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Editorial

Graham Connelly, Sarah Deeley & Nadine Fowler

Editors

Welcome to the spring 2025 issue of the *Scottish Journal of Residential Child Care*. In this issue the editors are making a special request to our readers to become involved in developing the journal's book review section. While we have an open invitation to readers to volunteer to review new books, this request is to review classic texts in our field.

The idea came from a member of our editorial board, Professor James Anglin. James describes his idea in a short article we publish in this issue: 'Do you have a book from over 10 years ago that has made a difference to your practice or your thinking about child and youth work? Perhaps others in our field could benefit from reading this text or at least might be inspired by your story of encountering it.'

We plan to include the first of these reviews in our next issue. Please consider getting involved. Is there a book that has particularly influenced you in your work? Perhaps it was reading this book that convinced you to work in our field. Or maybe it's a text you refer to regularly. Maybe the book has special meaning because it reminds you of the lecturer or mentor who recommended it, or because of what you were doing at the time you first read it. By re-reading with a review in mind, you are likely to come at the book with a fresh perspective which should be rewarding for you and our readers.

To get involved, just send an email to our book review editor, [Dr Nadine Fowler](#), with a brief proposal including the book title and name of the author(s). Book reviews should be around 500 words in length and Nadine will provide advice on aspects of style. We look forward to hearing from you.

In this issue we feature the usual mix of original research articles, shorter articles and book reviews. We also publish an article by Professor Kenneth Norrie based on his Kilbrandon Lecture at the University of Strathclyde in November 2024; readers can watch and listen to the lecture and the following discussion via the [Kilbrandon Lectures archive](#).

Long form articles

Mairena Hirschberg of the University of Zurich explores the work of the Australian Royal Commission into Institutional Responses to Child Sexual Abuse and the Swiss Independent Expert Commission (IEC) on Administrative Detention. Mairena examines the different approaches these two truth seeking commissions take in relation to personnel, mandates and framing of issues, and



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how these approaches then shape their recommendations and broader national responses to institutional abuse.

Sarah Parry of the University of Manchester, and Tracey Williams and Jeremy Oldfield of Manchester Metropolitan University examine the experiences of staff wellbeing in children's homes and how these in turn influence the care that children receive. The authors make recommendations for improvements and suggest that, if addressed, there would be an improvement to care quality and the support offered to children and young people.

Arora Akansha, Kalra Gurneet and Modi Kiran offer an account of research exploring a capacity building initiative by Udayan Care in India and Duke University in North Carolina, USA to enhance caregivers' attitudes, knowledge and skills while managing their own wellbeing in their roles supporting traumatised children. This study highlights the burnout experienced by caregivers in child care institutions arising from emotional, psychological, and structural pressures, with the authors emphasising that prioritising caregivers' wellbeing is both a moral responsibility and a strategic necessity for child development.

Julia Clark, a researcher based in Scotland, reviewed research articles concerned with holistic family support in early childhood, education and care settings with the aim of identifying lessons for the Scottish context. Julia found that 'family agency is built through collaborative relationships between parents and practitioners, parent participation in activities, and flexible, responsive ECEC programmes' and argues that these findings suggest a need for adaptations to the way health visitors work.

Grace Pellegrinelli and Ann Hodson of Queen Margaret University in Scotland used an online questionnaire to research Scottish foster carers' knowledge and awareness of children's speech, language and communication needs (SLCN). Their findings suggest that foster carers are knowledgeable about speech, language and communication needs and can identify support structures for advice and guidance. 'Only a small percentage of foster carers had receiving specific training with respect to speech, language and communication, and there was a strong desire for such training to take place'. The authors say there is a need for a national SLCN training programme for foster carers provided by speech and language therapists.

Carl Purcell of King's College London, with colleagues Martin Elliott, Cindy Corliss, Mary Baginsky, Rebecca Playle, Alyson Rees and Michael Robling of Cardiff University report the findings of their evidence review of the impact of reforms of regulatory processes in children's residential care in England and Wales. Their research identified four themes which they regard as being important for the design of good regulatory systems, including 'a stronger focus on organisational cultures and leadership'.

Dave Roberts of the Mulberry Bush Organisation in England discusses his doctoral research based on a case study of the Hill View School. His article explores understandings of therapeutic care by staff, children and families.



We are grateful to our many correspondents over the years, and we always welcome submissions; the editors will be pleased to offer advice on your ideas for an article.

Short form articles

Our short form articles provides an opportunity for a broader range of writers, including people with personal care experience, practitioners, policy makers and research students, to report on work in progress or innovation, or to explore current issues relevant to residential care or child and youth care generally. We are grateful to our many contributors over the years, and we always welcome submissions; the editors will be pleased to offer advice on your ideas for an article.

In the first of three short articles published in this issue, Margaret Davies of Red Dragonfly Services and David Lett of New Meaning Training describe the introduction of a 'Loving Care' approach to an alternative education provision in England. The article outlines the first phase of the project and includes feedback from staff and next steps plans to measure impact as the project continues. The authors include reflections on the lessons learned during phase one in the hope that they will be of benefit to other organisations who may wish to adopt a similar approach.

Mihaela Manole, Laura Quinn, and Gemma Watson of (CELCIS), the Centre for Excellence for Children's Care and Protection, at the University of Strathclyde in Scotland explore how the use of practice profiles can support develop residential childcare practice. They highlight the importance of a whole system approach, leadership support and a sense of shared ownership.

Finally, as trailed above, we include James Anglin's article establishing our challenge to readers to contribute reviews of classic texts in child and youth care.

The Kilbrandon Lecture

The 22nd Kilbrandon Lecture, 'Who then, in law, is my parent?' was given by the distinguished legal scholar, Kenneth Norrie, professor emeritus at the Strathclyde Law School. In his lecture, Kenneth explored the definition and concept of 'parent' and the different interpretations and understandings of this term in different legal jurisdictions, cultures and time periods.

Book Reviews

The book review section of this issue includes two reviews.

'Looked After, A Childhood in Care' by Ashley John-Baptiste (Hodder and Stoughton, 2024) is reviewed by Chelbi Hillan, a CELCIS Consultant with lived experience.

'In Harm's Way: The Memoir of a Child Protection Lawyer' by Teresa Thornhill (Harper Collins, 2024) is reviewed by Kenneth Norrie, professor emeritus at Strathclyde Law School, the University of Strathclyde.



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Obituary: Dr Ruby Whitelaw

It was with shock and great sadness that we learned of the sudden death of our friend and colleague at the University of Strathclyde's Children and Young People's Centre for Justice, Dr Ruby Whitelaw. Ruby was well known and loved by the child and youth care community in Scotland and beyond. As well as being an effective advocate for our profession, she was a huge supporter of the *Scottish Journal of Residential Child Care*. She will be sorely missed by us all, and especially by her family. We end this issue with a moving tribute by Ruby's friend and former colleague at Kibble Education and Care Centre, Neil McMillan. May Ruby Rest in Peace.

Open call for papers

We welcome submissions about relevant child care research and practice from around the world. If you are engaged in research or have an idea for a short article we would be delighted to hear from you. Please email us at sjrcc@strath.ac.uk

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Original Research Article

Comparing Truth Regimes and Discursive Practices in State-Led Inquiries into Cases of Compulsory Social Measures in Switzerland and Australia

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Abstract:

This paper explores approaches of two truth seeking commissions, the Australian Royal Commission into Institutional Responses to Child Sexual Abuse and the Swiss Independent Expert Commission (IEC) on Administrative Detention. It examines how the differing personnel compositions, mandates, and framing of issues in these two commissions shape their discursive practices in the form of recommendations and the broader national responses to institutional abuse. Based on their distinctive mandates, the Australian Royal Commission, as an official national truth commission, driven by practitioners with direct experience in law, mental health, and advocacy, adopts a forward-looking approach that emphasizes preventive measures and the protection of children in the present and future. In contrast, the Swiss IEC, as an academic research-led truth commission, composed mainly of academic scholars, focuses on historical analysis aimed at acknowledging and understanding past injustices. This results in divergent recommendations, with the Australian commission prioritizing systemic reforms for current child safety and the Swiss commission concentrating on historical redress, memory work and research-driven approach to preventing future abuses. The findings underscore the significance of context in shaping the outcomes of truth-seeking regimes in different national settings.



Introduction

State-led inquiries play a crucial role in addressing historical abuses, as they present a comprehensive mechanism for admitting past injustices and providing a platform for victims to share and convey their experiences to the public.¹ These inquiries often open-up a way to legal and policy reforms, aimed at preventing the recurrence of similar abuses, and fostering the process of social healing (Hayner, 2011, p. 5). A collective memory of a nation or society develops, when these inquiries document abuses and create official records, encouraging societal reflection and dialogue around these harms (Boraine, 2006, p. 18). Extensive research has been devoted to these inquiries.^{2 3} While this research has largely focused on implementing Truth Commission recommendations (Moffett, 2019; Skaar, 2019), there is a notable gap in studies exploring how these recommendations are shaped in the first place.

This study specifically explores the recommendations from two state-led investigations in Switzerland and Australia regarding cases of compulsory social measures. It compares two distinct approaches for seeking truth and making recommendations, investigating how different frameworks present varying discursive practices.

In Switzerland, tens of thousands of children and (young) people were subjected to compulsory social measures and placements until 1981, suffering severe physical, psychological, and sexual abuse. These measures included forcing children, known as *Verdingkinder* or 'contract children', to work on farms where they faced exploitation and abuse. Others were placed in harsh residential institutions or administrative detention without criminal charges, subjected to forced abortions, sterilizations, adoptions, and even medical experiments without consent.

In response to these injustices, the Swiss government took steps to address this dark chapter of its history. Between 2010 and 2013, formal apologies were issued, leading to the creation of the Federal Act on Compulsory Social Measures

¹ This article draws on research supported by the NRP76 grant 26042593

² See for example Van der Merwe for an overview of more than 70 countries (Van der Merwe et al., 2009).

³ See, for example, Priscilla Hayner (2011) who has provided foundational work on the global rise of truth commissions, analyzing their processes and outcomes, while highlighting the importance of context in determining their success in achieving justice and reconciliation. Mark Freeman (2006) offers a comprehensive analysis of different truth commissions worldwide, highlighting their role in restorative justice, while Paul Gready (2011) explores the long-term effects of truth commissions in terms of institutional reform and victim rehabilitation. **Catherine Cole's** work (2019) analyses the role of cultural memory and performance in the aftermath of South Africa's truth commission. In the context of truth commissions in colonial and post-colonial settings, Karen Engle's (2020) research has brought attention to the limitations of truth commissions in addressing colonial legacies (Cole, 2010; Engle, 2020; Freeman, 2006; Gready, 2011; Hayner, 2011).



and Placements prior to 1981 (CSMPA) in 2014. The act provides a framework for acknowledging these injustices, offering financial compensation, counselling and support services. In the same year, an Independent Expert Commission (IEC) on Administrative Detention was established to further investigate these historical abuses, with a particular focus on cases of administrative detention (Federal Office of Justice, 2024). This initiative was followed in 2017 by the launch of National Research Programme 76 (NRP 76), which was tasked to go beyond a focus on administrative detention and to examine compulsory social measures more broadly. This program aimed to enhance the understanding of present-day social and legal frameworks, thereby contributing to shaping the future (Swiss National Science Foundation, 2025).

In contrast, the Australian Royal Commission into Institutional Responses to Child Sexual Abuse was established in 2013, as part of the government's broader nation-building agenda. Between 2010 and 2013, a wave of legislative changes brought significant reforms, particularly in education and disability insurance. The Royal Commission focused on addressing past injustices to ensure a safer future for children, serving as a significant element of Australia's drive for secular modernization (Gleeson & Ring, 2020, p. 2).

The inquiries in both Switzerland and Australia serve as a form of truth commission, however with differing frameworks. Freeman (2006) has defined a truth commission as:

A truth commission is an ad hoc, autonomous, and victim-centred commission of inquiry set up in and authorized by a state for the primary purposes of (1) investigating and reporting on the principal causes and consequences of broad and relatively recent patterns of severe violence or repression that occurred in the state during determinate periods of abusive rule or conflict, and (2) making recommendations for their redress and future prevention (Freeman, 2006, p. 13).

The Australian inquiry qualifies as an official national truth commission (Gleeson & Ring, 2020, p. 3), while Switzerland's IEC functions as an academic research-led commission (Paixão, 2019, p. 20).

This analysis is based on Foucault's theory of the 'regime of truth', which emphasises that each society develops its own 'politics of truth'. Foucault's concept of the 'regime of truth' is crucial to understanding how truths are constructed and validated in societies through institutional practices, discourses, and power structures. Foucault (1980) states that a 'regime of truth' is not only about what is considered true or false; rather, it is established in a society through long procedures, mechanisms and discourses. This framework describes the interwoven connection of power and dissemination of knowledge, stating that the accepted truth or falsehood is often a reflection of power dynamics. (Foucault & Gordon, 1980). Further, he describes his idea of the 'politics of



truth,' which refers to the ways in which methods of producing and validating truth are shaped by power relations. (Foucault, 1995, p. 26). These power relations allow only the power holder to speak the truth, legitimise knowledge, and grant power to certain institutions for producing it. In the context of truth commissions, their formation, given mandate, and compilation of inquiries directly influence their results and the 'truth' they produce.

State-led inquiries, such as the Australian Royal Commission and the Swiss Independent Expert Commission (IEC), can be investigated by using the framework of 'regimes of truth'. These commissions involve not only the documentation of past abuses, but they also engage in institutional processes for producing certain narratives around those injustices. Foucault's concept of discourse is crucial in understanding how these commissions frame problems like child abuse and compulsory social measures. These discourses are not only ways of describing reality, but they also shape and construct it.

Drawing on Foucault's concept of discourse as the foundation of 'truth' and the institutions that produce it, this study maps the 'regimes of truth' emerging from the Swiss and Australian commissions. It examines how elements such as each commission's formation, composition, issue framing, and mandate shape their respective 'regimes of truth.'

I argue that these structural factors that shape these two truth commissions — personnel, mandate, and framing—construct specific distinct discursive narratives about the abuses under investigation, ultimately leading to distinct discursive practices reflected in their recommendations. The Swiss IEC, driven by academic research, focuses on historical documentation and scholarly explanations of administrative detention, resulting in recommendations centred on memory work, victim rehabilitation and a research-based approach to examine past abuses to help prevent similar issues in the future. In contrast, the Australian Royal Commission prioritizes the prevention of future abuses, leading to recommendations for systemic reforms and the establishment of safeguarding bodies like the National Office for Child Safety.

These two cases were chosen to comprehensively compare how different types of truth commissions, that is the Royal Commission as an official national truth commission in Australia versus the IEC as an academic research-led truth commission in Switzerland influence the framing of issues and the resulting discursive practices in the form of recommendations. The choice of these cases thus ensures a more nuanced analysis, capturing the diverse ways in which power, history, and social structures shape regimes of truth and their outcomes.

This article delves into a comparative analysis of recommendations of the Swiss and Australian commissions. The study is grounded in an investigation of key reports: the Schlussbericht by the Swiss IEC (Germann et al., 2019) and the Annual Progress Report by the Australian Royal Commission (Commonwealth of



Australia, 2018). Space constraint has compelled the study to focus on selected recommendations to extract the broader argument.

This study frames its analysis as a comparison between the Australian Royal Commission into Institutional Responses to Child Sexual Abuse and the Swiss Independent Expert Commission (IEC) on Administrative Detention. Hence, all references to the Swiss case pertain specifically to the IEC, all references to the Australian case pertain specifically to the Australian Royal Commission. However, I do acknowledge the relevance of other truth commissions on similar issues in both Australia and Switzerland, such as the National Research Programme 76 (discussed below).

Background information

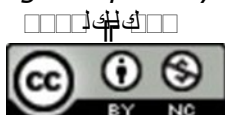
The establishment of the Royal Commission in Australia and the Independent Expert Commission (IEC) in Switzerland reflects distinct political contexts that have shaped the scope and focus of their work.

Setting up an academic research-led truth commission: Political conditions of production and composition of the Swiss IEC

Based on the mandate and personnel composition of the Swiss IEC, this commission can be classified as an academic university-led truth commission. The Swiss IEC positions itself among a broader international movement of truth commissions and inquiries that have emerged in recent years. These efforts reflect an increasing focus on addressing historical injustices linked to democratic welfare states in the post-World War II period.

The Swiss IEC was established following the passage of legislation aimed at rehabilitating individuals subjected to administrative detention. The Swiss Federal Council tasked the IEC with conducting a scientific and historical investigation into the use of compulsory social measures and forced placements prior to 1981. However, unlike the other commissions, its mandate was explicitly retrospective, oriented towards a historical reappraisal rather than addressing ongoing issues. This focus aligns with Switzerland's broader 'Erinnerungspolitik' or memory work (a national memory), which seeks to acknowledge and understand past injustices through historical inquiry, thus contributing to collective memory.⁴ (Germann et al., 2019, p. 20) No immediate policy reforms were sought but the dissemination and use of the research are envisaged. This includes raising awareness among the public, authorities, institutions, and private individuals involved in compulsory welfare measures and out-of-home

⁴ The Swiss IEC states that «Die Entwicklung in der Schweiz ist in diesem Kontext insofern eine Ausnahme [...als das] der historischen vor einer juristischen Aufarbeitung Priorität [eingeräumt wurde].» ('The development in Switzerland is an exception in this context [...in that] historical investigation was given priority over legal proceedings.' (translation by the author))



placements under current law (Bundesversammlung der Schweizer Eidgenossenschaft, 2014).⁵

Due to its mandate, the Swiss regime of truth is academically orientated, with its members primarily drawn from university settings. The commission includes scholars such as Prof. Dr Lukas Gschwend and Prof. Dr Martin Lengwiler, whose expertise lies in historical analyses, legal studies, and the social sciences. This composition emphasizes scholarly research and historical contextualization, reflecting a model of truth-seeking that prioritizes academic rigour and systematic exploration of historical and legal contexts over the practitioner-based approach seen in Australia (Unabhängige Expertenkommission, n.d.).

Setting up an official national truth commission: The Australian Royal Commission

The Australian Royal Commission was initiated in response to a Letters Patent, which directed it to investigate institutional responses to allegations and instances of child sexual abuse (Australian Government, 2013). The Letters Patent required the Royal Commission to *'inquire into institutional responses to allegations and instances of child sexual abuse and related matters'* and produce findings and recommendations to *'better protect children against sexual abuse and alleviate the impact of abuse when it occurs'*. It is important to note that *'occur'* is in the present tense, meaning that ongoing sexual abuse should be prevented rather than conducting a broad historical reappraisal. This directive led the Royal Commission to concentrate narrowly on sexual abuse, excluding other forms of child abuse (Royal Commission into Institutional Responses to

⁵ The IEC was conceived as a preparatory phase aimed at investigating historical practices, with the expectation that a second academic truth committee, the National Research Programme (NRP76) would follow, conducting further research and issuing recommendations.

In 2017, the NRP76 was tasked with deepening and expanding upon the work previously conducted by the IEC. (Leitungsgruppe NFP76, 2024, p. 9), looking at a wide range of compulsory social measures.

The NRP76 explicitly situates its work within a forward-looking paradigm. The program is not merely an exercise in historical documentation but is designed to make an impact in the present and future by drawing lessons from past experiences.

Structurally, NRP 76 is predominantly academic in its orientation, with limited involvement from practitioners working directly in the field. The composition of the research team reflects a commitment to rigorous scholarly analysis in the first place.

The mandate of NRP 76, as assigned by the Swiss Federal Council, was designed in order to *'die Bedeutung der historischen Aufarbeitung für die Schaffung für die Gerechtigkeit zu berücksichtigen und ausgehend von der Vergangenheit den Versuch zu unternehmen, die Gegenwart zu verstehen, um die Zukunft besser gestalten zu können'* [*'take into account the significance of historical inquiry for achieving justice and, building on past experiences, to attempt to understand the present in order to shape the future more effectively.'*] (Knüsel et al., 2024)). It is important to note that the mandate emphasizes an attempt to understand and shape the future, rather than prescribing a definitive course of action.

The program aims to develop *'Grundlagen für künftiges Handeln in Politik und Praxis'* [*'foundations for future action in policy and practice,'*] (Leitungsgruppe NFP76, 2024, p. 9) This suggests that the program aims to establish a foundation for potential future action in policy and practice through research, rather than issuing explicit policy recommendations (Leitungsgruppe NFP76, 2024, p. 9).



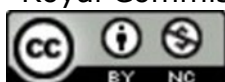
Child Sexual Abuse, 2017, p. 7). Importantly, the Commission itself recognizes that the requirement to examine child sexual abuse in an institutional context gives them a narrower focus than most governmental and non-governmental institution redress schemes have had.

Based on its mandate, practitioners with direct experience in the relevant fields predominantly influence the Australian regime of truth. Members of the Royal Commission into Institutional Responses to Child Sexual Abuse, including Justice McClellan and Commissioner Helen Milroy, come from diverse backgrounds including law, policing, mental health, and advocacy. These commissioners bring practical, ground-based expertise to their roles, having worked with families, children, and vulnerable populations. This practitioner-oriented approach reflects a model of truth-seeking that prioritizes applied experience and direct engagement with affected communities (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017). This allows the commission to frame its recommendations around immediate, actionable measures to prevent future abuse and address ongoing issues within institutions. The commissioners' backgrounds in dealing directly with vulnerable populations and their firsthand experiences with the consequences of institutional failures likely contributed to recommendations that emphasize robust, proactive measures, such as the establishment of the National Office for Child Safety, and systemic reforms designed to protect children in the present and future.

Also comparing the chairs of the two commissions, that were appointed on the basis of the mandate, is revealing. Importantly, the Swiss Commission is chaired by Dr. Dr. h.c. Markus Nötter, a jurist by training who before his retirement worked as a policy administrator (Unabhängige Expertenkommission, n.d.). Furthermore, he served as the chair of the Foundation for Minorities in Switzerland (Gesellschaft Minderheiten in der Schweiz, n.d.) and the Foundation for the Future of Travellers (Schweizerische Eidgenossenschaft, n.d.), whose children were also deliberately placed in out-of-home care. As a result, he possesses expertise in this field. The chair of the Australian Commission is Justice Peter McClellan, who is a Judge of Appeal in New South Wales (Royal Commission into Institutional Responses to Child Sexual Abuse, n.d.).

The contrasting backgrounds of the chairs of the Swiss and Australian commissions highlight important differences in the leadership styles and the orientation of these truth regimes, which influence both the commissions' approaches and the outcomes of their work.

The chair of the Swiss Independent Expert Commission (IEC), a retired political leader, suggests an institutional and bureaucratic approach, emphasizing governance, consensus, and historical analysis in line with Switzerland's cautious political culture. This, combined with the academic composition of the commission, prioritizes research and memory work. In contrast, the Australian Royal Commission, chaired by a lawyer, took a legalistic, justice-oriented



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approach, focusing on fact-finding, survivor engagement, and accountability. The legal expertise of the chair contributed to strong recommendations for systemic reform, redress, and future abuse prevention.

Discursive framing of the issue by the two truth commissions

The Royal Commission into Institutional Responses to Child Sexual Abuse, as an official national truth commission, presents the issue as a discourse of practitioners on the ground. It frames the problem primarily within the context of sexual abuse in residential institutions, effectively narrowing the focus and, consequently, silencing other forms of abuse in diverse settings. Interestingly, the Royal Commission itself disapproves of this narrow focus, as the scope of our Letters Patent does not extend to addressing claims of physical abuse, neglect, or emotional and cultural harm unless these experiences occurred alongside child sexual abuse within an institutional context. The members of the Royal Commission regret that the mandate does not permit to consider redress for all individuals who were in state care, former child migrants, or members of the aboriginal '*Stolen Generations*' unless they specifically suffered child sexual abuse within an institutional setting (Royal Commission into Institutional Responses to Child Sexual Abuse, 2015).⁶

The Commission emphasizes the recognition and condemnation of institutional child sexual abuse, portraying it as a long-standing issue that demands national acknowledgement. Survivors are portrayed with respect and elevated status, whose stories are vital for understanding the problem and informing future preventative measures. 'The survivors are remarkable people with a common concern to do what they can to ensure that other children are not abused. They deserve our nation's thanks' (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017, p. 2).

This framing contributes to a national narrative that equates sexual abuse with severe, pervasive trauma, using strong condemnatory language to describe the abuse as 'one of the most traumatic and potentially damaging experiences', 'a national tragedy' and a 'fundamental breach of trust' (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017, p. 5). However, the emphasis on trauma, framed through professional terminology, limits the discourse by sidelining other psychological consequences of sexual abuse, such as emotional and dissociative disorders. While the Commission's approach effectively highlights the gravity of institutional sexual abuse, it simultaneously constrains and silences the broader understanding of abuse and its varied

⁶ The original text from the Redress and Litigation Report reads: '*We do not accept that our Letters Patent allow us to consider redress for those who have suffered physical abuse or neglect, or emotional or cultural abuse, if they have not also suffered child sexual abuse in an institutional context. Also, we do not accept that our Letters Patent allow us to consider redress for all of those who were in state care, who were child migrants or who are members of the Stolen Generations, regardless of whether they suffered any child sexual abuse in an institutional context.*' ((Royal Commission into Institutional Responses to Child Sexual Abuse, 2015, p. 6)



impacts, potentially overlooking the complexity of survivors' experiences, despite their potentially equally devastating impacts. For example, child migrants and members of the Stolen Generations—groups who faced systematic abuse—are only included if sexual abuse in an institution occurred, neglecting broader harms like cultural displacement, physical abuse, or forced labour. While this allows for a concentrated inquiry, it risks overlooking significant dimensions of abuse that merit public acknowledgement and reparative measures. Although the Australian Royal Commission explicitly condemns past abuses, it frames them as part of a broader, ongoing failure to protect children, advocating for redress both for past and potential future abuses.

The Swiss IEC, as an academic truth commission, owing to its personnel composition of academics and to its mandate, presents its findings through a '*wissenschaftliche Synthese*' (scientific synthesis) focusing solely on administrative detention and excluding other compulsory social measures (which are addressed in other research programs like the Swiss National Research Programme 76). The Swiss IEC frames the issue of administrative detention as a historical injustice. Administrative detention is described as a '*historisches Ereignis*', which should be explained using the concept of '*historische Erklärungen*' acknowledging the limitations that come with it, such as sketchy historical records (Germann et al., 2019, p. 31). It frames the issue primarily within the context of administrative detention, effectively narrowing the focus and, consequently, silencing other forms of compulsory social measures in diverse settings. Due to its mandate, coming from law, the problem is framed within legal-administrative terms, with a strong emphasis on past-tense narratives, which reinforces the perception of administrative detention as a bygone issue, disconnected from contemporary relevance.

Approaches to addressing abuse via recommendations

These commissions exhibit divergent approaches in handling abuse and rehabilitation in their recommendations based on their functions as an official national truth commission and an academic research-led truth commission, and their different setups in terms of mandate, composition and ultimate framing of the problem.

The Royal Commission's recommendations are predominantly forward-looking, aiming to enhance the protection of children in contemporary residential institutions and other settings. This future-oriented focus is evident in the commission's 17-volume final report, which emphasises recommendations aimed at improving the prevention, detection, and response to child sexual abuse in current institutional settings (Royal Commission into Institutional Responses to Child Sexual Abuse, 2015). This approach reinforces the commission's commitment to contemporary safeguarding measures. Only one volume, 'Redress and Civil Litigation', is specifically addressing redress for victims of historical abuse.



At the same time, the Australian Royal Commission recommends establishing robust oversight systems to ensure the recommendations are effectively implemented.

In contrast, the Swiss IEC's recommendations are rooted in a historical reappraisal, focusing primarily on achieving reconciliation and reparative justice for those affected by compulsory social measures before 1981. The IEC's recommendations, emphasize redress measures such as financial compensation, formal apologies, and access to personal files for the affected individuals. The commission's work, while acknowledging that '*questions of yesterday are questions of today*' recommends a research-based approach to understanding past abuses which should also help to prevent similar issues from arising today (Metraux et al., 2019). The recommendations of the two regimes of truth will be discussed in the subsequent sections, framed within distinct thematic contexts.

Different discursive practices across the two regimes of truth

The themes presented by the Australian Royal Commission differ from those in the Swiss IEC. However, similar considerations were also observed, which are highlighted here.

Recommendations by the Australian Royal Commission

Australian Royal Commission's Theme 4 – 'Criminal Justice and the Protection of Children'

Theme 4, which is deeply rooted in a legal framework, centres around Working with Children Checks (WWCCs) in Australia that are a crucial component of a broader framework aimed at ensuring child safety within institutions. These checks serve to prevent individuals with known histories of child-related offences from engaging in work or volunteer activities involving children. However, the effectiveness of WWCCs is limited because they rely on prior reports or convictions, which only identify individuals, previously documented for such offences. Over-reliance on WWCCs can foster a false sense of security and may contribute to complacency in child protection efforts. To achieve comprehensive child safety, it is essential to implement a multifaceted strategy that includes strong leadership, effective governance, robust recruitment practices, and ongoing training (*Working with Children Checks Report, 2015, pp. 3–5*).⁷

⁷ The current state-by-state WWCC schemes are characterized by inconsistencies, complexities, and a lack of integration, which render significant gaps in child protection. One such gap is the inability to share information across jurisdictions, which creates opportunities for '*forum shopping*', where individuals with adverse records in one region may obtain clearance in another.



To further enhance child safety, a national approach to WWCCs has been recommended by the Royal Commission. This approach would involve standardizing the WWCC process, making checks portable across jurisdictions, and improving information sharing between states and territories. These reforms are crucial for better protecting children in Australia, and their implementation would represent a significant step forward in the country's child protection framework (*Working with Children Checks Report*, 2015, p. 60).

In a similar vein, in Switzerland, on December 13, 2013, the Swiss Parliament passed the 'Federal Act on Activity Bans and Contact and Exclusion Orders' (Amendment to the Criminal Code, Military Criminal Code, and Juvenile Criminal Law). These legal amendments, which took effect on January 1, 2015, established the legal basis for activity bans and replaced the previous professional ban. These legal amendments were not recommended by the Swiss IEC (as it was the case in Australia) but resulted from the implementation of a 'Volksinitiative' (popular initiative).⁸

Australian Royal Commission's Theme 5 – Accountability and Annual Reporting

The Royal Commission's framing of the problem as an ongoing abuse and trauma and the moral imperative to protect children reinforces the urgency of implementing its recommendations.

The theme addresses the current accountability measures of the Australian government, states, and territories concerning their response to the recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse. Notably, this accountability pertains to present actions rather than addressing past instances of child abuse. The key recommendations outlined include:

In response to these challenges, the government established a Working with Children Checks report working group, which developed the National Standards for WWCCs. These standards are aligned with the recommendations from the WWCC report and are intended to prevent ongoing sexual abuse by addressing the identified shortcomings. (*Working with Children Checks Report*, 2015, p. 60)

⁸ Under this new legislation, convicted offenders who have violated the sexual integrity of a minor or a particularly vulnerable person permanently lose the right to engage in professional or voluntary activities with these groups (mandatory lifelong activity ban). These new prohibitions are enforced, among other means, through the instrument of the special private criminal record extract (Netzwerk 'Prävention sexueller Gewalt gegenüber Kindern und Jugendlichen im Freizeitbereich', 2020).



The Australian Government and state/territory governments have provided a formal response six months after the Final Report by the Royal Commission and conduct annual public reporting on the progress of implementation over five years, followed by a comprehensive review after ten years to assess the effectiveness of these measures.

Additionally, the preservation of the Royal Commission's website throughout the duration of the national redress scheme was advised, alongside the commissioning of a national memorial for victims and survivors in Canberra, which was developed with input from survivors (Commonwealth of Australia, 2020, p. 134).

the Australian Government's response to these recommendations has been notably comprehensive. The government has not rejected any of the Royal Commission's recommendations; instead, all have been either accepted, noted (particularly when they were considered the responsibility of state and territory governments), or are under further consideration. This commitment is reflected in the Annual Progress Report 2018, which details the current status of the implementations of the Royal Commission's 409 recommendations. (Commonwealth of Australia, 2020)

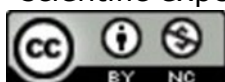
The involvement of other non-governmental institutions, such as the Catholic Church, in responding to the Royal Commission's recommendations further illustrates the broad engagement with the Commission's findings (Royal Commission into Institutional Responses to Child Sexual Abuse, 2015).

This approach contrasts sharply with the situation in Switzerland, where the recommendations made by the Independent Expert Commission (IEC) regarding coercive welfare measures have largely not been implemented. Switzerland's absence of structured monitoring and reporting mechanisms could explain the limited accountability and slow progress in addressing the Commission's recommendations. This comparison highlights the importance of ongoing oversight and transparency in implementing measures intended to redress past abuses and prevent future occurrences.

While Australia has taken a proactive stance by integrating the Royal Commission's recommendations into broader social policy frameworks, the Swiss approach remains more retrospective and research-based, with less emphasis on implementing comprehensive measures of social policy to prevent future abuses. This divergence highlights the different ways in which the two countries address the legacies of past abuses and their efforts to ensure such abuses do not recur in the future.

Recommendations by the Swiss IEC – Themes 2 and 3

The IEC's recommendations as regards themes 2 and 3 are framed within a scientific expert discourse (*Die Forschungsarbeiten der UEK haben*



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bestätigt... [the research works of the IEC have confirmed...] (Germann et al., 2019, p. 373)), focusing on the rehabilitation of those who were subjected to compulsory social measures. Theme 2 of the IEC's recommendations highlights the marginalization and isolation experienced by victims of compulsory measures, noting that these individuals were often denied opportunities for social participation. The IEC recommends the creation of spaces and instruments to mitigate these restrictions, such as substantial financial support for civic engagement, the creation of forums for political exchange, and the establishment of comprehensive financial support for individual and collective projects. The goal is to enable these individuals to participate more fully in public debates and political mobilizations, which they were historically excluded from (Unabhängige Expertenkommission, 2019, p. 376).

