives and backgrounds were most able to provide effective care (Johnson, Copley & Ferguson, 2017). Discussing care needs with staff was seen to have a positive impact both long- and short-term. The authors of this study recognised that young people interpreted staff taking the time to talk to them about their **personal experiences as demonstrative of 'genuine' care, which was conducive to developing trusting relationships**. As well as being a step in the direction for seeking and engaging with professional psychological support, trusting relationships are an established protective factor for young people engaging in self-harm (Bryant et al. , 2021).

Rouski and colleagues' (2021) recent study similarly suggests that participants seek genuine care through their self-harming behaviours. The authors of this study identified the need to be understood as a key theme, as young people highlighted the importance of acknowledging that their lives, experiences, and current context contribute to their engagement in self-harm. As in Johnson and

colleagues' (2017) study, participants reflected that young people have idiosyncratic care needs, and expressed a desire for more opportunities to discuss these needs with staff. For instance, some participants described staff **'checking in' as demonstrative of genuine care**, while others felt it was an invasion of personal space. Young people also associated being understood with emotional containment, which is seen as an important factor in managing and reducing self-harm. Staff who are familiar with the individual and their behaviours are less likely to respond with panic, fear or uncertainty, and consequently young people feel more accepted and more able to trust those who are looking after them.

Effective care strategies differ between individuals, and also over time for the same individual, further highlighting the importance of open and frequent conversations about the needs of the individual. Wadman and colleagues (2017) looked at the differences **between young people's first engagement with self-harm** and their most recent. Many reported feeling better after their first episode, but this was not a significant motivating factor for those who continued to engage in self-harm. Instead, the perception that they could not tell anyone how they were feeling was cited most frequently for care-experienced young people who had recently engaged in self-harm. This study also revealed, through pre- and post-study emotional state ratings, that discussing the topic of self-harm was not emotionally detrimental to participants. The authors conclude that interventions which prioritise sharing emotional distress and communicating feelings are likely to be effective in a residential care setting, corroborating the above findings that young people would benefit from more opportunities to discuss their experiences.

Taken together, these findings indicate that communication is central to effective care strategies for self-harm. Young people can identify what care processes work for them, and staff benefit from increased confidence when they know they are delivering the care that the young person in question finds helpful. In line with the desires expressed in these studies, incorporating space for young people to talk to staff about their historical and current experiences with self-

harm is likely to strengthen relationships and improve engagement with a variety of support services.

This is already reflected in the practice of many residential care settings and forms an important part of individual care plans. Having a culture of open dialogue between young people and staff (and within each of these groups) would facilitate even greater adaptability of care plans, ensuring that the care the young person is receiving remains helpful and relevant. Furthermore, increasing the number of people that a young person feels able to talk to would increase the number of trusting relationships they are able to establish, which is doubly beneficial as a protective factor for self-harm, and as a means of relieving pressure and responsibility for individual members of staff.

Practical supports

There is a scarcity of research into the impact of specific care processes designed to manage self-harm in residential settings. Ethical concerns and logistical obstacles limit the number of appropriate methodologies for conducting research in this area. Many of the existing studies have small sample sizes and produce data that relates to a highly specific context. Nonetheless, it is useful for practitioners to understand the individual procedures as well as the broader themes that contribute to effective care, given the nuanced and potent emotional triggers for young people in care.

A recent study by Cliffe and colleagues (2021) looks specifically at the usefulness of harm minimisation techniques for young people who engage in self-harm in secondary mental health care. Harm minimisation constitutes using actions that in some way emulate the act of self-harm, but in a way that reduces the potential physical harm to the person. Some examples include snapping an elastic band against the skin to create short, sharp pain without creating an incision in the flesh, or drawing with a red pen on the skin to create the visual impact of cutting. Their results indicate that of the participants who use these methods, 92% found them to be helpful in reducing self-harm. Specifically, harm minimisation was cited as an effective way to reduce the negative outcomes of self-harm without aggravating the emotional distress brought on by stopping

altogether or imposing unrealistic expectations on young people to stop. The authors note that there are barriers to implementation that include ensuring staff are well-trained and comfortable with the use of the techniques, as well as a necessity for further research using cohort studies. Their findings, for instance, contradict those of Holland and colleagues (2020), who reported that one-third of participants found harm-minimisation techniques actively helpful, while one-third found them actively unhelpful. Research into staff attitudes towards harm minimisation is a necessary first step in developing training programs for staff and would yield insights about barriers to implementation from the perspective of people with direct experience of caring for at-risk young people.

A similarly ambivalent body of evidence surrounds the efficacy of direct interventions. Johnson and colleagues (2017) found that processes that were understood to protect the safety of residents were perceived by young people as necessary even when experienced as unpleasant. Participant responses generally endorsed systematic care processes such as room checks and removal of means, while also giving suggestions about how to mitigate unhelpful consequences. These suggestions focused on minimising the emotional distress that arises because of invasive practices and limiting interventions to what is practical rather than punitive. One young person, for instance, mentions the importance of keeping photographs of family and loved ones in her room; another suggests returning items to their room once they have calmed down. Furthermore, improper implementation of these processes is perceived to directly contribute to the emotional distress of the young person, thereby increasing their drive to self-harm, rather than reducing it. Young people mention careless slamming of doors and showing little respect as particularly distressing.

Rouski and colleagues (2021) similarly found that young people demonstrated ambivalent feelings about direct interventions. Room checks and observation **routines were described as 'unnerving'** (Rouski et al., 2021, p. 424) and served as a reminder that they were not at home, which exacerbated risk factors of self-harm, such as losing control and social isolation. Likewise, some found that the depersonalised aspect of routine care was emotionally distressing, while **others found that consistency within and between individuals' care routines was**

a key factor in eliminating the need to test boundaries through self-harm. Young people in this study also described the danger of boredom that arises from restrictions, which on the one hand eliminates distractions from negative thoughts and on the other hand builds frustration in response to having limited freedom.

These findings highlight the importance of explaining the reasons behind care procedures, and the scope and extent of the procedure, so that young people understand what is happening and know what to expect. Lack of control and autonomy are known risk-factors for young people engaging in self-harm and developing these skills in young people is a foundational aspect of trauma-informed care approaches. Similarly, procedures that are structured around positive emphasis, for instance goal-based procedures, are more likely to be effective and to cause minimal emotional distress than punitive processes that have little or no practical benefit, like removing non-harmful belongings from a **young person's room**. As Wadman and colleagues (2017) identify, punitive and restrictive interventions conflict with the goal of creating as normal a setting as possible for the young person to feel at home and accepted in.

This relates, too, to implicit or explicit indications that young people need to stop self-harming. Young people have expressed the difficulty of stopping (Rouski et al., 2021), and there is evidence that the combination of adults imposing unrealistic expectations on young people and removing their tool for emotional regulation causes emotional distress in the young person (Cliffe et al., 2021). This can lead to increased secrecy around self-harming behaviours, and the breakdown of trusting relationships between adult and young person, all of which inhibit help-seeking. The notion that self-harm is **something 'wrong'** insinuates a lack of acceptance. Rejection of all kinds is associated with increased prevalence of self-harm (Cawley et al., 2019), which implies that young people feeling safe to freely be and express themselves – even if that is through self-harm – is an important step towards emotional resilience. Balancing the competing implications for the long- and short-term safety of young people in care settings is a complicated and persistent challenge, but it is essential that

policies consider the long-term psychological effects of the immediate practical interventions implemented to protect the physical safety of the young person.

Practical training for care staff is crucial both when new to a care setting, and regularly to maintain a high standard of implementation. Additionally, providing young people with a channel for communication, where they can voice their experience of specific procedures, without fear of criticising individuals or the organisation as a whole, is also likely to contribute to greater efficacy and understanding across the care setting. This is particularly challenging and important in the context of self-harm, as people who engage in self-harm often struggle to articulate what they find distressing or helpful. Co-designing procedures and regularly reviewing these will be challenging but likely to result in much more effective supports.

Distraction is used increasingly as a short-term intervention for self-harm, with the aim of breaking the chain of thoughts, emotions or habits that lead to self-harm (Walker et al., 2016). Distraction techniques include engaging in activities such as gardening, exercise, crafts, or puzzles (Harrison and Sharman, 2005). In a study comparing care-experienced and non-care-experienced young people, Holland and colleagues (2020) found that distraction was effective for young people who are not in residential care, whereas fewer care-experienced participants reported using it. The authors of this study note the efficacy of distraction as a time-targeted and immediately accessible intervention, which implies that it would be easy to implement in a care setting; however, caution should be used if encouraging young people to try this or any other technique. Distraction may be a helpful technique, but practitioners should be mindful of proportionality i.e., it is unclear whether distraction would be effective in the face of significant distress.

Wadman and colleagues' (2017) analysis of the timeline of self-harm incidents gives an insight into the important factors that immediately precede an act of self-harm. They note that impulsivity and a reduced fear of death, combined with social isolation and having access to means, can be interpreted as warning signs. Wadman and colleagues suggest that time-targeted interventions could be

an effective way of addressing the varied and changing factors that lead to self-harm.

Holland and colleagues (2020) also found that care-experienced and non-care-experienced participants reported differing engagement with external support services, family members, and medication. The study did not identify whether these differences were a result of different preferences between the groups, or of accessibility differences. Identifying where accessibility to desired strategies of self-care management could be improved for care residents would be a useful follow-up to this study. As highlighted by Wester and Plener (2020), reinforcing help-seeking behaviours in young people before they engage in self-harm is a robust means of reducing the amount and severity of self-harm, making this an important behaviour for residential care staff to understand and nurture.

The way interventions are carried out also impacts staff well-being. Across several studies residential care staff indicate that having clear protocols surrounding self-harm gives them confidence and reduces fear of being blamed for failing to prevent instances of self-harm. Piggot and colleagues (2004) found that staff were apprehensive about the responsibilities attached to working with young people who engage in self-harm. Staff expressed a desire for greater training to help their decision-making abilities in moments of crisis, and indicated that they lacked knowledge and understanding of the legal implications of incidents of self-harm in a residential care setting, which contributed to their uncertainty and reluctance to take responsibility. Despite improvements in the training and support care staff receive since 2004, a recent study (Brown et al., 2019) indicates that staff still feel undertrained, and this impacts their approach to working with young people. The authors found that staff would avoid working closely with at-risk young people out of a fear of blame, which was coupled with feelings of ineptitude in their own training and the available support.

Staff responding with fear and uncertainty has been identified as something that **exacerbates young people's emotional distress, making this a doubly important** area to address. Most importantly, staff need to be informed of the legal framework in which they are working, with clarity of roles and responsibilities and clear channels of communication between staff levels. Additionally,

implementing response processes that minimise decision-making for staff following incidents of self-harm would be beneficial both for staff, in that they can respond effectively with confidence, and for young people, whose experience of care will be improved. Finally, it is crucial that care settings avoid blame culture, and frame incidents of self-harm as an indication that something needs to be learnt or changed systemically, rather than as the result of an individual failing.

Professional supports

The professionalism of staff is a prominent issue in the care sector that emerges from research across a variety of themes. Historically, care roles have been associated with non-professional nurturing roles such as parenting, and there is some evidence that this remains apparent in the care sector in the form of the inadequate remuneration and training that care workers often experience (Jennings & Evans, 2020). Young people, care staff and practitioners have identified a **lack of clarity around care workers' roles and responsibilities, and** insufficient training or experience as barriers to effective care and the development of new care approaches (see Rouski et al., 2021).

There is a persistent tension in the existing body of evidence between staff expressing a desire for increased professionalism – through training, responsibility, and acknowledgement – and critiquing other professionals in the **care system. In Piggot and colleagues' (2004) study, residential care staff** express a desire for more accessible information on self-harm for both young people and care staff, as well as increased levels of training for staff. This is expressed alongside ambivalence towards external organisations, who are perceived as having the means to provide effective care but being difficult to reach in a moment of crisis. Increased expertise for staff can be understood in this context as a way of reducing dependency on external support and improving internal staff ability to cope with instances of self-harm.

In the same study, young people also recognise the importance of staff training and expertise as it impacts their experience of support services (Piggot et al., 2004). Young people indicated that internal staff are the most salient source of

support within the care setting and highlighted that staff responses to incidents of self-harm **impact the young person's emotional containment in the moment**. Almost twenty years later, **young people's experience of care is still affected by** insufficient staff training and experience. Rouski and colleagues (2021) found that participants recognised fear or panic in staff responses to self-harm, and this leads to emotional instability for the young person in the short-term and a **lack of trust in the staff's ability to do their job in the long-term** (Rouski et al., 2021).

Evans (2018, p. 946) refers to care staff as 'corporate parents', encapsulating the tension involved in occupying a statutory role that also demands the intimacy and emotional investment inherent in nurturing a child. A key theme that emerges from this study is the demarcation of responsibility according to severity and type of self-harm. **Residential care staff associate 'hidden' self-harm** with biomedical issues that are the remit of psychologists and clinicians, while **'visible' self-harm** is seen as a relational issue that tests and reifies the social dynamics within the care system (Evans, 2018). Although these differences map onto existing literature, there is no corresponding demarcation of responsibility that functions across the care system, nor is there a national minimum standard of training for care workers, despite the complex and demanding nature of their job (Brown et al., 2019). One concern regarding these systematic grey areas is **that the lack of clarity could translate into young people's experience of care**, leaving them unsure as to from whom and where support will come, and reinforcing the use of self-harm to test existing channels.

Jennings and Evans' (2020) study corroborates the above findings. Their results suggest that care staff undergo an effort of legitimisation when working with external organisations and feel disenfranchised in the context of healthcare professionals with formal qualifications. At the same time, they express an aversion to increased professionalism of their role, which the authors of this study interpret as a wariness that increased professionalism will come with **increased scrutiny and culpability should something 'go wrong'**. This ambivalence reappears in participant responses regarding medical professionals. While their attitude towards self-harm is regarded as lacking in understanding and

compassion, their role in the care process is acknowledged as essential and distinct from that of care workers, because of their technical expertise.

By contrast, care workers see their role as providing them with a unique perspective because of their close relationship with the young person, and they place value in experiential over academic expertise (Jennings and Evans, 2020). Participants in this study mentioned that excluding care workers from the decision-making process of a young person's care plan means that valuable insights are lost. At the same time, staff describe how they often experience poor treatment as a direct result of their close relationships with young people. Participants in this study reflected on several situations in which they experienced negative interactions with medical professionals, including the assumption that they are underqualified to support children with complex needs as a result of past trauma, being associated with 'problem patients' in hospitals, and consequently being treated with exasperation, and in some cases receiving blame for failing to prevent or even contributing to a young person's engagement in self-harm.

There is a clear need for increased knowledge among care staff. Standardised training across the care sector would help to distinguish care workers from non-professional roles, and to ensure a consistent level of knowledge and ability throughout the sector. Moving between care units can be emotionally distressing for young people, and this is exacerbated by the inconsistency of care provision available within different units (Brown et al., 2019). Sector-wide consistency in the kind of practical, medical, and psychological support that is available internally and externally to a care organisation, as well as similar standards and expectations upheld by staff, would help to reduce the stress involved in moving to a new care setting. Training should be coupled with access to information resources that are designed with both staff and young people in mind. The insights from young people that staff responding to instances of self-harm with fear and panic is actively unhelpful indicates that scenario-based training could be a useful way of preparing staff for situations that are highly emotional. Additionally, collaborative training programs whereby staff share their experiences, perspectives and support would help to create consistency as well

as strengthening bonds between staff and helping individuals to develop coping mechanisms when faced with high-stress situations.

There is also a need for clear distinctions between the responsibilities of residential care workers and those of medical and psychological practitioners, which should match the level of training and capacity of each group.

Acknowledging the progression of training and responsibility through formal qualifications would be a useful means of ensuring consistency and legitimising the work of care staff in the eyes of organisations both within and outwith the care sector. The studies above indicate that distinguishing between biomedical issues and the relational functions of self-harm could be a useful framework for establishing different responsibilities. For instance, residential care staff indicate that they consider it their responsibility to create an environment that promotes the general safety and emotional resilience of the young person, while it is the responsibility of specialist services to manage their immediate medical and psychological needs following instances of self-harm. Communicating these distinctions to young people in residential care means that they know who can and will provide what kind of support, reducing the need to test these limits.

Increased professionalism, however, should be carried out with caution, as there are several **potential negative outcomes linked to staff and young people's** perceptions and experiences of professional organisations. Crucially, care **workers perform an important social role in young people's lives (as discussed above)**, which risks being obscured by increased professional status. Training that prioritises personal engagement, empathy and the social aspect of care roles is likely to be most effective in managing self-harm. Young people themselves have indicated that incorporating perspectives of people with care experience and histories of self-harm would increase empathy and understanding, and thereby improve relationships between young people and staff (Rouski et al., 2021). Furthermore, it is important that changes to roles, responsibilities or qualifications are carefully accounted for and clearly delineated, to avoid confusion for young people and to ensure that staff remain clear as to the remit of their job. This includes clarity on the legal implications, as well as the escalation processes within the care setting.

Conclusions

Across the existing literature on self-harm among young people in residential care settings, the importance of positive relationships between staff and residents emerges as a predominant theme for both groups. This is consistent **with existing evidence that social factors play a significant role in young people's** experience of and engagement with self-harm (Bryant et al., 2021). Developing and maintaining these relationships is a complex and challenging aspect of **care workers' roles. Connecting emotionally with young people who have histories of** trauma, and who struggle to trust and engage with adults, is draining and can lead to secondary trauma. Witnessing self-harm incidents, particularly when the person self-harming is in your care, can cause traumatic stress for the staff. Young people who form close relationships within the residential setting are also likely to experience emotional distress as a result of their **friends' self-harming** behaviours, which can lead to an increased likelihood of them engaging in self-harm.

The importance of positive relationships is further reflected in conceptualisations of the role of residential care staff, both in how they perceive their duties, and in how they are perceived within the care sector and more broadly by society. The nurturing aspect of their role, which is crucial to the delivery of effective care, is contingent on understanding the individual and developing a trusting relationship. At the same time, this dynamic is often what causes residential care staff to be overlooked and disenfranchised with regards to their professional status within the care sector. There is a notable lack of training across the **care sector in the U.K., coupled with a lack of clarity about residential care staff's** duties, which can translate into a lack of clarity for the young people they are caring for.

Greater levels of training pertain to carrying out individual processes, as well as increased professionalism in general. Young people express ambivalence towards certain processes that aim to protect their safety, often because of negative interactions or poor delivery from staff. Looking beyond residential care to incorporate methods that are effective for young people experiencing self-harm is necessary to ensure that care-experienced young people are provided with

every opportunity to take their mental and physical safety into their own hands, and benefit from available support services. Approaching self-harm management in a way that helps young people to feel accepted and safe in their environment **furtheres the goal of care settings to provide a 'normal',** stable, and nurturing home for young people.

Finally, at every level, talking and having open discussions has been highlighted as a crucial aspect of developing care processes. Young people have indicated that there is a need for more opportunities to discuss their histories of self-harm with staff, and to be listened to and understood by external healthcare professionals. Staff acknowledge this, though admitting that it can be **emotionally challenging, and that their shift patterns often don't allow the time** to properly engage with a young person. Both staff and young people have also indicated that talking about what care requirements the young person has in moments of crisis and more broadly makes for positive interactions. Young people feel heard and can build autonomy, while staff are able to deliver the right care with confidence.

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A qualitative study of the views and experiences of those working in residential children's homes

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Abstract

Young people in residential children's homes have typically experienced significant child maltreatment and will have likely experienced multiple placement moves; both are associated with a range of poor outcomes and impact on wellbeing. Whilst much is understood about the impact of child maltreatment, little is known about how residential health care workers experience and understand the potential difficulties the children they look after experience. Our study aimed to gain an insight into the views of residential workers, how they understand their role, and what barriers they experience in their work, as well as supportive factors. We used a qualitative design to **understand residential workers' perspectives of supporting their young people.** Five focus groups were run with a total of 22 participants. Participants were predominantly female and ranged in age and years of experience within the sector. Participants worked in five residential care homes across England and Wales. Three core themes were identified using thematic analysis. Firstly, residential workers feel this is a rewarding profession but not one that is well understood and valued by society. Secondly, factors such as shift demands and managing challenging behaviour can be barriers to residential workers being emotionally available to the children in their care, but factors such as being part of a cohesive team and access to reflective spaces help promote resilience. Thirdly, workers recognise that confidence and skill impact their ability to successfully manage challenging behaviours. The implications of the findings can **be used within children's services to promote workers' wellbeing**, to reduce staff burnout and secondary trauma, and to improve retention, which can increase

positive outcomes for young people in their care and can guide practice within the residential care sector.

Keywords

Residential care, residential healthcare workers, looked after children and young people, **children's services**

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Introduction

There are approximately 102,000 young people under the care of UK local authorities (NSPCC, 2021), with this number continuing to rise (Parry et al., 2021). **Although occupancy data within children's residential homes is not easily identifiable for a full year, at the end of March 2019 there were approximately 6,400 children in English children's homes alone (Ofsted, 2020).** The most common reason for a child being placed in care is exposure to maltreatment (Ofsted, 2020; Welsh Government, 2020). Child maltreatment is considered a key risk factor for poor outcomes, including high rates of psychopathology, behaviour difficulties and poor educational outcomes (Chapman et al., 2004; McCrory & Viding, 2015). The prevalence of mental health problems is particularly high for children who have experienced maltreatment and been placed in out-of-home care (Baldwin et al., 2019).

A common experience of those in residential care is multiple placement moves; a third of children in residential care will have had at least six previous failed foster placements (Narey, 2016). Research has shown that placement breakdowns often have a further detrimental impact on a child's wellbeing (Rahilly and Hendry, 2014), with estimates suggesting that 75% of young people in residential care meet the criteria for at least one mental health disorder, compared to 40% of those in foster families (Meltzer et al., 2003).

There is currently very limited research into understanding how those who care for young people in residential care experience their role, and cope with the difficulties of the children they look after. The workforce has been largely overlooked by past research, compromising the ability of the sector to develop and meet the needs of its staff (Haggman-Laitila et al., 2019; Parry et al., 2021).

Limited research has shown that residential workers often find it difficult to define and understand their role (Smith, 2015). A common perception emerging in the literature is that residential workers are unsure how to best manage challenging behaviour and lack practical advice and strategies (Smith et al., 2015). Within the current study, the term 'challenging behaviour' is used as an umbrella term to encompass a broad range of behaviour that can be difficult for

residential workers to manage, often underpinned by emotional dysregulation and/or attachment related needs. Research with foster workers has highlighted their concerns about how to navigate social care and mental health services, and mixed views about how best to support young people with complex mental health needs (Hiller et al., 2020).

The current study aims to explore the issues residential workers experience when working with children who have experienced maltreatment, including their perceptions of the support they receive and their methods for managing challenging behaviours. This research could provide a deeper understanding of residential workers' experiences and perceptions to inform policies and practices to promote positive outcomes. Respondents who participated in this research all work within a private residential care company within the United Kingdom.

Method

Ontology and epistemology

Critical realism asserts that whilst an external world exists and humans can gain knowledge of it, this knowledge relies on perception which is influenced by individual interpretation (Burr, 2015). The current research was conducted through a critical realist perspective with regards to ontology, thus being compatible with the chosen qualitative paradigm (Braun & Clarke, 2022). The researchers adopted a constructivist stance on epistemology. Constructivists recognise that humans gain knowledge and interpret reality according to pre-existing knowledge and experiences. The ontology and epistemology outlined led the researchers to a reflexive thematic analysis methodology. This approach enables an inductive **exploration of residential health care workers' experiences** of dealing with challenging behaviour, placing emphasis on what can be learnt from their subjective perspectives.

Sample and procedure

This project was completed as a service improvement study, to learn about the needs of residential healthcare workers. All participants provided informed

consent for their participation. Participants were 22 residential healthcare workers, who cared for young people within private residential care homes across multiple local authorities within England and Wales.

Flyers advertising the focus groups were circulated via email to children's homes served by a large national provider. Five children's homes responded, and all workers were invited to participate. The five focus groups were then organised, consisting of between three and six participants.

Focus groups ran for between 1-2 hours via the virtual medium of Microsoft Teams. Prior to the focus group, all participants completed a self-report background questionnaire, with details of their age, region of the UK in which they work, gender, and duration of time working as a residential care worker. Focus groups were run using a semi-structured question guide that was intended to capture information on (i) the types of challenging behaviours workers see, (ii) how they manage challenging behaviour, (iii) common challenges they face as residential care workers, (iv) how workers deal with and support young people when discussing disclosures, (v) how workers become equipped with the skills and knowledge needed to work effectively, (vi) what further support/training workers would like and, (vii) common challenges workers face in their role.

Transcribing and coding

The focus groups were recorded and then transcribed verbatim, with transcripts further quality checked by another researcher who had not attended the focus groups. Using NVivo software, the transcripts were then analysed and coded using Braun & Clarke's (2006, 2013) guidelines for thematic analysis. The researchers were interested in investigating the experiences of residential health care workers, exploring what could be learnt from them in an inductive way. Reflexive thematic analysis was used to develop themes across the dataset in a way that embraced researcher subjectivity, viewing it as a resource (Gough and Madill, 2012), rather than a buffer to knowledge production. Additionally, thematic analysis was used to allow for detailed exploration of the transcripts without the need for concrete theoretical frameworks in place prior to coding (Braun & Clarke, 2006).

The coder first read all five transcripts to gain an overview of the data, after which each transcript was systematically coded. Codes were then grouped to form themes. Each transcript was then analysed by a second coder to allow for richer analysis and interpretation of codes. Key themes were consistent across the five focus groups. There was not capacity within the study to seek further input from participants at this point. However, reflective practices were used throughout all interviews by the interviewer to confirm a strong understanding of the conversation and to reduce the chances of misconstruing what was being said (e.g., summarising back to participants and seeking further clarification where needed, and reflecting on the answers given).

Results

Descriptive information

Participants were spread across the adult age range, but the greatest number were within the 25-34 age bracket, and they were predominantly female. There was a range of experience within the sector, with four participants being new to the role, and eight having over 10 years of experience. Descriptive information for the participants is presented in the table below.

Demographic	Number *
<i>Age (years)</i>	
18-24	2
25 -34	8
35-44	2
45-55	4
Over 55	3
<i>Gender</i>	
Female	14
Male	5

<i>Location of residential home</i>	
Shropshire	2
Lancashire	4
Northeast	3
South Gloucester	4
Wales	6
<i>Experience</i>	
Less than a year	4
1-3 years	5
4-7 years	2
8-10 years	1
Over 10 years	7

*Three workers did not report this information

Table 1: Descriptive information for the participants

Focus group themes

Thematic analysis identified three core themes across all five focus groups. (1) Workers identified that it is a rewarding profession but one that is neither well understood nor valued by society. (2) Many factors can be barriers to the residential workers being emotionally available to the children in their care, but other factors help promote resilience. (3) Workers recognise that their confidence and skill impact their ability to successfully manage challenging behaviours. Within each theme, several sub-themes were also identified.

Theme 1: It is a rewarding profession but one that is not well understood or valued by society

Participants discussed the main challenges they face within the role, in terms of both the pros and cons of being a residential worker. Responses across all five groups fit broadly into four subthemes.

Subtheme 1: Workers feel very well supported within their teams

Across all focus groups, workers agreed that they are provided with a high level of support from their teams and within their organisation.

I think we have enough support, you know we are supporting each other, you know we have regular supervisions, we know we can go to [...] if we have any issues, we know we can have a supervision if we need it, if something is playing on our mind, you know I feel supported enough here.

Subtheme 2: Although supported by their colleagues, wider society does not value residential care workers

All focus groups outlined within the discussion that society does not understand how difficult the role of a residential care worker is, and therefore they do not get the recognition they deserve.

Don't think people outside of this industry realise quite how difficult it is. They think it's like a home from home and you would just go and sit all day doing what you usually do at home. It's not like that, the shifts are long, it's tiring, emotionally draining.

Subtheme 3: Wages and benefits are too low across the sector, and not congruent with the responsibilities and demands placed on residential care workers

During the discussion, participants were asked to explore common challenges to the role, and what they would like to change. Across nearly all focus groups, low wages for workers in general were a focal point of the conversation, with the general consensus being that wages and benefits should better reflect the intense demands and responsibilities placed on residential care workers.

I think for what we do, we are very very poorly paid [...] because I think that we are doing social workers jobs most of the time, and not getting any of the financial rewards or recognition.

Subtheme 4: Although challenging, the role is unique, enjoyable and rewarding

Participants consistently reported that they continue to do the job because they enjoy the work and it is rewarding, not because of other factors such as the salary and benefits associated with the job.

I absolutely adore my job, it could be easier, but **it's that reward at the end.**

I've never been happier in a job than I am with this one.

Theme 2: Many factors can be barriers to the residential workers being emotionally available to the children in their care, but other factors help promote resilience

Within the focus groups, workers explored how a multitude of demands on workers whilst on shift, including emotional, physical, and administrative demands, impact their ability to be emotionally present for the children in their care, which all agreed was the most important part of their role. This theme encompasses staff having significant responsibilities placed on them, the emotional load of caring for young people, and the difficulty of being away from their own family and personal life.

Almost all participants commented on one of these three factors preventing them from being physically or emotionally available for the young people in their care. In contrast, participants were also aware of factors that promoted resilience and helped them manage the emotional demands of the job; these included cohesive teams and reflective spaces/conversations. Across all five focus groups, there were four consistent subthemes.

Subtheme 1: Shift demands such as lack of sleep and dealing with difficult incidences can prevent workers from being emotionally available for the young people they care for

Almost all participants agreed that lack of rest can cause staff to feel burnt out, therefore hindering their ability to be emotionally available for the young person they are working with, as well as carrying out day-to-day tasks such as driving the young person to school.

My biggest problem is that perhaps the expectation that you go through 24 hours without any sleep and have another 24 hours in front of you.

Two participants suggested (with strong agreement from others in their focus group) an on-call system for workers to utilise in the event of lack of sleep caused by incidents throughout the night, to allow workers to rest before coming back onto shift.

Think if you were up all night with a young person, or had an incident all night, and you're back on shift the next day 7 o'clock in the morning but you haven't been off shift, there should be a thing to try and get your shift covered so you can go home maybe for a good 5 hours sleep or something like that and come back in or something.

Subtheme 2: Workers often struggle being away from their own family, and separating work life from personal life can be difficult

Many participants discussed the negative impact the role can have on their own personal life, such as missing out on family life and special occasions.

I suppose from a personal perspective, my stress comes from what's happening in my life when I'm not there. Two days is a long time to be away from family, especially if there are issues. So yes you can go into work and have a bad day, but there's worrying about others that you leave behind as it were.

Many participants also discussed the difficulty of having to 'switch off' from your personal life and leave personal feelings outside of the workplace. For example,

there is the perception that residential care staff must present as calm and jolly around the young people they work with, but this can be difficult whilst dealing with personal problems, coupled with stressful incidences in work (such as challenging behaviour). Some staff reported compartmentalising their personal and work life as a coping strategy to deal with this challenge, and feeling like they lead double lives.

It's almost for me like I've got two homes, two houses. This is my main house that I'm sat in now, but I have another house and another family. That's the only way that I can cope, almost shutting one off and going to the other. It's an odd situation.