Theme 3 addresses the lack of access to education, which is identified as part of a vicious cycle involving economic precarity, social exclusion, and limited opportunities for civic participation. The IEC notes that victims of compulsory welfare measures were often subjected to forced labour with minimal educational or therapeutic support, affecting their long-term economic performance and social integration. In response, the IEC recommends measures to enable these individuals to exercise their right to education, including free access to training courses, museums, and public cultural and sports activities. This focus on redressing past educational disadvantages is not mirrored in the Australian recommendations, which are more concerned with current and future protections. While the IEC's recommendations are robust in their emphasis on historical redress, less focus is given to preventing future abuses.

Similar discursive practices across the two regimes of truth

The Australian Royal Commission and the Swiss Independent Expert Commission (IEC), as two regimes of truth, share various more or less similar themes which are also evolving around redress and prevention.

Discursive practices calling for redress of survivors of past abuses

Theme 2 Causes, Support and Treatment of the Royal Commission into Institutional Responses to Child Sexual Abuse delves into the complexities surrounding the reasons why child sexual abuse occurs within institutions. Also, necessary support mechanisms for children who are exhibiting harmful sexual behaviours are addressed. This theme is particularly focused on acknowledging the profound trauma experienced by survivors and emphasizes the importance of providing comprehensive support to facilitate their recovery. Theme 2 also advocates for the establishment of the National Center for the Prevention of Child Sexual Abuse and a national study on the current prevalence of child maltreatment (Royal Commission into Institutional Responses into Child Sexual



Abuse, 2017, p. 42), both of which were put into practice.⁹ This theme widens its focus to include targeted support for victims and survivors of past abuse, emphasizing the need for trauma-informed services.

Theme 3 Responses to Abuse (Redress and Litigation Report) of the Australian Royal Commission into Institutional Responses to Child Sexual Abuse in Australia focuses on redress for survivors of historical child sexual abuse within institutional settings. The Commission's work, grounded in extensive evidence from public hearings, private sessions, and written testimonies, culminated in the 'Redress and Civil Litigation Report' (Royal Commission into Institutional Responses to Child Sexual Abuse, 2015) .

This report provides comprehensive recommendations for addressing the severe, lifelong impacts of abuse experienced by survivors. Based on these recommendations, the National Redress Scheme for Institutional Child Sexual Abuse was established under the National Redress Scheme for Institutional Child Sexual Abuse Act 2018. The scheme offers survivors access to counselling and psychological care, a direct personal response from the institution responsible for the abuse, and financial compensation, ranging from \$10,000 to \$150,000, based on individual circumstances.

In response to the Royal Commission's recommendations, the Australian government introduced a legal advice and assistance service alongside an information, referral, and support service. These services provide victims and survivors with essential information and trauma-informed legal advice regarding their options (Royal Commission into Institutional Responses into Child Sexual Abuse, 2017, p. 27). This legal support was a significant addition that was notably desired by participants in Switzerland's survivors, (Bundesamt für Justiz, 2013), but only partially addressed through non-legal information services (Anlaufstellen)(Mottier et al., 2024; Eidgenössisches Justiz und Polizeidepartement EJPD, 2014).¹⁰

Additionally, under Theme 2, the Australian Psychological Society conducted further research into complex trauma, resulting in recommendations on best practices for treating survivors who have experienced complex trauma. This focus on evidence-based research approaches highlights the Royal Commission's commitment to ensuring that survivors receive the most effective support for their recovery. This commitment parallels efforts in Switzerland, but with a

⁹ In 2021, the National Center for Action on Child Sexual Abuse was established. (*The National Centre for Action on Child Sexual Abuse*, 2024)

¹⁰ In Switzerland, we find divergent frameworks through which state and institutional actors, on the one hand, and victim activists, on the other, conceptualize the political process. While the former operates within the paradigm of restorative justice, the latter invoke the normative framework of criminal law. Many victim activists seek to attribute individual culpability and advocate for punitive measures, interpreting the authorities' reluctance to pursue legal avenues as a profound injustice. (Mottier et al., 2024, p. 79)



stronger emphasis on current and ongoing therapeutic interventions (Royal Commission into Institutional Responses into Child Sexual Abuse, 2017, p. 46).

Theme 1 Rehabilitation of victims of compulsory social measures by financial contributions by the Swiss IEC discusses the ongoing social, financial, physical, and psychological hardships faced by victims of coercive welfare measures in Switzerland. IEC identified that difficulties stem directly from their disrupted life courses, which are marked by forced placements and administrative detentions. The text highlights the severe marginalization, stigmatization, and detrimental conditions experienced in these institutions, which lead to lasting health and social integration challenges. The IEC recommends additional financial support beyond existing emergency aid and solidarity contributions¹¹ to improve their quality of life. Proposals include lifetime rail passes, tax relief, a medical expense fund, a special lifelong pension independent of social welfare, and the removal of deadlines for claiming solidarity contributions. These measures aim to address the enduring impacts of coercive welfare practices and the responsibility of authorities in mitigating these harms (Unabhängige Expertenkommission, 2019, pp. 373–374).

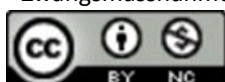
In contrast to Australia, the solidarity contribution is intended for all victims of coercive welfare measures, not solely those who suffered sexual abuse within institutions. Despite the IEC's recommendations, the removal of deadlines for claiming solidarity contributions has only been implemented so far. The contrast highlights differences in political will and public recognition of historical injustices, Switzerland's limited response reflects broader challenges in addressing past state-led abuses within its current political framework.

Discursive practices calling for the prevention of the recurrence of past abuses

Overall, while both regimes of truth emphasize the importance of addressing prevention measures of child sexual abuse, their approaches to achieve this differ in part. In both contexts, research is seen as a critical tool for uncovering the systemic issues that allowed such abuses to occur, thereby informing more effective prevention strategies.

However, due to its mandate, Australia's approach extends beyond research. The Australian strategy includes a broader array of social policy measures designed to make institutions safer for children. Notably, the Australian Royal Commission advocates for the establishment of a National Office for Child Safety, which would play a central role in coordinating efforts to protect children in institutional settings. This office would not only conduct extensive research

¹¹ The Federal Act on Compulsory Social Measures and Placements prior to 1981 (CSMPA) entitles victims of administrative detention to a solidarity contribution, which serves as a recognition of the injustice they have suffered and is intended to redress (Bundesgesetz über die Aufarbeitung der fürsorgerischen Zwangsmassnahmen und Fremdplatzierungen vor 1981 (AFZFG), 2016)



but also implement and monitor practical measures that directly contribute to child safety, reflecting a more proactive and comprehensive approach to preventing future abuses (Commonwealth of Australia, 2018, p. 26).

The Australian framework also involves the development of a National Strategy to Prevent Child Sexual Abuse, which, like Switzerland's IEC, incorporates survivor involvement. However, unlike Switzerland, which focuses on historical cases, Australia's strategy addresses ongoing issues such as online child safety and safe sports environments.

Finally, the Australian safety measures extend across diverse environments, including the Australian Defence Force and detention settings (Commonwealth of Australia, 2018, p. 17). A notable parallel with Switzerland is the emphasis on archival practices. In Switzerland, the IEC recommends establishing archives to preserve documents related to the life courses of victims of coercive welfare measures, often in collaboration with existing archival institutions (Unabhängige Expertenkommission, 2019, p. 383). Similarly, the National Archives of Australia has issued guidelines for the management of documents related to child sexual abuse incidents, ensuring that survivors can access their records. This access is crucial for enabling disclosures and supporting claims related to past abuse.

The Swiss IEC's Theme 4 focuses on the production and dissemination of knowledge, framed under the title 'Rehabilitation of Victims of Compulsory Welfare Measures through the Production of Knowledge and Its Dissemination'.

The Swiss approach does not incorporate the same level of prescriptive institutional and social policy reform or forward-looking protective measures as Australia's broader child protection strategy.

However, the IEC emphasizes that the history of administrative detention, as documented in its findings, must be meaningfully addressed through concrete political measures, some of which necessitate new legal provisions. The IEC suggests this can be accomplished by building upon and expanding existing initiatives (Unabhängige Expertenkommission, 2019, p. 372).

In this vein, the IEC recommends initiatives to produce and disseminate further knowledge on this topic, with a focus on underexplored aspects of coercive measures, particularly through participatory research that includes the expertise of those directly affected. This approach aims to challenge traditional academic knowledge and to empower victims to reclaim authority over their histories by correcting official records that have shaped their lives.

Finally, as regards knowledge dissemination, the Commission advocates for the integration of coercive welfare measures into school curricula, developed in collaboration with affected individuals, as a fundamental part of Swiss history (Unabhängige Expertenkommission, 2019, pp. 377–378).



The IEC highlights the importance of preventing the recurrence of past abuses by questioning the normative, social, and legal frameworks that once justified coercive measures. The commission calls for an additional systematic study of current laws to identify groups currently deprived of rights under Swiss law. Additionally, the IEC recommends developing a critical approach to the social norms embedded in today's welfare practices. The IEC suggests the introduction of a training program on the issue of criminal, civil, and administrative measures aimed at restricting individuals' freedom today. This training would be open to all stakeholders involved in the current implementation of these measures (for example, in the fields of law, social work, and healthcare). It is primarily designed to raise awareness of the negative consequences that have sometimes been associated with applying some of these measures in the past (Unabhängige Expertenkommission, 2019, pp. 377–378).

Conclusion

This paper has examined distinct approaches of the Australian Royal Commission into Institutional Responses to Child Sexual Abuse and the Swiss Independent Expert Commission (IEC) on Administrative Detention. The similarities and differences highlight the varying national responses to addressing past abuses and preventing their recurrence.

We see how each commission's personnel, mandate, and framing of each commission establish particular discursive narratives about the abuses they investigate. These discursive narratives directly shape the recommendations, which can be understood as discursive practices—manifestations of how the commission interprets and responds to past abuses within their respective truth frameworks, of academic-research led truth commission versus as an official national truth commission. Thus, each commission's regime of truth shapes how recommendations are framed—whether as tools for societal reflection and memory or as instruments of policy change and reform.

The final report of the Swiss National Research Programme 76 (NRP 76) further exemplifies this distinction. Unlike the Australian Royal Commission, which issues direct and prescriptive recommendations and follows up on their implementation, the NRP 76 does not issue formal recommendations but rather impulses, primarily conceived as 'Denkanstöße'—that is, stimuli for further reflection and discussion. This non-binding nature is explicitly acknowledged in the synthesis report, which states: 'Die Leitungsgruppe hofft, dass die Akteur:innen sie prüfen und in ihren Handlungs- und Berufsfeldern aufgreifen.' ['The steering group hopes [but cannot guarantee] that stakeholders will examine these recommendations and integrate them into their respective fields of practice.'] (Leitungsgruppe NFP76, 2024, p. 9). Rather than prescribing concrete policy measures, these impulses serve as suggestions, entrusting relevant stakeholders with the responsibility for their consideration and



implementation. This contrasts with the Australian Royal Commission's structured and mandatory monitoring mechanisms, which ensure that recommendations are actively pursued and implemented.

From a Foucauldian perspective, the findings of this paper underscore how truth commissions are not neutral arbiters of fact but are embedded within a 'regime of truth' that reflects the power dynamics of the society in which they operate. By examining how these commissions produce and validate certain truths, we see that their institutional practices, mandates, and personnel shape not only the narrative of past abuses but also how societies respond to those truths.

According to Foucault's theory, truth is constructed through discourse, shaped by power relations, and maintained by the institutions authorized to produce it. The Australian Royal Commission, by focusing on trauma and institutional accountability, amplifies a discourse that mobilizes legal and policy reforms. The Swiss IEC, by contrast, constructs a historical discourse that emphasizes reflection over action, largely because its academic framework is oriented toward understanding past events to prevent similar abuses in the future. Both commissions show how power operates through truth-seeking mechanisms to define what is remembered, acted upon, or left unresolved.

The differences between the Australian and Swiss commissions highlight key practical implications for future truth commissions.

The findings suggest that future truth commissions must carefully consider how to set up their truth commissions, as their composition, mandate, and framing influence not only the scope of their investigations but also the broader societal impacts of their work. It should be taken into account that the set-up of a truth commission also shapes the discourse that emerges from each commission, determining how past abuses are understood, addressed, and remembered.

As regards the legacy of the regimes of truth, the success of implementing of the recommendations is crucial to understanding their long-term impact (see Theme 5). This paper emphasizes the importance of not only issuing recommendations, but, as the case of the Australian Royal Commission demonstrates, also establishing structured mechanisms for monitoring and reporting their implementation. The absence of such mechanisms, as the cases of the IEC and NRP76 demonstrate, can result in limited accountability and slow progress in addressing a commission's recommendations. To enhance the impact and effectiveness of truth commissions, it is critical to implement robust systems for ongoing oversight and evaluation, ensuring that recommendations are effectively put into practice. Truth commissions can have significant national-level effects by identifying the institutions - and, in some cases, individuals - responsible for past crimes, while also generating recommendations to prevent such conditions' recurrence in the future.



In this way, truth commissions play a critical role in nation-building, as they seek to expose past injustices and contribute to a new democratic trajectory. By confronting historical grievances, these commissions help foster human rights, reconciliation, and peaceful coexistence in post-conflict societies (Brahm, 2007, p. 21). The implementation of well-monitored recommendations is thus essential to ensure that the truth commission's work leads to substantive societal change and helps to prevent future abuses.

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Original Research Article

Exploring the impact of work-related stress and professional wellbeing with practitioners in homes for children

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Abstract:

This study examines experiences of staff wellbeing in homes for cared-for children and theoretically considers how staff wellbeing influences the care children receive. Staff in these settings often experience high levels of stress and burnout, due to the demanding nature of their roles and the lack of professional support. Personal accounts and approaches to coping were collected through an anonymous online platform, then explored through descriptive statistics, a correlation matrix, three separate multiple regression analyses, a multiple linear regression, and thematic analysis. Staff wellbeing is significantly influenced by coping strategies, self-compassion, and support systems. Participants who reported higher levels of compassion satisfaction exhibited lower levels of burnout. Conversely, avoidant coping strategies and unprocessed secondary traumatic stress were associated with increased burnout. The study also underscores the importance of a supportive work environment, including regular supervision, professional development, and access to mental health resources, in enhancing staff resilience and reducing turnover. Recommendations for the homes for children sector include implementing comprehensive support systems to enhance staff wellbeing, and integrating trauma-informed care training and principles. By addressing these areas, the sector can improve care quality and better support the developmental needs of vulnerable children through enhanced placement stability and therapeutic value.



Introduction

According to the Children's Social Care in England 2024 report¹², there are currently 10,200 children living in homes for cared-for children in England. Children entering the care system in the UK are among the most vulnerable members of society. These young people frequently encounter multiple traumas, losses, and challenging interactions with caregivers (Santos, do Rosário Pinheiro, & Rijo, 2023). To recover from these early relational traumas, emotional warmth and safety within therapeutic relationships is crucial (Magalhães & Calheiros, 2017), which is one of the reasons why the wellbeing and emotional availability of their practitioners must constantly be attended to in research and practice.

Frontline staff in homes for cared-for children, often deemed 'placements of last resort' (Nixon & Henderson, 2022), lack a designated professional body to represent their specific needs, despite the increasingly therapeutic nature of their roles. Indeed, residential children's homes can be challenging environments for both carers and young people (Parry & Jay, 2022). The COVID-19 pandemic exacerbated many of the existing challenges faced by children's social workers (McFadden et al., 2024), and the cared-for children's workforce specifically (Parry, Williams & Oldfield, 2022), such as heightened safeguarding concerns, reduced opportunities for face-to-face contact with fellow professionals and families and increased emotional strain. This essential workforce still faces significant hurdles in delivering tailored and trauma-informed care while also safeguarding their own wellbeing at work.

Organisations that provide trauma-informed care must create a safe environment, promote service user involvement, identify trauma-related needs on both individual and systemic levels, and foster a culture of wellbeing and resilience for both individuals and the organisation. This involves a 'whole systems' approach that supports cross-agency collaboration and integrates communication (Dermody et al., 2018; Robinson & Brown, 2016; Wilson et al., 2013). Children's home providers often encounter obstacles in delivering trauma-informed care due to difficulties in coordinating care among a broad range of health, social care, and educational organisations (Hummer et al., 2010), each with their own standards and quality appraisal processes. The challenges posed by competing demands, complex needs, and a lack of national guidance can overwhelm available resources, leading to suboptimal care standards in homes for cared-for children. An intersectoral, coordinated approach to care for cared-for children is crucial to supporting a holistic, continuous, and safe provision, through integrating health, education, social services, and family involvement. This avoids fragmented services and

¹² <https://www.gov.uk/government/statistics/childrens-social-care-in-england-2024/main-findings-childrens-social-care-in-england-2024>



addresses the child's full developmental, emotional, and physical needs within their home environment (Saunders et al., 2023; Thomson et al., 2023).

Furthermore, the demands on residential children's workers are exceptionally high, encompassing responsibilities for children's safety, emotional support, discipline, boundaries, and crisis management (Parry, Williams & Oldfield, 2022; Seti, 2007). Additional stressors include unsociable working hours, inconsistent access to psychologically informed supportive supervision, and financial hardship resulting from low remuneration across most of the sector. Recent research (e.g., Brend et al., 2024) has identified that care workers supporting children and families report higher levels of exhaustion, moral distress frequency, and overall emotional distress. The frequency of moral distress and the intensity of emotional distress were significant predictors of burnout in this group, suggesting that social workers who work with children and families are particularly vulnerable to these challenges. These factors collectively contribute to high levels of work-related stress and burnout within this crucial yet often undervalued occupational group (Heron & Chakrabarti, 2002; Seti, 2007; Zerach, 2013). Burnout, a prolonged stress reaction not uncommon among those in frontline helping professions (Schaufeli & Buunk, 1996; Schaufeli & Peeters, 2000), can impair emotional availability and negatively impact therapeutic outcomes (Kokkonen et al., 2014; Parry, 2017).

The stability of out-of-home placements is closely linked to the mental and emotional health of staff. As such, research indicates that high staff turnover and burnout are correlated with placement instability, which adversely affects children's outcomes (McFadden et al., 2022). Staff who are well supported, through adequate supervision and management, and manageable caseloads, are more likely to remain in their roles long-term, contributing to consistent care and a stable environment. Conversely, staff who experience stress, burnout, or lack of support may struggle to manage the emotional and behavioural challenges presented by children in care, potentially leading to placement breakdowns (Longshaw, 2023). Additionally, staff wellbeing affects the quality of care through its influence on staff's ability to engage in therapeutic interventions, day-to-day nurturing relationships, and the implementation of care strategies tailored to individual needs (Farmer & Lutman, 2022). Reduced wellbeing amongst frontline practitioners can therefore impact vulnerable children who have already experienced disrupted attachments and relational losses.

In summary, supported staff, with access to supervision, adequate training, and mental health resources, are better positioned to build meaningful and stable relationships with children, which is crucial for their emotional and psychological wellbeing (Ogilvie et al., 2023). Children in stable placements with engaged caregivers able to attune to the child's needs are more likely to experience positive outcomes, including improved mental health, better educational



performance, and enhanced social skills (McFadden et al., 2022). Staff wellbeing also impacts broader developmental outcomes for children and young people in care. When staff maintain positive mental health, they are better able to create environments that foster resilience and emotional regulation in children (Jennings & Greenberg, 2009), which is particularly important for those who have experienced trauma, abuse, or neglect prior to entering the care system.

Therefore, creating a workplace culture that values and prioritises staff wellbeing can ultimately improve the consistency and quality of care provided to children. Trauma-informed care training can be particularly beneficial, equipping staff with skills to manage challenging behaviours and support both their own psychological needs and those of the children in their care (McPherson et al., 2022). A recent scoping review by Saunders et al. (2023) on trauma-informed approaches in various care settings raised the question: 'If trauma is not well defined, can a trauma-informed care framework suitably wrap around people and needs?' This question is pertinent to care-experienced young people in homes for children, who often face multiple documented traumas and implicit relational stresses. Further, frontline staff may experience work-related stress and secondary traumatic stress from witnessing the impact of trauma on the children they support. This workforce, relatively unsupported in terms of specialist training and psychological supervision compared to other social and therapeutic care disciplines, often has fewer opportunities to process their challenges. Thus, it is important to understand what support would be beneficial, and what this resourceful workforce is already achieving to promote staff wellbeing and positive outcomes for children and young people in homes for children.

Consequently, this study sought to understand the relationships between certain measurable risks and protective factors facing practitioners working in homes for care experienced children. With greater understanding of the needs of this practitioner group working in the unique environments of children's homes, supportive interventions to care for them in their work can be better tailored and more effective, leading to improved outcomes for young people, as well as enhanced staff wellbeing and retention.

Method

Design

The design of this study was informed by a series of online webinars held with stakeholders from across the homes for children sector between 2020 and 2022. Through stakeholder consultation and discussion, the need for the project was identified and anonymous online participation was deemed most practical for a busy workforce largely working on a shift basis. To enhance methodological transparency, we chose a multi-methods approach to capture both the quantitative and qualitative dimensions of staff wellbeing, aligning our



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measurement tools with theoretical foundations rooted in previous research on professional quality of life, secondary traumatic stress, and resilience, as well as stakeholder consultations that emphasised the need for a comprehensive exploration of coping strategies and restorative factors.

The study was hosted via Qualtrics, a secure online platform that uses Transport Layer Security (TLS) encryption (also known as HTTPS) for all transmitted data. Personal data was stored separately from research data, and information about how the data would be stored, used, and shared through publications was included in the information sheet, alongside signposting information to self-care guides for people working in health and social care (e.g., [Self-care Tools](#)). Participants were able to access the survey once they completed the consent form within Qualtrics, where demographics information was also recorded. The study was approved by the research ethics committee of Manchester Metropolitan University.

Measures

A selection of five widely used measures were implemented to explore secondary traumatic stress, professional quality of life, self-compassion, a history of adverse childhood experiences, and coping strategies. Participants were also invited to answer four qualitative free-text open-ended questions relating to their professional experiences, exploring both restorative and challenging factors. The selection of these measures to assess coping and wellbeing within the cared-for children's workforce was informed by previous research by the authors and stakeholder consultations. The Professional Quality of Life Scale and Secondary Traumatic Stress Scale were used to assess the emotional toll and rewards of caregiving, based on previous qualitative accounts of caring in this unique environment (Parry & Weatherhead, 2014; Parry et al., 2021). The Self-Compassion Scale is included as a protective factor against burnout, recognising its relevance in fostering resilience, as seen in Parry's work on restorative and trauma-informed approaches (Parry et al., 2021; Parry et al., 2023). Finally, the COPE Inventory was chosen for its ability to evaluate diverse coping strategies, crucial for staff wellbeing in high-stress environments, as informed by consultations with stakeholders in the field. These tools collectively offer a comprehensive approach, aligning with Parry's research on fostering resilience and wellbeing in both care staff and children.

- Professional Quality of Life Scale (brief-ProQOL)
- Secondary Traumatic Stress Scale: 17 items, offering an overall secondary trauma score (subscales: intrusion, avoidance and arousal)
- Self-compassion Scale: 12 items, a protective factor against burnout (Neff, 2003)
- Adverse Childhood Experiences Scale (brief 12 item self-report survey, increasingly used with social workers and those in social care to connect overcoming adversity with resiliency factors in research [Felitti et al., 1998])
- COPE Inventory (Carver, 2013)



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Participants

Of 144 participants (F=113, M=30), recruited through social media (e.g., LinkedIn, Twitter, Facebook) and professional networks, participants had a mean age of 40.11 years (SD 11.11) and had worked in children's homes for an average of 10.9 years (SD 9.64 years). Demographic information for the children's home workforce is not available, so we have used demographic information from children's social workers as the closest available comparison group to contextualise our participant cohort. Of the participant group, 70.1% identified as White British, which is roughly in line with the 2022 average of 76.6% for the 34,680 social workers supporting children and families in the UK (Department for Education, 2022). Participants self-identified as being a residential childcare worker, support worker, or therapeutic parent (62), a senior support worker (8), team lead (8), deputy or assistant manager (7), registered home manager (32), educator (9), operations manager (7), assistant psychologist (1), registered nurse (1), or director (9). We understood all participants to be UK-based.

Analytic approaches

Multiple regression was used to analyse the data. This type of analysis is useful to explore the relationship between the dependent variables (the three subscales of the Professional Quality of Life Scale, i.e. compassion satisfaction, burnout, and secondary traumatic stress) and the predictor variables (ACE score, avoidant coping, approach coping, self-compassion score, secondary traumatic stress, years of experience, age, gender). Multiple regression can reveal the strength and direction of the relationship between the outcome and predictor variables whilst acknowledging the relative importance of the predictors in influencing the outcome (Tabachnick & Fidell, 2013).

Thematic analysis offers a nuanced, interpretative, and in-depth approach to the analysis of heterogeneous qualitative data, with ever-increasing use across applied health and social care research (Braun & Clarke, 2012, 2013). Drawing upon Braun and Clarke's robust, systematic framework for thematic analysis, data was inductively coded following anonymisation, tabulation, and familiarisation. Emerging themes gradually coalesced into stronger themes, until a draft of the analysis was discussed within the team, prior to finalising the three analytic themes presented (Braun et al., 2014). Participants completed the open questions after the measures, so the authors would like to draw attention to the likelihood that qualitative answers were influenced by the topics of the measures.



Results

Statistical analysis

The descriptive statistics relating to the three dependent variables from the PROQOL metric (compassion-satisfaction, burnout, secondary traumatic stress), alongside the predictor variables (ACE score, avoidant coping, approach coping, self-compassion score, secondary traumatic stress, years of experience, age, and gender) are shown in Table 1.

Table 1: Descriptive statistics

	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>
PROQOL: Compassion	141	40.18	6.12	23	50
Satisfaction					
PROQOL: Burnout	141	23.70	5.57	12	39
PROQOL: Secondary	141	21.90	6.76	11	44
traumatic stress					
ACE score	137	2.28	2.29	0	10
Brief coping:	131	22.51	6.15	12	40
Avoidant					
Brief coping:	131	30.02	7.80	12	46
Approach					
Self-compassion	136	35.90	7.91	17	59
Secondary traumatic	144	37.45	12.41	17	76
stress					
Years of experience	144	10.09	9.64	0	44
Age	144	40.11	11.11	20	64
Gender	144		-	-	-



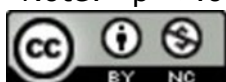
A correlation matrix was computed to show the relationships between the variables within the study (see Table 2). PROQOL compassion-satisfaction was significantly negatively correlated with avoidant coping and secondary traumatic stress and positively correlated with self-compassion. PROQOL burnout was significantly positively correlated with ACE score, avoidant coping, and secondary traumatic stress, and negatively correlated with self-compassion. PROQOL secondary traumatic stress was significantly positively correlated with ACE score and avoidant coping and negatively correlated with self-compassion. The PROQOL Secondary Traumatic Stress scale unsurprisingly correlated with the Secondary Traumatic Stress Scale.



Table 2: Bivariate correlation between variables

	1	2	3	4	5	6	7	8	9	10	11
PROQOL:	-										
Compassion		-.680									
Satisfaction											
PROQOL: Burnout											
PROQOL: Secondary											
Traumatic Stress											
ACE score											
Brief Coping:											
Avoidant											
Brief Coping:											
Approach											
Self-Compassion											
Secondary Traumatic											
Stress											
Years of Experience											
Age											
Gender											
(Male = 1											
Female = 0)											

Note: *p < .05; **p < .01



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Three separate multiple regression analyses were carried out to investigate the amount of variance within the dependent variables (the three PROQOL measures) that could be accounted for by the eight predictor variables (ACE score, avoidant coping, approach coping, self-compassion score, secondary traumatic stress, years of experience, age, and gender). The predictor of secondary traumatic stress was not added within the Secondary Traumatic Stress model due to high levels of multicollinearity. Within all three models, the assumptions for testing using multiple regression were met (i.e., multicollinearity, normality, linearity, homoscedasticity, independence of residuals, and outliers within the data).

Table 3: Predictors of PROQOL: Compassion satisfaction

	Unstandardised		Standardised		
	coefficients		coefficients		
	B	Std. error	Beta (β)	t	Sig.
(Constant)	35.65	5.44	-	6.55	.000
ACE score	.110	.233	.042	.474	.637
Brief coping: Avoidant	-.174	.107	-.176	-1.62	.107
Brief coping: Approach	.164	.075	.210	2.19	.030*
Self-compassion	.142	.085	.184	1.67	.097
Secondary traumatic stress	-.079	.049	-.162	-1.61	.111
Years of experience	.016	.067	.027	.242	.809
Age	.002	.061	.005	.041	.968
Gender	1.062	1.305	.071	.814	.417

Dependent variable: PROQOL: Compassion satisfaction

Note: *p < .05; **p < .01



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A multiple linear regression was calculated to predict compassion satisfaction based on participants' ACE scores, brief coping: avoidant score, brief coping: approach score, self-compassion score, secondary traumatic stress score, years of experience, age, and gender. Using the enter method, a significant model emerged ($F(8,120) = 3.42, p = .001$), with an R^2 value of .186, which indicates the predictors in the model could account for approximately 13% ($R^2_{adj} = .131$) of the variance in compassion satisfaction. The only significant variable in this model was brief coping: approach ($\beta = .21, p = .030$), which indicates that participants' compassion satisfaction increased as brief coping approach scores increased.

Table 4: Predictors of PROQOL: Burnout

	Unstandardised		Standardised		
	coefficients		coefficients		
	B	Std. error	Beta (β)	t	Sig.
(Constant)	22.47	3.99	-	5.63	.000
ACE score	-.046	.171	-.019	-.271	.787
Brief coping: Avoidant	.190	.078	.213	2.42	.017*
Brief coping: Approach	-.154	.055	-.218	-2.81	.006**
Self-compassion	-.150	.062	-.215	-2.41	.018*
Secondary traumatic stress	.183	.036	.415	5.08	<.001**
Years of experience	-.004	.049	-.007	-.079	.937
Age	.002	.044	.004	.046	.963
Gender	.060	.958	.004	.063	.950

Dependent variable: PROQOL: Burnout

Note: * $p < .05$; ** $p < .01$



A multiple linear regression was calculated to predict burnout based on participants' ACE scores, brief coping: avoidant score, brief coping: approach score, self-compassion score, secondary traumatic stress score, years of experience, age, and gender. Using the enter method, a significant model emerged ($F(8,120) = 13.03, p < .001$), with an R^2 value of .465, indicating that the predictors in the model could account for approximately 43% ($R^2_{adj} = .429$) of the variance in burnout. There were four significant predictors in this model: secondary traumatic stress ($\beta = .42, p < .001$), brief coping: approach ($\beta = -.22, p = .006$), brief coping: avoidant ($\beta = .21, p = .017$), and self-compassion ($\beta = -.22, p = .018$). Participants' burnout scores increased as their coping avoidant and secondary traumatic stress scores increased but decreased when their scores on self-compassion and coping approach increased.

Table 5: Predictors of PROQOL: Secondary traumatic stress

	Unstandardised		Standardised		
	coefficients		coefficients		
	B	Std. error	Beta (β)	t	Sig.
(Constant)	24.075	4.89	-	4.92	.000
ACE score	.373	.232	.126	1.61	.111
Brief coping: Avoidant	.355	.107	.321	3.33	.001**
Brief coping: Approach	.011	.076	.012	.145	.885
Self-compassion	-.245	.080	-.283	-3.06	.003**
Years of experience	-.001	.068	-.001	-.010	.992
Age	-.038	.061	-.062	-.617	.538
Gender	-1.41	1.31	-.084	-1.079	.283

Dependent variable: PROQOL: Secondary traumatic stress

Note: * $p < .05$; ** $p < .01$

Finally, a multiple linear regression was calculated to predict secondary traumatic stress, based on participants' ACE scores, brief coping: avoidant score,



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brief coping: approach score, self-compassion score, years of experience, age, and gender. Using the enter method, a significant model emerged ($F(7,121) = 8.66, p < .001$), with an R^2 value of .334, indicating that the predictors in the model could account for approximately 30% ($R^2_{adj} = .295$) of the variance in PROQOL: Secondary traumatic stress. The only significant variables in this model were brief coping: avoidant ($\beta = .32, p < .001$), and self-compassion ($\beta = .28, p = .003$), which indicates that secondary traumatic stress increased as brief coping avoidant scores increased but decreased as self-compassion scores increased.

Thematic analysis

Due to the nature of remote data collection, there was variety in the qualitative responses from participants, with some responses very brief and others more in-depth. Overall, the thematic analysis offers a collective insight into common themes of experience. Firstly, while personal experiences can enhance empathy and support, emotional strain and the risk of over-identification with children's situations was also a feature of some accounts. Secondly, although self-care is recognised as crucial, many participants struggled to prioritise self-care due to the demands of their roles. Relationally, supportive collegial working helped to manage stress and enhance job satisfaction. Finally, systemic pressures and constraints, such as regulatory demands and organisational policies, were reported to adversely impact care quality and job satisfaction. Each theme provides an interpretation of the original data, with quotes included verbatim.