Yeah sometimes you have something going on at home as well as this life and it is hard sometimes. I mean just walk through that door and be professional and kind of leave all of your personal problems [...] and that sometimes it is really really hard and then you are having a hard time at **home and you are coming to work and it is chaos... it is like a double barrier that is really hard work.**

Subtheme 3: Being part of a supportive and close-knit team helps to deal with these demands

Within each focus group, participants were asked to discuss what they do to cope with the challenges of being a residential care worker, and what support they currently receive to help manage the demands of the role. All participants strongly agreed that seeking and receiving support from their individual staff teams and being able to share their thoughts and feelings within the team was the most important coping mechanism. There was a strong perception that being part of close-knit team allows staff to be resilient and access support whenever it is needed, and a good relationship with colleagues was vital to manage the challenges that are associated with the role.

Obviously we all know each other, I know ___ is obviously new but the staff team are really close and we are able to share our thoughts and feelings, and work together as a team.

Staff teams lean on each other during stressful incidences and find it helpful to share their thoughts and feelings in a safe, confidential space. Participants also noted the importance of jumping in to support colleagues during challenging incidences, and value lifting each other up by highlighting what they have done well, as well as reflecting on what could be done next time.

We all have a very tight knit **team, that if there is something that's been really stressful or upsetting afterwards, it'll be everyone bands together to support that where needed.**

Subtheme 4: Having a safe, confidential space to vent and reflect would be valuable

Across nearly all focus groups, participants outlined the need for residential care workers to have access to a safe, confidential space where they are able to discuss and reflect on their thoughts and feelings about challenging incidences within work. Participants suggested that this would not only make them feel supported on an emotional level, but the opportunity for reflective conversations would allow them to learn from their experiences and identify what is going well.

A safe space to talk about the incident, your feelings, and everything surrounding outside the residential environment itself. Umm, there are **some things that you can't/shouldn't take home and talk about, there are some things you can't talk about within the home, but a safe space to talk is essential.**

Theme 3 - Confidence and skill impact on the ability to successfully manage challenging behaviour

Across the five focus groups, participants discussed how they become equipped with the skills and knowledge to manage challenging behaviour successfully, what areas of support they find useful, and what further support could be offered. Three consistent subthemes emerged.

Subtheme 1: Training and consultations are helpful in equipping staff with the skills to manage challenging behaviour

Many participants noted how useful the current training system within their company is. This includes an induction week before staff enter the residential home, as well as regular consultancies and informal training with the therapist attached to their home.

What is good as **well for the new staff team is they have a full week's** induction before they ever do a shadow shift.

Our consultancy [...] we have a really good relationship with our therapist. I can ring her this week at any time and ask if she has any strategies that we can work with. I think therapists are our first support call.

Although most participants were satisfied with the current level of training they received, some suggested that more bespoke and in-depth training shaped around the needs of the young people in their care would be useful. Staff also noted that although the online training videos can be useful, live and face-to-face training sessions where there is an opportunity to ask questions and engage in relevant conversations are more valuable.

So it's basic **videos of this and that, what you're training is that then you** answer some questions at the end. It can be very difficult to understand the importance of the training, based on what we have in my opinion, **because I've had training beforehand where it's** been face-to-face so I know the value of that.

Subtheme 2: It is helpful to work alongside and learn from experienced staff members

An overwhelming theme within the focus groups was the belief that learning from experienced residential care workers by working with them and having the opportunity to ask questions is more valuable than formal training.

The training is useful but learning on the job and seeing different ways of doing it, different, different workers and different experiences is possibly more powerful.

Subtheme 3: Support from specialist support teams and outside agencies is helpful in managing challenging behaviour

All workers agreed that the support received from the Specialist Support Team was a valuable service. Across all focus groups, participants reported that they utilise the services available from the Specialist Support Team and were satisfied with the support they had received.

I think we do get a lot of support with the clinical side of things, I think we are all right and then we have behaviour management specialists, missing from care specialists, CSE specialists...

Although participants were happy with the support services provided within their company, many were not satisfied with the level of support available from outside services. Participants reported seeking additional support from external services such as CAMHS, regarding the mental health of a young person who was, or had been, in their care. There was a strong perception that perceived support from services is somewhat limited, or they are not able to access the support when it is most needed (for example, when a young person is at crisis point).

Kind of being able to access external agencies or statutory services, being able to kind of liaise with them quicker and work, get appointments quicker.

Discussion

Residential children's homes have more recently been viewed as a 'last resort' for young people by local authorities (McLean, 2015) and the young people often have significant mental health needs (Narey, 2016). Residential workers face the complex role of managing significant challenging behaviours (Berridge et al., 2012). This study examined residential care staff members' **perceptions of** providing support to the young people in their care. Three main themes emerged from the analysis. Firstly, is it a rewarding profession but not one that is well understood and valued by society. Secondly, many factors can be barriers to the residential workers being emotionally available to the children in their care, but

other factors help promote resilience. Thirdly, workers recognise that confidence and skill impact their ability to successfully manage challenging behaviours.

With regards to the first theme, previous literature supports the notion that workers feel undervalued by society. Maclay et al. (2006) found that foster workers in the UK often feel under-supported and undervalued by society. While Colton and Roberts (2004) have argued that the low status and poor salary **levels for children's residential care workers means many staff perceive the** career as a short-term option, thereby creating staffing issues within the sector. Research has demonstrated that when employees feel undervalued, **they're** more likely to disengage, experience burnout and underperform within their role, as well as this **having a negative impact on employees' mental wellbeing (Walsh, 2011).**

The role of a residential worker is very demanding. Staff are required to provide 24-hour care and are responsible for the supervision, welfare and safety of the young people in their homes (Heron & Chakrabarti, 2003). Residential worker roles go above and beyond that of typical parenting due to the extensive needs of the young people they look after (Delfabbro et al., 2005). A challenge for the sector is how to promote a better understanding of the skilled nature of the role, and for it to be perceived by society as a profession. This could partly be achieved by considering whether the title 'worker' adequately reflects the complexities of the position, but this study did not ask workers whether their job title affected their sense of the value society places on their role, so this would be an area for future research to consider. Would workers find a title such as therapeutic parents or child practitioners more meaningful?

Within the sector, the challenge is also how we ensure staff have their work recognised, progress celebrated, and morale maintained. Future research needs to identify what methods are effective with the residential sector in helping workers feel valued, other than pay. For example, how useful are nominated awards, 'thank you' away days or long service one-off payments?

With regards to the second theme, workers consistently identified that the primary task in their role was to be emotionally available and present for the children. Workers insightfully recognised the factors which may compromise

their ability to be emotionally available, including (1) tiredness due to long shifts, (2) feeling overburdened by administrative tasks, and (3) juggling their own lives. This supports the findings of previous research (Whitaker et al., 1998). It is very prudent that workers identified this theme as it highlights the potential for burnout in teams; past research has well documented that burnout affects emotional availability and therefore therapeutic outcomes for young people (Parry, 2017; Zerach, 2013).

In terms of practical demands, an ongoing challenge is how to cover long shifts whilst acknowledging workers get tired, especially if children are unsettled at night. Providers could consider on-call workers for teams on waking nights to reduce staff tiredness the following day. Further options could be finding ways to reduce the admin load and offering more supervision or debriefs with a clinician who is not part of the management team (Kent, 1997). The importance of supervision and reflective practice is often discussed in relation to wellbeing in many caring professions including social work (Crowder & Sears, 2016), inpatient nursing (Buckley et al., 2020), and therapy and counselling (Bray, 2019), and further research is needed into how much and by whom is helpful for residential care staff.

Significantly, workers reported the importance of supportive teams and places to promote emotional resilience, which is consistent with previous research. The Secure Base model (Schofield & Beek, 2014) developed through attachment theory (Bowlby, 1979) suggests that cohesive and supportive staff teams are imperative to promoting emotional regulation and resilience in care staff. Schofield and Beek (2014) emphasise within the model the importance of colleagues being available, sensitive, accepting, and cooperative and encouraging team belonging.

Beyond the emotional challenges and shift demands within the role, workers also reported on the importance of feeling skilled and confident to manage some of the difficulties the young people in their care experience, as identified in the third theme. It was reported that workers recognised the usefulness of formal training but found learning through experienced staff members on the job was the most impactful way of building skills. Furthermore, the residential workers discussed how they felt they had access to good support and training internally

and that this was useful, but not as meaningful as learning from experienced colleagues. However, they did not feel consistently well supported by external services and access to CAMHS was highlighted as a concern. This is supported by previous literature exploring foster workers' **experiences of support received** from specialist services, which suggests that foster workers also experience a frustration with the lack of support from statutory services (Hiller et al., 2020).

The implications of the current study can provide insightful research to support workers **within residential children's homes. It is important for providers to** utilise the findings to address the obstacles workers face and thereby to reduce staff burnout and secondary trauma, to promote better practice for the children in their care. The strengths of this study include the qualitative approach to gain a deeper understanding of the perceptions of workers **in residential children's** homes. The study also explores the views of a group of social care workers who have not received much attention in the literature. However, it is also important to address the limitations of the study. Firstly, the research was only conducted within children's **homes** run by one national provider and so findings may not be generalised to all care providers. Furthermore, the researchers were from the same company as the care staff, which may create biases or mean workers do not volunteer particular information. That said, in all groups workers seemed freely able to critique and evaluate their concerns in their role and findings match similar work done in other related groups (e.g., foster workers; Hiller et al., 2020). Finally, an opportunity sample was obtained given that all participants worked for the same company, which may have influenced the findings. Workers may have participated if they were particularly frustrated, alternatively homes experiencing significant difficulties may not have had the time or motivation to attend the focus groups. However, it is important to note that the aim of this study was not to provide generalisable findings, but to conduct an in-**depth exploration of the participants' experiences as residential** health care workers, congruent with the values that underpin reflexive thematic analysis. The researcher also did not consider or collect demographic information **on the participants' education level of qualifications, to explore if there were any** correlations between these factors, and the themes identified in the analysis. This could be an interesting avenue for future research.

Conclusion

Given the current gap in the literature exploring residential workers' experiences within their role, coupled with the high prevalence of children living within residential homes within the UK, it was important to give a voice to residential workers through research. The researchers explore one potential way; that is, investigating the experiences of residential workers who work closely with children and young people within residential homes, and what can be learnt from their experiences of their role with regards to supporting residential workers. It is hoped that those within this field can utilise this information to identify factors that may support residential workers, empowering their voices in the process.

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The results obtained from the **HRA's** decision tools can be taken as an authoritative decision and are line with:

- The harmonised UK-wide edition of the Governance Arrangements for Research Ethics Committees (GAfREC) 2018;
- UK Policy Framework for Health and Social Care Research (2017)
- The National Research Ethics Service (NRES) Defining Research table and the algorithm Does my project require review by a Research Ethics Committee?

The decision obtained from the decision tools should not be interpreted as giving a form of ethical approval or endorsement to your project on behalf the HRA. However, it may be provided to a journal or other body as evidence if required.

Declaration of conflicting interest

The first four authors all worked for the same company as the participants. A **private, national provider of residential children's homes.**

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Investigating the understanding and management of self-harm in a children's residential therapeutic community

Katy Ervine

Abstract

The definition of self-harm has been widely debated and has expanded from the traditional idea of habitual cutting to more abstract versions, such as self-harm by inadequate self-care (Hunter, 2011). There is sparse research on self-harm involving young children, with the focus predominantly upon adolescents. This small-scale, work-based study explores the understanding and management of self-harm within a therapeutic residential community caring for children aged 5-12. A mixed-methods design was used, combining quantitative analysis of secondary data of self-harm with qualitative data derived from professional discussions with community directors and semi-structured interviews with care staff. Results reflected the variance in defining self-harm and how semantics **such as 'intent', 'level' or 'risk' are based on subjective interpretation and may vary between children and contexts.** Such fluidity in terms can make self-harm a challenging subject to understand, compounded by the idea that self-harm is often seen as a taboo subject. The study concludes that identifying self-harming behaviour relies on the therapeutic relationship, and responses to this should be **tailored to the child's individual needs. The value of staff communication,** training and support were highlighted as recommendations for future practice.

Keywords

Self-harm, therapeutic, residential care, children, England

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Introduction

The definition of self-harm has been debated for decades, having expanded from self-cutting to include extreme physical activity, swallowing objects and eating disorders (Koutek et al., 2016, p. 788). Encompassing children in their definition, the National Institute for Health and Care Excellence (NICE) guidelines use the term self-harm to describe 'any act of self-poisoning or self-injury carried out by an individual irrespective of motivation' (2011, Clinical Guideline 133, n.p.). These guidelines refer to children aged 8-17 and there is little mention of younger children self-harming within the wider literature.

Research indicates the high prevalence of self-harm within residential settings. Meltzer et al. (2004) reported 39% of children in residential care had tried to harm themselves, in comparison to 14% in foster care (as cited by Johnson et al., 2017, p. 444). Storey et al. (2005) reported individuals in care were significantly more likely to have a history of self-harming behaviour dating back to childhood which increased in intensity as they grew older. It is necessary to note here the limitations of this literature in relation to the current study, as it was written several years ago and based upon an older age range of children. Again, this highlights the sparse representation of self-harm within the younger age group in the current literature.

This study explored the understanding and management of self-harm in children within a residential therapeutic community (pseudonym Fairview) caring for children aged 5 to 12 years. Fairview is one of four therapeutic communities within an organisation caring for children who have experienced early life trauma and present with emotional and behavioural difficulties, including self-harm and sexual or physically aggressive behaviour. Fairview offers a methodology of treatment named Integrated Systemic Therapy (iST) where 'robust theory and organisational structures together provide the setting within which the art of healing can take place' (Blunden, 2007, p. 6). This is specialised work, not **restricted to the child's conscious contributions, but wherein** their unconscious communication is also attended to. Blunden (2007, p. 11) states this is 'a particularly significant mode of communication for those who have troubled

emotions, or who have not had the development opportunities to learn to make feelings and thoughts conscious and to verbalise them'.

Some children at Fairview present with self-harming behaviour, for example head banging or self-biting. Although this may be viewed by some as low level in severity, it might be argued that addressing such behaviours at this early age could influence future behaviour. Murray (2003, p. 41) stated that 'escalation occurs when self-harm behaviour is not being heard or understood in the context of why it is happening'. Work with children at Fairview is continuously viewed within the IST model which emphasises the importance of relationships. Those relationships within the residential therapeutic community setting can offer children an alternative experience of relationships to those they have had in their early lives, providing a robust, nurturing, and safe base within which each **detail of the children's lives can be carefully thought about and understood.**

Sellers et al. (2020, p. 136) highlighted that 'for children in residential care, safety and supportive relationships, particularly with direct care staff, are critical to recovery, growth, and development'. These relationships and attention to detail provide an opportunity within the work of the therapeutic community to reach an enhanced understanding of self-harm, which could help clarify the potential meaning of this behaviour, influencing how it might be responded to. This has implications for informing future placements and preparation for adolescence.

Self-harm has been described as a means of seeking attention (Klineberg et al., 2013), expressing traumatic experiences (Inckle, 2010), and a self-punishing or self-soothing method (Murray, 2003). The various approaches in the literature led to the question of whether such inconsistencies in understanding self-harm would be reflected at Fairview, exploring whether there was a consistently shared definition of the term used to identify self-harm, as well as how children were supported with this behaviour.

Method

This study employed a sequential exploratory design using mixed methods (Robson & McCartan, 2016), initially collecting quantitative data which then

informed the collection of the qualitative data. This met both university and organisational ethical requirements. To gain an initial understanding of reported self-harming behaviour, quantitative data was collected and analysed from recorded incidents of self-harm between October 2019 and March 2020. This included any acts or attempted behaviours which caused or had the potential to cause physical harm, as well as suspected self-harm where the behaviour was not directly witnessed.

This recorded data is exclusively informed by the serious incident and physical intervention reports, **where the children's actions are categorised into 'hard measures actions', such as self-harm or physical aggression.** Staff record these by ticking relevant hard measures boxes when completing these reports. The frequency of recorded incidents involving self-harm, type of self-harm, antecedents to self-harm and staff response were collected. Evidence of self-harming behaviour being noted but not recorded within the hard measures data was collected **for the same time period, for example in children's daily records or** within the text of serious incident reports where the hard measure action was not ticked.