Theme One: Experiencing but not knowing how to manage the role

A prominent theme throughout the qualitative data related to how participants drew upon their own experiences of being parented and cared for to aid them in their role supporting the children. However, a key differentiation was made between experiencing being cared for, providing care to others, and not presuming to know what a young person's experiences had been. For example, '[my] experience of a loving stable home as a child helps in the separation process of child and behaviour during difficult times'. Similarly, experiences of hardship could inform participants' approaches to empathy: 'experiences of adversity help me empathise and balance needs for positive risk taking and independence'. Whilst memories of difficulties in their own past could be powerful with respect to insight and empathy, some participants highlighted the workplace support they needed to help them professionally navigate their way through powerful memories and emotions, identifying a need for support around how to manage the emotional toll of their role.

It is difficult to keep a boundaries and easy to cross a line between professional and personal life. The majority of the days I take my work to



home and it makes an impact on my personal life, relationships and my own well-being. It is an area which I still need to learn.

Perhaps akin to reports of vicarious resilience, hope and strength were important codes within this theme. For example, 'I feel hopeful for the children I work with because of what I have already overcome'; 'I know from personal experience the difference a positive role model can make, which gives me strength in my work'; 'they're safe now and we're making a difference'. However, codes of sorrow and sadness were also clear, as participants reflected on what they could see the children did not have in comparison to their own experiences of love and care: 'I feel sad as I know what the children are missing not having their own happy families'; 'separating home and work can be hard, especially after a challenging shift'; 'accept that you are not a robot and that this can have an impact'.

Overall, past experiences, both positive and challenging, provided participants with insight, patience, and the ability to empathise, although they could also stir challenging emotions that could be hard to leave at work. Participants' accounts suggested an appreciation that everyone is different and that it was important not to assume knowledge of someone else's inner world, although containing their emotional reaction to the suffering they witnessed could cause direct distress. In conclusion, the theme of experiencing but not knowing how to manage the role highlights the complexity of balancing personal history with professional responsibilities. Participants drew on their own experiences, both positive and challenging, to inform their approach to supporting the children in their care. However, they also recognised the limitations of presuming to understand another person's experiences, emphasising the importance of empathy without overstepping boundaries. While personal experiences could provide valuable insights and strength, they also evoked difficult emotions that required careful management. Participants acknowledged the emotional toll of their role, underscoring the need for professional support in navigating these complex feelings, and the ongoing challenge of maintaining a balance between personal and professional life.

Theme Two: Navigating feelings and professional roles whilst caring

Most of the participants discussed their awareness of secondary traumatic stress, most commonly using the term 'vicarious trauma'. Many participants described an ability to talk openly with managers, supervisors and colleagues: 'I have cried about young people but been able to manage those emotions safely', which was supported as a process by feeling safe enough professionally to be vulnerable. Additionally, a minority of participants seemed to describe vicarious resilience through witnessing the strength of the young people they worked with: 'At times holding in tears because they [the child/children] are showing such strength, it has empowered me further'.



Participants also discussed navigating their wishes with a recognition of the limits of their role, and managing their expectations: 'I have a strong empathy for them and feel protective but understand sometimes I can't help as much as I would of wanted'; 'It's important to remember to take small baby steps and not expect miracles from the young people I am supporting'.

In terms of how participants navigated taking care of themselves, codes were typically centred around: 'Knowing that I am doing my best'; self-care, 'self-care is something that is greatly missing in my own life. When I reflect on my own coping strategies I realise that there is much missing'; their professional role, 'My ambition to progress helps me realise that this is all experience and will help me grow as a practitioner'; and team work, 'being part of a team and it's a team effort'. Participants identified particular strategies they found helpful, such as compassionate self-talk, 'use self talk a lot in relation to planning difficult conversations', and processing challenges with colleagues, 'I always make sure I debrief with colleagues after a difficult session with a young person'. However, self-care was not always easy to prioritise alongside their role of caring for others: 'I am aware that the lack of the care for myself might lead me to burning out'; 'I do not look after myself much I centre myself around my work and others'.

Theme Three: Relationships with colleagues and systems

The impact and importance of relationships was central to many participant accounts, specifically in relation to feeling connected and encouraged, and with respect to communication: 'Having a good team around me can help as I know who to talk to and I encourage others to speak with me'. However, staff relationships could also be challenging and add to work-related stress: 'Another thing I find difficult is staff who have less commitment and aren't interested in the young people and I do get stressed about that at times'. Additionally, participants reflected on how communication between staff could influence their perceptions and expectations: 'How one person perceives and tells the events of an evening or weekend during a handover can hugely impact on how others react'. Finally, the restorative nature of relationships was reflected upon:

I have good relationships with the children I work with which makes my job often pleasurable. Also being able to talk with my colleagues and a supportive manager. We also have access to psychology support if needed and have on occasion talked my feelings through with the psychologist.

Participants' accounts also highlighted the relationships within the systems in which they operated. For instance, external pressures from regulatory bodies like OFSTED were reported to impact the nature of care, sometimes diverging from what was in the child's best interests or from care plans. One participant noted, 'Managers almost micromanage us nowadays and that makes me feel a

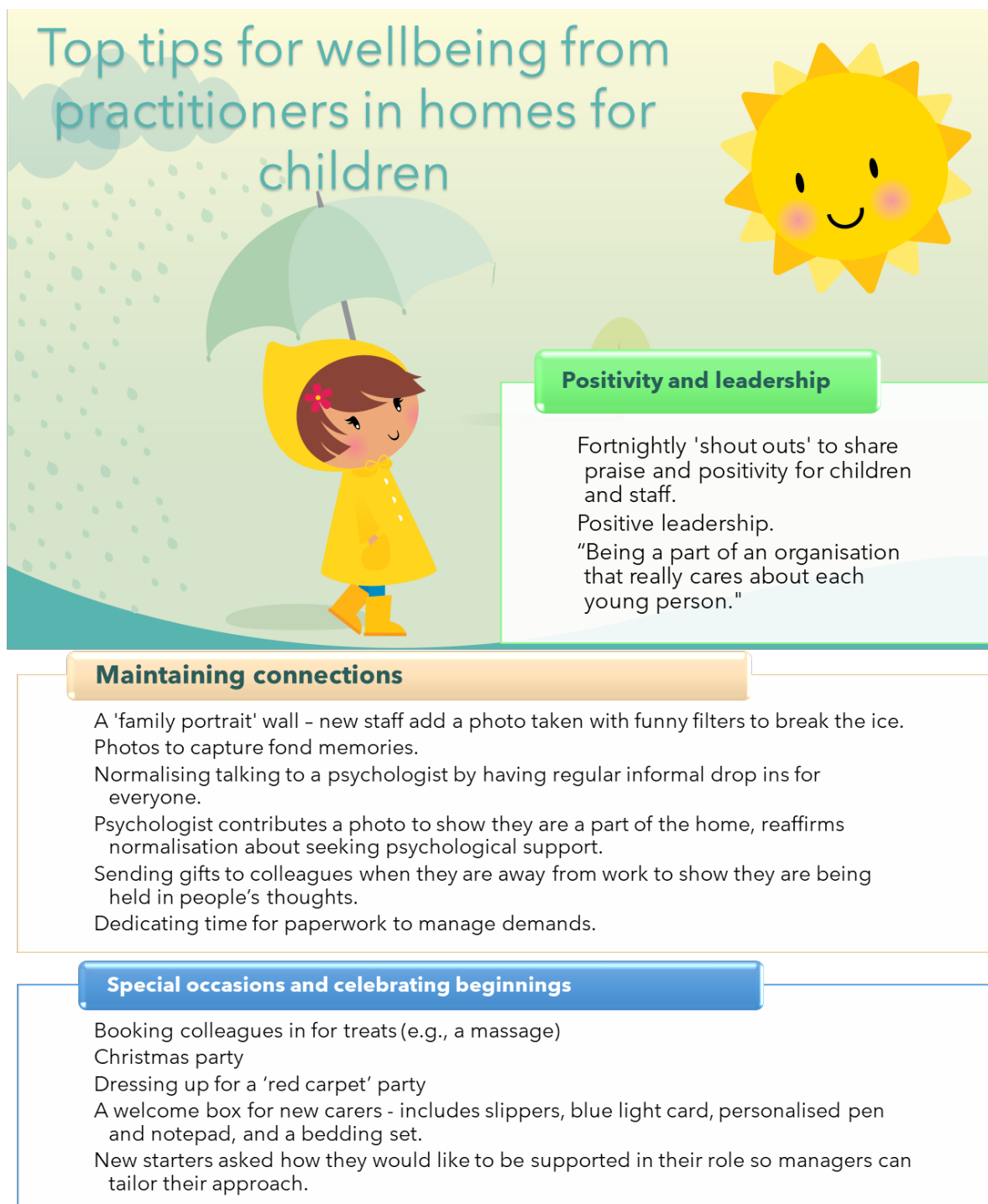


little less human in my delivery of care (if that makes sense) and more robotic. It's a service that aims to meet OFSTED targets.' Additionally, the role of working in children's social care could be ambiguous within the broader health and social care system, a situation worsened by COVID-19. As one participant described, 'Going to work every day and not being eligible for testing initially had a massive impact on stress levels and the worry about what could happen to the home and kids if the virus came to us.' However, systems could also offer protection, as reflected in another participant's experience: 'My appreciation for young people and our healthcare system helps me at work, and the gratitude I feel shapes me personally too.' These accounts illustrate how various perspectives shape perceptions of systems and the personal resources participants felt they had to navigate them.

Overall, relationships with colleagues and the broader systems in which practitioners operate play a pivotal role in shaping their work experience. Positive relationships with colleagues and supportive systems can offer restorative benefits, fostering connection and providing emotional support. However, challenges such as communication issues and external pressures from regulatory bodies can contribute to stress and feelings of disconnection. The balance between personal commitment and the demands of institutional systems, particularly in children's social care, highlights the complexity of navigating professional environments. Based on the qualitative data collected throughout the study, recommendations from the workforce contributed to the development of Figure 1.



Figure 1: Top tips for wellbeing from practitioners in homes for children



Discussion

Overall, the findings from this study highlight the emotional and psychological challenges faced by the cared-for children's workforce. Findings highlight the importance of developing effective coping strategies and self-compassion. Additionally, the emotional toll of the role, shaped by personal experiences and



empathetic connections with the children, emphasises the need for ongoing support for staff, both professionally and emotionally. The study also highlights the value of strong, supportive team relationships and open communication, which can help alleviate stress and improve job satisfaction. However, the workforce is also impacted by organisational pressures, such as regulatory demands, which can place strain on the quality of care provided and increase stress levels. Therefore, ensuring that staff have access to adequate professional support and are able to prioritise self-care is essential to maintaining their wellbeing and ensuring high-quality care for children. In summary, the findings suggest that a balance between personal resilience, workplace support, and a manageable workload is crucial for sustaining the emotional health of the children's workforce (Table 1).

The findings of this study provide valuable insights into the individual factors that influence burnout among professionals working in residential care settings, particularly in relation to adverse childhood experiences (ACEs), coping strategies, and compassion satisfaction. The data suggest that age, gender, years of experience, and time working in the field do not significantly affect an individual's likelihood of experiencing burnout. However, participants who reported higher exposure to adversity in their own lives showed a slightly increased likelihood of burnout, which is consistent with existing literature on ACEs. Previous research has highlighted that increased exposure to ACEs is associated with heightened workplace stress and a tendency to adopt less helpful coping mechanisms (Steen et al., 2021). Our study found a mean ACE score of 2.28 (SD = 2.29) among the participants, aligning with earlier studies that identified higher ACE scores among social workers compared to the general population (Steen et al., 2021).

The most prominent protective factor against burnout identified in this study was the development of helpful coping strategies to manage workplace stress. Specifically, participants who reported high levels of compassion satisfaction, defined as the joy and satisfaction derived from helping others, were less likely to engage in avoidant coping strategies. This is important, as if people in helping roles feel as though they are being prevented from delivering high quality care, i.e., from undertaking their roles effectively, this could lead to an additional risk factor. As may have been predicted, avoidant coping and unprocessed secondary traumatic stress were identified as the two main risk factors for burnout in our sample. Those who were able to cultivate helpful coping mechanisms and self-compassion were better equipped to maintain their emotional wellbeing, thereby reducing the risk of burnout. As a result, interventions focused on enhancing self-compassion and promoting healthy coping strategies could be beneficial for staff in homes for cared-for children's settings.

The findings also shed light on the potential influence of attachment styles on burnout. Attachment theory suggests that individuals develop internal working



models of relationships based on their early caregiving experiences, which can shape how people cope with stress (Bowlby, 1973; Calkins & Leerkes, 2011). Previous research has identified a link between insecure attachment styles and burnout (Kokkonen et al., 2012; Pines, 2004; Ronen & Mikulincer, 2009). In the context of residential care for children, the interactions and behaviours of traumatised children can activate attachment-related coping mechanisms in caregivers, which may exacerbate stress and burnout, particularly for those with insecure attachment styles. Recent research suggests insecure attachment styles, such as anxious or avoidant attachment, can exacerbate stress and contribute to higher levels of burnout. For example, McConnell, Wong and Ferrey (2025) conducted a narrative review exploring the relationship between attachment and mental health at work, noting that individuals with insecure attachment styles are more likely to experience higher emotional demands, which in turn increases burnout. Navas-Jiménez et al. (2025) further emphasise the role of leadership in buffering the impact of emotional demands. Their study on secure base leadership found that leaders who offer a secure base can help reduce exhaustion among employees by providing emotional support, and thereby demonstrating the importance of secure attachment dynamics in the workplace. Additionally, Mostafa et al. (2025) highlight the role of perceived abusive supervision, suggesting that such negative leadership dynamics can trigger insecure attachment responses in employees, leading to burnout. Furthermore, Marmarosh, Liu and Du (2025) discuss how attachment and trauma intersect in therapeutic contexts, providing insights into the challenges faced by social workers in emotionally demanding environments. These findings underscore the need for strategies that enhance attachment security, such as supportive leadership and reflective supervision, to mitigate burnout among carers and social workers. Therefore, further research could address the importance of considering attachment theory in efforts to mitigate caregiver burnout in the unique environments of homes for cared-for children.

The concept of a 'culture of fear' within the residential children's workforce, as discussed by Brown, Winter and Carr (2018), may also be relevant to understanding the high levels of burnout in this profession. This culture, compounded by frequent experiences of aggression and emotional exhaustion (Winstanley & Hales, 2014), creates a challenging work environment that can significantly impact staff wellbeing. Recent literature suggests that professionals in residential care settings, similar to those in other high-stress fields such as healthcare and forensic settings, face comparable risk factors for burnout (Brouwers & Tomic, 2016). Understanding these risk factors is crucial for developing targeted interventions to improve staff retention, reduce burnout, and ensure the delivery of consistent, high-quality care to vulnerable children and young people.

Lastly, it is important to consider the impact of trauma-informed care (TIC) on staff wellbeing. While the introduction of TIC can initially be met with resistance



and anxiety by staff, as noted in Saunders' scoping review (Saunders, 2021)., TIC ultimately led to increased empathy, compassion, and job satisfaction. TIC may therefore have potential implications for staff with personal histories of trauma, emphasising the need for adequate support and supervision to help them process these experiences. Future research should explore how TIC influences staff wellbeing, relationships, and turnover, an ongoing concern in both inpatient and residential care settings, where consistency in care is critical (Saunders, 2021).

Recent research further underscores the complex interplay between staff wellbeing and quality of care in residential settings. For instance, studies highlight that factors such as job stress, burnout, and resilience are significantly impacted by organisational support structures and personal coping mechanisms (McFadden et al., 2023). A systematic review by Longshaw (2023) indicates that fostering a supportive work environment, through practices like regular supervision, professional development, and mental health resources, can mitigate the adverse effects of stress and burnout. This aligns with findings from research by Ogilvie et al. (2023), which suggests that incorporating TIC and providing staff with skills to manage stress and trauma can enhance job satisfaction and reduce burnout.

Furthermore, McPherson, Andrews and O'Brien (2022) highlight that staff who receive targeted training in trauma-informed approaches experience improved emotional resilience and job satisfaction, which, in turn, positively impacts their interactions with children. This body of research suggests that comprehensive support systems and professional development opportunities are crucial to maintaining staff wellbeing, ultimately leading to better placement stability and quality of care for children. Such measures not only address the immediate stressors faced by staff but also contribute to the creation of a more resilient and effective caregiving environment. Therefore, developing a tailored TIC framework for the unique environments of homes for cared-for children seems a helpful priority to explore for staff, care providers, and the young people in their care.

Conclusion

Our findings suggest that promoting healthy coping strategies, self-compassion, and compassion satisfaction, while addressing attachment-related coping mechanisms and providing support for staff with high ACE scores, could reduce the risk of burnout in residential care settings. Considering the needs of the cared-for children's workforce, it may be that a tailored TIC framework could provide a structure within which to develop specific workforce support and training. See Appendix 1.



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Appendix 1

Category	Facilitators	Barriers
Individual	High self-compassion and effective coping strategies (e.g., compassionate self-talk)	Difficulty managing emotions tied to personal history and professional role
	Empathy and personal experiences offering strength and resilience	
Employment	Awareness of the emotional toll and the need for professional support	Avoidant coping strategies contributing to stress and burnout
	Supportive team dynamics and open communication with managers and colleagues	Lack of prioritisation of self-care due to role demands
	Opportunities for professional growth and debriefing after difficult cases	Strain from managing high emotional demands of the job
	Compassion satisfaction and mutual support within the team	Job ambiguity and role stress, leading to burnout
Organisational	Access to psychological support and regular supervision	Organisational constraints, such as targets, reducing job satisfaction and care quality
	Clear organisational support systems and trauma-informed care training	Micromanagement and lack of autonomy in delivering care
	Work culture that fosters vulnerability and emotional expression	Systemic pressures conflicting with care priorities (e.g., regulatory demands, safety concerns)



Category	Facilitators	Barriers
Social	Positive, empathetic relationships with colleagues and children	Challenging interpersonal dynamics with colleagues perceived as less committed
	Support networks within the workplace (e.g., team collaboration, debriefing)	Communication breakdowns leading to misaligned expectations and perceptions among staff
	Systemic support through professional development and training	External pressures from regulatory bodies affecting care delivery and job satisfaction



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Original Research Article

Compassion for the caregivers: An Indian perspective on the burnout of caregivers in child care institutions

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Abstract

India has over 23.6 million orphaned and abandoned children (OAC), many residing in child care institutions (CCIs). These children depend on caregivers, who often come from resource-limited backgrounds, impacting their ability to meet the children's emotional, physical, and intellectual needs. A 2018 study by the Ministry of Women and Child Development highlighted a 5% caregiver deficit, with 15% of CCIs exceeding capacity, raising concerns about the quality of care and supervision provided. Caregivers face significant challenges, including mental health issues stemming from the demands of their role.

This study focuses on a capability-building initiative by Udayan Care and Duke University to address these challenges. Capability building emphasises enhancing caregivers' attitudes, knowledge, and skills to better support traumatised children while managing their own wellbeing. Using a quasi-experimental research design, the study evaluates the impact of systemic interventions on caregivers' ability to provide holistic care for OAC. The findings underline the importance of empowering caregivers through training and resources to improve child welfare outcomes in CCIs. This research has significant implications for child welfare practices and policies, both in India and globally.



Introduction

According to the United Nations Children’s Fund (UNICEF), India has 29.6 million orphaned and abandoned children (The Pioneer, 2022). There is also evidence that almost 80% of children living in institutions in India have families who they could be reunified with, if their families were strengthened (Nundy, 2022). In India, ‘registration’ of child care institutions (CCIs) refers to the mandatory licensing of these facilities under the Juvenile Justice (Care and Protection of Children) Act, 2015. This law requires all institutions housing children in need of care and protection to be officially registered with the state government. Registration is intended to ensure minimum standards of care, accountability, and oversight, and to bring greater uniformity and child-rights-based governance to alternative care settings across the country.

Only about 50% of Indian CCIs have an adequate number of caregivers per child, even though the Juvenile Justice Act, 2015 (JJ At, 2015) mandates a child-staff ratio because individual attention is a basic premise of care (MOSPI, 2018). It leads to two probable outcomes – there is a shortage of caregivers at a system level that makes them a scarce resource, and the caregivers who are currently involved in caring are potentially stretched and overburdened (Ministry of Women and Child Development, 2018). They face an enormous workload while catering to the needs of children at more than the sanctioned capacity, alongside ensuring children’s wellbeing and safeguarding them. In either of these scenarios it becomes imperative that caregivers are cared for.

Research context

Caregivers¹³ give of themselves in the course of their work with care-seekers. Ideally, they are accessible emotionally, as well as physically and intellectually, in creating meaningful relations with care-receivers. Caregivers thus risk becoming emotionally drained, giving of themselves until they have nothing more to offer to care-receivers. This is known as **job burnout**, defined as

[a] state of emotional exhaustion, detachment from or depersonalization toward those being served (e.g., children and families), and a lack of a sense of personal accomplishment about one's work. Burnout can be seen as the outgrowth of chronic, ongoing stress and low job satisfaction on the part of those working in emotionally strenuous settings (Maslach & Jackson, 1986).

¹³ A caregiver is someone who provides daily care, protection and supervision of a child. This does not necessarily imply legal responsibility. Where possible, the child should have continuity in who provides their day-to-day care. (UNHCR [2008] Guidelines on Determining the Best Interests of the Child, UNHCR)



Job burnout engenders a depersonalised emotional withdrawal that undermines the caregiver's personal connections with care-receivers. Given the widespread and detrimental effects of burnout, a valuable endeavour is one that examines and continuously evolves coping mechanisms that stifle the development of burnout in childcare providers. Coping is best viewed as a multidimensional process to deal with the perception of adverse situations such as job-related stress (Lazarus, 1966).

At Udayan *Ghar*, a residential care model under Udayan Care (mentioned in detail thereof), caregivers - referred to as care staff - play a central role in providing day-to-day emotional and physical support to children. Over time, many caregivers report experiencing chronic emotional exhaustion due to the high emotional demands of bonding with children who have experienced trauma, grief, or abandonment. This includes instances of resignations, emotional exhaustion, absenteeism, and psychological distress.

For instance, one caregiver who had been working in a *Ghar* for over five years shared how the cumulative stress of managing behavioural issues, administrative duties, and a lack of personal time led to persistent fatigue and irritability. Eventually, she began experiencing sleep disturbances and showed reduced engagement in team meetings. Another caregiver chose to resign after repeated episodes of stress-related illness, citing a feeling of being 'constantly overwhelmed and under-supported.' These examples are indicative of burnout—characterised by emotional exhaustion, depersonalisation, and a reduced sense of personal accomplishment. While some caregivers remain committed despite stress, others experience withdrawal or leave the system altogether, affecting continuity and quality of care for the children. Over the years, three broad types of coping (and inherent strategies) have been proposed (Carver & Scheier, 1999; Folkman & Lazarus, 1980, 1985; Scheier et al., 1989).

The first is **problem-focused** coping, which includes preventative strategies that are executed when the threat of stress is impending (i.e., active coping, planning, suppression of competing activities, restraint coping, seeking instrumental social support). The second is **emotion-focused** coping, involving more responsive strategies that are typically employed to handle stress that has already occurred (i.e., seeking emotional and social support, focusing on venting emotions, positive reinterpretation through growth, acceptance, turning to religion as a source of comfort). The third is **avoidant coping**, a less adaptive method of coping that includes repressing strategies that generally keep an individual from directly addressing the situation (i.e., denial, mental or behavioural disengagement, alcohol/drug use).

Previous research clearly indicates that strategies designed to purposefully change the nature of the stressors, through problem-focused coping, are much more likely to offset, reduce, or even eliminate occupational stress compared to avoidant coping strategies (Folkman & Lazarus, 1980). Generally problem-



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focused ways of coping are used more widely to remove the stressors (Carstensen et al., 2003), while emotion-focused coping methods pertain to short-term distractions and do not really help to increase individuals' social life satisfaction (Rook & Peplau 1982). This finding is consistent across diverse populations and professions (Mann-Feder & Savicki, 2003), including teaching and caregiving (Okabayashi et al., 2008). Emotion-focused strategies include methods such as the focusing and venting of emotions, denial, and positive reinterpretation of events, along with seeking out social support. This encourages avoidance, where the other strategies encourage approach (Roth & Cohen, 1986). Additionally, problem-focused coping, as opposed to emotion-focused coping, is more likely to be employed to diminish work-related stresses (Jenaro et al., 2007; Vitaliano et al., 1990a, b). Perhaps, this is because problem-focused coping consists of active strategies aimed at resolving stress at its source.

Caregivers' burnout and its impact on care receivers (children)

As stated in several studies, caregivers across sectors have reported significantly higher rates of clinical psychiatric disorders, poorer wellbeing, psychological distress, and more depressive symptoms and anxiety than non-caregivers (Butterworth et al., 2010; Kumagai, 2017; Venkatesh et al., 2016). Several studies have examined the factors causing stress for child care providers and its effect on both caregivers' wellbeing and the quality of their care. Chronic job-related stress has been found to be linked to job dissatisfaction (Moriarty et al., 2001), burnout (Goelman & Guo, 1998), and high turnover (Todd & Deery-Schmitt, 1996), as well as being associated with the psychological and physical wellbeing of caregivers (Groeneveld et al., 2012). Assessment of these factors is important, as literature suggests that ongoing stress amongst caregivers ultimately undermines child care quality. This can include low caregiver stimulation, less caregiver sensitivity, and poorer overall care quality in child care homes (de Schipper et al., 2009; Ghazvini & Mullis, 2002). There exists a strong relationship between caregivers' mental health, caregiver/child interactions, and child outcomes, linked to their emotional capacity and ability to deliver quality child care, and thus potentially leading to a probability of disruptive care (Doesum et al., 2005).

The key stressors and triggers for caregivers include stress and burnout, which are determinants of poor mental health, as stated by various studies, alongside low wages, low social support, and poor working conditions (LaMontagne et al., 2007). Despite the generalisability of triggers, stressors and other elements across the caregiver population in different sectors, the exact ways in which these stressors manifest and the strategies thereby required to address these work-related and human-centred determinants of mental health are context-specific (LaMontagne & Keegel, 2012).



COVID's impact on caregivers

Caregivers experienced negative physical and mental health outcomes as a result of the pandemic. They faced their own COVID-19 exposure risks and increased concerns regarding self-care and health, as well as additional caregiving responsibilities in care homes and catering to care-receivers increased needs, leading to stress. Many caregivers experienced feelings of social isolation, which were exacerbated by social distancing policy measures (Cash & Patel, 2020). The psychological and physical burden of the COVID outbreak on global mental health has been assessed, with the Indian Psychiatry Society revealing in its recent reports that since the start of the lockdown period in March 2020 there has been a significant increase in the number of reported cases of mental illness in India (Loiwal, 2020). While Indian law enforced care and support during the pandemic, especially for children without parental care, and with different needs and vulnerabilities, the essence of the child protection laws also aims to emphasise the importance of caring for caregivers.

Indicators of mental health difficulties related to the workplace, as reported by caregivers during the pandemic, included reduced productivity and job performance; rapid changes in mood, including crying spells, outbursts of anger, poor memory, and changes in communication with co-workers; impaired daily functioning, irritability and restlessness (Government of Karnataka & Department of Psychiatry, NIMHANS, 2020). Some of the reasons highlighted included high intensity caregiving work, limited social interaction, boring daily activities, a high burden of care, and financial and employment concerns (Butterworth et al., 2010; Kumagai, 2017; Venkatesh et al., 2016). All of this was exacerbated during the pandemic.

For instance, at Shreevatsa Child Care Institute in Pune, lockdown restrictions limited the movement of caretakers, leading to increased workloads for those who remained. Caregivers like Shalini Suresh Wadkar adapted by staying at the centre for extended periods to ensure continuous care for the infants, resulting in physical and emotional exhaustion (Bengrut, 2020). The COVID-19 outbreak also resulted in aid reductions and volunteer shortages, exacerbating resource constraints in orphanages. Institutions like Dhanna Bhagat Bridh Ashram faced uphill battles, leading to increased anxiety among caregivers responsible for the wellbeing of orphans (Hindustan Times, 2020).

The Udayan Care model and backgrounds of caregivers

Udayan Care, an NGO supporting orphaned and abandoned children in India, developed the 'Udayan *Ghar* Programme' in 1996, which is derived from the idea of 'Sunshine Homes'; a unique group home model, founded on the core concept of 'L.I.F.E.', an acronym for 'Living in Family Environment'. The purpose of these *Ghars* is to nurture OAC (orphaned and abandoned children), including once parentless, abandoned, or abused children in need of protection. Udayan *Ghars*



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house an average of 12 children per home at any given point. The care model consists of: mentor parents — a group of socially committed, civil society members who voluntarily commit themselves for their lifetime to nurture children in care; trained caregivers, who reside with the children 24/7; and certified social workers, mental health care staff, and supervisors, all of whom form the core carer team. The programme focuses on overall development, providing good education, nutritious food, support to develop excellent physical and mental health, and a variety of extra-curricular growth opportunities. The care homes are located in middle-class neighbourhoods, facilitating community participation and interaction. Presently, Udayan Care has 13 *Ghars*, spread across four states in India.

Caregivers are full-time guides and parent-like figures, living in homes with the OAC continually, with breaks to spend time with their families. In their roles they undertake all the physical work needed to raise the children, including that related to hygiene, nutrition, daily routines, etc. Like professionals in other caregiving fields, such as medicine, nursing homes, and special education services, child care institutions' caregiving responsibilities require a level of emotional commitment and regulation that can, over time, become mentally and physically draining. This, combined with the reality of caregivers, in terms of their own background, as well as the fact that they stay away from their families due to their employment, can influence caring styles, work motivation, and interactions with children. From financial needs to broader family obligations most OAC's caregivers, including those at Udayan Care, have entered the field of childcare with narratives, traumas and experiences that are as unique as they are varied (Venkatesh et al., 2016). Each caregiver has an untold story, often bearing the mark of personal struggles and sacrifices. They leave their own families and children behind in the care of another to move far away and care for other children.

Methodology

This study used a quasi-experimental research design as a means to collect and analyse the collected data.

The research and subsequent interventions focused on:

1. Periodic monitoring of the level of burnout for caregivers working with Udayan Care: Udayan Care believes in Maslach's argument that instead of classifying caregivers as 'burned out' or 'not burned out', burnout should be considered along a standardised continuum of low to high (Maslach & Jackson, 1986).
2. Identifying problem-focused coping strategies and gauging their efficacy: adopting a proactive stance, the endeavour of the study was to identify



problem-focused coping strategies that could work best for caregivers in the Indian context, in terms of mitigating and reducing burnout.

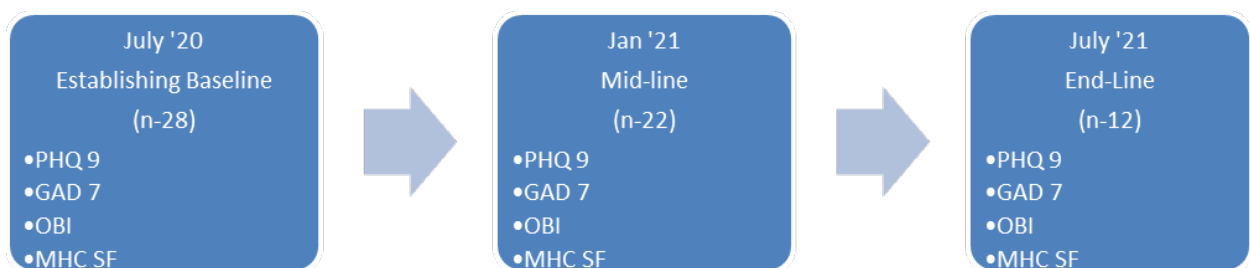
Duration of research

Data collection tools included standard mental health questionnaires (details discussed below), administered three times during the course of the study, in the summer of 2020, winter of 2021, and summer of 2021.

At the start of the study, in summer 2020, all caregivers working with Udayan Care for a period of at least 12 months were included (N=28). Of these 21 were women and seven were men. In the winter of 2021, we had 24 caregivers, which included 16 women and six men –22. In the summer of 2021, 21 participants were included in the study, of which 15 were women and six were men – 21. There were 12 participants who were part of the study across all three data points - seven women and five men. For all results presented herein, analysis using the subset of the total caregiver population interviewed at all three time points is presented first in order to enable within-subject’s analysis. Then, analysis for the subset of the overall group at the three time points of summer 2020, winter 2021 and summer 2021 is provided.

Research framework

Figure 1: Research framework



Confidentiality and ethics

This study was conducted by Udayan Care in partnership with Duke University. The project was submitted for ethical approval by the Institutional Review Board at Duke University to the Udayan Care Board which approved the final research design. Information about various measures gathered during the interviews was recorded on paper copies without audio or video recordings and encrypted using *Qualtrics* software, which ensured the protection and reliability of respondents’ data, as the certified secure platform for human subject data collection. Access to the account for this software is restricted to the research team, who are bound by confidentiality obligations, with access monitored and audited for compliance.



Training

Given the pandemic and reliance on virtual meetings, Duke University students with India-based interns collected data following training in the administration of research instruments and application in a culturally appropriate context in individual and group meetings. In 2020, data was collected from caregivers and examined for the aforementioned mental health indicators via virtual interviews.

Measures and tools

Measures used for this study were identified jointly and a combination of tools was deployed, with an intent to determine a comprehensive psychological profile of the caregivers involved (see figure 1).

- Patient Health Questionnaire-9 (PHQ-9) - a nine-item depression scale used to screen for depression and determine depression severity
- General Anxiety Disorder-7 (GAD-7) - used to assess symptoms of general anxiety
- Oldenburg Burnout Inventory (OBI) - used to measure overall burnout via two subscales which measure disengagement and exhaustion
- Mental Health Continuum-Short Form (MHC-SF) - used to gauge overall mental wellbeing with 3 subscales that measured emotional, social, and psychological wellbeing.