This study was focused on Fairview, but professional discussions with all four directors of each community within the organisation were conducted to gain context and an overview of practice.

Qualitative data was then collected through semi-structured interviews with members of the therapeutic care team at Fairview. This was designed to explore staff experiences of witnessing, recording, and managing self-harm. Sixteen therapeutic care staff were invited to participate in these semi-structured interviews. Initially, three staff members volunteered; one therapeutic care worker, one deputy team leader, and one team leader. Senior management were included to provide a purposive stratified sample of four participants spanning the hierarchy of staff. The four interviews were audio recorded and lasted for 30-40 minutes. Interviews were transcribed and a thematic analysis was conducted, guided by the phased method described by Braun and Clarke (2006), where the data was coded, patterns identified, and themes generated and named.

Results and analysis

Quantitative data: Incidents of self-harm

Hard measure actions recorded within serious incident and physical intervention reports between October 2019 and March 2020 were collected to ascertain the prevalence of recorded self-harming behaviour (see Figure 1). Self-harm had a lower rate of being recorded than physical aggression. It may be that physical aggression was more prevalent or that the definition of physical aggression was more consistently understood than that of self-harm.

Month	Hard Measure Actions					
	Physical Aggression	Serious Damage to Property	Self-Harm	Sexual Behaviour	Offsite without permission	Other
Oct-19	1	0	0	0	1	1
Nov-19	8	2	1	1	2	1
Dec-19	1	1	0	0	0	0
Jan-20	19	7	6	0	0	2
Feb-20	6	1	1	0	0	0
Mar-20	11	2	10	0	1	0
Total	46	13	18	1	4	4

(Note: 'Other' – involved verbally abusive/disruptive behaviour)

Figure 1: Recorded hard measure actions between October 19-March 20

There were 18 incidents reported as having involved self-harming behaviour, most commonly featuring head banging/hitting (28%), biting (19%) and hair pulling (16%).

Evidence of self-harming behaviour being noted but not recorded within hard measures data was also explored. A further 23 incidents involving self-harming behaviour were found. It was noted that further exploration as to why these were not recorded would be included within the interviews with staff. Head banging/hitting (31%), biting (16%) and pulling hair (10%) again featured most prominently, with the addition of suspected/attempted self-harm (13%) where self-harming behaviour was noted but not directly witnessed.

With incidents where self-harm was officially recorded, 94% were recorded by staff who had been working within Fairview for over six months, and 6% by newer staff who had been employed for less than six months. Within the documents where self-harm was not officially recorded, 57% were recorded by staff who had been working at Fairview for over six months, and 43% by newer staff who had been employed for less than six months. This raised the question of whether newer staff have less clarity around where and when self-harming behaviour should be recorded.

Context from professional discussions

Professional discussions with directors of each of the four residential communities within the organisation provided context and an overview of practice regarding which behaviours were classed as self-harm in training or recording systems. All four communities had children/young people self-harming to the extent that hospital treatment was required. The method of training varied between communities. At Fairview, external training was utilised, with this last occurring several years previously. There is no mandatory requirement for this training, which is employed as a precautionary measure to improve practice.

A common method across all communities was to record self-harm within **serious incident or physical intervention reports, within the child/young person's daily records** and in the accident book. Fairview exclusively utilised body map books, where the location of the self-harm was monitored.

Qualitative data: Semi-structured interviews

Data trends

Semi-structured interviews were designed to explore staff experiences of witnessing, recording and managing self-harm. Participants were asked the same set of questions featuring scenarios to allow comparison of opinion. All participants agreed brief self-biting, putting a cloth bag over their head and running into a road were examples of self-harm. Running into the road and

putting a cloth bag over their head were not included in the hard measures data within the quantitative analysis.

Many of the physical actions of self-harm raised by participants were consistent with those identified within the quantitative data. Participants also highlighted the broader spectrum of behaviour extending to suspected, indirect or attempted self-harm.

Thematic analysis

Following the phased method of thematic analysis described by Braun and Clarke (2006), six main themes were identified (see Figure 2 for thematic map of analysis).

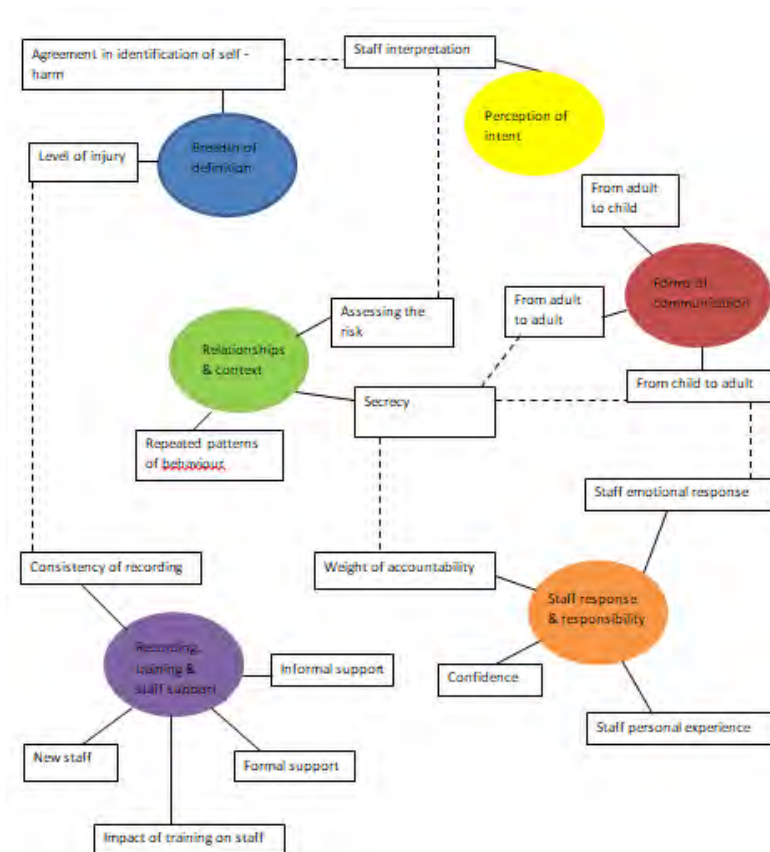


Figure 2: Thematic Map

1. Breadth of definition

All participants talked in terms of the scale of injury caused when identifying a behaviour as self-harm, describing this as '**low**' or '**moderate**' level, indicating a subjective breadth of definition. Many of the physical behaviours evident within the quantitative analysis, such as hair pulling, were reported by interviewees. By looking at this quantitative analysis alone, these behaviours may appear 'low' level. However, when behaviours were described by staff a more violent image of attack is often evident. For example *'I've seen children who have used sharp objects to scratch massive gouges out of themselves' or 'pulling their own hair, clumps out as well, I mean really wrapping their fingers around it, pulling it out as much as they can'*.

Communicating the intensity of self-harming behaviours appeared important to participants, with evidence of staff attempting to categorise the scale of these behaviours: *'there are possibly things that do get missed slightly. Especially, if it's not something that you would class as major self-harm'*. Here the definition of self-harm appeared to be based upon subjective staff interpretation. Attempts have been made by clinicians to construct scales of self-harm based upon severity of injury. This may help when medically treating an individual, however within a therapeutic environment it might be suggested that all forms of self-harm should be viewed with equal caution irrespective of the physical damage caused, due to the potential significance of this communication in itself. In accordance with this, one participant commented, *'it's not about the injury is it, it's about what's going on inside of them and in their minds'*. Participants agreed that brief behaviours should be regarded as self-harm. One participant commented, *'even if it's for a few seconds, one word takes a few seconds and one word can communicate a thousand things as well'*. If this perspective is not shared by staff, it could lead to inconsistencies in defining and identifying self-harm.

The word '**risk**' was used by three participants, and there was shared opinion that the behaviour did not need to have caused physical injury to be defined as self-harm, with the potential for harm being an indicating factor. This was concurrent with the quantitative data, where attempting to jump from a height

was reported as self-harm. Participants agreed that running into the road should be classed as self-harm, however, this was at odds with the quantitative data where this was not recorded.

One participant spoke about '*just not looking after yourself*', specifically the omission of a behaviour, such as not using eczema creams resulting in sore skin. This idea of defining self-harm by omission featured within the literature (Hunter, 2011) but was absent from the quantitative data.

Suspected self-harm was referred to by all participants. Knowing the individual child was seen to be important, **as by having an understanding of the child's** history or their patterns of behaviour it felt possible to attribute behaviour not witnessed or seemingly benign behaviours to self-harm. For example, a child purposefully falling off their bike or a child going into their bedroom and then appearing with bruises. This behaviour was absent from the recorded incidents of self-harm in the quantitative analysis. Long et al. (2013, p. 106) state that 'types of self-harm may present in various ways and hold multiple meaning for each individual who enacts the behaviour', highlighting how much of a challenge staff face in consistently identifying and defining self-harm.

11. Staff perception of intent

Three participants described how children had been verbally explicit about their intent alongside their behaviour. This might allow for these behaviours to be defined and identified as self-harm by staff. For example, '*biting herself and kind of trying to cut herself with bits of broken DVDs and she's always saying that she hates her life and **she doesn't deserve to live***', or '*that child will tell you that they want to die before doing it*' (running into the road). These details of what children say whilst they are harming themselves cannot be derived from the quantitative data alone, but when this information is viewed alongside it, we are able to gain some insight into staff interpretation of **the child's** intent. Many of the deliberate physical behaviours within recorded incidents of self-harm featured biting or scratching, which is consistent with the above description from the participant. However, running into the road was not recorded as self-harm in the quantitative data, which implies a discrepancy in staff interpretations of a

child's intent to harm themselves in this situation. This again highlights the complexity of identifying self-harm.

James and Stewart (2018) discussed the ambiguity in interpreting intent, **reporting that some practitioners would determine an individual's suicidal intent** based on what they told them. Others felt that those who did not disclose their feelings were more likely to be suicidal. In our interview one participant stated *'it's almost like if they do tell you, they are actually asking you for help. It's when they don't tell you, it's more of a worry'*. James and Stewart (2018) concluded that intent can be unclear and may change during a single incident.

One participant referred to the behaviour as being *'a real impulsive feeling within them that they have no idea how to communicate'*, which might suggest that the intent of the child might not necessarily be to harm themselves in that moment. This participant highlighted how these responses might be triggered by something unconscious related to past trauma, like sound or smell. Another participant spoke about how children are often unable to put words to this: *'I don't think they can actually name exactly why they do it. Or what even release they get from it after they've done it or how they feel afterwards'*. This can often be the case if the trauma occurred at a preverbal stage. Schore (2002) described how early trauma can directly **impact an infant's brain development** and ability to process emotions. One participant articulated this link as follows: *'the child's traumatic upbringing has an impact on their functioning'* and they *'resort to self-harm as a way of communicating'*. Another participant linked bruising to the **child's internal state of mind**, *'it was all to do with the fragile state of mind and if everything was great the bruises went and if there was a lot going on they got more'*. This highlights the depth of thinking within the therapeutic work around the child and how this can provide valuable insights. Interestingly, self-bruising was absent from recorded incidents of self-harm, which might further indicate a challenge in maintaining a consistent collective definition.

III. Relationships and context

All participants stated their relationship with the child was important when identifying self-harm and noticing repeated behaviours. One participant stated that *'CHILD last year, scheduled his own death date and then he this year around the same time he attempted to jump off the bannister to hurt himself'*. This highlights the quality of staff paying attention to and remembering details, as well as the importance of handing these over to newer staff who have not yet had the opportunity to forge such relationships.

Three participants spoke about the importance of holding the child's history in mind. One participant stated that someone *'might just think it's because they're clumsy or something like that, as opposed to knowing their history and knowing that it is self-harm'*. Long et al. (2013, p. 108) support this viewpoint, claiming *'if self-harm is to be understood in all its complexity it must be considered holistically in the context of a person's life'*.

Secrecy was raised by two participants, wherein *'sometimes it can be happening right under your nose and you not even know it'*. Some children were suspected of self-harming, as staff did not directly witness the behaviour but noticed bruises: *'we don't quite know where the bruises come from but that when she went to bed she didn't have them'*. Within the relationships children build with the staff at Fairview there is an opportunity for these details to be noticed and carefully thought about. Similarly staff spoke about needing to pay close attention to environmental factors, for example *'her bed was broken and it was in such a place that unless you moved the mattress you wouldn't have seen it'* (referring to a child bruising herself against furniture). Storey et al. (2005, p. 72) revealed how young people reported incidences of intentionally harming themselves during childhood that they had *'successfully disguised as accidents'*, thereby highlighting the need for close attention from an early age.

All participants commented on using their relationship with the child to assess the context of their behaviour and the potential risk. One participant stated, *'if it's repeated behaviour you know the risks a little bit more and how far they are going to push it'*. Participants also considered the risk to the child if they

intervened. For example, one senior participant said, *'it's their release and if it's a safe release then it's better that they do it that way'*. Different contexts were associated with different risks, highlighting how many variables are components to assessing self-harm. Cahill and Rakow (2012, p. 407) reported that how people predict self-harm risk in terms of 'low', 'moderate' and 'high' varies both between contexts and within the same context. This implies there could be great potential for ambiguity if discussions around these variables as a staff team do not occur.

IV. Forms of communication

Within all interviews it was clear that self-harming behaviour initiated significant communication from both children and adults.

i) Child to adult

All participants agreed that self-harm represented a significant communication from the child. Gardner (2001, p. 149) commented that 'attacking the body is both a symptom and a symbolic action, and like both symptoms and symbols needs to be **'read'**'. However, there was some variance regarding how this communication was perceived.

One participant spoke about *'self-harm as a way of communicating their stress and trauma'*. Two participants spoke about self-harm being a *'release'* or *'relief'*. There was some discrepancy around this, as the behaviour was also referred to as communicating an element of manipulation, *'a threat and that they can do it if they want to'* or *'it is effectively to get your attention'*. Rasmussen et al. (2016, p. 178) found evidence of motives from adolescents wanting attention, but the motive of wanting 'relief from a terrible state of mind' was most commonly reported. They found that multiple motives are often present simultaneously. This implies that multiple communications may be attributed to an act of self-harm, depending upon which resonate most with staff.

The way children communicate via self-harm was not always in an openly aggressive manner. One participant extended this to the use of 'physical ailments', stating that *'it says more about their state of mind and their need for*

care'. This might also be applicable to the act of a child putting objects in their ears, present within both interviews and the quantitative data. It may be debatable whether the child was aware of the potential damage they might cause to their ears, possibly focusing more on a goal of experiencing medical care in hospital. Hunter (2001) commented that there is often a discrepancy between intent to harm and the degree of actual harm caused in individuals with limited medical knowledge.

As an underlying principle of the work at Fairview, it was expected that participants would refer to being attuned with the unconscious. One senior participant referred to '*projections*' from children and stated '*you just get filled with such panic*'. There was also some less direct evidence of this, with two other participants describing feeling '*rubbish*' and '*useless*'. Nathan (2004) shared his experience in psychoanalytic terms, as containing intolerable feelings projected by self-harming patients.

Two participants made reference to children self-harming as a result of not being able to communicate their feelings or not feeling heard. One participant commented '*when I picture a child self-harming I almost picture a big cross of tape across their mouth, that it's like they just cannot get out whatever is inside*'. This idea is shared by Gardner (2001, p. 20): 'it is as if the attack on the body becomes the only way to communicate deep distress, which both at the time it was experienced and at the time it re-emerges, cannot be put into words'. McAndrew and Warne (2005) described women's experience of not feeling heard and resorting to self-harm to communicate their frustration. The feeling of not being heard appears to be reflected within the wider literature, where the majority of research focuses on adolescents rather than on younger children such as those at Fairview.

ii) Adult to child

One participant commented that '*there are different ways of intervening*' which was apparent within both interviews and the quantitative data. This is important to pay attention to as Johnson et al. (2017) highlighted that the response from caregivers can be pivotal in either easing or perpetuating a cycle of self-harm.