Data collection

In 2020, on average four online interviews were conducted per day, with each taking place after gaining informed consent from the caregiver. For caregivers who could not understand English well, interviews were conducted in Hindi by the Indian interns. Interviews took place via a Zoom meeting in the typical environments of caregivers. In winter 2021, the data collection was carried out by India-based interns and sent to the Duke team for data entry, while ensuring confidentiality. In summer 2021, four new Duke team members, along with India-based interns collected data.

Data collection procedures

A combination of the four tools, namely PHQ-9, GAD-7, OBI and MHC-SF, seemed to provide a robust indicator of the overall mental health of the caregivers. Any already available validated Hindi translations were used and checked by Duke and Udayan staff. Any tools requiring new translations were first translated into Hindi by Udayan Care and Indian speakers in the US, translated back into English by separate translators, and compared. Any inconsistencies were re-translated. Language and potential cultural and



contextual issues with measures and constructs are of particular importance to this work and of particular interest to the team.

Interventions and findings

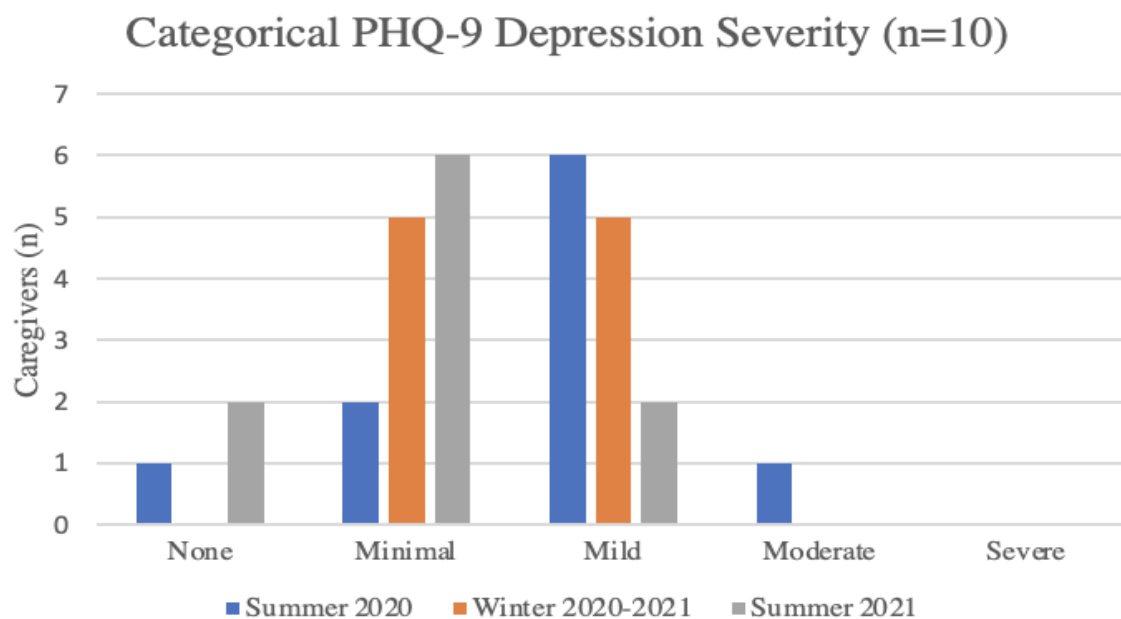
The findings derived from various tools are presented along the different timelines of data collection, corresponding to the baseline, mid-line, and end-line phases, along with the interventions undertaken in response to these findings. This is followed by a dedicated discussion section that offers an analysis and interpretation of the data across all three stages of the study.

PHQ-9 is a screening tool for depression symptoms, with possible scores ranging from 0 to 27. Its results were interpreted as a possible indicator of the presence and severity of depression symptoms in an individual (Kroenke et al., 2001). The threshold at which an individual is considered to have clinically significant depressive symptoms is a score of greater than five on the PHQ-9. During the summer 2020 baseline survey (N=12), scores suggested that at the start of study three caregivers had minimal depression, six had mild depression, one had moderate depression, and two had severe depression. The five caregivers who scored above four had gender and age distributions that indicated higher depression for female and younger (18-35 years old) caregivers.

There were 12 caregivers who were interviewed during summer 2020, winter 2021, and summer 2021. This sample size is smaller than the other longitudinal samples as some individuals did not complete the PHQ-9. Overall, the average overall PHQ-9 score for these caregivers appeared to decrease as time progressed (Figure 2); these results were consistent, even with stratification by gender. In winter 2020-2021, one caregiver reported severe depression, and in summer 2021, all caregivers from this subsample had mild or minimal depression, with three reporting no depression symptoms.



Figure 2: Categorical PHQ-9 depression severity



Category	Summer 2020 (N=12)	Winter 2020 (N=12)	Summer 2021 (N=12)
None	0	0	3
Minimal	3	4	5
Mild	6	5	4
Moderate	1	2	0
Severe	2	1	0

Table 1: Overall PHQ-9 level scores

GAD-7 was used specifically to assess symptoms of general anxiety and has possible scores that range from 0 to 21, with a score of 10 or higher indicating a risk of generalised anxiety (Spitzer et al., 2006). There are four categorical levels of general anxiety in the GAD-7 scoring. A summative score of <5 corresponds with minimal anxiety, 5-9 with mild anxiety, 10-14 with moderate anxiety, and >15 with severe anxiety (Spitzer et al., 2006).

GAD-7 at all three time points (n=12) - overall, the average GAD-7 score for these caregivers appeared to decrease as time progressed, regardless of caregiver gender (Table 3).



GAD-7 - Scores for caregivers interviewed at all interview times				
Time Period	Population	Mean (standard deviation)	IQR (1 st quartile, 3rd quartile)	Median
Summer 2020	Overall (n=12)	5.08 (3.87)	4.75 (2.75, 7.50)	3.00
	Female (n=7)	5.00 (3.65)	4 (2.50, 6.50)	3.00
	Male (n=5)	5.20 (4.60)	6 (3.00, 9.00)	3.00
Winter 2020-2021	Overall (n=12)	3.58 (2.47)	2.75 (1.75, 4.50)	3.50
	Female (n=7)	4.00 (2.00)	2 (3.00, 5.00)	4.00
	Male (n=5)	3.00 (3.16)	3 (1.00, 4.00)	2.00
Summer 2021	Overall (n=12)	2.08 (1.68)	3.25 (0.75, 4.00)	2.00
	Female (n=7)	2.43 (1.62)	2.5 (1.50, 4.00)	2.00
	Male (n=5)	1.60 (1.82)	3 (0.00, 3.00)	1.00

Table 2: GAD-7 - Scores for caregivers interviewed across all times

As GAD-7 scores can be categorised into varying levels of anxiety (minimal, mild, moderate, severe), the categorical changes of individual levels of anxiety were also noted between summer 2020 and summer 2021 (Table 2).

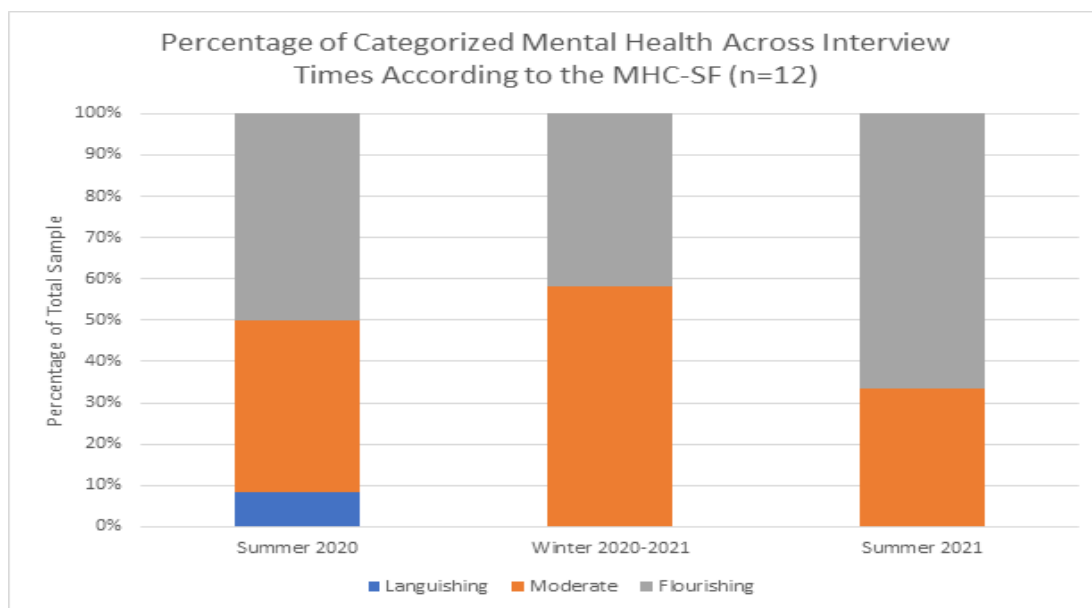
Population	Decrease	No change	Increase
Overall (n=12)	5	7 (*7)	0
Female (n=7)	3	4 (*4)	0
Male (n=5)	2	3 (*3)	0

Table 3: Shifts in categorical GAD-7 score for individuals interviewed summer 2020 and summer 2021

Table 3 above shows GAD-7 category change(s), if present, for caregivers who were interviewed at all three time points (n=12), stratified by gender (female n=7; male n=5). The asterisk represents the number of caregivers who experienced no change because they maintained the lowest level of anxiety.



Figure 3: MHC-SF scores of caregivers across interview times



It was found that no individuals experienced a categorical increase in their GAD-7 anxiety scores, and five individuals experienced a decrease in their categorical level of anxiety (Tables 4 & 5). For all those individuals who did not experience a categorical change in their anxiety levels, it was found that this was because they maintained the lowest possible level of anxiety (minimal).

Category	Summer 2020 (N=12)	Winter 2021 (N=12)	Summer 2021 (N=12)
Minimal	7	9	22
Mild	3	3	2
Moderate	2	0	0
Severe	0	0	0

Table 4: Overall GAD categorical scores

Category	Summer 2020 (N=12)	Winter 2021 (N=12)	Summer 2021 (N=12)
Minimal	7	9	12
Mild	3	3	0
Moderate	2	0	0
Severe	0	0	0

Table 5: Details of respondents interviewed across three data points (N=12)

OBI-9 is a 16 question self-report burnout scale for which individuals are asked to rate their answers on a four-point Likert scale from strongly agree (1) to strongly disagree (4) (Bakker et al., 2004). Half of the statements are positively framed while the other half are negatively framed. Those that are negatively

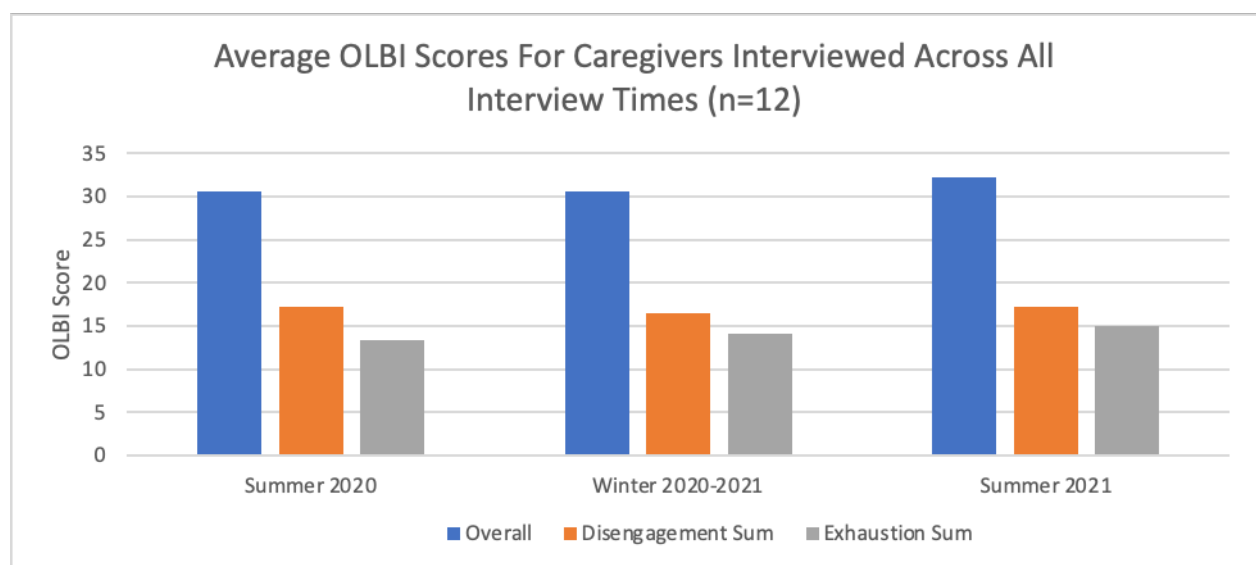


framed are reverse scored, such that higher numbers on the OBI always indicate higher levels of burnout.

In addition to overall burnout, OBI has two subscales which measure disengagement and exhaustion. Exhaustion results from intense and long-term exposure to physical, affective, and cognitive strain relating to one’s job (Pereira-Lima & Loureiro, 2015). Disengagement, on the other hand, involves a self-distancing from work and work-related activities/tasks and is frequently accompanied by a reduced willingness to continue working at that job (Pereira-Lima & Loureiro, 2015). The clinical threshold for burnout is defined as an overall score of 44 or more (Leclercq et al., 2021).

With respect to OBI at all time points (n=12), analysis was conducted using data from those caregivers who were interviewed during summer 2020, winter 2020-2021, and summer 2021 (n=12). Overall, the average OBI score, as well as both subscales for these caregivers, appeared to remain the same as time progressed (Figure 4); these results were consistent even when separated by gender.

Figure 4: Average OBI scores (overall, disengagement sum, and exhaustion sum) for caregivers across all three interview times (n=12)



Score	Summer 2020 N=12	Winter 2021 N=12	Summer 2021 N=12
Overall	30.58 (5.07)	30.67 (4.58)	32.25 (3.79)
Disengagement	17.17 (4.34)	16.50 (2.71)	17.25 (2.26)
Exhaustion	13.42 (2.78)	14.17 (3.13)	15.00(1.71)

Table 6: OBI mean scores at an overall level

The levels of burnout for all those caregivers interviewed in summer 2021 demonstrates that there were no cases of clinically significant burnout (Table 6).



Sample size in this instance is n=21 as there were 21 caregivers in summer 2021 that fully completed the OBI survey.

MHC-SF - General mental wellbeing was assessed for caregivers using the mental health continuum - short form. This measure contains three sub-scores: emotional, social, and psychological wellbeing. The summative, overall wellbeing score ranges from 0 to 70. Subscale scores range from 0 to 15 for the emotional (hedonic) wellbeing, from 0 to 25 for social wellbeing, and from 0 to 30 for psychological wellbeing. There are also categorical levels of mental health based on caregiver responses to certain questions. Flourishing mental health is defined by reporting \geq one of three hedonic signs and \geq six of 11 eudemonic signs (social and psychological subscales combined) experienced 'every day' or 'five to six times a week.'

Moderate mental health is defined by meeting flourishing requirements but having an individual emotional, social, or psychological score below six, 10, or 12 respectively. All other scores are classified as languishing mental health. Higher scores indicate greater levels of positive wellbeing (Keyes, 2009). Analysis was conducted with respect to those caregivers who were interviewed during summer 2020, winter 2020-2021, and summer 2021 (n=12). Overall, categorical levels of mental wellbeing appeared to increase as time progressed (Figure 10); these results were consistent across gender.

Score	Summer 2020 (N=28)	Winter 2021 (N=22)	Summer 2021 (N=21)
Cumulative	44.03 (12.76)	45.27 (11.42)	49.14 (13.31)
Emotional	9.64	10	10.76)
Social	14.67	15.22	15.57
Psychological	19.71	20.04	22.81

Table 7: MHC-SF scores for caregivers

First Intervention Point - The EMO AID (emotional aid) program was the first intervention used, which was designed to focus on self-care, equipping participants with supplies to create a personalised first aid box for their emotional wellbeing. Specific emphasis was put on becoming aware of emotions, regulating negative responses, and enhancing positive feelings. This program ran between September and December 2020.

Second Intervention Point - As a precursor to the second intervention of role appreciation and skill building, expansive round tables were facilitated with caregivers to determine the contours and exact focus this second intervention should take. Role appreciation and skill building was designed to focus on deepening the understanding of caregivers' roles and building skills around the evolving context of child care homes in India. The intervention was delivered



through training workshops, specifically emphasising empathising with children and handling them with compassion, appreciating the role of caregivers in the Udayan Care model, inducting new children, identifying and handling significant events, classifying visitors and working with them, and this program ran between March and June 2021. Considering the focus on skills, pre- and post-intervention tests were conducted. Designed as a simple nine-question instrument, this test was focused equally on the knowledge and skill elements of the caregiver role.

Statement	Pre-test	Post- test
Knowledge about type of children that come in care	64%	95%
Knowledge about authorities through which a child comes into care	59%	86%
Skills to work effectively with children in care	64%	73%
Awareness about their roles and responsibilities from a legal perspective as well as from being a go-to person for the child	64%	100%
Ability to identify the different types of visitors	73%	73%
Gauging standard protocols to be followed when someone arrives or leaves	45%	86%
Level of conceptualisation of participants of their role when a new child enters care	73%	86%
Knowledge of a significant event	73%	100%
Understanding of roles and responsibilities when a significant event occurs	68%	91%

Table 8: Statements pre-test and post-test

Discussion

Baseline data

Bringing the results of PHQ-9, GAD-7 and OBI together suggested that: The majority of caregivers (n=16) had scores that fell above the minimal depression range. There were low levels of average anxiety, but a majority of caregivers (n=15) indicated mild or moderate anxiety. With respect to burnout, there were moderate levels of average overall burnout, but a wide distribution of overall burnout scores, suggesting that some individuals may still be experiencing severe levels of burnout, despite the group as a whole experiencing moderate levels. We found that gender, age, and time spent working in Udayan *Ghars* all provided insights into the state of the individual. Females generally tended to have a higher frequency and severity of depression and anxiety. Moreover, they



also had higher burnout scores and lower overall mental wellbeing scores. Individuals in early adulthood in this sample tended towards having higher depression, anxiety, and burnout scores, as well as lower mental wellbeing scores. We observed that caregivers' depression, anxiety, burnout and MHC-SF scores varied considerably across length of employment.

The MHC-SF indicated moderate to high levels of average overall mental wellbeing, despite there being individuals in these groups who fell under low/languishing mental wellbeing. One intriguing possibility was that mental health scores followed a pattern in which we saw a decrease in score in the first year, possibly related to relief from previous life circumstances, an increase in scores the following year or two, related to mounting pressure from work, and then ideally a clear or gradual reduction in scores as length of time in Udayan Care increased, due to the stability and support structures in place.

Mid-line data

There was a very slight (1 to 1.5) mean score improvement in depression, anxiety and overall wellbeing, and a very slight increase in burnout, pre-/post-intervention (between testing in June 2020 and in Jan 2021). This result in no way suggested that the intervention was not effective; it only indicated that there isn't evidence that gains made after the intervention were large across the whole sample, or were retained across three to five months, as measured by the PHQ-9, GAD-7, MHC-SF, and OBI. However, there were a subset of caregivers who showed substantial clinical improvement across all four mental health categories.

In addition to the strengthening of knowledge and skills, a feeling of being a community which was learning together also enabled the participants. One of the participants stated, 'I will leave no stone unturned to make all the kids successful so that they are able to reach great heights.' They added, 'I have worked with many different spaces, but the life lessons and values I have learnt from the children in Udayan Ghar are helping shape my worldview.'

Another advantage of these sessions was the ability to engage in dialogue. For instance, punishment and shouting at children has been a common disciplining practice in the country. To get an idea about participants' views on corporal punishment and yelling at children, the caregivers were asked, 'Do you feel that under certain circumstances it becomes important to shout at children to make them understand their mistakes?' Pre-training assessment divulged that 68% of caregivers concurred that it is okay to shout at children under certain circumstances. The training effect is visible in the fact that in post-training assessment the percentage of people who agreed that shouting at and spanking children is okay dropped by 27%.



End-line data

Tool	Score Range	Base-line score	Mid-line Score	End-line Score
GAD	0 – 21	5.0	3.5	2.0
PHQ 9 (n-10)	0 – 27	7.3	6.4	3.2
MHC SF	0 – 70	47.7	48.1	47.7
OBI	16 – 64	30.5	30.6	32.2

Table 9: Overall scores across the survey for 12 participants who had valid data points across the three touch points. (N-12, 5 Men, 7 Women)

Investigation and conversation with these 12 participants indicated that while short-term interventions may not show a visible result, sustained interventions support caregivers to manage their overall anxiety and depression levels.

Conclusions

The issue of burnout among caregivers in child care institutions (CCIs) is a critical requiring more focused attention. In this study, the emotional, psychological, and structural tensions that caregivers work under have been brought to light, particularly in environments characterised by overdemand, under provision, and a high emotional investment in the health of vulnerable children. The caregivers act as containers for children's pain, trauma, and an underperforming system, sometimes at the cost of their own emotional health. There is a need for proactive and continued investment in the emotional development of caregivers, to enable them to better support orphaned and abandoned children (OAC). Despite the constraints discussed herein, there is hope for the future. It is significant that India has been witnessing a growing awareness of the importance of high-quality child care services and the wellbeing of caregivers. Government policies, like the Juvenile Justice (Care and Protection of Children) Act of 2015, and its *Model Guidelines for Foster Care* created in 2016, increasingly emphasise the rights and overall development of children, and the critical role of caregivers in the system. The Ministry of Women and Child Development has also made progress in the 'Child Protection Services' scheme, previously called ICPS, which aims to strengthen the capacities of child care institutions (CCIs) and personnel through the implementation of training programs around stress management and child psychology.

There has also been expansion in non-state led initiatives aimed at caregiver wellbeing. Organisations like Miracle Foundation India and Udayan Care have brought in practices like reflective supervision, formal emotional support meetings, and professional development for CCI staff. These initiatives reflect increasing recognition that the quality of care children receive is central to caring for the caregiver. Interestingly, the inclusion of mental health professionals and psychosocial support networks in CCIs is gradually picking up pace. A few states have experimented with the inclusion of counsellors at child welfare centres as a



step towards addressing the emotional burden faced by both workers and children. Concurrently, training initiatives that use trauma-informed and attachment-based methods are gaining traction, equipping caregivers with the ability to respond with more empathy and strength.

These positive shifts are uneven and must be integrated fully in the nation. This also requires support through a shift in cultural attitudes—beyond thinking of caregiving as administrative or vocational, to recognising its relational, emotionally textured nature, which is essential to a child's healing process. This is not merely a matter of policy and funding shifts, but also close attunement to the lived reality of caregivers, many of whom remain invisible in the child protection system.

As India develops its child care resources, it is important to incorporate the welfare of caregivers as not just a moral imperative but a strategic necessity for child development. A supported and compassionate caregiver could be a life-changing force in the lives of many of the country's most vulnerable children.

Limitations and future research

The research was consciously designed as a 'pilot study', to be administered to the caregiver pool working in Udayan Care for a period of at least 12 months. This resulted in a statistically small sample size, which reduced further through factors like attrition. Considering Udayan Care mostly runs girls' homes, the caregivers also tend to be women. Initial data indicates that gender nuances do factor into anxiety, depression and overall mental health. Going forward, our intent is for the study design to be replicated with a larger group working with not-for-profits across the country, with both genders equitably represented.

With three data points, the study has generated rich information providing useful insights into the anxiety, depression, burnout, and overall mental health of caregivers. Being able to monitor these across a longer timeframe would definitely provide richer insights into those mental health triggers for caregivers which are ecosystem driven.

The challenge of the short-term employment mindset that caregivers typically operate within may not be a limitation that can be addressed completely, but broad basing the research to caregivers across various organisations in India may help to rectify this issue to a certain extent.



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Original Research Article

Early childhood education and family wellbeing – A call for Scotland to reconsider policy and practice

Julia Clark

Abstract:

In 2012, Scotland's Early Years Collaborative committed to making Scotland 'the best place in the world to grow up'. The Scottish Government has acknowledged the importance of early support for children and families to reduce inequalities, deprivation, and health consequences throughout the lifespan. Research highlights the interconnected relationship of parental wellbeing and child wellbeing, and how this relationship can be improved through whole-family support in early childhood education and care (ECEC). This study examines cases around the world where holistic family support has been included in ECEC to improve family wellbeing. The aim of the study is to analyse how centres provide this support, and its impact on families, to identify how Scotland could promote family wellbeing in its ECEC settings. A thematic analysis was conducted, and it was found that families' wellbeing improved through ECEC provisions that were flexible, responsive, accessible, and welcoming. Parents and practitioners equally identified collaborative partnerships with each other as one of the most important aspects of an effective ECEC program. Integration of support beyond childcare and education helped increase families' attendance, agency, and overall wellbeing. Effective ECEC programs included support for the entire community in their philosophy of care. This community-focused philosophy of ECEC programs was found to create culturally-safe environments with a strengths-based approach to care. This study identifies three main recommendations for Scotland to promote family wellbeing in ECEC: an integration of education, health, and social services to provide holistic support for families; a pedagogical leadership structure between parents and practitioners; and ensuring programs are accessible, flexible, and responsive for families, which requires secure, long-term funding.



Introduction and context

In 2022, the Scottish Government published their Whole Family Wellbeing Funding (WFWF) plan which promotes wellbeing for families in Scotland through a more holistic, integrated, and early-intervention approach to services before families reach crisis (Scottish Government, 2022). While the outcomes of this plan include 'improved family wellbeing', there is no specific definition in the plan as to what this terminology entails.

International research indicates that family wellbeing encompasses physical, spiritual, economic, social, and mental aspects of wellbeing, as well as relationships between family members and the quality of those relationships (Samsudi, 2022; Wollny et al., 2010; Wong et al., 2022). Quantitative indicators of family wellbeing include education level, household income, health, and safety (Noor et al., 2014). Rountree and Smith (2016) highlight that these indicators are based on a deficit-based model and suggest additional strengths-based indicators such as community connections and cultural practices. These strengths-based indicators of family wellbeing reflect social capital, a term used to describe the interconnected relationships in a community which are mutually beneficial for society (Falk & Kilpatrick, 2000).

A Scottish Household Survey was conducted in 2022 and explored strengths-based indicators of wellbeing (Scottish Government, 2024a). Overall, 57% of adults rated their neighbourhood as a 'very good' place to live, but only 29% of adults living in deprived areas rated their neighbourhoods in this way, highlighting a link between household income and community wellbeing. Those living in deprived areas were nearly twice as likely to identify experiences of loneliness (30%) compared to those living in the least deprived areas (16%), which highlights a link between household income and mental wellbeing. Within the most deprived areas, 68% of adults agreed with the statement 'this is a neighbourhood where people from different backgrounds get on well together', with 79% of adults agreeing in the least deprived areas. This indicates the ubiquitous benefit of cultural inclusion for community connections.

Family wellbeing can also be quantified through children's wellbeing and safety. Scotland's Children's Social Work Statistics identify that 2,094 children were listed on the Child Protection Register (CPR) halfway through 2023 which is an increase of 4% on the previous year (Scottish Government, 2024b). Of those children on the CPR, 47% were under the age of five. The top four concerns identified for children on the CPR were: domestic abuse (42%), neglect (40%), parental mental health problems (39%), and parental substance misuse (38%). This highlights the link between parental wellbeing and child wellbeing, which was also found in the Growing up in Scotland study (Parkes et al., 2016). Data from the study identifies a statistically significant relationship between maternal distress, dysfunctional parenting, and child subjective wellbeing (Parkes et al.,



2016). The impact on child wellbeing by age seven was additionally impacted by family poverty and area deprivation, two evidence-based quantitative indicators of wellbeing.

Improved family wellbeing 'provides a foundation for positive parenting and child wellbeing' (Newland, 2015, p. 3), two key commitments of the National Parenting Strategy (2012). Key partnerships involved in the Strategy include 'universal services, health, education and social work [who] provide crucial support to children and their families from preconception, throughout childhood and into adulthood' (Scottish Government, 2012). In Scotland, social work has the statutory responsibility for child protection per the Children (Scotland) Act 1995 and Social Work (Scotland) Act 1968. Early-intervention support before a child is listed on the CPR by age five requires a preventative model of care as opposed to a reactive one. However, Stalker and Moscardini (2012) highlight that many families end up receiving support only at times of crisis due to pressures on resources in the public sector. Addressing family wellbeing through integrated family support in ECEC is one way to provide preventative and early-intervention support, which positively impacts children throughout the entire lifespan (García et al., 2016).

A focus on family support is not a new concept in the political context of Scotland. This is exemplified by numerous pieces of guidance across both education and social services, including: The Early Years Framework (2008), Getting it Right for Every Child (GIRFEC) (2008), The Early Years Collaborative (EYC) (2014), The Children and Young People (Scotland) Act 2014, Building the Ambition (2014), The Promise (2020), and the Mental Health and Wellbeing Strategy (2023). While there has historically been a call for more support with respect to child and family wellbeing, this is not reflected in practice across Scotland. One of the difficulties in providing universal services is that each of the 32 local authorities in Scotland have different policies, funding, and resources. These are barriers to providing holistic family support in ECEC.

There is a need for more resources from social services across Scotland to provide this family support in ECEC. Without additional resources families may feel uncomfortable speaking with ECEC practitioners about sensitive family circumstances, ECEC practitioners may not feel comfortable taking on a 'lead professional' role, and ECEC centres alone may not have the means to provide necessary support (Jopling & Vincent, 2020). A collaborative relationship between social work and education, either through shared resources and training for ECEC practitioners or inclusion of social workers in ECEC settings, is one way to provide holistic family support in the earliest years of a child's life. In Scotland, social workers have the training, resources, and experience supporting vulnerable individuals that ECEC practitioners may not have and can therefore bridge this gap in support. While GIRFEC and The Promise highlighted the need for this integrated, preventative family support in Scotland, Rose (2015) argues



that more consistent implementation of this family support across Scotland is needed to 'demonstrate that the programme has actually had an impact on individual children's well-being in both the short and the long term' (Rose, 2015, as cited in Jopling & Vincent, 2020, p. 8).

Other ways to improve family wellbeing in ECEC centres are rooted in the structure, environment, and collaboration within the centre. These methods are identified in the current study through families' voices regarding their child's ECEC centre.

Methodology

Study design

The current study examines qualitative data to identify how the outcome of improved family wellbeing can be achieved in ECEC settings. Eight articles were chosen for analysis in this study.

Coffey and Atkinson (1996, p. 2) state that 'there is no single right way to analyse qualitative data; equally, it is essential to find ways of using the data to think with'. In the data analysis for this study, it was important to empower the voices and experiences of families, as opposed to generalising their experiences. Thematic analysis felt the most appropriate method of data analysis because it aims to identify patterns in the literature and 'can emphasise the social, cultural, and structural contexts that influence individual experiences' (Kiger & Varpio, 2020, p. 847). Furthermore, thematic analysis helps to 'understand a set of experiences, thoughts, or behaviours across a data set' (Braun & Clarke, 2012, as cited in Kiger & Varpio, 2020, p. 847), which suits the research aim of this study as it involves investigating families' experiences to inform policy and practice.

The inclusion criteria for this study were: (1) a setting of ECEC or related terminology for the cultural context of the research, (2) written in English, (3) peer-reviewed sources, (4) research from all dates; this choice was due to a lack of relevant literature on the topic.

The exclusion criteria for this study were: (1) sources that analysed only children's wellbeing; although it is related to overall family wellbeing it did not directly address the research aim, (2) reviews of relevant policies; while these sources were useful for supplemental information about the topic they were not as relevant for direct analysis of specific examples in the context of this study, (3) sources that analysed families with children older than six years old; the focus of this study was on early childhood which was defined as 0-6 years old to reflect national guidance.



Data analysis

Originally, the intention was to conduct a more narrative model of data analysis, as it felt disconnected to analyse the selected articles all together considering they focus on a few different perspectives (parents', practitioners', and researchers' views) and utilise different types of data (qualitative, quantitative, and mixed methods). However, it became clear that several topics were emergent as themes regardless of the perspective or type of data. This finding justifies the use of thematic analysis and highlights the further significance of the themes and codes to support family wellbeing in ECEC as they are prominent across all data collection methods.

Although most codes are interconnected, it was a choice to include them separately because there are unique qualities to each one which was identified through the data.

Figure 1 displays the themes and codes which were identified in the thematic analysis used in this study. **Figure 2** displays the interconnected nature of the identified codes.