All participants spoke about the value of talking with the child and acknowledging their behaviour. Piggot et al. (2004, p. 47) reported how young people in residential care described the most helpful support as when staff 'took time to talk and find out about the young person who self-harmed'. Gardner (2001) posits that this may begin to role model the value in using words to replace wounds.

Within the quantitative data and the interviews, it is clear that on occasion it is necessary for staff to physically intervene to ensure the safety of the child. Staff have MAPA (Management of Actual or Potential Aggression) training in safe and age-appropriate physical intervention. This training was directly referenced by one senior participant, while another described an alternative way of physically intervening: *'do you need a cuddle? That's really important, especially with some of the younger children that we've got at the moment, that tends to be the thing that they're actually craving after self-harming'*.

Participants spoke about the possibility of ignoring behaviour or using distraction techniques to avoid escalation. This was not a shared opinion amongst all participants however: *'I wouldn't ignore the behaviour, I would acknowledge it, I think that's really important'*. This highlights how staff response is tailored to the individual child, and no response can be prescribed for all contexts. Inckle (2010, p. 161) supports this, stating 'responses to self-injury need to be equally multifaceted and developed in collaboration with the individual'.

iii) Adult to adult

All participants raised how self-harm initiated communication between adults. One participant shared how they worked with a colleague to helpfully approach the child. One senior participant also described role-modelling a response to a colleague: *'reassure them that you feel that it's safe to take a step back and just observe and not intervene'*. There was also evidence of staff discussions about self-harm within their smaller teams. There was agreement regarding the accessibility of reflective groups, with senior staff being *'very available'*, and the value of supervision. These details were not obvious from the quantitative data, but there is consistent emphasis within the literature on the value of colleague

support. Wilstrand et al. (2007) described nurses working with self-harming individuals as reporting value in feeling supported by co-workers. However, there was also a consistent opinion within the current study that *'it's not spoken about enough'*.

V. Staff response and responsibility

There was some variance in staff **members'** emotional responses to self-harm. Three participants described how it felt *'really disturbing'*, *'distressing'*, and *'heart-breaking'*. One senior participant described witnessing the response of other staff members: *'you can see their anxieties rising'*, sharing how they felt *'a bit desensitized'* and could *'rationally detach from it'*. It might be that this is a reflection of staff experience. Gardner (2001, p. 8) suggests *'such feelings do not necessarily go away with familiarity, but over time they can become blunted and so easier to handle'*.

Two participants expressed the responsibility associated with caring for children who self-harm. One commented *'there's always a bit of disappointment in yourself in that moment that you've not managed to catch something before they feel like they have to get to that point'*. Another participant spoke of feeling unable to *'switch off'*, stating that *'you've got to live with it if the worst happened and you couldn't prevent it'*. Both these participants shared that they had personal experiences with self-harm and *'what it can put you in touch with'*, highlighting the sensitivity of the topic and how personal experience can influence staff response to self-harming behaviours.

Furthermore, Smith (2002, p. 599) reported that care-workers felt anxious about patients self-injuring, which *'resulted in staff and patients feeling that they were unable to talk about the subject'*. All participants in the current project voiced how they felt self-harm was not spoken about enough: *'it's a bit taboo and so it's just something that you don't really concentrate on'*, and *'because it's such a hard subject to think about, how easy it is to forget about it'*.

VI. Recording, training and staff support

All participants reported feeling clear about where self-harm was recorded, but with the suggestion of needing a '*more solid system in place*' to improve consistency. This might go towards explaining some of the variance between the quantitative data and interviews. For example, all participants agreed that a child running into the road should be recorded as self-harm, but this was absent from recorded incidents in the quantitative data. Several recording systems were described as useful: incident reports, accident books and daily records. Body map books were regarded by all participants as valuable in documenting suspected self-harm and identifying patterns of behaviour. However, not all children have a body map book, with these being generated when the need arises. Consistent with the aforementioned potential fluidity in intent, Wadman et al. (2017, p. 401) stressed 'young people in care should undergo regular monitoring and assessment of each self-harm episode'.

All participants agreed that the incident example where a child bit herself and pulled her hair should be recorded as self-harm. This was consistent with the quantitative analysis of recorded incidents as these particular behaviours were two of the most commonly recorded. In response to the question of why the hard measure action self-harm was not ticked for this example, one participant wondered whether it had been recorded elsewhere. Three participants linked this to individual staff interpretation, such as '*different people's definition of what self-harm is*'. Two participants spoke about the pressures of working on shift meaning '*things do get missed, but not intentionally*'. One of these participants spoke about reliving the traumatising experience of the incident and being '*shut off to where it's happened*' which can impact report writing. These examples highlight the need for a consistent method of recording that is understood by staff, alongside acknowledging the strain felt with respect to completing paperwork following incidents.

With regards to staff support, all participants were clear about formal support systems, mentioning supervision and group forums. There was shared agreement that '*there's enough support around*'. Smith (2002, p. 599) echoes this sentiment, reporting that when working with self-injury 'supervision was

thought to be essential, as was peer group support and working as a team'. Despite these structures being in place, three participants recognised that self-harm was not often a topic of discussion. One participant commented *'we know that we've got these forums where we can talk, but acknowledging these feelings, I guess this is the hardest part'*. Two participants commented positively on the availability of colleagues for more informal support. Perhaps due to the highly sensitive nature of this topic, these conversations on a one-to-one basis felt more comfortable.

Although all participants commented they had not received self-harm training for some time, they agreed it was useful and expressed a desire for further training. Research has shown that supporting staff to work through their discomfort and explore self-harming behaviour ignites a willingness to learn. Samuelsson and Asberg (2002, p. 120) described how training in suicide prevention for nursing personnel *'stimulated a growth in awareness that makes it reasonable for them to seek further information'*, which is encouraging. Although training appeared to be highly regarded within Fairview, one participant commented *'I guess even if you were trained up to your eyeballs in that moment, do you follow that? Or do you just go with your gut?'* This highlights how it is not possible to be prescriptive when training staff around self-harm, with the complexity of each situation depending on multiple variables, meaning staff are required to further draw upon their experience and relationship with the child involved.

The benefit of training was reiterated by another participant, suggesting *'having a refresher maybe every year and that would kind of help us with our practice and maybe passing on our practice to the new members of staff'*. All participants spoke about the potential difficulties for newer staff in identifying self-harm: *'where we've got new staff and that if people don't know about it, they don't notice it'*, as well as recording it: *'there's a situation where we don't pass on the knowledge of this being recorded and the need of this being recorded'*. This top-down influence of senior staff was supported by Brown and Kimball (2013, p. 205): *'if supervisors understand self-harm and assessment and treatment protocols, then supervisees may be more attentive to those issues as they arise'*.

Conclusion

Through pulling the quantitative and qualitative data together throughout this study, and alongside the informing literature, the wide variance in defining self-harm is clear. This, combined with the variance in semantics used in the taxonomy of self-harm, makes understanding it more challenging. The terms **'risk', 'intent' and 'level' can** have different meanings to different individuals and may vary between children and contexts, or even within the same context. Such fluidity in definition and terms can make self-harm a challenging subject to understand. This is compounded by the idea that self-harm is often seen as a taboo subject, uncomfortable to look at or discuss.

It was an intention of this study to compose a definition of self-harm in relation to what this means within the therapeutic residential setting of Fairview. As with the nature of the management of this behaviour, it can be concluded that there is no quick fix in answering this, with the answer ultimately being found within the therapeutic relationship with the child. Self-harming behaviour within Fairview is well held by a network of people working together to support the children, so it is hoped that as a community by opening up a conversation about self-harm, we may be able to reach consistency and enhanced understanding. As such, the success of this study would be best measured not through the achievement of reaching a specific definition, but rather through the successful implementation of discussion groups across all roles.

Clinicians have attempted to categorise self-harm, and although this may have value in a medical setting when treating injuries, it arguably has limited use in a therapeutic environment, where there is value in thinking about the communication behind each behaviour. Furthermore, it would not be helpful for children to become categorised as **'self-harmers'** as this would risk this behaviour being perceived by the child as an intrinsic part of them that is difficult to separate from. Instead, in line with the fluid nature of the definition, a fluid approach to self-harm is advised, based on the relationship with the child, an awareness of its possible existence, and staff being prepared and informed with regards to how to notice and respond.

The **child's repeated** experience of a care-giver's response to their self-harm can shape their future behaviour (Johnson et al., 2017). It could be argued that this also applies to the therapeutic care staff looking after them. Through repeated exposure to formal training, it is hoped that staff would have increased confidence in voicing their feelings around self-harm. This would complement the individual supervision and support from colleagues that was rated so highly within interviews.

Limitations and future work

This study was limited to a small scale where four participants were interviewed, and thereby cannot be viewed as representative of the entire staff population. Attempts were made to gain a broader perspective by interviewing a stratified sample of participants with varying experience. This was combined with professional discussions with directors from each therapeutic community and an analysis of quantitative data. This mixed methods approach provided rich data which can be built upon in future work.

This project set inclusion criteria for participants having been employed for over six months, inviting staff with experience working with children who self-harmed. The importance of the relationship with the child and understanding their history has been given great weight within this study, so future work could explore with newer staff how they could be supported with this.

Further work might also adopt the approach employed by McAndrew and Warne (2014), seeking views of adolescents around their self-harm and the usefulness of support. This approach for the younger age group at Fairview would need to be sensitively managed, but Curtis et al. (2004) have illustrated how children as young as four were able to respond meaningfully regarding their experiences of a health provision. This might also explore how it feels to be a child witnessing a peer self-harm, as well as providing children with the opportunity to have a voice, where they often feel unheard. Latif et al. (2017, p. 192) advocated for **this 'bottom up' approach, allowing children to inform** us about useful strategies.

Implications

This study has instigated discussions within Fairview regarding self-harm being integrated within MAPA training, added to the internal iST training course, as well as the need for a clear recording system.

Recommendations for future practice include self-harm becoming an agenda item within post-incident reviews to promote discussion and identify human error in recording hard measures data. A focus group was held as part of the dissemination process of this study within which the value of including self-harm in the new staff induction and the new staff Foundation Course was discussed. This would provide new staff with an introduction to the prevalence of self-harm and an explanation of how this is recorded, as well as offering details of emotional support available. It is hoped that in the longer-term further consideration of this topic may contribute to discussions around the broader implications of how self-harm is defined within other therapeutic communities, both within and outside of this organisation, as well as other residential care provisions or fostering services.

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About the author

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Katy sees children weekly for individual psychotherapy as part of the network of professionals offering care, education, and treatment to the children within the residential setting.

Recruitment, retention and professionalisation in residential childcare in Ireland

Martin Power

Abstract

Residential childcare workers have been at the vanguard of the development of the professionalisation of social care work in Ireland, and in late 2023 a register for social care workers is finally expected to open. Over two decades ago, Williams and Lalor (2001) highlighted the lack of statutory registration as one of the main obstacles to professionalisation, alongside obstacles such as the recruitment of unqualified staff, pay and status concerns, and a lack of clarity around job titles and roles. Moreover, they expressed concern about a short shelf-life for residential childcare workers, arguing that many did not perceive it as a long-term career option. In the intervening years, much has changed in **children's residential care in Ireland and some of those obstacles have been overcome**. Nonetheless, others, such as pay and status have proven more stubborn, with clear implications for recruitment and retention. This paper draws **on data collected as part of Social Care Ireland's recruitment and retention in social care survey (2019)** to examine the **professionalisation of children's residential care** and suggests that what was an already short shelf-life may have reduced further.

Keywords

Residential childcare, social care worker, professionalisation, recruitment, retention, workforce, Ireland

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Introduction

In the Republic of Ireland, social care work has emerged and expanded from 'its roots in residential child care' (McSweeney & Williams, 2018, p. 2). Prior to the foundation of the Irish state, the Catholic Church played a significant role in the **provision of health and social services (Adshead & Millar, 2003; O'Sullivan, 2018)**. This continued with the establishment of the Irish state, where the **Catholic Church's role was not only cemented but also expanded, and religious and voluntary provision became the mainstay in many areas, including children's residential services, up until the 1980s**. By the 1980s however, dwindling numbers were entering religious orders and a series of scandals damaged the **Catholic Church's reputation and standing, reducing vocations further**. As a consequence, lay people were increasingly recruited, leading to secularisation of the social care workforce (Moran, 2013).

Residential childcare workers were a critical group in this secularised workforce, and they were at the forefront of developments in the professionalisation of social care work (McSweeney & Williams, 2018; **O'Sullivan, 2008; Williams & Lalor, 2001**). In the 1990s, for example, residential and community childcare workers alongside colleagues in the health professions launched a Labour Court challenge in relation to pay and conditions. This led to the Expert Group on Various Health Professions (2000) recommending professional status for childcare workers, not least because this should eventually lead to a cessation of the then common practice of recruiting 'non-professionally qualified personnel' (Expert Group, 2000, p. 25). The Expert Group also recommended the establishment of a Joint Committee on Social Care professionals, envisaging that this committee would make recommendations to 'deal with the issues arising from the recognition of the autonomy of the child care workers profession' (Joint Committee, 2002, p. 2).

By the time the Joint Committee on Social Care Professionals reported in 2002, its work had expanded to include social care workers in the intellectual disability sector, via a similar Labour Court challenge. Central to these challenges were issues of pay and conditions, the absence of progression opportunities and clear career routes and structures, as well as the recruitment of unqualified staff

(Joint Committee, 2002). Indeed, the Joint Committee found that in a survey of 1,216 childcare staff, less than half (44%) had a professional qualification (Joint Committee, 2002, p. 7).

If the vocational legacy of provision may help to explain the limited extent of professional qualifications, academic publications of the time warned that professionalisation 'will continue to be an oxymoron as long as unqualified people are routinely employed in the field' (Williams & Lalor, 2001, p. 80). Along with such concerns, which Williams and Lalor included under the theme of 'education and training', they also identified three further obstacles to professionalisation, namely 'pay and status', a 'multiplicity of job titles' and the absence of 'state regulation' (Williams & Lalor, 2001, p. 84). More tellingly perhaps, all but one of Williams and Lalor's (2001) twenty interviewees felt that residential childcare 'was not an attractive long-term career option and that there was an inbuilt 'shelf-life' of five to seven years' (Williams & Lalor, 2001, p. 78).

Two decades on and the rollout of state regulation through a register of social care workers is nearing completion, and after a long wait a date for the opening of a register has been announced – 30th of November 2023 (CORU, 2022). While the pandemic exacerbated this delay, much of the long wait can be attributed to the difficulties in establishing a register for a previously unregulated profession. Indeed, even estimates of the number of possible registrants have varied substantially over the years with suggestions ranging from 5,000 to 10,000 potential social care worker registrants (Flynn, 2019; Lalor, 2009; Power & D'Arcy, 2018).

The extent of difference in estimates is no doubt related to the issue of multiplicity of titles, which has been a constant frustration for social care workers and researchers (Byrne, 2016; Power & D'Arcy, 2018; Williams & Lalor, 2001). This lack of a common title has been shaped by several interrelated factors, particularly the absence of a professional register, but also a mixed economy of care provision within which individual employers most often dictate job titles, roles, responsibilities and progression and career pathways (Byrne, 2016; Flynn, 2019; Power & D'Arcy, 2018).

As if to complicate matters further, the expansion in recent decades of social care work beyond the traditional areas of residential childcare and disability services has introduced even more title variation (Byrne, 2016; Mulkeen, 2016). This expansion has been facilitated by a substantial increase in the number of educational programmes and social care graduates since the early 2000s (Lalor, 2009). In 2019, for example, CORU highlighted that the 40 different social care programmes within 18 different educational providers vastly exceeded the nine social work programmes it regulated (CORU, 2019).