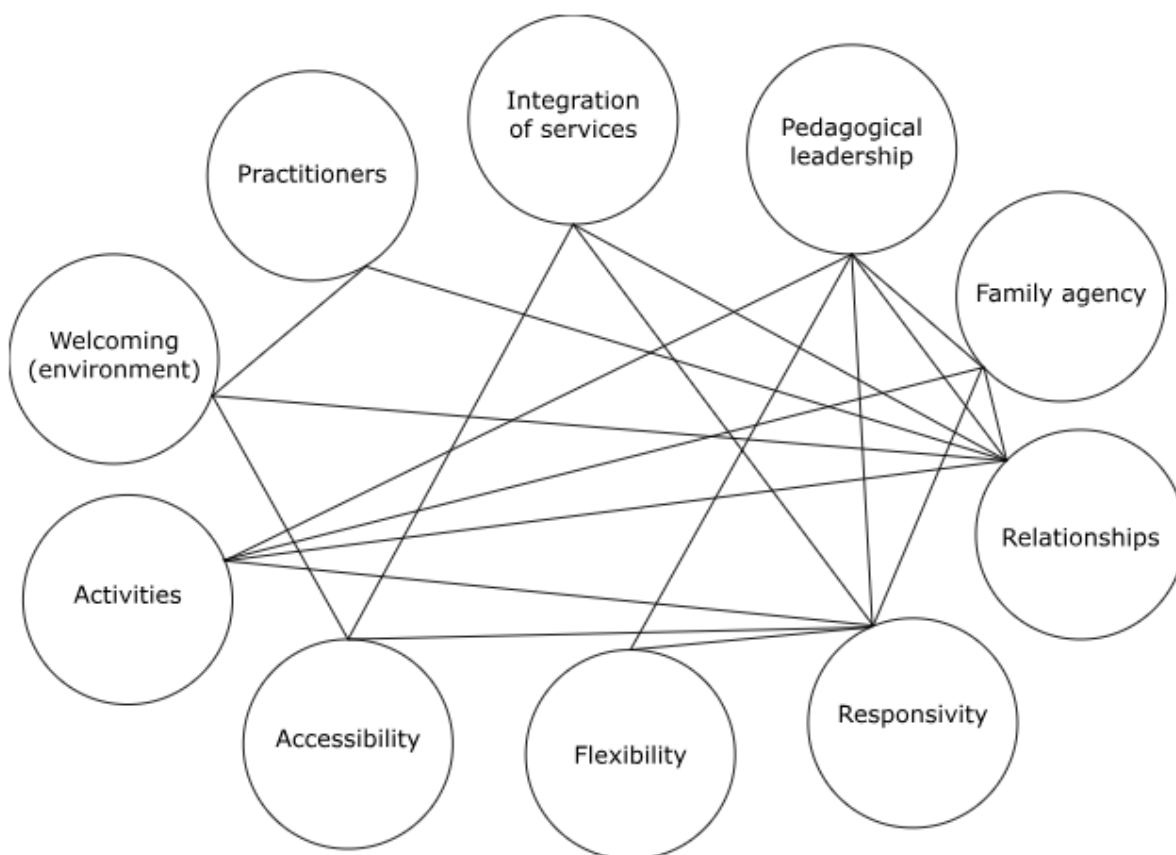


Figure 1: Themes and codes

Themes	Codes	Details
Collaboration	Integration of services	Integrated or access to services including education, family support, social services, health, etc. available through the ECEC setting
	Pedagogical leadership	Giving parents shared responsibility for shaping the program, environment, and structure of the ECEC setting along with practitioners (flat organisation vs. hierarchical organisation)
	Family agency	Parents and carers having expertise in their lives and about their children, practitioner respect for family values, family-centred approach
	Relationships	Bi-directional between practitioners and parents, peer support, children's social support, trust
Structure	Responsivity	To families' needs, children's needs, families' circumstances
	Flexibility	Attendance, parental involvement, structure
	Accessibility	Location, financially feasible, culturally appropriate
	Activities	For parents and children (both one-to-one and groups), home visits
Environment	Welcoming	The ECEC setting should feel relaxing, comfortable, organic
	Practitioners	Practitioners need to be skilled at supporting families and children, have welcoming attitudes, and contribute to a safe environment



Figure 2: Interconnected codes



Research findings

Integration of services

The facilitator has more of a holistic view of what the children are like both inside and outside the classroom, so that is really useful. I think the facilitator role is like a bridge. (Parent interview in Leitão & Shumba, 2024, p. 7)

The need for integrated social supports was discussed in six of the articles as an important component for family attendance in ECEC (Hale et al., 2020; Kaiser et al., 2022; Kirk, 2003; Leitão & Shumba, 2024; Leske et al., 2015; Skattebol et al., 2014). Integrated support included home visits, connections with community services, and professional support. In the report conducted by Skattebol et al. (2014), researchers found that families being less involved in ECEC was due not to a lack of interest in early childhood education but rather the need to prioritise family stability and safety. It was found that 'families from disadvantaged contexts were able to thrive when supported to articulate their priorities and find resources to meet their basic everyday needs' (Skattebol et al., 2014, p. 5). By offering opportunities for professional support in ECEC settings, accessibility is increased for families and 'vulnerable and resilient families [can participate] together' (Kirk, 2003, p. 95). This promotes an inclusive approach that benefits the wellbeing of children and families. There is a reduction of stigma for vulnerable families when they are included in a collective community of support which highlights how 'early years' centres can help to provide a foundation for future resilience' (Kirk, 2003, p. 96).

While not all ECEC settings assume responsibility for holistic family support, sometimes limited by funding regulations, Leske et al. (2015) found that ECEC settings that included this holistic support in their philosophy had more success. One ECEC centre in Ireland structured their program to include a facilitator role which acted as a main family support contact for families, separate to the teachers within the centre. Parents indicated the support from the facilitator reduced their stress and increased wellbeing, as exemplified by one parent's response that the facilitator helped them '[learn] more about myself and how I am only one human' (Leitão & Shumba, 2024, p. 9).

Pedagogical leadership

Parents experience the staff more as partners in their children's everyday lives and their upbringing, rather than just as the staff of a child care unit of a municipal ECEC department. (Parent interview, in Purola & Kuusisto, 2021, p. 8)

Collaboration between families and practitioners instils an environment of connectedness and shared responsibility (Purola & Kuusisto, 2021). The ECEC



service Te Aroha Noa in New Zealand follows the traditional Maori principle *ako*, which means everyone is a learner and a teacher in a collective process (Munford et al., 2007). Practitioners at Te Aroha Noa found that children's wellbeing improved when parents were more involved in the centre and participated more in their children's lives.

Parents want to be involved and have a say in the ECEC setting their children attend (Skattebol et al., 2014). The data highlighted examples of when this joint collaboration has been successful in ECEC settings. At Te Aroha Noa, parents helped shape the program structure from a playgroup in the 1990s to a collaborative ECEC model that employed parents as joint educators alongside facilitators of the program (Munford et al., 2007). At the Open Kindergarten in Mayfield, Scotland, practitioners brought in sleep specialists and members from the local social work team to meet with parents after families discussed a need for these supports in the program (Hale et al., 2020). At an ECEC centre in Finland, parents helped to organise events and activities throughout the year, such as flea markets, parties, and soup nights (Purola & Kuusisto, 2021). Parents reported that this engagement with the program built trust between parents and practitioners and positively impacted the wellbeing of families.

Family agency

A sense of security is created: I am being heard and appreciated as a human being, so surely my child is also being heard and appreciated as his/her own person. (Parent interview in Purola & Kuusisto, 2021, p. 9)

Related to pedagogical leadership is the agency a family has over their experience in ECEC settings. Family agency can be described as how instrumental families can be in the ECEC setting as a result of practitioners showing an interest in parents' points of view and those views being taken seriously (Kaiser et al., 2022). Leske et al. (2015) found that family agency was directly related to attendance at ECEC programs where attendance was not mandatory. In the report by Skattebol et al. (2014), researchers found that families wanted their knowledge about their children respected and incorporated into the programs. When this does not occur, parents can feel deficient (Munford et al., 2007). Such was the case for one parent interviewed who felt she was 'seen as "complaining" rather than respected as a mother engaged in her children's learning' (Skattebol et al., 2014, p. 7). In facilitating family agency in ECEC programs, parents have the opportunity to 'become powerful advocates for their children' (Munford et al., 2007, p. 82). With an increase in family agency, parents feel more valued in the ECEC community and more confident in their own knowledge and abilities (Munford et al., 2007; Purola & Kuusisto, 2021).

At Te Aroha Noa, parents' expertise is recognised and valued by practitioners, which has resulted in some parents gaining confidence to pursue further



educational opportunities in their own lives (Munford et al., 2007). In the Open Kindergarten models piloted in Scotland, there was a focus on parent-led models of ECEC which promoted a person-centred approach. Hale et al. (2020, p. 51) described the importance of family agency in Open Kindergartens by stating, 'a model reliant on the "expert" input potentially de-skills parents and carers by undermining their sense of parenting competence independent of the expert'.

Relationships

We have become a larger group, a part of a larger village, a family; we have people to whom we can turn, with whom we can speak in confidence about anything, gain friendship, genuine caring, and growth for the whole family. (Parent interview in Purola & Kuusisto, 2021, p. 7)

Relationships are critical to families' positive experiences in ECEC, as parents and practitioners overwhelmingly reported in all eight articles considered in this study. Parent/practitioner, parent/parent, practitioner/child, and child/child relationships were all identified as influential in an effective ECEC program. Parents reported an increased feeling of community and connectedness through positive relationships at ECEC settings which improved their children's development and wellbeing (Hale et al., 2020; Kirk, 2003; Purola & Kuusisto, 2021; Skattebol et al., 2014). In the parent surveys for Open Kindergarten models in Scotland, $\frac{2}{3}$ of parents in one program reported the reason for attending was related to interactions with others for both the parents and their children, with $\frac{1}{3}$ of parents in another program reporting a similar motivation (Hale et al., 2020). In the study analysing parents' participation in a Finnish ECEC centre, 'there were 211 mentions of being or doing together in the community, which represents the largest number of mentions in this study' (Purola & Kuusisto, 2021, p. 6).

Relationships in ECEC improve family wellbeing by forming a network of social support which improves parents' confidence in their abilities (Hale et al., 2020; Purola & Kuusisto, 2021) and 'empower[s] families as collaborative educators' (Leske et al., 2015, p. 117). Purola & Kuusisto (2021, p. 3) identified through parents' responses the recurring theme that 'continuous, open, and bi-directional communications between parents and ECEC teachers were a way to improve the collaboration, contributing towards supporting the child's development'. Munford et al. (2007, p. 81) describe the collaborative model at their centre as 'a strong foundation that parents can draw on throughout the life course as they face other challenges [...] [with] the potential for spill-over benefits to other families/whanau in the wider community'. Kirk (2003) found that supportive relationships between families and ECEC settings contributed to parental support, which promoted resilience across the family.



Responsivity

The facilitator went beyond what was needed to do [...] the facilitator is very aware of people's needs [...] [they] had gone to the trouble of finding this source which could help me, and my child was delighted. (Parent interview in Leitão & Shumba, 2024, p. 6)

Responsivity of a program can be described as practitioners' adaptability and commitment to meeting families' needs and interests. Responsive programs promote family agency, which supports pedagogical relationships between practitioners and parents. Parents reported that ECEC services responsive to their needs benefited both the child and family wellbeing (Hale et al., 2020; Leitão & Shumba, 2024; Leske et al., 2015; Munford et al., 2007; Skattebol et al., 2014). Leske et al. (2015) describe an example of an ECEC centre that provided food for families who were unable to pack snacks for their children, when practitioners noticed attendance was impacted by the 'shame factor' associated with this circumstance. At an ECEC centre in Ireland, families described the 'tailored support' they received from facilitators which supported their family's specific needs through home visits, assessments, and joint activities (Leitão & Shumba, 2024). By creating a responsive program, ECEC services adopt a holistic approach to care that caters to both the children and the parents.

Responsivity is particularly important for vulnerable families and children who have additional or complex needs. Munford et al. (2007, p. 84) describe the belief at Te Aroha Noa that 'vulnerable children stand to gain from early interventions and support that address both their education/developmental needs and provide support and education for their parents'. Skattebol et al. (2014, p. 7) echo this belief as their data highlights parents' wish for accessible ECEC that includes 'additional services and supports for families in disadvantaged circumstances'. One parent at an Open Kindergarten centre in Scotland described the responsive nature of practitioners: 'they're more supportive to some of the other mums, which I think is nice. I think that's important' (Hale et al., 2020, p. 60).

Flexibility

Building up those relationships, they don't necessarily get to do it when they're in a group that's really structured. (Mayfield practitioner interview in Hale et al., 2020, p. 50)

A component of effective ECEC identified in the data was flexibility in attendance and structure. Parents and practitioners reflected on the positive impact that flexible attendance had on family wellbeing (Hale et al., 2020; Leske et al., 2015; Skattebol et al., 2014). In the report which looked at the ECEC



experiences of low-income families in Australia, parents described a common experience of unstable work impacting their access to ECEC services (Skattebol et al., 2014). It was 'valued' when families could continue participating in an ECEC centre despite this instability (Skattebol et al., 2014). This flexibility as an acknowledgment of family circumstances was found to be present in non-licensed ECEC services in Australia which adopt a philosophy of family learning as opposed to a focus on only the child (Leske et al., 2015). Hale et al. (2020) found that parents who participated in the Open Kindergarten pilots in Scotland appreciated the flexible attendance policy because it took pressure off them and created a relaxed environment. Many parents reported poor mental health at the onset of the Open Kindergarten pilots and that the flexible structure positively impacted their wellbeing. One parent's description of the flexible Open Kindergarten program was, 'this is a lifeline. It gets me out of the house' (Hale et al., 2020, p. 47). A more structured ECEC program could pressure families experiencing poor mental health to attend regular hours which could lead to disengagement from services.

Flexibility in program structure was present in effective ECEC programs as well, including unstructured parent groups. Mayfield practitioners at the Open Kindergarten in Scotland highlighted the value of natural, unstructured discussions for parents, which help them to feel relaxed and unjudged (Hale et al., 2020). This organic and 'family feel' structure was compared to traditional parenting classes which were described as more judgmental (Hale et al., 2020). Leske et al. (2015) found that the flexibility of non-licensed programs allowed greater responsiveness to family needs and a focus on whole-family support.

Accessibility

If it wasnae free I wouldnae be here because I wouldn't be able to afford it. (Mayfield parent interview in Hale et al., 2020, p. 44)

Barriers to accessible ECEC services include the location (Hale et al., 2020; Kaiser et al., 2022; Leitão & Shumba, 2024; Leske et al., 2015), costs to attend (Hale et al., 2020; Leske et al., 2015; Skattebol et al., 2014), and cultural inclusivity (Hale et al., 2020; Leske et al., 2015; Munford et al., 2007). Location of ECEC services can impact transportation needs and community connectedness for families. The Mount Isla centre in Australia identified the lack of transport in indigenous communities as a main barrier to effective support for families (Leske et al., 2015). Similarly, costs for transportation prevented families from attending the Mayfield Open Kindergarten, which prompted the centre to provide a free bus service to address this need (Hale et al., 2020). Prioritising an accessible location for families increases attendance and allows opportunity for more connectedness across the community, inside and outside the walls of the ECEC centre (Hale et al., 2020; Leske et al., 2015; Munford et al., 2007; Purola & Kuusisto, 2021; Skattebol et al., 2014).



Parents reported that cost-free programs were vital for their families (Hale et al., 2020; Leske et al., 2015; Skattebol et al., 2014). Free or low-cost ECEC services are essential for low-income families because they prevent vulnerable families from being excluded from receiving the benefits of high-quality ECEC. One parent described his experience applying for childcare subsidies to afford ECEC as a long process of many referrals. Until the subsidies were processed, the parent had to use over half his income paying for ECEC and described that time by saying, 'I'm so scared every single day' (Skattebol et al., 2014, p. 6). Kirk (2003, p. 96) highlighted the positive impact of including the entire community in ECEC: 'child and family well-being and the strengthening of communities can be enhanced when all types of early years' provision adopts an open, inclusive approach.'

Cultural inclusivity emerged as another important element of accessibility for effective ECEC services (Hale et al., 2020; Leske et al., 2015; Munford et al., 2007). A main component in promoting cultural inclusivity is the presence of diverse ECEC practitioners, with one parent reflecting that '[the indigenous practitioners] have such a huge role in making families feel safe and encouraging them to come' (Leske et al., 2015, p. 114). Overcoming cultural barriers proved to be a priority in non-licensed programs which adopted a holistic philosophy of care (Leske et al., 2015). Hale et al. (2020, p. 54) describe Open Kindergarten as having 'the potential to enable children to develop a sense of inclusivity if there is a range of cultural backgrounds represented'. By creating a place where families of all cultural backgrounds feel welcomed and respected, the ECEC program demonstrates its 'culturally and socially responsive management practices' which contribute to the success of programs like Te Aroha Noa (Munford et al., 2007, p. 83).

Activities

[The activity] gives you the opportunity to see and maybe meet other parents [...] it was great to be social and see familiar faces. (Parent interview in Leitão & Shumba, 2024, p. 9)

Activities are a central method to promote social connections, parental involvement, and opportunities for joint collaboration in the development of ECEC services. Parents described various activities offered at ECEC programs which improved their experiences, including one-to-one activities involving parents and practitioners, peer group activities for parents, and group activities for the entire ECEC community (Hale et al., 2020; Kirk, 2003; Leitão & Shumba, 2024; Munford et al., 2007; Purola & Kuusisto, 2021). In the survey conducted by Purola and Kuusisto (2021), parents (N = 93) gave all activities high ratings, with 59% of parents highly rating even the lowest-rated activity, which suggests that the type of activity did not matter as much as the general opportunity to engage in them. Conversely, Leitão & Shumba (2024) found that parents preferred activities which reflected particular needs, as identified by families.



These findings highlight the importance of ECEC programs incorporating families' views in the facilitation of activities and adopting a responsive model. One parent described their experience with positive ECEC activities, stating 'it gives a whole new dimension to the children's world' (Purola & Kuusisto, 2021, p. 7). Group activities in the ECEC community provide opportunities for community development and social interaction between families (Leitão & Shumba, 2024). One-to-one activities between parents and practitioners provide opportunities for wellbeing support and building trusting ECEC-parent relationships (Hale et al., 2020).

Welcoming

That's why we get a lot of people off the street who come through the door – because they feel comfortable. (Non-licensed practitioner interview in Leske et al., 2015, p. 114)

Four articles mentioned the ECEC setting as a welcoming environment that contributes to family attendance and/or wellbeing (Hale et al., 2020; Leske et al., 2015; Munford et al., 2007; Purola & Kuusisto, 2021). In Finland, families reflected that feelings of connectedness were directly related to the atmosphere cultivated by the ECEC centre (Purola & Kuusisto, 2021). Parents in Open Kindergartens in Scotland described the environments as making them feel 'comfortable and safe', 'relaxed', and 'like being at home' (Hale et al., 2020). Attributes of the environment which promoted feelings of comfort include: an open-door policy, a relaxed and flexible structure, simple greetings every day, and a non-judgmental approach (Hale et al., 2020; Leske et al., 2015; Purola & Kuusisto, 2021).

A safe, welcoming environment is particularly necessary in ECEC settings which provide holistic support to families, due to the nature of topics that may be discussed – such as child development and parenting (Kaiser et al., 2022; Leitão & Shumba, 2024; Munford et al., 2007) – and the mental health challenges that families may be facing (Hale et al., 2020; Kirk, 2003; Leitão & Shumba, 2024; Skattebol et al., 2014). Parents involved in Open Kindergartens in Scotland viewed the program as 'a source of relief from [feelings] of being trapped, stuck, or overwhelmed' (Hale et al., 2020, p. 50). With such powerful potential to support families in a variety of ways, it is essential that ECEC settings are non-judgmental, comfortable environments and venues (Leske et al., 2015).

Practitioners

They [practitioners] just make you feel like you're at home basically when you come in, which just makes you feel relaxed the minute you walk in the first door. (Mayfield parent interview in Hale et al., 2020, p. 56)



Practitioners' personalities and attitudes contributed to the development of a welcoming atmosphere, improved communication with families, and increased attendance at ECEC centres (Hale et al., 2020; Leitão & Shumba, 2024; Leske et al., 2015). Parents reported that positive interactions with practitioners improved both theirs and their children's wellbeing (Leitão & Shumba, 2024). It was important to parents to receive a welcome from practitioners upon arrival to ECEC centres (Hale et al., 2020; Purola & Kuusisto, 2021), and parents involved in Open Kindergartens in Scotland described this welcome as directly influencing their decision about whether to return to the program (Hale et al., 2020). In addition to the frequency of positive interactions with practitioners, parents reported the need for 'the right person' to be in these roles (Leitão & Shumba, 2024). It was appreciated when practitioners were approachable, visibly happy to see families, and good communicators (Hale et al., 2020; Leitão & Shumba, 2024; Skattebol et al., 2014).

Discussion

The findings of this study highlight aspects of ECEC settings' structure, environment, and the collaboration within the setting which promote family wellbeing.

The majority of articles included in this study highlighted the need for integrated social supports (Hale et al., 2020; Kaiser et al., 2022; Kirk, 2003; Leitão & Shumba, 2024; Leske et al., 2015; Skattebol et al., 2014). In studies conducted by Kirk (2003) and Leske et al. (2015), it was found that there was a link between parental welfare and child development which was supported by integration. This increased opportunities for families to access support beyond childcare and education for their child. Kirk (2003, p. 95) summarises this finding by stating, 'the integrated nature of child development, parent-child relationships, resilience and well-being emphasises the importance of ensuring that outcomes for parents as well as children are included in the planning, delivery and evaluation of early years' provision'.

In being offered integrated services in accessible ECEC settings, families receive the opportunity to seek support for needs beyond childcare and education which may otherwise require specialist services and interventions that are tagged with stigma both publicly and internally. Access to these resources through ECEC settings could reduce stigma and promote human agency by de-individualising disadvantage through collaboration with other services, thus increasing accessibility for all families.

Pedagogical leadership was identified as a way to improve family wellbeing. It relies on trusting, bi-directional relationships between parents and practitioners (Purola & Kuusisto, 2021), which were highlighted in every article included in this study as an important factor for improved wellbeing. The collaborative relationship between parents and practitioners respects the expertise of both



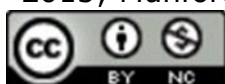
parties to achieve a joint goal: supporting the best development and interests of children (Sadownik & Visnjić Jevtić, 2023).

This leadership approach promotes family agency, which describes an acknowledgement of families as experts in their lives. There is consideration for how to promote agency for disadvantaged groups within social and political contexts, with Booth (2019) asserting that a culture has been created in the UK whereby there are biases and prejudices around how disadvantage occurs. This culture negatively impacts opportunities for agency in the lives of disadvantaged groups. 'This is tangible in the (re)conceptualisation of the term "service user" which has become increasingly synonymous with the idea that some individuals are overly dependent on the state, and not worthy of the support that "hard-working families" deserve' (Booth, 2019, p. 283).

In the current study, whole-family support improved parent and child agency through parent responses such as '[the facilitator's support] was re-affirming for the parents as much as it was for the kids' (Leitão & Shumba, 2024, p. 8) and 'the children, as well, have this person they can come to, and the Facilitator is also involved in their care' (Leitão & Shumba, 2024, p. 8).

Accessibility in ECEC, as defined by the OECD, includes location, affordability, flexibility, and availability for all children's needs and age groups (OECD, 2001). Vandebroek (2015, p. 175) adds to this definition by stating, 'as families living in poverty are often less mobile than more affluent families, it is crucial that high quality services are located where poor families and ethnic minority families reside'. This crucial consideration of accessibility was highlighted in the current study as families reported transportation to and from ECEC sometimes prohibited their attendance altogether (Hale et al., 2020; Leske et al., 2015). Several locally based ECEC settings in the current study increased feelings of community for everyone when accessibility was made a priority (Hale et al., 2020; Leitão & Shumba, 2024; Leske et al., 2015; Munford et al., 2007). Duncan (2012, p. 81) describes ideal ECEC services as optimal community hubs which promote stronger, healthier communities, asserting that 'strong communities and networks support strong families' which are more resilient. It is with a recognition of the strengths of all children and families that ECEC centres can support resilient communities (Bove & Sharmahd, 2020). Benson et al. (1998, p. 138) highlight the interconnected relationships between families and communities by stating, 'families do not exist in isolation [...] family capacity is strengthened when partnerships of mutual support and trust unite around shared goals'.

Relevant to accessible ECEC locations is the financial accessibility for families. The current study highlighted costs as a barrier to participation in ECEC (Hale et al., 2020; Leske et al., 2015; Skattebol et al., 2014), as well as a need for stable, long-term funding for ECEC centres (Hale et al., 2020; Leske et al., 2015; Munford et al., 2007; Skattebol et al., 2014). Skattebol et al. (2023, p. 1)



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note that 'families with young children who face economic and related adversities are the most likely group to miss out on the advantages of regular sustained participation in high quality early childhood education and care'. Secure, long-term funding for free or low-cost ECEC supports increased opportunities for long-term relationship-building, which increases social networks (Munford et al., 2007), with centres able to offer more responsive, flexible programs, which are vital, particularly for families experiencing economic adversity (Munford et al., 2007; Leske et al., 2015; Skattebol et al., 2014).

Accessible locations and costs for ECEC could have an intersectional impact in the case of Scotland, as the 2020-2023 national census identified that 43% of children in a minority ethnic household were in relative poverty and 38% were in absolute poverty – the highest proportions of children across all priority groups, including single-parent households and households with three or more children (Scottish Government, 2024a). An inclusive approach to care is particularly important as ECEC centres may be the first opportunity for immigrant, refugee, and asylum-seeking families to build a new community, a population which has increased in Scotland since 2015 (Scottish Government, 2023b). Bove and Sharmahd (2020, p. 7) argue that if systems fail to develop culturally sensitive services, 'too many children and their families will remain or become invisible in our societies, an extremely grave risk that we, as the early childhood community, cannot accept'.

Limitations and ethics

One limitation of this study is that six of the eight studies mentioned all or majority female participants. This is a major limitation to understanding family functioning and family wellbeing, as it skews data to a female perspective. A consideration for future research should be the inclusion of more male responses, as family wellbeing could look very different from a male perspective.

Another limitation is the lack of a definition of 'family' and whether families included in the research were nuclear, single-parent, or extended. This limitation may impact an understanding of family wellbeing with looked-after children through kinship, foster, or residential care. A consideration for future research is that it should include experiences from a variety of types of families.

There exists a limitation in this study of researcher bias through use of data that has already been interpreted. Given that the literature analysed in this study underwent its own data analysis by researchers before being included in my thematic analysis, it is unknown whether the same themes would have arisen had my analysis been conducted with the raw data. This limitation is inherent in literature reviewing but is an important consideration for the present research findings and study conclusions.



There are ethical considerations around the use of language, both as a limitation in seeking out relevant literature and in understanding of the literature. As one of the inclusion criteria was articles written in English, there is a limitation of excluding research in other languages that may have been relevant to include. Similarly, there is a limitation to analysing data which has been translated from the original language, such as in the article written by Purola & Kuusisto (2021), which was conducted in Finnish and translated to English.

Conclusion

The aim of this study was to explore ways of promoting family wellbeing in ECEC settings to inform the Scottish context. In the findings, themes of collaboration, program structure, and program environment emerged. Many families expressed a positive experience with ECEC that provided both formal and informal support. There emerged a need for integrated services that supported families outside of ECEC to improve their attendance and experiences within ECEC. It was found across all studies that family agency is built through collaborative relationships between parents and practitioners, parent participation in activities, and flexible, responsive ECEC programs. Free or low-cost ECEC programs need to be accessible for all families in the community to promote social capital, community resilience, and cultural inclusion.

To achieve improved family wellbeing as an outcome of the recent WFWF plan set out by the Scottish Government, adaptations of The Universal Health Visitor's Pathway (UHVP) could be made in ECEC settings. The integrated, whole-family approach of the UHVP has already been a success, and a similar approach in ECEC would support children and families further (Doi et al., 2022). Compared to the guaranteed 11 home visits through the UHVP, ECEC could provide similar holistic support every day for years in a central, community-based setting. More support could be dedicated to parental mental health, and practitioners could provide more intense support due to the smaller number of families in ECEC settings. This support could provide opportunities for more sustained relationships and social networks for parents. Scotland would benefit from this approach to ECEC, to improve family wellbeing and abide by its commitment to make Scotland 'the best place in the world to grow up' (Scottish Government, 2014a).

Recommendations for practice

From these findings, there are three key elements of ECEC that could promote family wellbeing in Scotland:

1. The integration of education, health, and social services to provide whole-family support beyond child care and education.



2. A pedagogical leadership structure between practitioners and parents which promotes family agency and collaborative, bi-directional relationships.
3. Accessible programs that are flexible and responsive to include all members of the community, supported by secure and long-term funding.

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About the author

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Original Research Article

Foster carers in Scotland's knowledge and awareness of speech, language, and communication needs

Grace Pellegrinelli & Ann Hodson

Abstract:

Up to 90% of children experiencing care have speech, language and communication Needs (SLCN) (Clegg et al., 2021). Despite this, there has been no research into foster carers in Scotland's knowledge and awareness of SLCN, their experience of supporting children with SLCN, or training they receive in this area. Thirty-nine foster carers in Scotland responded to an online questionnaire exploring their experiences.

Findings suggested that foster carers are experienced in caring for children with SLCN, with or without a neurodevelopmental condition, and can identify many communication difficulties. They are confident in using strategies to support SLCN. Very few participants had received training specifically for SLCN; those who had found it useful, and the majority of those who hadn't stated they would value training in SLCN. To uphold Article 12 (the right of a child to express their views and have these listened to and taken seriously in all matters affecting them) of the United Nations Convention on the Rights of the Child (1989), recently incorporated into domestic law in Scotland (2024), we recommend the development and delivery of a national SLCN training programme for foster carers, with speech and language therapists being best placed to enact this.



Introduction

Foster care in Scotland

In Scotland, local authorities hold primary responsibility for addressing the needs of children who have come to the attention of that authority for care or protection, as well as those in conflict with the law. The Children's Hearing System is tasked with ensuring that children's rights contained within the United Nations Convention on the Rights of the Child (UNCRC) (United Nations, 1989) are realised. This includes the right to regular review of the standard of care for children cared for away from home (Article 25), as well as the right to protection from violence, abuse and neglect (Article 19).

Scotland has recently further protected children's rights through formalisation of the UNCRC in domestic legislation. The UNCRC (Incorporation) (Scotland) Act 2024 deems that everyone up to the age of 18 is legally considered a child. Therefore, in this article, 'child' or 'children' means anyone up to the age of 18.

The Children's Hearings System works with a number of agencies to provide care and support, including social work, education services, the National Health Service (NHS), Police Scotland, and the Scottish Children's Reporter Administration. The focal point of decision-making is a children's hearing, which has the option of recommending the local authority takes legal responsibility for the wellbeing of that child. Foster care is commonly put in place when a child cannot stay in their own home or in kinship care. Foster care can be short-term, emergency care, interim care, longer-term care, or permanent care (Scottish Government, 2024a), and means the child lives with their foster family. Local authorities in Scotland are legally required to provide fostering and adoption services in their areas. There are 58 fostering services registered in Scotland, made up of 32 local authority services and 26 voluntary/not-for-profit services (Care Inspectorate, 2025). The latest available data shows that in 2023 there were 3918 children in foster care (32% of all children experiencing care), consistent with a downward trend over the last five years (Care Inspectorate, 2024; Scottish Government, 2024b).

Long-term outcomes of children experiencing care

Children experiencing care are at a significantly higher risk of poor long-term outcomes compared to those who have not experienced care (National Centre for Social Research, 2025). These figures are strikingly similar to the poor long-term outcomes of children who have speech, language and communication needs, which are well documented (Clegg et al., 2021, Dubois et al., 2020; Speech and Language UK, 2023). They include poorer mental health outcomes (Engler et al., 2022), poorer literacy levels (Clegg et al., 2021), lower levels of academic attainment (Scottish Government, 2024c), lower levels of employment



(Department of Education, 2024), and increased contact with the law (National Centre for Social Research, 2024) than the child population as a whole.

Speech, language and communication needs of children experiencing care

Speech, language and communication needs (SLCN) affect a person's ability to understand, listen to and communicate with others. Although SLCN commonly develop in childhood, they often persist into adulthood. Children with SLCN are likely to need support to develop the complex and numerous skills involved in communication.

Children with SLCN experiencing care can have difficulty understanding what is being said to or asked of them, as well as making themselves understood. Common difficulties include learning and using complex vocabulary, social communication skills, naming and managing emotions (including self-control), self-awareness, vocabulary, concepts related to time, working memory, and the ability to retain, process, recall and sequence information. Difficulties can present in one or all of these areas, occurring in isolation as a result of trauma or injury, or alongside neurodevelopmental conditions such as autism or developmental language disorder (RCSLT, n.d. -a). It is also important for us to remember that every child has unique strengths (Afasic, n.d.).

Speech, language and communication needs are often hidden. Older children in particular may have developed techniques to mask the communication difficulties they are experiencing (RCSLT, 2019). Some care experienced children communicate through behaviour that may result in contact with the law (RCSLT, n.d. -b). All children, with or without a diagnosis of SLCN, are likely to need support in understanding legal processes (Children and Young People's Centre for Justice, 2024), which has implications for upholding those rights embodied in the UNCRC (Incorporation) (Scotland) Act 2024.

The prevalence of SLCN in children and young adults who have experienced care ranges from 35% to 90% (Clegg et al., 2021; Krier et al., 2018). With estimates of around 10% of all children having SLCN (Norbury et al., 2016), it is clear there is a greatly inflated level of SLCN for those experiencing care. Identifying, assessing, and supporting SLCN falls within the professional remit of speech and language therapists (SLTs), but these figures suggest that it is almost certain every foster carer will care for at least one child who struggles with their communication.