While the number of educational programmes presents a challenge for regulators, it has been instrumental in addressing the issue of education and **training, and the 'oxymoron' of unqualified staff. Certainly, a degree in social care is now the norm, with studies finding that over 80% of respondent held a social care qualification at degree level or above (Power & Burke, 2021; Power & D'Arcy, 2018). A significant obstacle has therefore almost entirely been removed** and the opening of a register will both remove a further obstacle, and in time should help to tackle the issue of multiple titles. At the very least it will provide social care workers with protection of title and some boundaries around the role, as well as providing researchers with an answer to the question of how many social care workers there are in Ireland.

At the same time, registration is unlikely to have any significant impact on **issues such as pay and conditions, as CORU's role is to protect the public rather than to engage in industrial relations matters (Doyle, Power & Zubelawlor, 2022; Power & Dashdondog, 2022).** Pay and conditions have long been a thorny issue, with obvious implications for recruitment and retention (Byrne, 2016; Clarke & McMahon, 2020; Power & Power, 2022; Williams & Lalor, 2001). Against this **backdrop, and drawing upon Williams and Lalor's (2001) depiction of the obstacles to professionalisation, this paper examines what social care workers in children's residential services who hold the title, a social care qualification, and a permanent role (full- and part-time) view as the greatest challenges to recruitment and retention. It argues that notions of a 'shelf-life' are not without foundation, as long-hours, shift-work, and aggression and violence take their toll. Moreover, it appears that what was an already short shelf-life may be shortening further.**

Methods

This paper uses data collected as part of Social Care Ireland's 2019 recruitment and retention in social care work survey (n= 557) (Power & Burke, 2021). This survey included 116 respondents from the children's residential sector, 84 of whom held a social care qualification at degree level or above, currently worked under the title social care worker, leader, or manager, and were in permanent employment, either full (n=75) or part-time (n=9). Data was collected anonymously via Survey-monkey and a mandatory consent question was included to meet informed consent requirements. A tick-box and/or Likert scale was employed for the majority of questions, with an open-ended question on what respondents viewed as the greatest challenge to recruitment and retention used to gather respondents' views. These responses were categorised using an inductive qualitative content analysis approach. As such, the response 'Pay, hours' (011) was included under both pay and conditions, and hours. While the response 'Shift in annual leave entitlement. Violence and aggression in the workplace. Mirco management style in some areas' (072) was included under pay and conditions, violence, and support (see table 1).

Pay and conditions	Wages, poor contracts and/or contract differentiations between public, private and voluntary, limited entitlements, such as sick leave or pensions, general working conditions and understaffing due to funding shortages.
Hours	Long, unsocial, sleepovers/waking nights or work/life balance.
Respect (and recognition)	Feelings of lower status and being undervalued by employers, other professionals or even other social care workers, role overlap and confusion.
Support	Lack of supervision or management support and/or poor supervision or support.
Progression	Limited progression or career opportunities.
Violence	Challenging behaviour, abuse, violence, aggression or assault.
Stress	Emotional challenges of the work, burnout, bullying, unsafe environments.
Admin burden	Volume and extent of paperwork and documentation and time demands it incurred.
Other	Recruitment practices and general comments on retention challenges.

Table 1: Categorisations of responses

Findings

The respondents were predominately female (75/87%), with only nine (13%) **male respondents**. **Respondents' age ranges were 20-29 (21/25%), 30-39 (19/22.6%), 40-49 (36/42.9%), and 50-59 (8/9.5%),** with no respondents in the 60+ age range. The level of qualifications respondents held varied between an ordinary degree in social care (27/32.1%), honours degree (47/55.9%), or a master's/post-graduate diploma (10/11.9%).

The respondents highlighted several challenges they perceived to recruitment and retention in social care work (Figure 1).

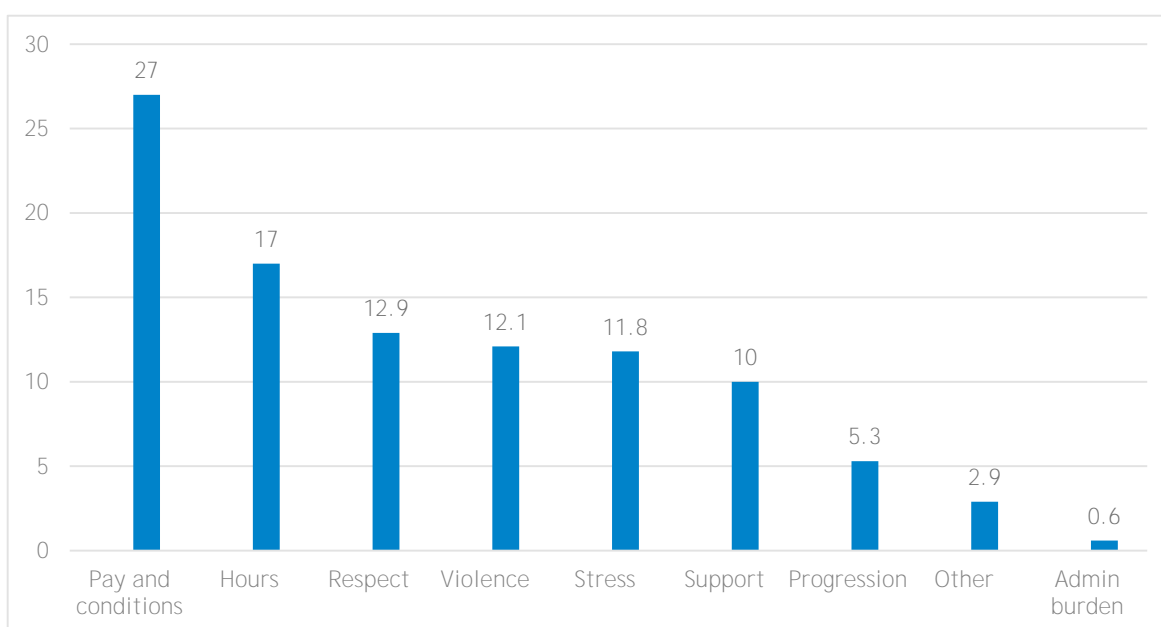


Figure 1: Greatest challenges to recruitment and retention in **children's residential** settings, as a percentage of overall responses.

Pay and conditions were perceived as the greatest challenge (27%). Indeed, 46 (54.8%) of the 84 respondents noted pay and conditions within their response. For example, respondents highlighted:

Poor pay and conditions (024),

Pay scales. Current job has had 12 (and counting) people leave since the end of last year' (057),

Work environment, pay, too many responsibilities (064).

Pay and conditions was followed by hours (17%), respect (12.9%), violence (12.1%), stress (11.8%), support (10%), progression (5.3%), other (2.9%), and admin(istrative) burden (0.6%).

Similar colleagues (i.e., social care qualification and title, and permanent position) in disability (n=154) and other services (i.e., homelessness, addiction, community-based services etc. n=85) noted much the same issues in their responses, though they felt respect rather than hours was the second biggest challenge (Figure 2).

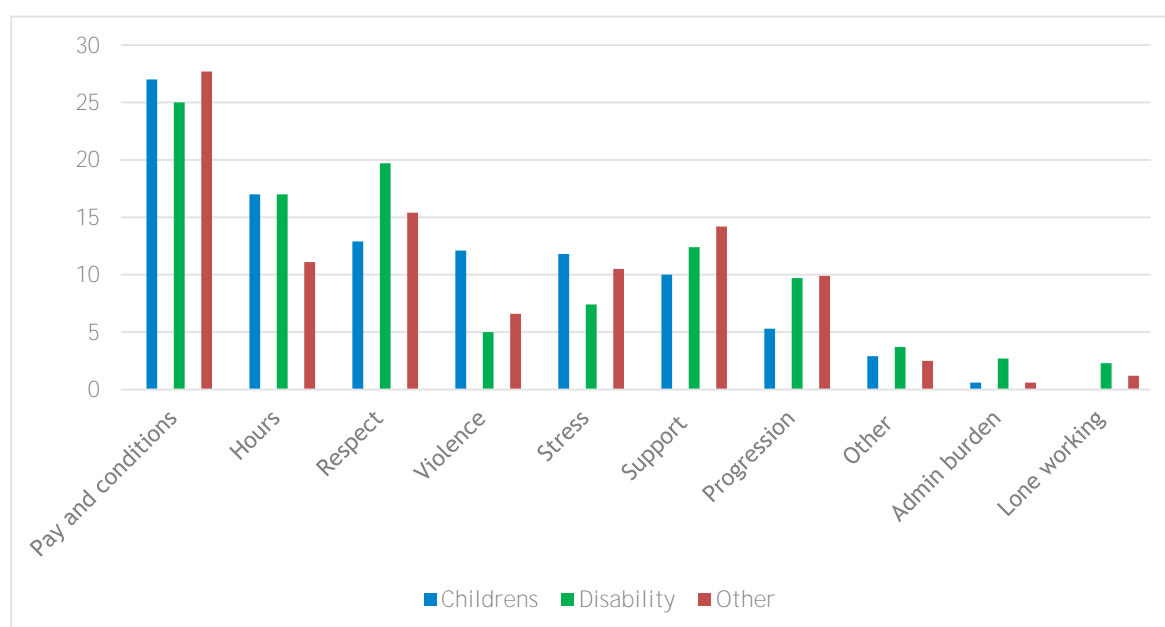


Figure 2: Greatest challenges to recruitment and retention by service sector, as a percentage of overall responses for that sector.

Regardless of sector, the noting of hours was unsurprisingly very much related to completing sleepovers/waking nights. In children's residential services, this was most often as part of 24-hour shifts, with 44% reporting 24-hour shifts as their most common weekly shift pattern. This was markedly different from the 20% in disability and 7% in other services who indicated weekly 24-hour shifts, and no doubt informs considerations of 'shelf-life', as 24-hour shifts are not conducive to social/family life.

More worryingly, those in children's residential services noted aggression and violence far more often. Indeed, in terms of the number of respondents who noted some element of aggression and violence rather than as percentage of overall responses, one in four (25%) of those in children's services highlighted aggression and violence. In contrast, only 12.9% of those in other services and 9.7% of those in disability services noted aggression and violence as a particular issue affecting recruitment and retention. For example, responses detailed:

Poor pay, lack of defined role, companies not looking after staff/retention levels. No sick leave esp post assault XXXXXX (company name redacted), management ignoring those who have to work on the floor. Little or no communication between staff and management (009).

Risk of assault or threats, treatment and expectations of social care workers, pay, working hours, risk of allegations (036).

Higher levels of aggression in young people regular assaults by young people admission to care for young people is too late. lack of residential centres so placement of young people with same issues placed together ... Burnout from staff due to aggressive behaviour (058).

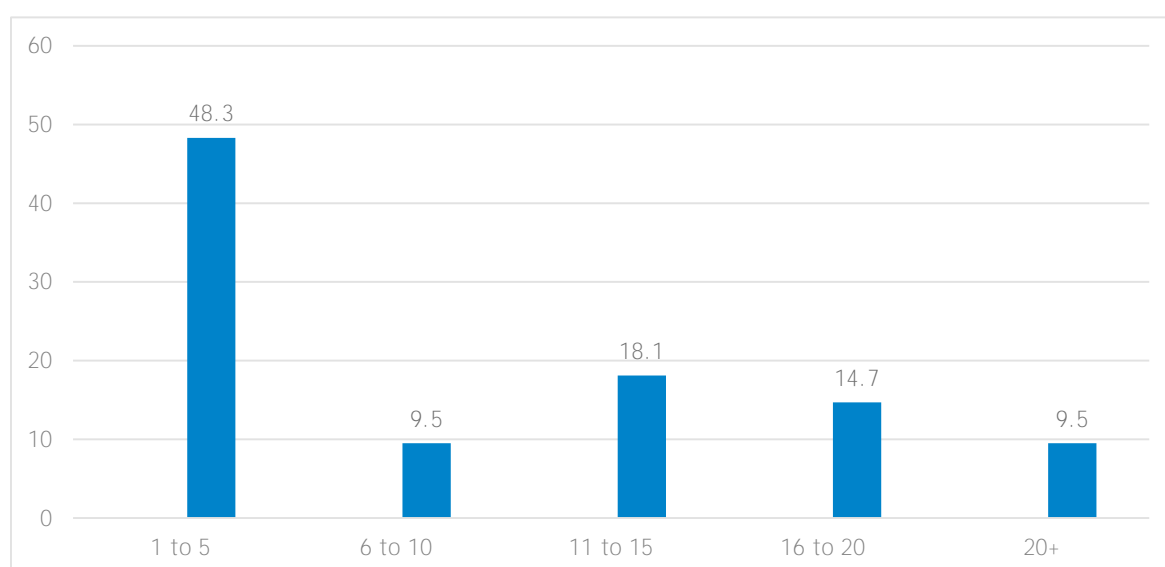
Physical assault on staff and employers not paying sick pay... Bank Holiday pay [...] Burnout as employees don't get enough rest in between shifts especially mixed shifts like day into waking nights (065).

Such comments help to humanise the absence rates that are publicly available, such as those in statutory services run by Tusla. Tusla is the Child and Family Agency, established in 2014, with a remit of 'improving wellbeing and outcomes for children' (Tusla, n.d.). In addition to the provision of children's residential care centres and the commissioning and regulation of private and voluntary children's residential providers, Tusla is responsible for areas such as child protection, family support and alternative care (Tusla, n.d.). In Tusla services, residential social care staff have the highest rates of absenteeism, consistently both above other social care staff and significantly above social workers or other grades (Table 2).

Year	Quarter	Residential/social care	Social work/other grades
2022	1	14.06%/13.25%	8.04%/7.02%
2021	4	13.93%/11.77%	5.61%/5.4%
	3	10.11%/8.67%	6.03%/4.72%
	2	9.23%/8.04%	5.01%/3.59%
	1	10.1%/7.67%	3.75%/3.56%
2020	4	9.46%/7.57%	3.36%/3.31%
	3	10.83%/8.82%	3.91%/3.78%
	2	11.43%/8.67%	2.93%/2.1%
	1	9.69%/8.56%	4.5%/4.42%
2019	4	8.06%/7.97%	4.71%/4.17%
	3	9.01%/8.38%	3.63%/4.46%

Table 2: Tusla staff absence rates.

If the higher rates of absence may help to explain the phenomenon of shelf-life, examining the years of experience of respondents provides strong indications of a short shelf-life for many. Certainly, there is a very steep drop in the number of years of experience respondents had, with almost half of respondents best described as newer entrants, with between one to five years of experience (Figure 3).

Figure 3: Years of experience in **children's residential services**

This profile was markedly different to that of their colleagues in disability and other services, where closer to a third were newer entrants. Moreover, in neither the disability nor other sector is the drop-off between one to five and six to ten years as stark (Figure 4).