In the only Scotland-specific study of SLCN in children experiencing care to date, McCool and Stevens (2011) investigated communication impairment in 30 children in residential care, using a carer-administered questionnaire (Children's Communication Checklist-2 [Bishop, 2003]). Impairment was indicated in 19 of the 30, with eight profiles suggestive of autism. In nine out of 10 available case



histories, no concerns had been raised regarding communication; in the one remaining case, no referral to SLT had been made, despite recorded concerns. The same checklist was used more recently by Maguire et al. (2021) in the UK, establishing that 68% of the children whose carers or social workers completed the survey had a level of difficulty consistent with developmental language disorder. A multi-agency service in Yorkshire, No Wrong Door, found that 58.4% of the children had SLCN, with the majority being previously unidentified (Department for Education, 2017). Clegg et al. (2021) directly assessed the language skills of 44 children and young adults (aged 16-24 years) leaving care in England and found that 90% had scores below average and 60% would meet the criteria for developmental language disorder (DLD). None had a diagnosis of DLD.

Similar findings have arisen internationally. In the US, Amster, Greis, and Silver (1997) found language delay in over 50% of more than 200 children under 31 months of age in foster care. Also in the US, Schneiderman et al. (2011) retrospectively accessed the medical records of 449 children receiving child welfare services; of those children living with a foster carer (n=261), 27% experienced a language delay. In Australia, a developmental screening for children aged between six months and five years living in out-of-home care (Nathanson & Tzioumi, 2007) found that 45% of children presented with speech delay, and 28% had abnormal hearing, which may go on to affect speech and language development (Nathanson & Tzioumi, 2007).

A further Australian study aimed to investigate the knowledge and experiences foster carers had of speech and language development. A written questionnaire was completed by 20 carers, 12 of whom took part in a follow-up interview. Foster carers were able to identify the speech and language skills that children needed to have before entering a school setting, such as understanding instructions and communicating with other children. Most were also able to identify if a child required intervention (Golding et al., 2011). Foster carers were also asked about seeking advice from other professionals, with 60% saying they would see a doctor if they were concerned, and over 50% stating that they would go to either private or government speech and language therapists for advice (Golding et al., 2011). Foster carers reported that training often did not target speech and language development, with 45% of respondents stating that they would like this type of training. Respondents felt ill-equipped to support speech and language development at home due to limited resources and knowledge, and felt they needed more training to help develop a child's speech and language (Golding et al., 2011).

Foster placements are more successful and stable when foster carers are trained to cope with the needs of the children in their care (Redding et al., 2000). Speech and language therapy services are an underdeveloped resource for children experiencing care (Clark & Fitzsimons, 2016). In Scotland, one way in



which this is being addressed is through the recent development of REACH in Perth and Kinross. REACH is a multi-disciplinary team which includes speech and language therapists and provides intensive support to families with multiple complex needs, where their child (aged 12-18 years) is likely to be cared for outside the family home.

We would argue that it is essential foster carers are equipped with knowledge of speech, language and communication needs in children. This is foundational in supporting them to identify any needs and to support the children they care for, including referral to speech and language therapy services when needed.

The first author was studying for her MSc in Speech and Language Therapy at Queen Margaret University, Edinburgh, and the second author is a Speech and Language Therapist and Senior Lecturer at Queen Margaret University, and the first author's supervisor. The authors were interested in exploring the experiences of foster carers in Scotland with respect to the speech, language and communication needs of the children in their care.

Specifically, the study's aims were

1. To explore foster carers in Scotland's knowledge and experience of speech, language and communication needs
2. To find out which strategies foster carers in Scotland have used to address speech, language and communication needs
3. To find out what foster carers in Scotland do to seek further support for children with speech, language and communication needs
4. To find out what training foster carers in Scotland have received in relation to speech, language and communication needs.

Specific questions within the questionnaire targeted the respondents' views in relation to these aims.

Methods

Ethical approval

Ethical approval was granted by the research ethics committee of the Division of Speech and Hearing Sciences, Queen Margaret University, Edinburgh.

To collaborate with the City of Edinburgh local authority, there was a requirement to complete a research access form. This was completed and approved.



Data collection and analysis

An online questionnaire was housed on JISC Online Surveys (version 2). There were 26 questions. Each of Scotland's 32 local authorities were contacted regarding the research project and sent a link to the questionnaire, which was then passed on to foster carers within that local authority. Several fostering charities within Scotland were also contacted with a link to the questionnaire. The link was further posted on social media platform X through an account affiliated with the Speech and Hearing Sciences Division, Queen Margaret University. The survey was open from December 2023 to February 2024.

Braun and Clarke's (2006) thematic analysis framework was used to analyse written responses.

Respondents

Inclusion criteria were the same as the criteria to become a foster carer, as laid out by the Scottish Government (2024d): being a full-time resident in the UK, being aged 18 or over, and having a spare bedroom, regardless of other factors, including having any protected characteristics. One additional criterion was to have fostered at least one child for at least six months. This was to help ensure foster carers would have had sufficient time with at least one child to become aware of any communication difficulties experienced. All respondents met these criteria.

Thirty-nine foster carers living in seven local authorities across Scotland responded (Table 1).

Local Authority	No of respondents	% of full sample
City of Edinburgh	21	53.8%
Dundee City	5	12.8%
Perth and Kinross	4	10.3%
West Dumbartonshire	4	10.3%
East Lothian	2	5.1%
Falkirk	2	5.1%
Fife	1	2.6%

Table 1: Number and percentages of respondents by local authority area

Slightly over half of the respondents were 56 years of age or older (n=20), 13 were aged between 46 and 55, and six were between the ages of 36 and 45. There were no responses from foster carers aged between 18 and 35.

Years of experience as a foster carer varied, with 12 having 16 years or more experience, eight having between 11 and 15 years, 11 between six and 10



years, seven between two and five years, and only one participant having between six months and a year of experience. Twenty-five respondents said that they exclusively worked as a foster carer, 12 said that they also had another profession, and two were retired.

Findings

Aim 1: To explore foster carers in Scotland's knowledge and experience of speech, language and communication needs

Respondents were asked 'what do you understand speech, language and communication needs to be?' Thirty-two provided written answers. The most common response was an explanation of speech, language and communication difficulties. Examples included:

'Not being able to make correct sounds.'

'Difficulties with fluency, forming sounds, formulating sentences, understanding what others say.'

'Difficulty processing verbal information, imprecise or limited vocabulary, unable to form some sounds.'

'Trouble with speaking or communicating with others, and with understanding.'

'Difficulties with expressing themselves.'

'Children with speech difficulties.'

'Difficulty in understanding by the child, difficulty in being understood. Mispronunciations, difficulty in listening and focus.'

Foster carers also referred to typical communication development, as shown here:

'Developing in line with age and stage.'

'Clear formation of words, understanding language.'

'Development of communication and speech.'

'Understanding of language and instructions.'

Several foster carers responded with what children use language for, focusing on communicating their needs, as the following examples show:

'Making yourself known and understood, communicating needs, likes and dislikes.'



'Communicating their feelings and thoughts effectively.'

'Communicating needs.'

'The ability to express your feelings and advocate for yourself.'

Overall, the quotes above suggest that the foster carers more often identified aspects of language production as opposed to language understanding. Lastly, a small number of foster carers reported on strategies they used to support children they cared for. For example,

'Communicating with face, hands, gestures, constantly repeating the same words, using toys and books.'

Children with a confirmed diagnosis of a neurodevelopmental condition

The foster carers were asked if they had ever fostered a child with a confirmed diagnosis of the most common neurodevelopmental conditions. Responses suggest fostering children with a diagnosis was common, with 24 respondents saying yes, 14 saying no, and one participant being unsure.



Participant	Autism	ADHD	ODD	DLD	LD	FASD	Other	Total
1							X	1
2	X	X			X			3
4	X	X	X	X	X	X		6
7		X	X		X			3
9				X			X	2
10		X			X	X		3
11	X	X				X		3
13	X				X	X		3
14	X			X	X		X	4
15		X						1
18				X				1
20	X				X			2
21	X				X		X	3
22		X			X	X		3
23							X	1
24	X	X		X	X	X	X	6
25		X						1
26	X			X				2
27	X				X			2
28	X	X		X	X	X		5
31					X	X		2
33		X			X	X		3
37	X	X		X	X	X		5
39	X	X			X	X		4
TOTAL	13	13	2	8	16	11	6	

Table 2: Diagnoses of children as reported by their foster carers (ADHD = attention deficit hyperactivity disorder, ODD = oppositional defiant disorder, DLD = developmental language disorder, LD = learning disability, FASD = fetal alcohol spectrum disorder)

The most common diagnosis reported was learning disability (16). Autism and attention deficit hyperactivity disorder were the second most common, with 13 reports each. Fetal alcohol spectrum disorder was reported by 11, and developmental language disorder by eight foster carers. Fourteen of the 24 who answered reported having experience with more than three diagnoses, with two saying five, and two mentioning six (see Table 2).

When asked to expand upon which other diagnoses their foster children had, six participants responded, reporting global developmental delay, cerebral palsy, hearing loss, bipolar disorder, and specific genetic chromosomal disorders.

Speech, language and communication needs of children with no confirmed diagnosis of a neurodevelopmental condition

Foster carers were also asked whether they had ever fostered a child who they thought or knew had SLCN with no confirmed diagnosis of a neurodevelopmental



condition. The majority (34) said yes, four said no, and one said they weren't sure. One respondent commented that:

I would say that all of the children we have fostered have had some level of language and communication needs.

Foster carers were provided with a list of 10 common speech, language and communication difficulties and asked to mark all those they had seen in a child. Responses were received from all 39.



Participant	Difficulty understanding words or sentences	Difficulty expressing themselves using words or sentences	Difficulty listening and/or paying attention	Difficulty understanding facial expressions and/or	Difficulty answering questions	Difficulty telling a coherent story	Difficulty with the clarity of their speech	Difficulty using words to describe emotions	Difficulty understanding non-literal language	Difficulty speaking fluently without pauses, repetitions or stuttering	Total out of 10
1		X	X				X		X	X	5
2	X	X	X	X	X	X		X	X	X	9
3	X	X	X	X	X	X	X	X			8
4	X	X	X	X	X	X		X	X	X	9
5	X	X	X	X	X	X	X	X	X	X	10
6	X			X			X	X			4
7	X		X	X		X	X	X	X	X	8
8	X	X	X		X	X	X	X	X	X	9
9	X				X		X		X		4
10	X	X	X		X	X	X	X	X		8
11		X	X	X	X		X		X		6
12				X	X				X		3
13	X	X	X	X	X	X	X	X	X	X	10
14	X	X	X	X	X	X	X	X	X	X	10
15			X						X	X	3
16		X			X	X	X				4
17	X	X	X	X	X	X	X	X	X	X	10
18	X	X	X	X	X	X	X	X	X	X	10
19	X	X	X	X		X		X	X		7
20	X	X	X	X	X	X	X	X	X	X	10
21		X					X		X		3
22		X	X		X			X	X	X	6
23	X	X	X		X	X	X	X		X	8
24	X	X	X	X	X	X	X	X	X	X	10
25	X	X	X	X	X	X		X		X	8
26	X	X	X	X	X	X	X	X	X		9
27		X	X	X	X	X	X	X	X	X	9
28	X	X	X	X	X	X	X	X	X	X	10
29			X							X	2
30		X	X	X	X		X				5
31	X	X	X		X	X	X		X		7
32		X	X			X		X	X		5
33	X	X	X	X	X	X	X	X	X		9
34	X	X	X						X	X	5
35		X	X				X		X		4
36	X	X	X	X	X	X		X	X	X	9
37	X	X	X	X	X	X	X	X	X	X	10
38	X	X	X	X		X	X	X	X	X	9
39	X	X	X	X	X	X	X	X	X	X	10
Total	27	33	34	25	28	27	28	27	32	24	

Table 3: Participant by participant responses to which speech, language and communication difficulties they have observed in their foster children



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No one responded with 'none of the above'. Thirty-five respondents had observed four or more difficulties, with just over a quarter (10) having observed all listed difficulties. The most common difficulty which was observed by nearly all (34) was listening and paying attention. Difficulties expressing themselves using words and sentences was the next most common (33), and difficulties with non-literal language the third most common (32). All of these were more commonly observed than difficulties understanding words or sentences (27). A further 13 respondents offered information about further difficulties observed, including undiagnosed hearing difficulties, SLCN associated with trauma, and attachment difficulties which manifested as 'nonsense chatter', lack of eye contact, and situational mutism.

Aim 2: To find out which strategies foster carers in Scotland have used to address speech, language and communication needs

The foster carers were asked 'Have you ever used any strategies to support a child in your care who may have speech, language and communication needs?' Six carers responded to this question simply by stating 'yes', without any further elaboration, and one answered that they have not used any support strategies. Thirty-two written responses were given.

Many named specific approaches they had used, such as signing, visual support, and repetition, as shown below:

'I learnt Makaton with one child.'

'Yes we use some signing.'

'Signalong.'

'Encourage them to use other methods of communication, visual.'

'Yes through pictures.'

'We use visual routines and timetables.'

'Picture exchange communication system.'

'Yes [...] repetitions. I constantly repeat what she says "correctly".'

'I subtly repeat the words she mispronounces.'

Foster carers also commented that they themselves had been given professional advice:

'Yes – but normally following an assessment and advice from an appropriate professional.'



'Yes. Using guidance from NHS Tayside worker.'

'Yes as advised by paediatrician.'

Encouragingly, the foster carers also reported taking a positive attitude towards the child's communication:

'Yes, lots of patience and understanding! Giving breathing space.'

'Just listen and be understanding.'

'We never criticised his speech and gave him time to communicate in his way.'

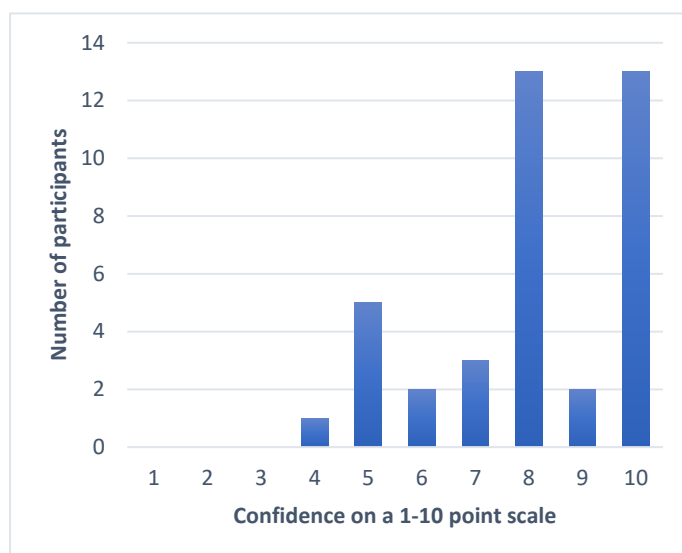
'Tried to make it fun so as not to impact his self-esteem.'

'A lot of care management, patience and nurture.'

'Sitting patiently with them reading, writing.'

Foster carers were asked to rate their confidence in supporting a child with SLCN, with one being not at all confident and 10 being extremely confident. All participants rated their confidence as four or above, with the majority (28) rating themselves as eight and above (Figure 1).

Figure 1: Foster carers' self-rating of their confidence in supporting and recognising a child who might have SLCN



Aim 3: To find out what foster carers in Scotland do to seek further support for children with speech, language and communication needs

Accessing professional support

When asked how they would access support if they were concerned about the SLCN of a child, foster carers commonly said they would seek advice from a professional.

Contacting the education profession was the most common way foster carers accessed support:

'Speak to school first.'

'Look for professional help as recommended by the school.'

'Assistance from special needs school staff.'

'Speak to school/nursery re concerns.'

'Discuss with school to find out how child presents there.'

'Approaching social services was the second most common avenue:

'Report to social worker.'

'For children over 5 via social worker.'

'Telling social worker and asking them to refer.'

Contacting medical professions was identified as a third way to access services:

'Report to their paediatrician.'

'Contacting health visitor or school nurse.'

'Through the GP.'

'Contacting health visitor/doctor for referral to speech therapy.'

Referral to speech and language therapy services

Foster carers were asked whether they had ever referred a child in their care to NHS speech and language therapy services. Responses were split evenly, with 20 respondents saying 'yes' and 19 'no'.

Furthermore, 21 foster carers did not know about the open referral process for NHS speech and language therapy in Scotland, that is, anyone can refer directly



to NHS speech and language therapy services (with the permission of their carer). Eighteen respondents reported that they knew about this.

Aim 4: What training have foster carers in Scotland received in relation to speech, language and communication needs?

Five respondents said they had received SLCN training as part of becoming a foster carer. All five, who came from three different local authorities, said the training was 'useful'. These same local authorities were also represented by people who had not received training.

Of the 34 participants who did not receive training, 23 stated they would have liked to receive this as part of the process to become a foster carer, three said they would not have, and the remainder stated they were unsure if they would have wanted to or not. The most common theme was suggestions as to what it would be helpful for the training to contain:

'We should be sent on training for signalong.'

'Useful to have an understanding of how such issues can be manifested.'

'Having and understanding of "tell-tale" indicators.'

'Recognising the difference between normal or slightly delayed development, to more complex delays.'

A second theme was timing of training, with not all respondents agreeing with the timing of training being at the start of the process of becoming a foster carer:

'We received training once we were already a foster carer.'

'We receive ongoing support meetings on subjects in general.'

'Training would be most useful at the time you have a child requiring support.'

'If you have too much training then you can perceive that each child has a problem [...] unless of course there is prior knowledge of difficulties.'

Discussion

Foster carers in Scotland are an invaluable part of the 'team around the child', having a much needed and highly valued place in supporting our most vulnerable children and their families. Most of those who took part in our study had six or more years of experience of being a foster care (31/39, 79%).

Encouragingly, many recognised several of the communication challenges experienced by children with SLCN, and that children used communication to express their needs. They more often identified difficulties with listening and



using language, rather than understanding language. This is similar to findings in a previous paper co-authored by the second author, where police officers working with children in contact with the law were asked a similar question (MacRae & Clark, 2021). Others described SLCN in terms of how communication develops, rather than the difficulties faced. Knowledge of typical communication development is reassuring. However, it also suggests there may be room to provide foster carers with a stronger foundational training on speech, language and communication needs.

Twenty-four (62%) foster carers said they had fostered a child with a confirmed diagnosis of a neurodevelopmental condition, the most common being learning disability, autism, ADHD, and fetal alcohol spectrum disorder. Each of these conditions, as well as requiring support for the underlying condition, is known to have co-occurring speech, language and communication needs (Erickson & Geist, 2016; Hendricks et al., 2021; Naigles & Chin, 2015; Westby & Watson, 2021), underlining the need for foster carers to have SLCN specific training. In the future, it might also be helpful to ask whether foster carers are concerned about a suspected neurodevelopmental condition, or whether the child is waiting for a formal diagnosis.

Thirty-four (87%) foster carers said they had fostered a child who they thought, or knew, had SLCN, similar to the prevalence figure of 90% reported by Clegg et al. (2021). It is unknown whether the children cared for in the current study were known to SLT services. The difference in percentages between children with a confirmed diagnosis (62%) and those thought to have SLCN (87%) suggests that children may have had undiagnosed SLCN, such that their needs remained unmet.

Confidence in addressing SLCN was also explored, with 28 foster carers rating themselves as an eight or above out of 10. This was reflected in the 32 (82%) who reported using strategies to address a child's SLCN, but perhaps also reflects confidence in identifying aspects of language production and use rather than language understanding. It would be interesting to explore further which areas foster carers felt most confident in, as identifying difficulties in how children produce and use language can be more straightforward, as these are often more observable than difficulties in understanding. Strategies used included specific approaches such as Makaton, Signalong, and the Picture Exchange Communication System. A recent review looking into the effectiveness of Makaton found using signs can increase basic communication and help to initiate spoken language (Larkin, 2021). Some foster carers commented they had also received professional advice and that taking a positive attitude to communication was helpful, using 'lots of patience and understanding'. Giving a child time to express themselves is a commonly implemented strategy in targeted language development interventions across different environments (Akamoglu & Meadan, 2018; Haring Biel et al., 2020; Leung et al., 2020) and is



good practice, as children experiencing care have reported they feel they are not listened to (Winter, 2010).

If foster carers have been concerned about the speech and language of a child in their care, they have sought advice from medical professionals, education staff, or social workers. This aligns in part with the findings of Golding et al. (2011), who reported that Australian foster carers would contact a doctor or teacher in these circumstances. When asked whether they had ever referred a child to NHS SLT services, there was an even split, with 20 respondents saying yes and 19 saying no. Twenty-one respondents did not know that in Scotland there is an open referral system for NHS SLT services (RCSLT, 2024). This may suggest that, in half of cases, following concerns raised by foster carers, medical professionals, teacher, or social workers make referrals to NHS SLT services. The Royal College of Speech and Language Therapists has a professional duty to raise awareness of the open referral system operated by NHS SLT services (Clark & Fitzsimons, 2018).

Only five of 39 respondents said they had received training specifically on speech, language and communication needs. The five respondents who had received training came from three different local authorities, with these same local authorities also being represented by foster carers who had not received training. It is not possible to comment on whether these respondents provided local authority care or independent foster care. This highlights potential disparities in training opportunities within the local authorities and across Scotland as a whole. Everyone who received training responded that they found it useful. In their scoping review, Lorio et al. (2023) found that none of the papers they reviewed reported specifically on training targeting speech and language development. This current study provides some evidence of SLCN training being provided; however, more detailed investigations are required to fully comprehend the scope of this training. It would be beneficial to ask about how the foster carers are supported to apply the training they receive, as training should include coaching and support to ensure opportunities for applied learning (Ebbels et al., 2019).

Of the 34 respondents who had not received SLCN training, 23 said they would have liked training, although there was uncertainty about when training would be most helpful. Given the high percentage of children experiencing care who struggle with their communication (Clegg et al., 2021; McCool & Stevens, 2011) and reported this to our study, foster carers will almost certainly care for a child with SLCN. The recent incorporation of the UNCRC into domestic law means it is a legal requirement that all duty bearers actively seek the views of the child in all matters which relate to them. Recognising, listening, and responding to the voice of the child is considered fundamental by the Independent Care Review (2020), and is a key aspect of the vision of The Promise. Therefore, children who are in foster care will be highly likely to need a specialist level of communication



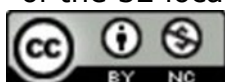
support to be able to meaningfully share their views, and for their views be given due weight (Article 12, UNCRC). Last year, the Scottish Government stated 'we need enough foster carers, with the right skills and the right support, to care for the children and young people they are looking after' (Scottish Government, 2024e, p. 3). Foster carers should, therefore, be offered outcome measured training and coaching to strengthen their identification of and support for children with SLCN, and also to support their confidence in referring a child to speech and language therapy services when needed. This would allow referrals to SLT services to be made more efficiently, with support being put in place where needed, for as long as it is needed, in line with Getting it Right for Every Child (GIRFEC) (Scottish Government, n.d.). Speech and language therapists are uniquely placed to provide such training.

Recommendations to the Scottish Government have recently been made to recognise communication as a fundamental children's right and to include the SLT workforce in realising these rights (MacRae, 2025). The Scottish Government's Ready to Act policy (Scottish Government, 2016), underpinned by the principles of the UNCRC and GIRFEC, details that speech and language therapy services should adopt a tiered model of service, meaning there should be targeted support available to children at risk of having SLCN, and stipulates that their role includes training professionals and caregivers. This paper has specifically looked at the experiences of foster carers, but our findings and recommendations are relevant to those who support children in other care settings, such as residential care.

Partnership working between the Scottish Government, the Association for Fostering, Kinship and Adoption Scotland, Children's Hearings Scotland, the Scottish Children's Reporter Administration, and the Royal College of Speech and Language Therapists to develop such training, which speech and language therapists are best placed to deliver, is strongly recommended, leading to the delivery of a national training programme as a gold standard.

It is important to bear in mind that there is a high likelihood that parents and siblings of children experiencing care may have SLCN of their own, which may be unidentified and therefore unmet, as part of an intergenerational cycle of need (RCSLT, 2016). They are likely to require support themselves, both in their daily lives and in specific situations, for example, when a parent attends a hearing (Clark & Fitzsimons, 2018). It is essential that parents and/or siblings of a child experiencing care are referred for assessment and support by a speech and language therapist if there are any concerns around their communication.

The study has several limitations. Latest data shows there were 2998 foster care households in 2023 (Care Inspectorate, 2024). This means the number of respondents represents only a small percentage of foster carers across Scotland. Furthermore, responses were only received from foster carers living in seven out of the 32 local authorities in Scotland. Therefore, this study is not necessarily



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representative of the Scottish foster care system as a whole. Future research should aim to cover a greater geographical area. It would be valuable to find out whether the foster carers were linked to a local authority provision or a voluntary/not-for-profit provision, to explore any differences therein in knowledge and awareness of SLCN and training experience. The paper presents the views of long-term foster carers, excepting one, and sought the views of those who have experience of caring for children with SLCN, so this may have skewed the findings. Future research should seek the views of foster carers offering short-term, emergency, or respite care, and those with less direct experience of SLCN. Further, it would be useful to explore the ages of the children cared for in future research.

Conclusion

Foster carers have a good knowledge of what speech, language and communication needs are, and, encouragingly, are effectively able to identify professional support structures for advice and guidance. Half of the foster carers had referred a child to speech and language therapy services. They also report using strategies to support speech and language needs. Foster carers' experiences support evidence that there is a high prevalence of speech, language and communication needs amongst children who are experiencing care, with or without a neurodevelopmental diagnosis. If these needs remain unidentified, and therefore unmet, this stands in conflict with children's right to express their views and have these listened to and taken seriously in all matters affecting them (Article 12 of the UNCRC [1989]).

Only a small percentage of foster carers had receiving specific training with respect to speech, language and communication, and there was a strong desire for such training to take place. With the recent adoption of the UNCRC (Incorporation) (Scotland) Act (2024), and in line with The Promise (Independent Care Review, 2020), it is timely to suggest that this desire for training be valued and explored further at a national level to allow foster carers to be confident in supporting children in their care. Speech and language therapists are best placed to provide this training. This would empower Scotland's foster carers by providing essential information on supporting children with speech, language and communication needs, and also on why, when and how to refer children in their care to speech and language therapy services, providing the right support at the right time, for as long as is needed, for our vulnerable children experiencing care.

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Original Research Article

Understanding the impact of regulatory reforms in children's residential care: Findings from an evidence review

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Abstract:

Children's residential care in the United Kingdom is regulated by separate agencies in the four home nations to which responsibility for this area of public policy is devolved. The development of these regulatory systems has followed a long sequence of inquiries and scandals that have exposed serious failings in the provision of care to some children and young people. This article reports the findings of an evidence review considering the impact of regulatory reforms as part of a wider research project comparing the development of different systems of regulation across England and Wales. We identify four key themes from this review that should be addressed in the design of regulatory systems and explored through further research. These include: (1) balancing the enforcement of minimum standards against support for service improvement; (2) improving worker autonomy and relationship building with children and young people; (3) addressing unresolved debates regarding minimum qualification and ongoing training requirements; and (4) a stronger focus on organisational cultures and leadership within children's residential homes and care home groups.



Introduction

The regulation of children's residential care across the UK has been shaped by several decades of inquiries and scandals that have exposed serious failings in the provision of care to some children and young people. These include inquiries that have investigated the abuse and neglect of children and young people by residential childcare staff (Corby et al, 2001; Sen et al, 2008). But more recent inquiries have also served to highlight the dangers faced in the wider community and repeated missed opportunities to protect children and young people from criminal and sexual abuse (Berlelowitz, 2013; Casey, 2015; Jay, 2022). Regulatory reforms have aimed to improve the safety and well-being of children and young people in care through the development of minimum performance standards for children's homes, qualification and training requirements for workers, and processes to 'weed out' adults judged to be unsuitable to work in the sector.

However, children's residential care remains in a perilous state and concerns about care quality are arguably more pronounced than ever. The association of children's residential care with scandal has contributed to difficulties in the recruitment and retention of suitably qualified and committed staff (Colton & Roberts, 2007) and the use of children's homes by local authorities as a 'last resort' (Hart et al, 2015). The challenge of improving care quality has also become increasingly complex following the fragmentation of the children's residential care sector involving a remarkable increase in the proportion of private sector run homes. The pursuit of profit by some providers has been highlighted as a factor driving up placement costs and the financial burden faced by LAs without improvements in care quality (Competition and Markets Authority, 2022; Sen et al, 2024). Moreover, notwithstanding the reputation of children's homes as a last resort, demand for places has increased over recent years as the complexity of care needs and the size of local authority care populations have increased (Samuel, 2023). A lack of capacity in the sector has even resulted in some young people being placed in unregistered homes where care quality is not overseen by regulatory agencies (Care Inspectorate Wales, 2019; Ofsted 2024a). In this perilous context, this article considers the impact of recent waves of regulatory reform on children's residential care, identifying key areas where regulatory systems may need to be reviewed and where further research may be needed.

Background

Children's residential care in the United Kingdom (UK) is regulated by separate agencies mandated by national governments in the four nations of England, Scotland, Wales, and Northern Ireland. Each country has an agency responsible for the inspection of children's homes. In England, children's home managers must be approved and registered with the same inspectorate. However, in



Wales, Scotland and Northern Ireland all children’s residential care workers, not just managers, must register with a separate workforce regulator (Table 1). These regulators set and enforce professional standards for practice and conduct. The purpose of this is to protect the public and to ensure that only individuals who are competent and qualified can work in children’s residential care, and other social care roles where registration is required. These workforce regulators also oversee ‘fitness to practise’ procedures under which individuals judged unsuitable to work in the sector can be removed from the register.

Country	Inspectorate	Workforce regulator
England	Office for Standards in Education and Children’s Services (Ofsted)	Ofsted – home managers only
Wales	Care Inspectorate Wales	Social Care Wales
Scotland	The Care Inspectorate	Scottish Social Services Council
Northern Ireland	Regulation and Quality Improvement Authority	Northern Ireland Social Care Council

Table 1: Inspectorate and Workforce regulators

The suitability of current regulatory arrangements in England has become the subject of debate over recent years. Both the recent *Independent Review of Children’s Social Care* (MacAlister, 2022) and the final report of Professor Jay’s (2022) *Independent Inquiry into Child Sexual Abuse* recommended the introduction of a compulsory system of registration for children’s residential care workers, as in place elsewhere in the UK, in response to failings they uncovered. Responding to this debate, this evidence review contributes to a wider research project comparing the development of the separate regulatory systems across the England and Wales and their application to the children’s residential care workforce. As a first stage in this research project, the aim of this review was to identify key themes from previous research on the impact of regulatory reforms in children’s residential care, including on the workforce, to inform key research questions.

Children’s residential care in England

- At the end of March 2023 in England 83,830 children were looked after (a rate of 71 per 10,000 aged 0-17yrs) and 17% were living in children’s homes, secure units or semi-independent placements (DfE, 2023).
- There were 3,119 registered children’s homes (including secure homes, residential special schools, and short-breaks homes) at the end of March 2023 (Ofsted 2023).
- A recent estimate suggests that the workforce in England comprised approximately 39,300 residential care workers (Kantar Public, 2024).



Under existing arrangements in England, children's homes must be registered with Ofsted. Ofsted monitors compliance with the Children's Homes (England) Regulations 2015 and as part of this process Ofsted inspects all homes usually at least once a year (Ofsted, 2024b). All homes in England must also have a registered manager approved by Ofsted. Managers must hold or be working towards a Level 5 National Vocational Qualification (NVQ) or equivalent. All other workers are required to hold or be working towards a Level 3 NVQ. Ofsted inspectors investigate the recruitment and vetting of staff in English homes, as well as any induction and training they receive. However, staff are not required to be registered in the same way as managers.

Children's residential care in Wales

- At the end of March 2023, in Wales 7,210 children were looked after (a rate of 116 per 10,000 aged 0-17yrs) and 10% were living in children's homes, secure units or hostels (Coram BAAF, 2023).
- There were 277 registered children's homes in Wales at the end of March 2023 (Care Inspectorate Wales, 2023).
- In September 2023 there were 2,879 registered children's residential care workers in Wales (Social Care Wales, 2023).

All children's homes must be registered with, and are inspected by, the Care Inspectorate Wales to ensure compliance with the Children's Homes (Wales) Regulations 2002. Qualification requirements for managers and other staff match those in England. However, all children's residential care workers in Wales, not just managers, must register with Social Care Wales. Completion of the All Wales Induction Framework (AWIF) is a mandatory part of the initial registration process which must be completed within six months of starting work. Workers are required to commit to continuous professional development and must re-register every three years.

Methods

The research team and advisory group comprised of experienced researchers in children's social care agreed that a non-systematic evidence review, incorporating peer-reviewed and 'grey' (non-peer-reviewed) literature, would be appropriate given the narrow focus of this research project. Moreover, an earlier rapid evidence review that pursued a much broader set of questions relating to the regulation of the children's residential care workforce (Munton et al, 2021) identified several grey studies of potential relevance to our research. However, the Munton et al review only considered studies published since 2013 and was unable to follow up an initial database search for peer-reviewed studies through 'reference chaining' because of time constraints.