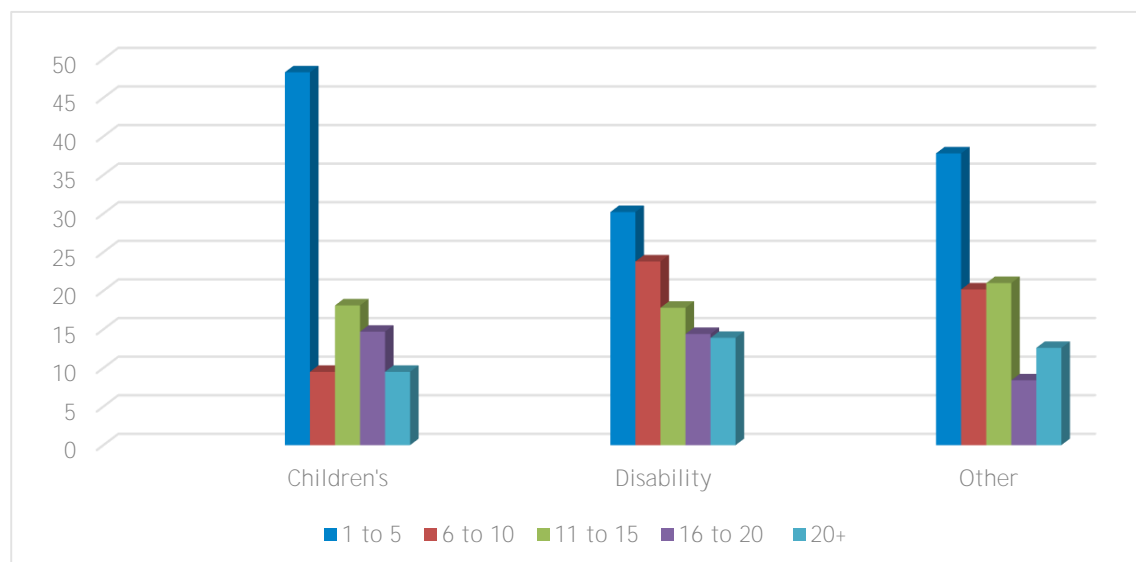


Figure 4: Years of experience by sector

In addition, when compared to the findings for the same group from the 2017 **Registration Awareness Amongst Social Care Workers** study (Power & D'Arcy, 2018) the proportion of newer entrants has increased slightly in the intervening years, while the proportion with six to ten years of experience decreased. If such **a trend continued, by now around half of social care workers in the children's residential sector could be newer entrants.** Furthermore, the comparison suggests a steeper drop-off in 2019 than in 2017, potentially suggesting that **five rather than seven years may now be the 'shelf-life'** (Figure 5).

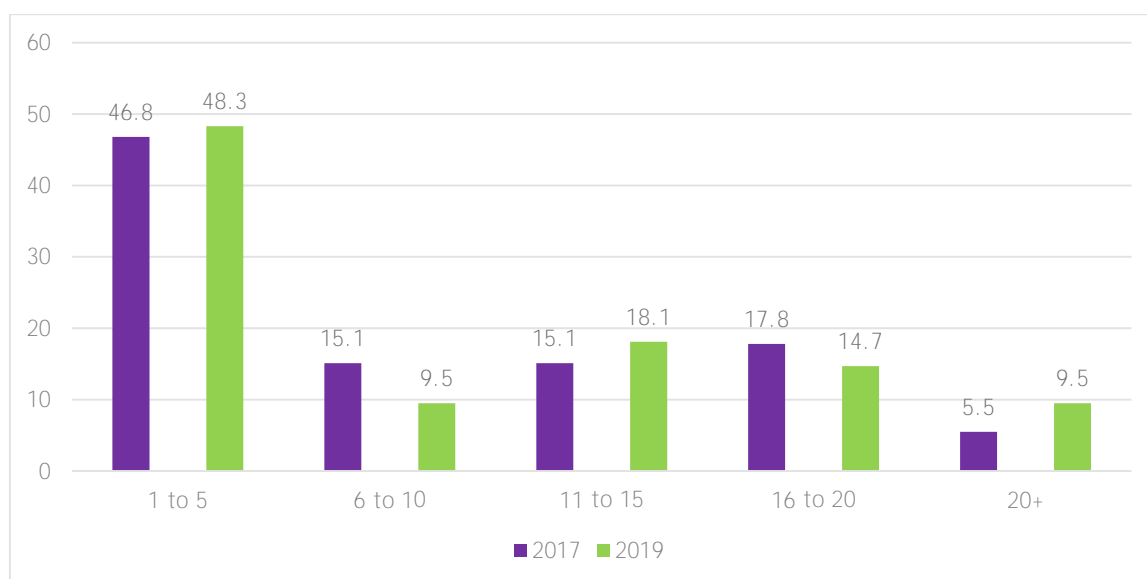


Figure 5: Years of experience of staff in **children's residential services in 2017 and 2019**

Discussion

Just over two decades ago, Williams and Lalor (2001) identified four major obstacles to the professionalisation of residential childcare work. Today, the **'oxymoron' of recruiting unqualified staff has been largely removed, as a degree in social care has become the norm** (Keogh & Byrne, 2016; Power & D'Arcy, 2018). Though a multiplicity of titles remains problematic in the social care field, **social care worker, leader or manager are more often the norm in children's residential services** (Power & Burke, 2021; Power & D'Arcy, 2018). In addition, the obstacle of registration should be removed in late 2023, when the register opens.

If three out of four suggests significant, if perhaps slow, progress, this may be **cold comfort to children's residential social care workers**. In their analysis Williams and Lalor (2001) included within 'pay and status' not just pay and status, but also a 'lack of support' or 'value and recognition by employers', the 'stressful nature of the work', that it was 'difficult to measure success', a lack of 'education and training opportunities', and 'a lack of career structure' (p. 78). If these factors were combined within this study, they would make up around 67% of the totality of responses, followed by hours (12.4%), violence (11.7%), other (3%), and administrative burden (0.5%). Thus, while registration may provide

social care workers with state recognition as a profession, professionalisation as described by Williams and Lalor (2001) may yet be some way off. In addition, though Williams and Lalor (2001) mentioned violent behaviour and the potential for physical assault, these received only scant attention.

Nonetheless, aggression and violence in social care work have long been a problem in Ireland (Keogh, 2001; Keogh & Byrne, 2016; Meck-Butler & Swift, 2019). Here, Keogh and Byrne (2016) found that both age and experience shaped the probability of exposure to aggression and violence of all types. Newer entrants (i.e., 1-5 years of experience) in particular experienced more aggression and violence, including verbal abuse, threatening behaviour, and bullying and harassment, when compared to those with fifteen years or more experience. They were also over four times more likely to be assaulted physically. However, Keogh and Byrne (2016) concluded that it was less age and limited experience that were the underlying risk factors, but rather the high-risk nature of some social care environments and that younger newer entrants often **worked in such higher risk settings, which included children's residential care.**

Within children's residential care Keogh and Byrne (2016) observed that almost three times as many social care workers in private services had experienced physical assault in comparison to colleagues in voluntary or statutory providers (Keogh & Byrne, 2016). They suggested this was likely an indication 'that young people with complex needs and behaviours are being placed with private providers of residential care', **resulting in a 'concentration' of individuals with violent behaviours** (p. 34). More worryingly, they observed that private providers generally offered the least support after incidents, and that of their respondents 62% felt there was a general acceptance by employers of violence as part of the job, except in the voluntary sector. Indeed, they noted that while 74% of respondents from private providers and 66% of those in statutory services felt violence was accepted by employers. In contrast, in the voluntary sector the majority (66%) 'were more likely to indicate that their employer did not accept workplace violence as part of the job' (Keogh & Byrne, 2016, p. 58). This may help to explain the generally low rates of staff turnover that voluntary providers often enjoy (Power & Power, 2022).

Since the formation of Tusla **in 2014 the children's residential sector has** undergone significant change. Though privatisation had been a trend since the late 2000s, it expanded significantly in the wake of the austerity period that followed the 2008 global crash and today almost two thirds of providers are private providers (65%), with limited statutory provision (21%) and few voluntary providers (14%) (Branigan & Madden, 2020; Fenton, 2021; Mulkeen, 2016). **Privatisation rarely ushers in improvements for workers' pay and** conditions and thus there may be little surprise that social care workers in **children's residential services viewed pay and conditions as the greatest** challenge to recruitment and retention (Mulkeen, 2016; Munton, Carter, Gomersall & Jackson, 2021). In the voluntary sector the absence of pay restoration is nothing less than a shameful indictment of the way **children's** residential social care workers, amongst many others in the voluntary and **community sector, have been treated (O'Donovan, 2022; Power & Power, 2022; Wilson, 2022).**

Considering such a backdrop, concerns that the shelf-life of those in children's residential care is shortening may have been somewhat predictable. Alarming, **while Williams and Lalor (2001) suggested 'five to seven years', the findings** here suggest five years is now more likely the case and the situation appears to have worsened in recent years. In part, this is likely to be shaped by the volatility of private provision, as centre closures and new centre openings happen far more often in the private sector than in the statutory or voluntary sectors (Branigan & Madden, 2020; Mulkeen, 2016; Power & Power, 2022). This cannot help but have an impact upon continuity of care and incidents of aggression and violence. Certainly, Keogh and Byrne (2016) found that **'threatening behaviour escalating to physical assault was most likely to occur between 1 year to 3 years after admission of a young person to the service' (p. 38).**

The extent of volatility in private provision came to the fore in Ireland at the end of March 2022, when media reports emerged that Positive Care had not received referrals from Tusla in more than a year, had not had its contract renewed, and would be **'stopping operations in the near future'** (Baker, 2022a; Power, 2022b). **In 2019 Positive Care received €15million from Tusla (Baker, 2022a), rising to**

€15.8million in 2020 (Power, 2022b), which at the time made it Ireland's highest paid children's residential provider and earned it €1.7million in profits (Power, 2022a). Almost incomprehensibly, voluntary children's residential providers commonly have low volatility and low staff turnover, and yet receive significantly less per placement than private providers, which has led to concerns over the future of voluntary providers (Baker, 2021; Power & Power, 2022).

Against such a backdrop it is unsurprising that Tusla's Strategic Plan for Residential Care Services for Children and Young People 2022-2025 highlights that 'recruitment of staff is increasingly challenging, job satisfaction is described as low, with an increase in the number of incidents of violence, harassment and aggression against other children/young people and staff' (Tusla, 2022, p. 4). **Tusla's immediate strategy is to rebalance private/public provision to 50:50 by 2025, with a stated 'ambition' of further rebalancing to 40:60 private/public by 2027** (Tusla, 2022, p. 6). If such moves are likely to provide more stable work opportunities to social care workers and may provide a lifeline to voluntary providers, they will have to be enacted within a system under increasing pressure (Power & Power, 2022). The pandemic further increased demand on stretched services, which was then exacerbated by the influx of those fleeing the war in Ukraine, and concerns are increasingly being expressed about children and young people having to be placed in hotels and holiday homes (Libreri, 2022; O'Donnell, 2022).

At the same time, the introduction of registration for social care workers has features of a double-edged sword. On the one hand, registration will provide protection of title and should place social care workers on a more equal footing with other health and social professions. Thus, social care workers are optimistic and positive about the potential benefits registration may bring (Doyle et al., 2022; Power & Dashdondog, 2022). On the other hand, registration will likely increase individual costs for social care workers, given registration fees, continuing professional development requirements and the need for professional indemnity insurance (Byrne, 2016; Power & Power, 2022).

In the case of the latter, the culture of residential care in Ireland has been **described as one of 'fear' on behalf of workers who are extremely conscious of**

the legacy of previous scandals, which has nourished risk averse and defensive practice and led to 'the growth of record keeping' (Brown, Winter & Carr, 2018, p. 664). Within the context of the shift toward evidence-informed and evidence-based practice as key components of professionalisation, it has been suggested that 'using evidence to support decision-making may be one way for practitioners to retain a sense of power in their practice' (Flynn, 2019, p. 12). In a risk averse defensive practice culture however, detailed record keeping may be less attractive for supporting decision-making and more attractive as a means to defend how and why decisions were made if called upon, such as in the case of an investigation or inquiry.

Increased bureaucratisation and ever more emphasis on managerial and technocratic approaches, manifested in the expansion of record keeping and documentation, clearly reflect the dominance of risk, and by extension litigation, as overarching concerns shaping professional decision-making (Banks, 2003; Brown et al., 2018; Byrne, 2016). As Banks (2003) highlighted two decades ago, the response to the increasing complexity of dilemmas confronting social professionals has been for 'codes of ethics to get longer and more prescriptive' (Banks, 2003, p. 133). In turn, increasing prescription can individualise and heighten risk for social care workers if there may be an investigation or inquiry, as it tends to 'decontextualize both actors and actions from the wider systems of which they were a functional part' (Alaszewski & Burgess, 2007, p. 352). There may be little wonder therefore that concerns have been raised about the extent of moral distress those working in residential childcare may be exposed to (McMillan, 2020).

Certainly, the upping of the ante that regulation brings, in the form of potential loss of career rather than just loss of job, will not be lost on registrants, and professional indemnity insurance is likely to be seen as a necessity (Byrne, 2016). As McLaughlin observed with respect to the regulation of health and social care professionals in the U.K., there 'is a clear imbalance of power in access to legal expertise' between the regulator and regulated (2010, p. 324). In Ireland, analysis of the Standards of Proficiency for Social Care Work (CORU, 2017), which educational providers are required to ensure are met within their programmes, may do little to quell concerns (Mulkeen, 2020). Certainly, it has

been highlighted that the standards are shaped heavily by a 'focused and detailed approach to proficiencies on responsibilities related to risk and **regulation while the approach to relationships is more limited and diffuse**' (Mulkeen, 2020, p. 18).

If evermore technocratic approaches to care work may be off-putting for new entrants, they must also contend with a context within which potential career advancement options are being increasingly closed off rather than opened up. For example, the current lack of a register means social care workers are excluded from applying for Decision Making Representative positions within the Decision Support Service system established under the Assisted Decision Making Capacity Act (2015), while clinical expertise is privileged for other lead positions, including adult safeguarding (Connelly, 2022; Doyle et al., 2022). As such, social care workers may reasonably feel that the rug of professionalisation is being pulled from under them just as they have the opportunity to step onto it, with obvious implications for recruitment, retention and shelf-life.

Conclusion

This paper's consideration of the context of social care work in children's residential services and the introduction of registration and regulation should not be taken to suggest that statutory registration is an unwanted development. Indeed, registration and state regulation are to be welcomed as the next critical step in the ongoing journey toward recognition and parity of esteem for social care work and social care workers. At the same time, it is important that due attention is given to the potential outcomes of any significant development, since to do otherwise would be to step blindly. For example, as has been noted in relation to the standards of proficiency, they 'may bring about both an unfortunate reduction, and welcome progression, in varied aspects of the discipline of social care' (Flynn, 2020, p. 54). Similarly, registration may help to tackle some of the challenges social care workers perceive around recruitment and retention, such as issues of status and standing. The challenge of pay and conditions, however, may prove more intractable, especially as registration has associated costs.

If increases to the costs of working are never popular, against the backdrop of upwardly spiralling inflation and a cost-of-living crisis, they are likely to be extremely unwelcome. As if to compound the situation further, recruitment and retention have been long-simmering issues for health and social care work in Ireland, with recent calls for CORU to 'speed up the registration process for health and social care graduates' to help address vacancies (Bermingham, 2022; Power & Burke, 2021). This follows on the back of warnings that thousands of health and social care workers will be needed by the middle of this decade alone to support an expanding population (Baker, 2022b). With the recruitment of **staff to children's residential services clearly 'increasingly challenging', talent acquisition in an ever-tightening labour market can only become more difficult, with implications for all stakeholders, especially in relation to retention and shelf-life.**

Limitations

The self-selecting nature of the participants must be considered, as respondents were most likely those who are more active or engaged with topics such as professionalisation. Certainly, previous research has found a split within social care work in Ireland, with some anxiously awaiting professionalisation, while others view registration more as a burden and something to be avoided if **possible (Flynn, 2019; Power & D'Arcy, 2018). It must also be acknowledged** that the survey was conducted shortly before the COVID-19 pandemic and the situation has changed significantly since then. As such, a similar survey today might reveal different concerns. The absence of a question around type of provider, i.e., public/private/voluntary, also limited comparative analysis, and a limitation of the survey overall was the question around average weekly shift patterns, which threw up many **'other' responses. Thus, in hindsight, average monthly shift pattern might have provided a more useful framing of that question.**

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Book review

Marginalised Communities in Higher Education: Disadvantage, Mobility and Indigeneity

by Neil Harrison and Graeme Atherton (Eds)

Publisher: Routledge; 1st edition (27 Aug. 2021)

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In this edited book, Harrison, Atherton, and the contributing authors highlight the importance of developing understandings of the lived experiences of groups experiencing/at risk of marginalisation in higher education. While acknowledging **that the term 'marginalisation' is 'slippery' (p.3), in the opening chapter the** editors point to the importance of conceptualising this term, particularly in the context of higher education. The focus in this edited book is not on issues of gender, class, and disability, but rather on other groups at risk of marginalisation that have received less attention to date. To that end many of the chapters report on findings of small-scale, exploratory research studies, or desk-based analyses drawing on demographic information, policy documents etc. The result is a highly engaging text that provides the reader with a glimpse into the experiences of groups/populations at risk of/experiencing marginalisation in higher education who have not traditionally been at the forefront of discourse in relation to this issue.