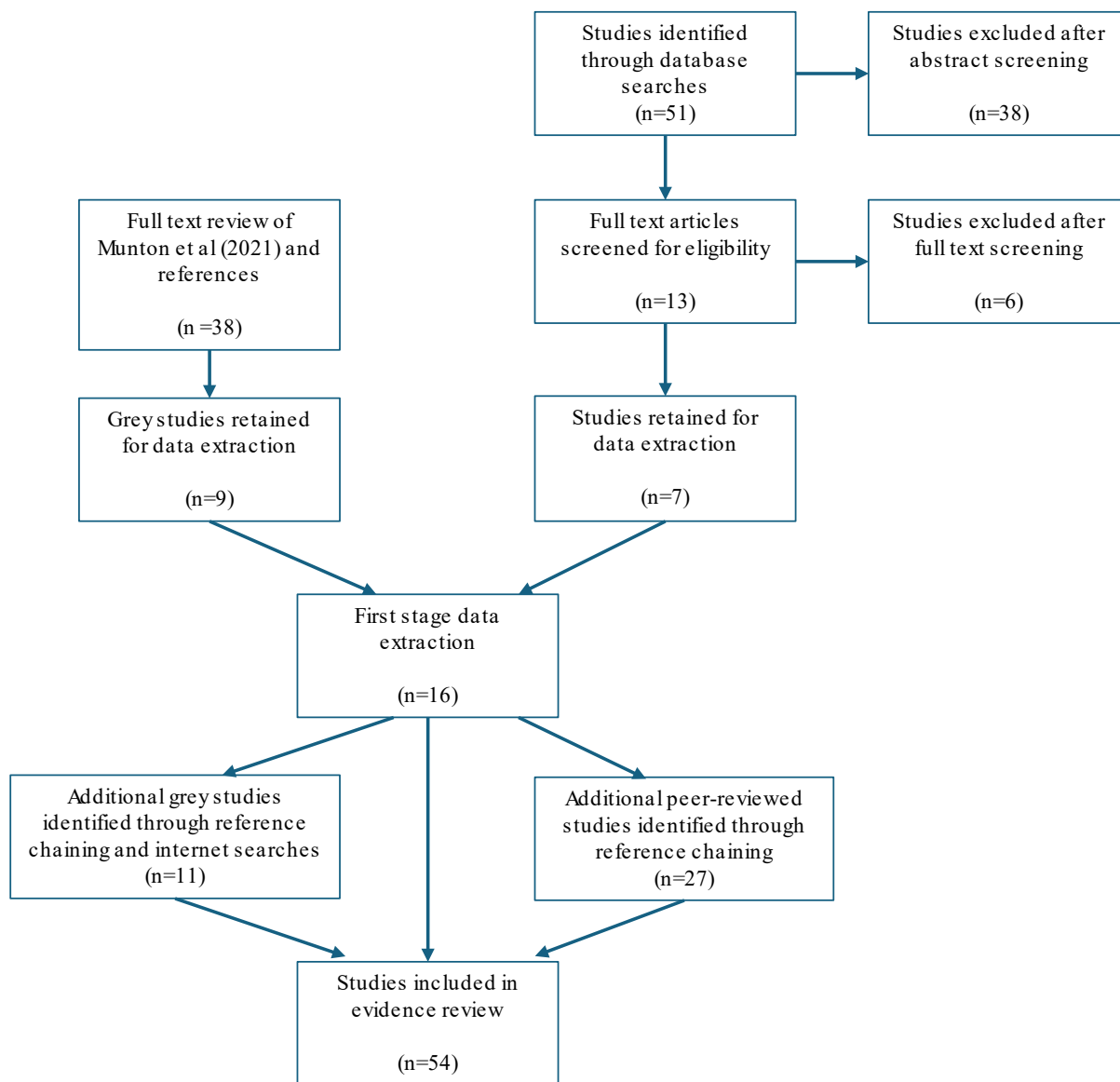
We began our literature research by asking the Clinical Support Librarian at King's College London to carry out a database search in September 2022 applying the terms 'child(ren's) residential home', 'child(ren's) residential unit', 'children's home', and 'staff registration', 'staff regulation' and 'residential social worker'. Databases searched included Ovid MEDLINE, Embase, APA PsycInfo, Scopus, CINAHL and Web of Science. The inclusion criteria for the review incorporated international academic research published in English in peer reviewed journals. We searched further back than the Munton et al review (2021) to consider articles published since 2000 as this marked the introduction of the Care Standards Act 2000 (then covering England and Wales) and the publication of the landmark Waterhouse Report (DoH, 2000) on the findings of an inquiry into the widespread sexual abuse of children in care in the Welsh counties of Gwynedd and Clwyd.

The database search returned 51 separate articles and the titles and abstracts of each were reviewed separately by two members of the research team to assess their relevance. Thirteen of these studies were retained for full text screening after which seven were retained for data extraction. A further nine grey studies were identified for data extraction after reviewing Munton et al's (2021) rapid review. Grey studies included a mixture of non-peer reviewed research, inquiries and evidence reviews. Studies were retained if they reported evidence relating to the impact of regulatory activities. Data were extracted using an Excel template capturing the country (or countries) where the research was carried out, the research questions, research methods, and key findings.

Beginning with these 16 studies a process of 'reference chaining' and internet searches for recently published grey reports helped us to identify a further 27 peer-reviewed and 11 grey studies. In total, data were extracted from 54 studies (34 peer-reviewed and 20 grey) by Carl Purcell. Although the 54 studies were all published since 2000 the findings of a series of studies commissioned by England's Department of Health (DoH, 1998) in the 1990s are incorporated as they are considered in several literature reviews published since 2000. The key findings data extracted were analysed following a thematic approach (Braun & Clarke, 2019). This began with an initial coding of the data by Carl Purcell which was then reviewed by two members of the research team to group codes under key themes. The subheadings reported in the findings section of this article follow the four key themes we identified.



Figure 1: Study selection flow chart



Overview of the evidential material

The list of studies identified and which we draw upon in this evidence review are listed in the appendix to this article. These include 20 'grey' studies carried-out in the UK – including research and inquiry reports published by or on behalf of central government, the Local Government Association (LGA), large children's charities, and the Independent Children's Homes Association (ICHA). A further 15 peer-reviewed UK studies, and 19 international studies were also used – these include journal articles and academic books, or book chapters. The main sources of evidence presented in these studies are summarised in the table 2.

Main evidence sources	Count
Evidence review	15
Staff surveys	11
Small scale qualitative/ mixed methods (<50 interview participants)	18
Large scale qualitative/ mixed methods (>50 interview participants)	4
Census/ large survey of providers	1
Expert panel, inquiry or independent review	5
Total	54

Table 2: Main evidence sources

We present the key findings from our data extraction under four key areas that we identified through our thematic analysis. We take care in separating the findings from non-UK studies because of variations in national (or regional) policies, workforce requirements and professional practices relating to the use of children's residential care (Berridge et al, 2011; Clough et al, 2006).

Findings

Balancing enforcement and support for improvement

The need to balance regulatory activities to ensure compliance with regulations against those that could support the development of children's residential care was a key theme to emerge from our analysis of several grey studies from the UK. Following the enactment of the Children's Homes Regulations (England) 2015, the DfE commissioned a small-scale study by Gibb et al (2016) involving interviews with 21 home managers and 'other stakeholders' to explore experiences of implementing the new regulations. Whilst acknowledging that it was too early to assess the impact of these regulations, Gibb et al (2016) reported generally positive reactions to them. Another small study commissioned by the DfE on the training needs of the children's residential care workforce involving interviews with 20 stakeholders (representing a mix of local authority commissioning managers, commercial and local authority providers, umbrella organisations and training providers), also carried out just after the introduction of the new regulations, reported similarly positive acceptance (Kantar Public, 2018).



However, the way in which the implementation of standards is monitored and enforced is a subject for greater debate. The DfE commissioned studies (Gibb et al, 2016; Kantar Public, 2018) highlighted concerns about the workload implications of having to provide evidence showing how standards are being met. Martin Narey's (2016) review of residential care in England for the DfE also stressed that the risk of receiving a poor Ofsted inspection judgement meant that children's homes allocated significant resources to compliance activities. But more fundamental concerns were expressed by stakeholders in the Gibb et al (2016) and Kantar Public (2018) studies regarding the ability of Ofsted inspectors to effectively measure the quality of practice in children's homes rather than just compliance with mandated standards and bureaucratic procedures. Similar concerns regarding the implementation of regulations were expressed by sector experts giving testimony to an earlier House of Commons Education Committee (2014) inquiry and in research reports on children's residential care published by the National Society for the Prevention of Cruelty to Children (NSPCC) (Biehal et al, 2014; Brodie, 2014).

Narey (2016) called for more dialogue between inspectors and homes in England to balance enforcement and support. Research commissioned by the Local Government Association (LGA) to explore the barriers and facilitators to local authorities' developing in-house children's home provision called for Ofsted to engage constructively with potential providers as part of the setting-up process and before significant investment in properties and staff are made (Newgate Research, 2021). Another area which may need to be considered by regulatory agencies is the relationship between local authorities and private providers. In a survey carried out on behalf of the Independent Children's Home Association, completed by 119 members (mostly small private sector providers in England), respondents called for closer collaboration to improve referral streams and the matching of children and young people to appropriate placements (Revolution Consulting, 2023).

The challenge of balancing enforcement and support within regulatory systems is also a theme within a small number of the international peer-reviewed studies we considered. Gharabaghi (2009) reported frustration amongst public and private sector children's home providers (n = 20) regarding regulators' focus on compliance rather than care quality in Ontario, Canada. The difficulties of developing performance standards from regulation and in measuring the quality of care is also surfaced in Pålsson's (2018) study of the licensing process of children's residential care in Sweden. He analysed 132 applications for licenses to operate children's residential homes and interviewed eight inspectors working for the Inspectorate of Social Care and Health responsible for reviewing applications. The conclusion reached was that the licensing process served as a rather crude mechanism only suited to weeding out manifestly unsuitable applicants. Similarly, Boel-Studt & Tobia (2016) conclude their evidence review by recommending that states in the USA should move beyond Residential Group



Care (RGC) licensing requirements and consider the development of core practice standards.

Worker autonomy

The peer-reviewed academic research in the UK offers a more critical perspective on regulatory reforms based on the argument that care is 'messy and ambiguous' and that bureaucratic restrictions stifle professional autonomy and workers' urge to care (Smith, 2009). Horwath (2000) described 'childcare with gloves on' after interviewing 45 workers at three children's homes in England. The phrase captures how staff exercised caution and strict adherence to the rules because they were fearful of allegations being made against them. Cameron et al (2011) carried out an evaluation of a pilot programme under which 48 workers from outside of the UK (mostly from Germany) trained as 'social pedagogues' came to work in 18 English children's homes. Social pedagogy is a broader form of training, typically at degree level, more common in continental Europe that incorporates an emphasis on the physical and emotional development of children and young people and their engagement in wider society. They reported that these social pedagogues identified hierarchical and bureaucratic obstacles to the more reflective form of practice found in their home countries.

Research carried out in Scotland also highlights the negative impacts of limits to worker autonomy. Heron & Chakrabarti (2002) report the findings of a series of interviews with 30 workers in 7 children's homes in Scotland (109 interviews were carried-out over a 9-month period). Staff reported wanting greater freedom to pursue meaningful goals for children and young people rather than completing administrative tasks. Staff from five local authorities interviewed for Milligan & Stevens (2006) study on the impact of health and safety regulations complained that they could not be spontaneous and take children out for a walk or a swim without filling in paperwork. Similarly, young people (n=27) who participated in Moore et al's (2018) Australian study perceived workers' administrative responsibilities as an obstacle to relationship building, but valued staff who found time to 'hang out' with them.

Findings from Steckley's (2011) study involving interviews with 37 young people and 41 workers in Scotland echo Horwath's (2000), highlighting a reluctance amongst staff to show affection towards young people through touch in case this led to accusations of inappropriate behaviour. Reviewing the findings of the *Kerelaw Inquiry* into abuse at a residential school and secure unit in Scotland, Davidson (2010: 406) states that 'a controlling and silencing culture of Kerelaw was found to be a fundamental cause underlying a complexity of factors'. Whilst recognising the impact of specific organisational cultures, Davidson (2010) argues that the professional autonomy of workers across the sector in Scotland is an essential area for improvement. Finally, drawing on survey responses from 61 Scottish workers McPheat and Butler (2014: 248) also discuss restrictions to



worker autonomy in the context of a 'culture of blame' and advocate for a shift towards a 'learning system' that promotes the exercise of professional judgment.

Qualifications and training

Recent reports in England commissioned by the DfE (Kantar Public, 2024) and published by the Welsh regulator (Social Care Wales, 2024) suggest that concerns about the recruitment, retention and training of children's residential care workers remain paramount. However, minimum qualification and training requirements for workers continue to be debated. Currently, in England new workers must hold or commit to work towards a Level 3 National Vocational Qualification (NVQ) in Residential Childcare (or equivalent) within two years of joining the work force. Workers in Wales must meet the same requirement but within three years. However, a census carried out between March and May 2023 involving 837 homes in England showed that 13 per cent of staff were not at least working towards the required level 3 qualification (Kantar Public 2024). The registered managers of children's homes in England and Wales are required to hold or work towards achieving a level 5 qualification in Leadership (or equivalent) within 3 years of taking up their position. The same census found that only 2 per cent of managers in England did not meet this requirement (Kantar Public, 2024). However, the MacAlister (2022) inquiry reported that 10 per cent of homes in England did not have a registered manager and recommended that another 700 managers be trained over a five-year period.

Notwithstanding difficulties in meeting the minimum qualification requirement, some studies suggest this may be too low. A report by Ofsted (2011) based on surveys completed by staff working in 12 'outstanding' children's homes highlighted commitments made to the CPD of workers beyond the Level 3 minimum. An expert panel reporting to the DfE (2012) over the following year also recommended the consideration of a higher-level minimum requirement for workers in England. The Care Inquiry (2013) commissioned by eight of the major children's charities the following year reached the same conclusion. Earlier research by Petrie et al (2006) involving 25 homes in England found that only 10 per cent of workers held a higher education qualification. This compared to 51 per cent in 19 German homes and 91 per cent in 12 Danish homes involved in study. Moreover, whilst Narey (2016) disagreed with the DfE (2012) panel's recommendation regarding the minimum qualification requirement for workers, he did conclude that a Level 5 qualification for managers was insufficient and that a social work degree should be required. On the other hand, reviews by Bullock and Sherry (2009) and Hart et al (2015) also highlight concerns regarding the suitability of a social work degree and the potential benefits of a broader degree programme as preparation for residential care work, as is common in many European countries.

On the other hand, after interviewing 21 home managers and other stakeholders for their small DfE commissioned study, Gibb et al (2016) warn that the



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introduction of higher mandatory qualification requirements for workers, including managers, could deter talented but less academic staff from joining or staying in the sector. Furthermore, Ofsted (2011) pointed out that managers leading 'outstanding' children's homes looked beyond formal qualifications aiming to recruit staff who were the 'right fit' for the ethos of the home and best suited to meeting the needs of the children and young people living there. Research by White et al (2015) for the DfE in England, involving interviews with 88 staff in 20 'good' or 'outstanding homes', reported divided views on the value of the Level 3 NVQ and highlighted the importance of more practical localised training to suit different learning styles and connected to the work of individual homes. The latter point is reiterated by Munton et al (2021) in their literature review for the DfE considering existing qualification and training requirements in England. In research reports published by the UK's NSPCC the need for specialised training to deal with behaviour and aggression (Barter, 2014; Biehal et al, 2014) and identifying and responding to risks of criminal and sexual exploitation (CSE) (Brodie, 2014) are highlighted. Winstanley and Hales (2008) also highlight concerns amongst English residential care workers they surveyed (n = 87) about dealing with aggression and threatening behaviour.

Courtney's (2009) review of the international evidence and Boel-Studt and Tobia's (2016) review of research in the USA suggest that concerns about the recruitment, retention and training of children's residential care workers extend well beyond the UK. A more recent small survey of workers in Jordan (Bani Ismail et al, 2018: n = 30) and an interview-based study in Norway (Steinkopf, 2021: n = 15) also discuss the need for ongoing training and support for staff. In the USA Smith (2017) carried out a 13-month ethnographic study engaging with 78 workers, mostly educated at degree level, at a large residential treatment centre. She describes the importance of 'informal apprenticeships' pointing out that most workers did not feel adequately prepared by initial professional training. International studies also report concerns relating to the professional status of residential childcare work. Workers (n = 43) who participated in Garcia Quiroga and Hamilton-Giachristis' (2017) study in Chile felt that they did not feel valued by other welfare professionals because of their limited training. Similarly, Heron and Chakrabarti's (2002) study involving residential care workers in Scotland (n = 30) highlighted feelings of low status compared to social workers. Forkby and Hojer's (2011) Swedish study suggested that social workers in this country did indeed hold negative views about children's residential care work. Social workers participating in focus groups (n = 29) talked about 'the difficulty of knowing what you'll get' when considering placing children and young people in residential care.

Organisational culture and leadership

Thinking about the importance of localised training and support to the development of the workforce leads us to consider differences in the culture and leadership of children's homes more widely. Clough et al (2006) reviewed a body



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of UK research, including studies carried out on behalf of the DoH (1998) during the 1990s. These studies showed that local conditions played an important role in effective practice and responding to the specific needs of the children and young people being cared for. Moreover, successive inquiries and investigations into abuse in children's homes in the UK have highlighted the pernicious impact of negative organisational cultures (Corby et al, 2001; Davidson, 2010; House of Common Education Committee, 2014; Sen et al, 2008).

More generally, UK studies have highlighted how insufficient training and support from home managers can contribute to workers' disillusionment. Specific areas of support needed can include dealing with distress, challenging behaviour and aggression, and the more emotional aspects of working with children and young people who have often experienced significant trauma (Biehal et al, 2014, Colton & Roberts, 2007; Heron & Chakrabarti, 2002; Winstanley & Hales, 2008). Burbidge et al's (2020) study, involving observations in four English children's homes and interviews with 12 workers, identified tensions around long hours and work rotas as problematic.

However, it is also important to recognise that some workers have reported feeling well supported and that they find their role rewarding. Mainey and Crimmens (2006) reported high levels of job satisfaction and morale following a survey of 1,197 workers across the UK. Heron and Chakrabarti (2002) reported that workers in Scotland valued consistent feedback and supervision from managers and the support of colleagues, especially when dealing with violence or aggression. Hart et al's (2015) literature review suggests that residential care work is more rewarding when workers can form closer relationships with children and young people and replicate a family environment. Interviews with 16 young adults who had spent time in eight different English children's homes also suggested the importance of relationships with staff (Gallagher & Green, 2012).

A large English study carried out in 2001 involving 60 homes highlighted the importance of the manager role in creating the working conditions for staff to form caring relationships with children and young people and move beyond compliance with externally set performance standards (Hicks et al, 2009). Effective managers provide individualised support to staff and children but also manage group dynamics to create a collaborative culture. Echoing these findings, Ofsted (2011) reported that managers in 'outstanding' homes make themselves available to everyone in the home and do not shut themselves away in an office. But the Hicks et al (2009) research also emphasised the importance of external factors that can influence the effectiveness of managers including: the status of the post, the clarity of the role, the ability to spend time in the home, and the degree of autonomy and external management support. The importance of the last of these was also highlighted by Whipp et al's (2005) study of the external management of children's homes that involved 12 LAs. They found that investment in non-operational posts (e.g. commissioning and



contract management) was vital to manage bureaucratic pressures on social workers and children's home managers.

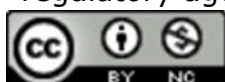
The evidence from international studies also highlights a contrast between the motivations of people joining the children's residential care workforce and the organisational environments they work in. After interviewing 25 workers in a large Residential Treatment Centre (RTC) Moses (2000) reported that wanting to do 'socially meaningful work' was a key motivation. On the other hand, Seti's (2008) review of research in the USA highlighted administrative pressures, lack of support from colleagues and managers, and confusion over roles and responsibilities as factors contributing to high worker turnover. Freundlich et al (2007) report fears relating to violence and aggression following interviews with workers and other stakeholders (n = 87) linked to large RTC in New York. More generally, Decker et al (2022) report feelings of exhaustion and lack of accomplishment as factors contributing to burnout following a survey of workers (n = 63) in a rural RTC in the USA. Nyerges et al's (2023) more recent survey of workers (n = 197) in a southeastern US RTC also links job satisfaction and burnout to organisational factors including leadership, peer support and feeling safe at work.

Silva and Gaspar's (2014) review of evidence relating to children's homes in Portugal and Steinlin et al's (2017) survey (n = 319) of workers in Switzerland reveal concerns about dealing with behaviour and aggression, as found in the UK and US studies. A survey of 147 workers from 24 homes in Israel identified 'compassion fatigue' as a potential consequence of the demands of children's residential care work (Zerach, 2013). Workers who participated in focus group discussions (n=43) as part of Garcia Quiroga and Hamilton-Giachristis' Portuguese (2017) study spoke of difficulties balancing work and their own family lives. Capacity, staff turnover, use of agency staff and leadership instability were identified as negative features of children's residential care work in Steinkopf's (2021) small study in Norway involving interviews with 15 staff in 1 home. This study also showed that staff valued a culture of openness enabling them to feel comfortable discussing strengths and weaknesses of the home.

Discussion

The aim of this evidence review was to identify key themes from previous studies to inform further research comparing the development of regulatory systems across England and Wales. Although there have been few studies directly concerned with the impact of regulation, findings reported in the wider grey and peer reviewed literature on children's residential care highlight important issues that need to be considered.

An overarching question to explore through further research should relate to the overall purpose of regulatory systems and the nature of relationships between regulatory agencies, children's homes and workers. Evidence taken mostly from



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grey studies carried out in England suggests broad support for the implementation of regulatory standards (Gibb et al, 2016; Kantar Public, 2018). However, there are concerns regarding the resources needed to demonstrate compliance and the bluntness of methods used by regulatory agencies to try and measure the quality of care provided to children and young people (Gibb et al, 2016; Kantar Public, 2018, Narey, 2016). Some stakeholders have called for closer partnership working across regulators, local authorities and providers to develop provision and methods to assess the quality of practice in children's homes (Narey, 2016; Newgate Research, 2021; Revolution Consulting, 2023). Findings from a small body of international studies also suggest a need to develop more nuanced approaches to the evaluation of children's homes (Boel-Studt & Tobia, 2016; Gharabaghi, 2009; Pålsson, 2018). However, it remains unclear how the approaches taken across England and Wales may differ in this regard and what specific activities might be most effective in promoting partnership working across regulatory agencies and children's homes to support improvement.

Furthermore, any investigation and comparison of regulatory systems and activities must consider the perspective of those working directly with children and young people on a day-to-day basis. Several studies highlight how the proliferation of rules and procedures linked to the implementation of regulatory standards can affect worker autonomy and stifle relationship building with children and young people (Davidson, 2010; Horwath, 2000; Heron & Chakrabarti, 2002; Milligan & Stevens, 2006; Moore et al, 2018; Steckley, 2011). Workers participating in these studies spoke of feeling pushed to focus on evidencing compliance and there is also evidence that workers can be fearful of accusations being made against them. These factors can combine to promote compliance cultures within homes and inhibit relationship building with children and young people. There is a need to examine how regulatory systems can be reshaped to promote cultures in children's homes that encourage innovation and learning rather than compliance and blame avoidance (McPheat & Butler, 2014).

A more specific area to investigate is qualification and training requirements. We found evidence of some concern regarding the minimum NVQ Level 3 requirement currently in place in England and Wales. Moreover, there was evidence from England that this requirement was not always being met (Kantar Public, 2024). Some research participants thought the requirement was too low and provided poor preparation for work in children's homes, particularly in comparison to other European countries where minimum training requirements were much higher (Bullock & Sherry, 2008; DfE, 2012; Care Inquiry, 2013; Hart et al, 2015). On the other hand, there is also evidence that those recruiting new workers also looked for practical experience, looking beyond formal qualifications (Gibb et al, 2016; Ofsted, 2011; White et al, 2015). Several studies also highlighted the importance of ongoing training including in specialist areas relating to the specific needs of children and young people being cared for



(Barter, 2014; Biehal et al, 2014; Brodie, 2014; Winstanley & Hales, 2018). In this area particular insights might be gained through comparing the experiences of recently recruited workers in England and Wales. In both countries staff must hold or commit to working towards the NVQ Level 3 requirement, but in Wales staff must also complete the AWIF as part of the process of becoming a registered children's residential care worker. Moreover, they must meet ongoing training and professional development goals as part of their re-registration process. In England, induction and ongoing training are left to employers. This could help us to better understand what support new workers are receiving and how prepared they feel for their new roles.

Finally, it will be important to consider the role of organisational cultures and leadership in supporting the development of the workforce and care quality in any future research. Evidence from UK research studies mostly carried out in the 2000s, but also some more recent inquiries, highlight the role of negative organisational cultures in failures to care for children and young people and feelings of disempowerment and disillusionment amongst workers (Clough et al, 2006; Davidson, 2010; House of Commons Education Committee, 2014). However, there is also some evidence from UK and international studies to show that workers can find their role rewarding when they are able to form close relationships with children and young people in their care and feel supported by managers and colleagues in their home or wider organisation (Gallagher & Green, 2012; Hart et al, 2015; Hicks et al, 2009; Whipp et al, 2005) . A stronger focus on organisational culture and leadership within regulatory systems could help workers to develop and help reduce the need to enact fitness to practise procedures for the 'weeding out' of unsuitable workers.

Conclusion

This article has considered evidence relating to the impact of regulatory reforms on children's residential care to inform a wider research project comparing the development of regulatory systems in England and Wales. We found limited research internationally that has directly addressed this topic and have therefore relied primarily on secondary findings reported in wider research on residential care, including from grey UK studies, although mostly those based on research in England. However, we have identified four key themes that we argue could be considered in the design of regulatory systems and further research in this area. These include: (1) balancing the enforcement of minimum standards against support for service improvement; (2) improving worker autonomy and relationship building with children and young people; (3) addressing unresolved debates regarding minimum qualification and ongoing training requirements; and (4) a stronger focus on organisational cultures and leadership within children's residential homes and care home groups.



Limitations

We acknowledge the potential limitations of a non-systematic evidence review involving reliance on studies that have not been assessed for quality through a peer reviewing process. We also recognise that most of the studies we draw upon were identified through 'reference chaining' and internet searches rather than through a systematic search of academic databases. Whilst we have taken care to build upon the previous rapid review of the academic and grey literature completed by Munton et al (2021) on behalf of the DfE in England, we cannot guarantee that some UK and international studies have not been missed. Moreover, the predominance of grey studies conducted in England rather than within Wales or other UK home nations could reflect limitations in our search strategy and that of Munton et al (2021).

It is also important to note that we found very limited research that had pursued research questions directly related to the impact of regulation on children's homes or the workforce. As such we have extracted data from studies that may be considered as peripheral to the key findings reported by the authors and must therefore be treated with caution. Furthermore, evidence taken from international studies must also be treated with caution as it relates to the regulation of children's residential care in countries where legislative, policy and workforce contexts may differ markedly to those in England and Wales.

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Ethics

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Appendix – Studies included in evidence review

UK grey studies	UK peer-reviewed studies	International peer-reviewed studies
Barter (2014)	Bullock and McSherry (2009)	Bani Ismail et al (2018)
Biehal et al (2014)	Burbidge et al (2020)	Boel-Studt & Tobia (2016)
Brodie (2014)	Cameron et al (2011)	Courtney et al (2009)
Care Inquiry (2013)	Colton and Roberts (2006)	Decker et al (2002)
Clough et al (2006)	Davidson (2010)	Forkby & Hojer (2011)
DfE (2012)	Gallagher and Green (2012)	Freundlich et al (2007)
Gibb et al (2016)	Heron and Chakrabarti (2002)	Garcia Quiroga and Hamilton-Giachristis (2017)
Hart et al (2015)	Hicks et al (2009)	Gharabaghi (2009)
House of Commons Education Committee (2014)	Horwath (2000)	Moore et al (2018)
Kantar Public (2018)	McPheat and Butler (2014)	Moses (2000)
Kantar Public (2024)	Milligan and Stevens (2006)	Nyerges et al (2023)
MacAlister (2022)	Smith (2009)	Pålsson (2018)
Mainey and Crimmens (2006)	Steckley (2011)	Petrie et al (2006)
Munton et al (2021)	Whipp et al (2005)	Seti (2008)
Narey (2016)	Winstanley and Hales (2008)	Silva et al (2014)
Newgate Research (2021)		Smith (2017)
Ofsted (2011)		Steinkopf (2021)
Revolution Consulting (2023)		Steinlin et al (2017)
Social Care Wales (2024)		Zerach (2013)
White et al (2015)		Freundlich et al (2007)



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Original Research Article

Therapeutic child care: Are we clear what we are talking about?

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Abstract:

The Hill View School provides therapeutic residential care, through its specialised therapeutic school, for primary aged children who have experienced early-life trauma. Despite children making significant progress whilst placed at the school the understanding of the term therapeutic child care is often misunderstood across both the school and the sector. This paper draws upon a case study of the Hill View School, including the experiences of children, their families, staff teams and senior managers who supported and interacted with them whilst they were placed at the school. Data analysis incorporates psychodynamic, reflective and phenomenological approaches to elucidate how misunderstandings associated with the term 'therapeutic child care' can, in part, be understood as an emotional defence against being in touch with children's traumatic early life experiences.

Introduction

This article draws on PhD research undertaken within the Hill View School (HVS), which focussed on how a therapeutic approach affected the capacity of children, who have experienced early life trauma, to understand and regulate their feelings and behaviour, whilst developing meaningful relationships. The original study explored the benefits and limitations of a therapeutic approach within the setting as well as how changes to children's behaviour were recognised by families, staff teams and the children themselves.

This paper focusses on one strand of that study, namely how the concept of therapeutic child care was understood by a sample of children, their families and the staff working with them.

The HVS, in central England, describes itself as a therapeutic, non-maintained, residential special school, with a purpose-built children's home. Up to 30



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primary¹⁴ aged children, from across England, are placed for 38 weeks of the year at the school, though up to six of these children reside for 52 weeks in the children's home. The children are placed at the school by local authority social service and education departments, for a period of around three years.

The children placed at the HVS have all experienced adverse early-life experiences, which have often included abuse, neglect or experiencing or witnessing violence (Harriss *et al.*, 2008). Most have an Adverse Childhood Experience (ACE) score of at least five out of ten, though some are as high as seven, resulting in complex trauma, ambivalent and disorganised attachments and the breakdown of multiple previous placements, both family and educational (Onions *et al.*, 2025). The work of the HVS is to help the children build trusting relationships, make sense of their feelings and their behaviour and engage in educational and social settings (Diamond, 2009). This is achieved through a carefully structured residential therapeutic milieu (Diamond, 2009).

Therapeutic residential child care (TRC)

Within the UK, therapeutic residential child care is often reserved for the most emotionally traumatised children, within a range of residential schools and communities outside of the mainstream education provision, for whom foster care is not appropriate (Bullock, 2009; Burns & Emond, 2023). The children in TRC settings are often referred to as 'troubled and troublesome' (Bullock, 2009) or the 'most disturbed and difficult children and young people' (Ainsworth & Hansen, 2005). Their early-life experiences have typically led to them becoming 'children looked after', previously referred to as 'looked after children' (LAC), with many experiencing multiple placements before a specialised residential setting, such as the HVS, is considered (Macdonald and Millen, 2012; Stanley *et al.*, 2005; Ward, 2006; Whittaker *et al.*, 2023).

Despite the importance of understanding the role and impact of TRC, it remains an under-researched topic (Dooner and James, 2019; Kor *et al.*, 2021), with most of the available research focussing on short-term residential care outcomes (Dooner and James, 2019; Martinovich *et al.*, 2007) and a lack of clarity about what is meant by 'therapeutic child care'.

Lack of an agreed definition of 'Therapeutic'

Perhaps the most helpful definition, for the purpose of this study, is that proposed by Whittaker, La Valle and Holmes (2015):

Therapeutic Residential Care involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education,

¹⁴ UK primary school age is 5-12



socialisation, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources.

Although the term 'treatment' is often more associated with settings in the US it is also widely used within HVS, for example to describe the integrated therapeutic provision carried out by a group of multi-disciplinary staff to meet the needs of the child, referred to as a 'treatment team' (Diamond, 2009).

Despite Whittaker *et al.*'s (2015) definition, the lack of a consistent definition regularly stands out in the literature. Evidence suggests that, in the USA, the term covers a wide range of provision (Gallagher & Green, 2013), and in the UK there is similar, though less wide, diversity (Ward *et al.*, 2003), although there is a noticeable lack of information relating to these UK services (Bullock, 2009). This diversity of provision is recognised to include several variables, such as the theoretical underpinning model (Bettmann & Jaspersen, 2009; Bradley & Kinchington, 2024), the duration of the placement, and the length and type of therapy (Curtis *et al.*, 2001). Many organisations describe themselves as offering TRC, with each developing their own models of practice. Accordingly, there is an underinvestment in staff training (Bellonci & Holmes, 2021), which, in England, is too often focussed on meeting mandatory standards rather than providing a clear therapeutic underpinning to the work (Roberts & Davidson, 2023). The literature relating directly to the HVS, for example Diamond (2018), suggests the issues of investment and development of staff training have been recognised and addressed as part of the HVS's model of practice, and linked directly to the HVS's training programme. However, the literature clearly highlights that this approach is based on the HVS's own work and not widespread, unlike other countries including Scotland (Smith, Monteux & Cameron, 2021).

Methods

Research Design

To understand the HVS's model of therapeutic work a case study approach was developed. The case study approach was selected as it would allow the research to capture the complexity of a primary case, the HVS, by investigating a phenomenon in its real-world context, and this would be particularly appropriate given that the boundaries between context and phenomenon are not evident (Yin, 2014). The case study approach was also chosen because it is associated with the exploration of processes and dynamics of practice, and because it was important to this study to understand the organisational context.

Following a short pilot-study, the participants in this research were identified as a sample of four children, their parents and carers, staff working with the



children and families and members of the school management team during an 18-month fieldwork period.

Ethics

Formal ethical approval for the research was granted by the Institute of Education/University College London ethics board, as well as by the senior leadership team of the HVS, prior to undertaking the research.