The book comprises 14 chapters altogether and is split into three sections, broadly representing different types of marginalised communities. These sections are framed under the headings disadvantage, mobility, and indigeneity.

The first section, on disadvantage, reports on the marginalisation in higher education of care-experienced young people in England and Scotland, former prisoners in the US, carers in the UK, transgender students in Hong Kong, and religious students in the UK. Interestingly, some of these groups may be **considered 'majority' groups (e.g. religious students in the UK) (p. 79)**, while others would be considered minority groups. Their experiences of marginalisation, however, bear many similarities – not least the impact of their circumstances on their ability to engage in higher education and the critical role that support (both in terms of policy and practice) can play, and in some instances has played, in improving the experiences of these students.

The second section of the book focuses on mobility and reports on the marginalisation of refugee students in Germany, Irish Travellers, Sami peoples in Finland, and rural students in South Africa – all in the context of higher education. Contributors in these chapters (as with the previous chapters) provide the reader with very helpful relevant background and historical

information on these groups. This provides important context for appreciating the, often deep-seated and long-standing, challenges these groups can face in relation to accessing and progressing through higher education.

The final section of this book focuses on indigeneity and reports on the experiences of Australian Indigenous peoples, the Orang Asli in Malaysia, and disadvantaged groups in India. These chapters provide insights into challenges relating to accessing higher education among these groups as well as highlighting promising practices that have gone some way to improving progression. These chapters also remind the reader of the importance of the wider economic and social context when considering issues such as marginalisation in higher education. The need for an institutional culture in higher education that respects diversity is highlighted in Chapter 13 (examining higher education and disadvantaged groups in India); arguably a core principle to guide efforts at reducing marginalisation in any context.

The editors include a final chapter in which they explore the relevance of Sen (1993, 2001, 2009) and Nussbaum's (2000, 2011) capabilities approach to social justice. Drawing on the content of the previous chapters and this approach, they highlight a useful framework for considering the dimensions of marginalisation - by society, by systems, by time/space, and by relevance. The authors note that any efforts to support marginalised groups are likely to also enhance the experience of the wider student body.

The chapters in this book make for incredibly engaging and informative reading and are noteworthy for their use - and integration - of multiple data sources to examine issues that have, to date, been relatively under-examined. Each chapter highlights key points in relation to policy and practice while also emphasising progress that had been made where relevant - a helpful reminder that progress can be made on this issue.

About the author

Dr Eavan Brady is an Assistant Professor in Social Work in the School of Social Work and Social Policy, Trinity College Dublin. Eavan is a registered social worker and vice-Chair of the Irish Aftercare Network. Her research interests are

located in the field of child welfare with a particular focus on the long-term **wellbeing and outcomes of children in care and care leavers**. Eavan's PhD research explored the educational pathways of care-experienced adults.

Book review

The Great Pretender: The Undercover Mission that Changed our Understanding of Madness

By Susan Cahalan

Publisher: Canongate, 2020 (First published in USA in 2019 by Grand Central Publishing)

ISBN: 1538715287

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I came to this book unexpectedly because it was referenced in another, *Desperate Remedies* by Andrew Scull (2022). **Scull's book is a fascinating and scholarly history of American psychiatry and its attempts to understand and treat mental illness.** Scull includes an account of a famous study by David Rosenhan, a psychology and law professor at Stanford University in California, **titled 'On Being Sane in Insane Places'.** **I remembered learning about this study when studying psychology in the 1970s. I can't now recall if I first learned of it in a lecture or in the course text.** But I do remember being so fascinated by the **study that I got hold of Rosenhan's 1973 paper in *Science*.**

Briefly, Rosenhan reported that eight volunteers (a ninth was omitted from the **findings for not following the study's protocols**) **had gained admittance to mental hospitals** by claiming they were hearing voices. All the volunteers – Rosenhan **called them 'pseudopatients'** - were admitted and spent between seven and fifty-two days in hospital before being discharged. The seven who were admitted to public institutions were diagnosed as schizophrenic, while the sole volunteer admitted to a private hospital was given a diagnosis of manic depression (an older term for bipolar disorder). Following diagnosis, the volunteers behaved 'normally', yet even normal acts such as recording notes in a diary were apparently interpreted as symptoms of their illness. The key points of the study were that psychiatrists appeared to be not very good at distinguishing the sick from the well, and that the context (i.e., mental hospitals) produced an expectation of mental illness. The study, which received considerable academic and media attention, according to Scull (2022), severely damaged the public perception of psychiatry in the USA, and in many other countries, caused a crisis within psychiatry, hastened the closure of residential mental health facilities, and, until recently, featured as a classic study in psychology textbooks.

Except that, **in the 2022 book that led me to Cahalan's**, Scull reports that Rosenhan 'perpetrated one of the most egregious and successful academic frauds of the twentieth century' (p. 305). This fraud was uncovered, '[t]hanks to some astonishing detective work by a New York journalist, Susan Cahalan' (p. 305). **I simply had to read Cahalan's book.**

At the age of 24, Susannah Cahalan, a journalist with *The New York Post*, began to experience depression, flu-like symptoms, and psychosis. After nearly **jumping out of the window of her father's third-floor apartment**, she was **admitted to hospital, dosed with antipsychotics, and marked up for 'transfer to psych'**.

Thanks to many lucky factors that helped set me apart – my age, race, location, socioeconomic situation, generous insurance coverage – doctors pushed for more tests, which led to a spinal tap that revealed the presence of brain-targeting autoantibodies...**People no longer implied that trouble was all in my head** (Cahalan, 2020, p. 8).

Cahalan had a neurological disease, autoimmune encephalitis. She wrote a book about her experience, *Brain on Fire* (2012) - subsequently released as a drama documentary produced by Charlize Theron, with Cahalan played by Chloë Grace Moretz - and gives talks about her experience. Soon after one of her talks, she had dinner with a clinical psychologist who had heard her speak, and who asked **if she had heard of the Rosenhan study. She hadn't but looked it up.**

On my first reading of 'On Being Sane in Insane Places,' in a quiet Boston hotel room, the first of hundreds of readings to come, I saw immediately why so much of the general public had hailed it - and why psychiatry writ large despised it (p. 40).

Using her journalism skills, Cahalan researched Rosenhan, who died in 2012, and attempted to track down family, colleagues – and the volunteer **'pseudopatients' documented** in his paper. *The Great Pretender* is the story of that detective work, set within a broader context of present-day psychiatry and treatment for mental health difficulties in the USA. The book is a great read – part detective story, part science journalism. I particularly enjoyed the insight **we get into Cahalan's research methods**: 'I kept coming across the name Perry London. *It's too bad Perry isn't here*, people kept saying to me. *He'd know everything.*' When Cahalan confirmed that Rosenhan had in fact gone undercover in a mental hospital, and when she tracked down two of his graduate **students who had also been pseudopatients, I found myself wondering if Scull's assessment of Rosenhan's work** had been overly harsh. My view changed when I

learned that one of the graduate student volunteers told Cahalan that his hospital experience had been entirely positive, yet this had not been represented in the paper, and that Cahalan was unable to trace any of the other pseudopatients.

I have only a mild criticism: in a book which deals with labelling and stigma, it's strange that Cahalan feels the need to describe accents in a stereotypical way: thus, the psychiatrist 'R. D. Laing came to Esalen in 1967, speaking in his enchanting Scottish brogue about his work at Kingsley Hall', and '[t]he next day **a man's Southern Californian drawl greeted me on the phone**'. Maybe she got unlucky with this Scottish reviewer who happens to have relatives in Southern California!

What did I learn? Something I have believed for close to 50 years turned out to be based on fraud (not least because all but two of the pseudopatients were most likely fictional, **according to Cahalan's research**). The value of having a different take on research: it took a journalist to unmask the deception; there **were many criticisms of Rosenhan's research at the time, but these were** directed ineffectually because they were expressed defensively rather than in a scholarly manner. Rosenhan was not wrong about the impoverished state of US psychiatry in the 1970s, but especially because he did not follow up his celebrated study, his critique was misdirected. It seems astonishing that the paper got past referees and editors without reassurances about the soundness of the methodology and **consent from the study's subjects**. I would hope that the **research proposal would not have got past today's ethics committees, but** Cahalan reports several contemporary examples of research fraud – admittedly those that were uncovered more quickly than **Rosenhan's deception** – and believes academic fraud may be more widespread than is acknowledged. On the other hand, Cahalan also notes reasons to be more optimistic about developments in neurology, pharmacology, and psychiatry:

I am aware of all the arrogance, incompetence, and failure, but I still believe that psychiatry – and the whole of medicine – will one day be deserving of my faith (p. 294).

Rosenhan's deception had more far-reaching consequences. His paper, and other critiques, such as Ken Kesey's 1962 novel, *One Flew Over the Cuckoo's Nest*, and the subsequent 1975 film starring Jack Nicholson, while not solely responsible for the closure of institutions, provided cover for the political decision to close hospitals on the false prospectus of providing care in the community, in the USA and in many other countries. This preference for community, or family, care, over residential care, has also influenced trends in social work. Rosenhan deliberately suppressed evidence of good institutional care because it did not fit his broader theory, and the very people he apparently cared deeply about were the poorer for it.

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The review copy was purchased by the reviewer.

About the author

Dr Graham Connelly is a chartered psychologist and an honorary senior research fellow in CELCIS and the School of Social Work and Social Policy at the University of Strathclyde. A non-executive director of Kibble Education and Care Centre, he is also the editor of the Scottish Journal of Residential Child Care.

Book review

Behind Closed Doors: Why We Break Up Families - and How to Mend Them

by Polly Curtis

Publisher: Virago/Little Brown

ISBN: 978-0349014531

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When approaching this book review, I initially started to write a 'classic' review in the time-honoured tradition that includes all the usual components. However, as I neared the end, the feeling grew that I should forego that road and take a different path. Because to be honest, there are other classic reviews of this book out there that are better than anything I could come up with. And so, I offer up **my own 'novel' approach**. I want to share how this book made me feel, what it means to be someone who cares about what this book concerns, what I learned, and what I agree and disagree with. The book – *Behind Closed Doors* by Polly Curtis – is a deep dive into the English Child Protection System.

Behind Closed Doors lays bare the difficulties for those working in the English system and highlights the often-devastating results for both the children and adults who come into contact with it. Using first-hand testimonies alongside her own personal reflections, Polly Curtis provides us with insights from those we rarely hear in such undiluted form. The problems within, and solutions to, the many issues arising from an imperfect system are investigated with a vigour that demonstrates the care with which she approached this book. She has not only used her talent to get to the core of the issues facing both families and professionals alike, but also self-reflects throughout, which adds greatly to the overall impact of the book. You may find yourself – as I did - agreeing with her on more than one occasion.

At first, I was scared to pick this book up (not that I don't always wait until the deadline approaches before I DO stuff). No, I was scared because I already knew of some of the damaging things I would read about. I understood that the system was unfit for purpose, that 12 years of cost-cutting policy and austerity had brought society to a darker place, that risk-averse practice was the norm because of the media scapegoating of Social Work over the years, and that poverty is the ubiquitous wallpaper that nobody mentions when intervening in the lives of the poor. So, it was with trepidation that I picked up a book that would sew all this and more into a cohesive picture, one that leaves the reader in no doubt as to the reality of the situation on the ground for all those involved. This book hammers home the pertinent points about where things go wrong in often heart-breaking detail. And if there is one thought I was left with following reading, it is that so much is wrong and so many lives have and are being

damaged unnecessarily because of decisions made by people whose focus is skewed by some political, cultural, economic, and/or social consideration that corrupts the work they are trying to do – protect children.

There are moments in this book when reading the personal testimony of those impacted by a broken system had me upset, angry, shocked, and shaking my head in a strange kind of all-too-familiar understanding. As someone who has lived through the care system and worked in and around it for nearly twenty years, I have come across too many similar situations to be surprised. However, to see it so starkly set out through individual examples and augmented with up-to-date statistics is a whole other level of sadness. It leaves the reader in no doubt as to the pain caused by a system that is supposed to find the best path forward for families. That it fails so often in so many ways is the most difficult bit of all to digest. It could and should be so much better.

Throughout the book, the (seemingly age-old) issues impacting how families are dealt with are recurring themes, a postcode lottery of good or bad services, resource issues, well-meaning but out-of-touch political interference, lack of cultural understanding (at worst blatant racism), the creation of a labyrinth of ways to avoid tackling head on a thorny issue, the negative narrative of poor people created by the political class (that is deemed so normal it has become TV entertainment), and the breakdown of community trust in the state. Put together, it makes for a bleak reality. When I then read the parts relating to the impact of the pandemic and the oft-polarising nature of the internet, my fears were realised, and then some. We can now add to that the cost-of-living crisis.

Polly shows us where the use of lived experience helps in pushing forward understanding. She notes the gargantuan efforts of some to support families (teachers delivering hundreds of hot meals during the height of the pandemic), she explores the efforts of those law professionals who challenge the status quo and do their utmost to lessen the impact of the system on those whose agency is but a side story as the machinations of the state grind through their lives. The good work – that should be rolled out across the country – is showcased to evidence how it could be done differently, and time and again she allows the voice of those with the knowledge of what is needed to say it clearly.

Relationships. Relationships. Relationships. However, the evidence is that the

system is only being held together by such efforts and that without wholesale changes it will continue to cause damage to many lives despite the efforts of all those good people trying to do the best they can.

There are so many more points to raise and that is the depth into which this book delves. The impact of social isolation, the nuanced take on addiction, the failure to address trauma in adults, the short- and long-term impact of adoption on all involved, the division of adult and children services (pertinent to the debate around the National Care Service in Scotland), capitalism and the marketisation of care, political ideology and its impact on society, the pace and nature of societal change leaving some behind, and much more. It was fascinating and enlightening to take the journey this book permits. I only wish I could have finished with more optimism. Because, whilst Polly gives us food for **thought about how things could be better, her offered 'thought experiment' is a** radical change to the system by replacing social workers with community workers alongside increased and targeted funding. I wonder if that is realistic given the circumstances on the ground. Is the political will there? I fear the good people that serve as the glue to keep the system (mal)functioning will be left to make do with whatever changes the recent English Care Review will see put in place and that those changes - though doing some good in some areas - will never be enough to bring about the change this book evidences as needed.

As a last word, I have chosen two points to offer some critique. The first is a **relatively quick one to decide upon for yourself. Do we really 'mend' families? I don't know how much the author had to do with the title of the book, I just don't think it is anyone's job to repair a family. We offer support and we should offer the right support at the right time. The second relates to the author's decision to give Josh McCallister, Chair of the Review of Children's Social Care in England, a** substantial opportunity to offer up his opinion. He is interviewed early on in the book and his words used again in a later chapter. Critics of the English Care Review - of which there are many - are mentioned, but only in passing. There are a number of individuals and groups who are both vocal and public about their misgivings and who offer up a different vision. I think this could have been explored further. Other than that, this is a book that offers the reader a lot more than I have spoken about and could be interesting to students, professionals,

academics and anyone with an interest in this area, even if you must steel yourself for the inevitable emotions such a read will evoke.

The publisher, Virago/Little Brown, supplied a copy of this book for review.

About the author

David is a care experienced activist who pushes for the necessary changes to ensure all care experienced people, past and present, can realise their rights and full potential. He is a father and a foster carer to three children with his wife. Together, in France, they run a therapeutic farm where they welcome anyone who may benefit from the mixture of animals, nature and connection. David is a member of The Promise Oversight Board and also teaches Social Work students and Social Educators of the importance of love, respect and equality for people experiencing the care system.