Consent was considered from the perspective of all participants, being gained by having participants 'opt in' to the study to enable respect and to encourage their free choice (Alderson, 2004). Consent was clarified as lasting throughout the data collection and dissemination period, with participants reminded and shown their consent form, before commencing each interview.

The potential risks to participants were considered to include issues of embarrassment, feelings of intrusion of privacy, fear of admitting anxiety, the risk of feeling coerced into participating (Alderson & Morrow, 2014) and the impact of discussing potentially traumatic histories. To ameliorate some of these risks, formal and informal opportunities for participants to decline participation were incorporated throughout the study (Mason, 2004), and children and families were made aware that their decision to participate, or withdraw, was not linked to the children's placements, and what they said would not be fed back or impact upon their placement. This was felt to be particularly important when interviewing the parents and carers.

Each participant was made aware that they could be directly quoted in the final thesis, and subsequent papers, and that brief details of their lives may be included, under a pseudonym. Given the small sample, of four children, it was explained that children and staff may be able to identify themselves, but that details would be anonymised as much as possible to prevent external readers identifying children, families or staff members.

Having gained ethical approval, parents and carers were interviewed as couples, though one was a single woman. The foster carers were all experienced and intended to continue with a long-term placement with their foster child. All the participants described themselves as white British, which also reflects the overall ethnicity of the HVS staff team, though not the child population.

Sources of evidence and analysis

The primary case study used multiple sources of evidence: literature, in the form of archival data and document analysis, primarily case files which allowed contextual data to be gathered. Having constructed a written profile of each child, semi-structured interviews were developed for each of the children, their families and staff teams. These ranged from 30 to 90 minutes in length,



depending on interviewees, and all were recorded and transcribed. This data was further supported by ethnographic observations of each child spread over the course of the data collection period. The semi-structured interviews with children were supported through the use of imagery created and shared with the children.

Initially six children were identified based on criteria to try and ensure they reflected the range of family placements, gender, age and placement. Data from four, see table 1, were used allowing two reserve cases in case of drop-out. Although each of the four children participated in three interviews, they, unsurprisingly, often found directly answering the questions difficult; they changed the conversation, wanted to move around and, on occasion, they left. This meant the data contained fewer direct quotes from the children, but their avoidance of specific topics was, in itself, considered significant data. Two interviews were undertaken with parents/carers of each child and two focus groups with between eight and twelve staff members undertaken, again in relation to each child. Lastly, individual interviews were undertaken with three, long-standing, members of the senior leadership team, none of whom, at the time, worked directly with the children or families involved.

Participant	Family placement	Gender	Age at start of data collection	Months into placement	Number of family members involved	Number of staff members involved in study
Leo	Birth family	Male	10 years, 6 months	6	1	8
Lola	Fostered	Female	7 years, 4 months	8	2	10
Jamie	Adopted	Male	9 years, 10 months	15	2	11
Kerry	Birth family	Female	10 years, 11 months	9	2	9

Table 1: Participant placement type, gender, age, duration into placement and number of family and staff members involved in the study.

Once the data was collected, a phenomenological approach was adopted to the analysis in order to gain depth by giving emphasis to participant's descriptions of their experiences, rather than adopting a definite 'cookbook of instructions' (Keen, 1975), and allowing the study to go beyond 'experience' drawing on 'the



participants' perceptions, feelings, and lived experiences' (Guest *et al.*, 2012). However, the analysis also drew on psychosocial methods as a secondary framework, a model with strong links to psychotherapy, counselling and group relations. As such, it is a thread linking ideas such as Bowlby's attachment theory, Bion's ideas about group functioning, Winnicott's ideas of holding and containment and the psychoanalytic understanding of the unconscious (Frosh & Baraitser, 2008), all of which are described as information the HVS' therapeutic model. These models were felt to complement one another and offered a research design that would prevent or restrict my own biases (Groenewald, 2004). This approach also allowed my counter-transference (my response to the transference from others) to inform my reflexivity (Jervis, 2009), thus giving greater insight and the recognition of emotional and relational processes (Froggett & Briggs, 2012).

Discussion of Findings

Within the data, several themes were identified which helped develop insight into how the term 'therapeutic child care' was understood by children, families and staff as well as the factors which might contribute to this understanding. For the purpose of this paper attention is given to two particular themes:

- Understanding the language
- Defences against anxiety

Understanding the language

When speaking about the children's life histories, all the parents/carers gave clear examples of the significant emotional trauma their child had experienced. However, understandably, they had a limited understanding of the impact of these traumatic episodes on the children's emotional development and behaviour; consequently, the children's understanding was also limited which felt appropriate to their age. It was apparent from the family narratives that, at times, the children's violent and impulsive behaviour drew attention away from their emotional trauma and that this had been a pattern throughout previous placements.

He was always hitting people and getting into trouble, getting sent home and stuff. I told them about what he'd been through but they didn't seem to care (Leo's mother – interview 2)

The term 'therapeutic' was noticeably absent from interviews with the children and families, none of whom made any direct reference to the therapeutic nature of the HVS and who, often, appeared confused about the therapeutic nature of the HVS:

I don't think we were quite sure about what it meant, no. I didn't really know what it meant to be honest. We did some research



on the school. We were looking on the websites, we visited here, to try and get a feel of it...and the social worker told us a bit. That's before it had been decided whether the funding was available. I don't think we had a very clear understanding of what a therapeutic school was, or what that involved...When he first came to us he seemed OK but then he started to get really difficult and we didn't know why. We thought maybe we were doing something wrong... (Jamie's mother – interview 1)

Because it's quite a tricky place to describe. Yes, they kind of tell you, 'This is what we do,' but I think until she was actually there, and you could actually see what it was. Then they would have meetings, and they would explain what they've done, what they're doing. I think you can't really understand it until they're actually there. (Kerry's mother – interview 1)

For some parents, the word 'therapeutic' referred to direct provision from a specialised therapist, rather than to the 24-hour-a-day therapeutic milieu which the HVS aims to provide, and which is integral to their work (Diamond, 2009).

Well, I've been told that the therapy will come after her initial time, 12 weeks or whatever, and then they'll see what therapy, if she needs it, is there for her then. Music, drama, all these sorts of things. (Lola's foster mother – interview 1)

Leo's mother was also unsure of the therapeutic input at the HVS, but described her son's previous school:

The last school: they had a therapeutic room, where they had waterbeds, 'touchy-feely', and an open-air heated swimming pool. It was actually the best thing you'd ever seen on the grounds. It was absolutely beautiful. Leo was quite pampered. Leo was quite spoilt there, to be honest, to the extent of the foot massages and the oil rubs. (Leo's mother – interview 2)

The comments from Leo's and Lola's parents appear to suggest what was expected by the term 'therapeutic' at the HVS. Previous experiences and placements had involved a set number of sessions with an individual therapist for each of the children. These had typically been provided by external services, such as CAMHS, and were brought into schools or therapy centres.

It should be recognised that the understanding of many parents/carers, and perhaps staff, was linked to a number of factors, depending on not only their ability to understand potentially complex concepts but by their own emotional needs and experiences. For example, a family at emotional and physical breaking point, which in different ways they all described themselves as being



at, may appear as just needing a break or placement, without showing a detailed interest in the placement's underpinning model of practice.

To be fair, I don't know what I was told. He'd been at home for so long we were, like, at breaking point... I just needed somewhere that could look after him, everyone else had kicked him out... (Jamie's mother – interview 1)

Whilst it may be unsurprising that parents and carers did not have a comprehensive understanding of the therapeutic approach, this could be seen as being at odds with the school's described model of working. It should not be assumed everyone will, or should have an identical understanding, however, if parental involvement is core to the school's therapeutic approach (Diamond, 2013), it should be considered there is the potential that a limited, or confused, understanding from parents and carers may impact their ability to fully engage in the work. Whilst the data highlights a limited understanding of therapeutic child care, it is important to recognise that the data does not question the overall effectiveness of the therapeutic model.

Staff understanding differed from that of the parents, which had been expected in part due to them undertaking specific therapeutically informed training (Roberts & Davidson, 2023). Most staff seemed clearer about the therapeutic milieu on which the school is based – though the term 'therapeutic' was also noticeably absent from staff focus group interviews. However, the language used differed between the care and education staff teams, with education staff making more reference to children 'attending therapy', despite the therapeutic milieu overarching the entire day. This suggests a possible split between these two staff teams, with a potential lack of shared understanding of the HVS's therapeutic approach. This may be understood as the education team have a greater focus on 'educating' the children.

...I think we do all work in a therapeutic manner, we always support the children to attend their therapy and let them talk afterwards if they want to... (Teaching Assistant, focus group 2)

Whilst this may simply represent the difference in tasks between education and care team, it should also be considered whether this might represent an unconscious defence (Collie, 2008) against the emotional pain of working alongside the children.

Defences against anxiety

Literature specific to the HVS frequently discusses the school's therapeutic model (Dockar-Drysdale, 1968, 1973; Diamond, 2009; Onions et al., 2025). However, as highlighted, evidence of a clear understanding of the therapeutic approach was at times lacking from children, families and staff. Whilst, to some extent, this was to be expected, an alternate way of understanding this difference is to



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suggest that it may not purely be due to a lack of understanding but may also be linked to the need to maintain an emotional distance, as a defence mechanism, from the children's trauma. Although the school's therapeutic model is relationship-based (Diamond, 2004; Turberville, 2018) the intensity of maintaining relationships, and remaining emotionally in touch with the children's traumatic feelings, can, for some, necessitate an unconscious drive to maintain an emotional distance (Ward & McMahon, 1998). The school uses a model of reflective practice to try and bridge this unconscious response, but this is dependent on individuals being emotionally resilient and open to reflective practice (Burns & Emond, 2023; Farrell, 2012; Price *et al.*, 2018), including being open to the idea of having defences.

The idea of defending of an unconscious emotional defence can be related to all those involved in the study, including, potentially, the organisation as a whole. For the families it was important that consideration be given to whether they may have experienced their own trauma (Cook *et al.*, 2005), either directly or through the child's trauma and how this might impact them. For example, Leo's mother spoke about how his life experiences were traumatic for him but had also led to the rest of the family being '*really distressed and impacted*' and being '*ready for him to move out*', desperate for the HVS placement, without being clear what the placement would involve. Both Kerry's and Leo's mothers recognised that the therapeutic work had been explained to them, but that they had not been able to fully think about or understood it due to being at '*breaking point*'.

They might have told me, I don't know. I hadn't slept and no-one was listening to me. I just needed some help... it felt like lots of people were saying stuff, but no-one listened to us and I don't really know what they were saying. (Kerry's mother – interview 2)

This sense of not being heard, at differing levels, was apparent for all of the families, as was the families experience of emotional exhaustion before their child's placement. This emotional exhaustion may also help understand their limited understanding of the therapeutic task. The evidence suggests them being emotionally unavailable to new information, perhaps through sheer exhaustion and frustration but perhaps also unconsciously being unable to take anything else on due to the emotional experience.

In therapy or in a therapeutic environment?

The lack of understanding of the therapeutic task was also highlighted when discussing the difference between being in 'therapy' and being in 'a therapeutic environment/milieu'. Professional documentation for each of the four children referred to prior individual therapy, provided by a qualified therapist, which had ended, and the subsequent need for a therapeutic placement. However, there



was contradictory evidence about whether the professionals understood the difference between the two.

This difference was also identified in the interviews with families/carers, particularly Leo's and Lola's, who were unsure why the children did not have individual therapy and felt they did not know what a therapeutic school was.

I thought she would have a therapist like she used to but that didn't happen for a while...I don't really know where the therapy happens, but I can see she's making progress (Lola's mother - interview 2)

Although Jamie and Kerry acknowledged that they were currently meeting with a particular therapist, none of the children could articulate what made the HVS therapeutic. Given the children's age this was not unexpected. Leo suggested that his previous placement had '*been more therapeutic 'cos they had a swimming pool I could use when I got angry*', suggesting he could recognise that an activity, swimming, was beneficial when he was angry. However, this is a more practical definition of 'therapeutic' than those considered in the literature review (Haigh, 2013; Whittaker *et al.*, 2016), further attesting to the lack of clarity surrounding the term. We need to recognise that therapeutic work involves emotional as well as the more practical aspects our work, for example being aware of feeling states (Price *et al.*, 2018) and matching body based and sensory interventions to children's needs.

The lack of reference, from many staff, to the term 'therapeutic' was felt to be significant. From the staff focus groups, it was clear that those who discussed the terms more were the senior staff, who were generally more distant from direct work with children and families.

We have quite a clear model and the treatment teams discuss and plan the therapeutic needs of the children, though it is different between the children... (Senior member of the residential side of the school – focus group 2)

This suggests that newer, or less senior, staff perhaps have less confidence in discussing the therapeutic model, or, have undertaken less therapeutic training. However, an alternative consideration might be that newer staff have less understanding of the unbearable feelings projected onto them (Reber, 1995) and that this may be understood as a potential means of protection from the anxiety and pain of the work (Bateman *et al.*, 2000).

In contrast to the data from children, families and some staff were the views of some senior staff, principally management and trustees, who stated that the school has a clear therapeutic model articulated through its training programme, practice and written documentation. These views were supported by the analysis



of documentary evidence, suggesting that it may not be that the therapeutic model is unclear, but rather that it is not always articulated by the HVS in a manner that supports understanding.

The therapeutic model of the HVS is built around the need for relationships. Diamond (2004) argued that staff should avoid overly close relationships which might become dependent and instead aim for a more measured emotional distance within these relationships. However, this concept was inconsistently understood or practised by staff. Staff in the care team, particularly keyworkers, indicated closer relationships – similar to those described by Dockar-Drysdale (1990) – than education staff and, naturally, those who did not work directly alongside the children.

My key-child finds it really hard when I'm not here and waits until I'm on shift to tell me stuff which can be difficult. It would be good if they could talk to the rest of the team but that is sort of my role I guess. (Key worker – focus group 2)

This suggests that written models of working may be articulated but not necessarily operationalised by staff working alongside the children.

One further way accounting for this understanding, while linking it to the ambiguity about the therapeutic model, is that, there perhaps exists an organisational defence against clarifying the exact nature of the work. For example, if work is too clearly defined, staff may be left holding the overwhelming anxieties of the children. Thus, the lack of clarity in the 'therapeutic model' may serve as a defensive function and help to understand the lack of understanding of the therapeutic model. Of course, these findings may be explained more basically as 'things are unclear' and 'children are anxious', but this seems rather simplistic, akin to looking only at the behaviour, and not recognising the communication behind it. It is difficult to comprehend that in an organisation with such good outcomes (Gutman *et al.*, 2018; Price *et al.*, 2018) the understanding of the model is simply unclear.

Why am I here?

A further finding from the study, which links to the lack of understanding, was the lack of comments from the children relating to the reasons for their placement. All the children believed their placement was due to their behaviour. Both Kerry and Leo stated that their placement at the HVS was to enable them to '*behave properly*' and '*stop hurting people*'. This brought to light parents', carers and several education staff members' perceptions of the children's behaviour, which, for many, overtook the children's emotional trauma. Unsurprisingly, this meant the trauma and abuse became hard to discuss with more focus on negative behaviours – a point stated by staff working directly with Kerry, Leo and Lola. The children focussed on their negative behaviours as some



professionals and families had done prior to the HVS, rather than the underlying reasons for the behaviour. Although not directly discussing childhood trauma, the ideas of Menzies Lyth (1988) can help clarify this focus as a defence against the emotional trauma and a defence from staff. Taking focus away from the early-life complex trauma may, unconsciously, 'protect children' from it, and from the potential negative perceptions which may arise if it is brought to consciousness.

Conclusions

The evidence from the study suggests that, despite, the HVS having a long history of therapeutic child care, as well as excellent outcomes, the nature of the therapeutic model is inconsistently understood by children, families and staff. Given the wide range of roles and experiences of those involved in this study, variance in understanding therapeutic child care is not a surprise. However, given the frequency of this finding, and that it was apparent from all participants, possible alternate interpretations should not be ignored. The findings suggest that this lack of understanding may happen unconsciously, acting as a defence, creating an emotional distance between staff, and families, and the children's trauma. Whilst the work is rooted in the development of relationships the closeness of these can be emotionally overwhelming leading to such defences.

The lack of understanding of the term therapeutic is unlikely to be restricted to the HVS meaning there are implications for the wider child care sector, particularly those who describe themselves as therapeutic. If professionals and providers have an inconsistent understanding of the term there is a real risk that placements may not be matched to the true needs of the children, with an over-emphasis on the behavioural rather than emotional needs of children.

Until these issues are explored and acknowledged the national provision for children who have experienced early life trauma, sadly, risks failing to fully meet the needs of those children who have already been, too often, failed.

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Dr Dave Roberts qualified as a social worker in the late 1990's and is currently the Head of Learning and Research for The Mulberry Bush Charity, having worked in the field of residential child-care for 35 years. Dave has written and spoken nationally, and internationally, about residential child care, therapeutic work with children who have experienced early life trauma and professionalising the workforce.



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Short Article

Bringing a loving care approach into an alternative education provision

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Abstract:

The article describes a project to introduce a Loving Care approach into an alternative education provision in England, for 16–24-year-old students, who have not been able to achieve in mainstream education. The approach is based on previous work by one of the authors to bring more love into children’s residential settings and is founded on the belief that love-led practice is beneficial for children who have experienced trauma and adversity, whatever the context. The project is in its first phase and the article describes the context, theoretical foundations, initial approach, initial feedback from staff, and plans to measure impact. It further outlines reflections on lessons learnt so far, which it is hoped will be of benefit to other organisations who wish to adopt a similar love-led approach.

Introduction

A Loving Care approach is one which enhances attachment aware and trauma sensitive practice, by encouraging staff to engage in a loving manner with the children they work with, in this context, as educators. The success of this approach has been seen in children’s residential care (Davies, 2023) and this article describes a project which applies it to an alternative education provision, New Meaning Training (NMT). Bringing the approach to the students here is particularly pertinent, as many have experienced disrupted family relationships and childhood trauma. Over the last 10 years 1300 young people have graduated from NMT. 30% had been excluded from mainstream schools, 20% had refused to go, and the others had attended but been unable to achieve grades. 15% were ‘in care’ and 70% report that they had experienced childhood trauma within the last five years.

A Loving Care approach aims to build fulfilling relationships between children and professionals, which replicate, appropriately to context, the secure attachment



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environment that children need to thrive. The hypothesis is that appropriate loving relationships with adults can exist beyond a home environment and be significantly beneficial for children and young people. Also, that any professionals working with children whose attachment experiences have been disrupted, or who have experienced trauma, will do better with and for them if they offer appropriately loving relationships, whatever their role and setting. It is hoped that the work done in NMT will provide useful guidance for other settings where young people experience similar issues, for example, youth justice, social care, health, and mainstream education.

Consultants Margaret Davies and Mary-Anne Hodd have been engaged to work with NMT, initially for an 18-month period, to train and support the organisation to embed a Loving Care approach within their work and to measure its impact. Work began in June 2024 with the first of two leadership team visioning sessions. The first phase of the project has now been completed, including training staff across the whole of the organisation.

Context

New Meaning Training is an English social enterprise focused on enabling young people, often with special education needs, to discover their pathway to earning their own meaningful living. This is achieved through NMT's vocational learning centres, where the focus is on development of both aptitude and attitude.

Young people aged between 16 and 24 are referred to NMT centres by referral partners, which include: mainstream secondary schools, virtual schools, local authority Special Education Needs (SEN) departments, youth justice teams, social services, career mentoring organisations, further education colleges, family support hubs, and parents or carers. NMT offers nationally recognised qualifications and many of the young people who graduate with these qualifications do so for the very first time, strengthening their self-belief and confidence to take their next steps into employment or to continue their studies. NMT recognises that the formality and structure of mainstream education doesn't support the learning needs of all young people.

There can be a multitude of reasons for low attainment and engagement, which can leave a sense of hopelessness and failure. The reality for many is that they have not yet discovered something that works for them. It is as if something is needed to 'flick the switch'. Through a coaching, mentoring, guiding and supporting approach, NMT tutors work in a holistic way to understand the young person's barriers to learning and create a path to them earning their own living.

Over the last 10 years, NMT has identified barriers to learning that young people accessing this service face. Through discussion with schools and other alternative provision settings, they have realised that these barriers are likely



characteristic of around 10% of all students who struggle to achieve in mainstream settings. They are:

- Young people becoming quickly dysregulated, even when staff do not perceive a threat is present, or the young person (over)reacts to a comment from another learner.
- Class dynamics: The goal is to separate young people with a history of bullying from those who have been bullied, but this is not always possible.
- Life events conspire to disrupt the young person's pattern of attendance. For example, an estranged father reaching out causing distress, an argument at home, conflict between friends, bullying social media posts, an unstable home environment, or past trauma being triggered can all lead to non-attendance.
- A high proportion of looked after children with low self-esteem and often little to no positive history within education.
- Many young people attending NMT have never felt 'understood', they are often searching for an attuned connection, and this shapes an underlying anxiety within them.
- No history of success within education, no pattern of praise, or acknowledgement of achievement or positive progress.
- Finally, no sense of 'my place' in the world – which is embodied in fatalistic behaviour, and disclosures of self-harm, abuse, rape, etc.

For achievement and progression to be consistent, NMT requires an underlying Social, Emotional and Mental Health (SEMH) professional development model with a strong evidence base. Such a model needs to provide practical approaches, methods and techniques that NMT tutors can adopt. Experience at NMT over the last 10 years demonstrates that once SEMH needs are addressed, learning achievement and progression follows.

A Loving Care approach is a good fit with the SEMH development needs of the young people who attend NMT. Understanding the theory behind the model (attachment and trauma informed practice, and positive emotions), will support tutors to create new Loving Care centric training methods and approaches, and to learn how to maintain their own personal wellbeing and mental health in what is a challenging work role.

NMT has a vision to build a continuous professional development programme for staff, that focuses on three core competencies: 1) role-based skills, 2) transferrable skills, and 3) attitude skills. The Loving Care approach is the 'golden thread' that will run through the whole professional development programme.



What is a Loving Care approach in education?

A Loving Care approach encourages adults to engage with young people from an open, positive emotional stance, characterised as a loving stance. The approach derives from an understanding of the fundamental importance of safe loving relationships for human beings, especially children, to thrive. It is also understood that young people who have experienced complex childhood relational trauma, need safe loving relationship experiences to begin to re-wire their interpersonal neurobiology, and become ready to learn. As Treisman (2016, p. 17) puts it, 'relational trauma requires relational repair', while Perry (2017, p. 258) notes that 'relationships are the agents of change, and the most powerful therapy is human love'. Love is described as our supreme emotion by Fredrickson (2013, p. 12), who evidences 'love's capacity to nourish, heal and do good', which 'is deeply wired into (our) biology.

A steady diet of love influences how people grow and change, making them healthier and more resilient, day by day. (Fredrickson, 2013, p. 12)

The assumption is that including love in attachment and trauma informed practice will improve young people's outcomes.

Stable and secure attachment relationships at home allow for cognitive and social development that makes children ready and eager to learn at school. Disrupted attachment experiences, plus the complex trauma of abuse and neglect in the early attachment environment, prepare children for survival in what can seem like shark infested waters. This gets in the way of being open to learning opportunities in a mainstream classroom. It has even been stated that children not loved at home, come to school to find love (Ferroni, 2018). For teaching to be effective, educators need to 'plug the gap' caused by a lack of familial love in children and young people's lives: 'Some children will experience familial love in abundance and come to school feeling very loved, safe and respected. But other children won't get that and will need something different and extra from the other adults in their lives' (Carter, 2020, p. 3).

One reason why a safe loving relationship with an educator – teacher, learning support worker, or tutor – helps young people to learn, is because the brain has evolved to learn best from closely connected others. Historically, children's learning took place within the family and close community before consistent state education began during the nineteenth century:

As a social organ, human brains have evolved to be linked to and learn from other brains in the context of significant relationships [...] our brains evolved to learn from caring and compassionate teachers who know us well and who are invested in our wellbeing. (Cozolino, 2014, p. 11)



It is not always obvious to educators, however, that they have a loving role to play with their students. Similarly, other professionals encountering children with developmental trauma may not perceive the benefit that a loving approach would bring to their work. To change these perceptions, we must address the dominant culture of placing love in the private, rather than public, space. It helps if staff look at the eight Greek types of love (Reed, 2019), Chapman and Campbell's Love Languages with children, (Chapman & Campbell, 2016) and what is loveable about the students (CELCIS, Aberlour, The Care Inspectorate and Includem, 2022)³. Then they can recognise and identify with loving action, which is neither romantic or sexual, and is appropriate outside of the private family arena. It is also helpful to consider love as being a micro moment of warmth and connection that is shared, a 'positivity resonance [...] that ripples through the brains and bodies of you and another' (Fredrickson, 2013, p. 35).

During our exploration of these wider concepts of love with NMT leaders and staff, it was noticeable that the non-verbal messaging of the groups changed. People's body language became more animated, expressive and open, their tone of voice was lighter, smiling and eye contact increased, there was laughter and a feeling of positive energy in the room. These are the forms of (automatic) expression and communication that will help students to feel safe and valued, at a level below their consciousness. As Cozolino states:

Much communication across the social synapse is automatic and unconscious – facial expressions, body language, tone of voice and words chosen. (2014, p. 33)

This leads us to suggest, therefore, that adults cannot *act as if* they feel lovingly towards their students and be effective. Their affection must be real to be communicated through their automatic, unspoken gestures. This is why the preparation for a Loving Care approach needs to include a change of heart.

The change process

The first phase of preparing for a Loving Care approach at NMT has been:

1. Two days facilitation with the leadership team to generate their buy-in to the approach, looking at: the rational and underlying evidence base, an exploration of what love means in an educational context, the principles of a love-led approach, and their application to the NMT context.
2. Three days training with all staff:

Day 1 to look at the importance of early attachment experiences, an understanding of trauma and Adverse Childhood Experiences (ACEs), and a model for the process of trauma recovery.

Day 2 to look at how to work with students, as informed by Bruce Perry's neurosequential therapeutics (2008), starting with co-regulation including



sensory signals of safety and connection, followed by relating, including a Loving Care approach, and reasoning including a restorative approach.

Day 3 to look at resourcing ourselves and each other for the work, self-awareness and self-love, supportive team-work and organisational compassionate leadership

3. Ongoing communication and support with the leadership team in between the staff training sessions; to pick up on and support staff who felt upset by the training, to adjust the environment and pace to support the adults' learning needs, and to reflect on leadership actions to support the approach.
4. Support for the leadership team to identify evaluation methods to measure the impact of the new approach.

Phase two will involve an action learning model, to enable NMT tutors to integrate the Loving Care approach theory and methods into their day-to-day practice. Action learning workshops will be held each term, facilitated by consultants. These workshops will initially run for 18 months and will enable tutors to learn from their experiences and to openly discuss what they perceive works, as well as encouraging them to strengthen their approach through reflective practice and discussion.

Analysis of staff feedback so far

Feedback on the three days of staff training has been given anonymously on Microsoft electronic forms. The feedback rate is as follows: for day one, 13 out of 62 participants responded, day two, 23 out of 54, and day three, 19 out of 58. The combined feedback return rate is 31.5%. The feedback on the training overall was positive, with the training rated good or outstanding, all but once. The rating for all days has been rated 42% 'outstanding' and 57.5% 'good'.

When asked about the usefulness of the training in their work, 78% of all respondents rated the training positively, between seven and 10 out of 10. A typical reason for the staff's rating of usefulness is 'a lot of our students have a hard time and often need that Loving Care approach. Having a better understanding of this will no doubt benefit our students and staff'.

There was less clarity about the usefulness of the second day's training. Comments range from 'this resonates with our teams' work in understanding how to support students in regulating their behaviour' and 'we do most of it already', to 'students may not respond to the approach positively'.

Comments on how staff members' approaches will change are, however, largely in alignment with the ethos of the training. For example: 'I will have a better understanding to why some students are disengaged'; 'I will remind myself of the learners' background/traumas when situations arise'; 'I will definitely be more aware than I am now to the students body language'; 'I will be kinder to



myself'; 'Focus on making connections one to one with my students even though the day is very busy, with loud and quiet students alike'; 'It has given me greater insight into how my emotional state impacts on learners'.

Overall, the feedback shows that experiences of the training have been very positive for staff, and that it aligned with what they already felt about their learners' needs and lived experience. The doubts and concerns that were expressed will serve as guidance for the leadership team in their staff support and supervision. The consultants will follow up on the themes raised in the action learning sessions, offering more opportunities to reflect, practice skills, and explore useful tools. Observations, reflections, and supervision will identify whether insights from training translate into daily practice, and the impact on students will be measured.

Reflections on important themes emerging

NMT leaders and the consultants have reflected on the discussions generated during and in between the training sessions, and several themes seem important to note for any organisation desiring to bring in love-led practice.

- The need to be prepared for some disruption to the staff, as their own love and trauma stories are stirred up by the material. NMT leaders have good relationships with their staff and were able to give time and emotional support to those participants who needed it. It may occasionally be necessary to facilitate external counselling-type support, and this should be planned for by leaders.
- Good relational practice may not be cutting through, because young people are still dysregulated. Addressing young people's dysregulation may require more emphasis, understanding, skill, and time before staff can use their relational skills to connect effectively.
- It can seem challenging to co-regulate in a chronological age, cognitive ability, and emotional age-appropriate way, at one and the same time. However, adult self-regulation and reducing stress for young people will always be helpful.
- At NMT there are challenges to sensory regulation, inherent in the physical environment, which is designed for sports and construction industry learning, e.g. large echoing spaces, which are hard to heat and make comfortable. To create environmental signals of safety, organisations may need to redesign their spaces to enhance sensory regulation, balancing this with the requirements needed for activities to be carried out.
- There may be a tension between the time needed to address attachment and trauma needs and the time desired to progress targets. At NMT it is understood that addressing SEMH needs will enable young people's progress towards targets, and staff need to be given the space to pursue this. This



may need wider communication and buy-in, for example with funders, or carers and young people.

- Staff can be exhausted by daily challenges and any resulting slow progress when working with traumatised young people. Feelings of overwhelm can lead to adults wanting to punish the young people (fight response), take time off or leave (flight response), or collapse/a feeling of helplessness (freeze response). Caring for staff, managing workloads, and building in breaks is vitally important.
- Good basic terms and conditions of employment are similarly crucial – annual leave entitlement, hours of work, pay, and workload – as is the leadership team being assertive about any generous terms. Negative comments about conditions, even from a very small minority, can have a big impact on overall morale, if they are not counteracted positively.
- It is important to collaborate with staff wherever possible, for example to determine staff welfare policies and wellbeing supports, to widen their circle of influence and sense of agency, which is protective against workplace burnout.

Overall, we have understood that it is necessary for the leadership team to apply the principles of an attachment and trauma informed Loving Care approach to their staff.

Plans for measuring baseline and impact

It is important to measure the impact of the approach over time, to see if an attachment and trauma informed Loving Care approach is in fact beneficial in an alternative education provision. The following outcome measures are already collected and analysed every six to eight weeks, and will be collated to understand the impact of a Loving Care approach:

- Individual and average attendance statistics
- Individual and average punctuality statistics
- Number of behaviour plans in place
- Number and nature of safeguarding alerts where dysregulation is indicated
- Learning progression statistics
- Achievement statistics
- The number of young people who successfully transition from NMT

In addition, the Action for Inclusion Tool - AFIT¹⁵ - will be used to assess individual attachment (in)security, progress towards greater security, and

¹⁵ The Action for Inclusion Tool (AFIT) is an evidence-based assessment tool and web-based application, used in education to identify underlying learning and relational needs that might be



reduction in behavioural challenges. The AFIT tool will be used with all learners from September 2025, to measure the impact of the Loving Care approach. They will be tracked over a period of 12 months, making two or three measurements of their progress on the AFIT app. The tool will also provide attachment related strategies for each learner, which will complement the training and support provided by the consultants.

All measurements will again be captured and compared to baselines at the end of the learning year (typically July each year), and again at 18 months from commencement of the project. The Loving Care approach is the single most important professional development programme at NMT, and so any effect witnessed in collating the measures will likely be the result of implementing the Loving Care approach.

Conclusion

This project assumes that a Loving Care approach is applicable to an adolescent education setting and that attachment and trauma informed practice will have positive impacts for the students and staff within the setting. At first it was not wholly apparent to NMT leaders and staff that 'loving' the students is a legitimate part of their role. The consultants have helped them to widen their view of 'love', to see its place and potency in the public, as well as the private, sphere. If the students do in fact benefit from a Loving Care approach, one could conclude that other professionals could also usefully adopt a similar approach in varying settings, and that the lives of children with developmental trauma can be enhanced by being surrounded by a community of compensatory secure relationships with the adults supporting them. Love need not be confined to their substitute family placement or children's home carers, as other adults involved in their lives could belong to a network of loving relationships, which together can offer the transformative care traumatised children really need.

The early signs in this project are positive, showing that most staff are now enthusiastic about working in this way and can see how it fits with and enhances the relational practice already in place. Phase one of the process has been completed, and impact measurements will indicate, over time, whether students do benefit from a Loving Care approach.

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contributing to a student's challenging behaviour or poor academic performance, providing targeted strategies, based on attachment theory, to help them settle and learn effectively in the classroom. It is designed to promote inclusion and to minimise exclusions. Available from coursewedo.com



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Margaret Davies has been a qualified social worker for almost 40 years, specialising for 20+ years with children in care and their carers, and creating therapeutic placement services. Since 2014 she has been an independent social work manager, trainer and consultant, and in 2022 co-created the Lovin' Care approach for children's homes with Children's Homes Quality.

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Short Article

Observing high quality children's residential care: Reflecting on an implementation approach

Mihaela Manole, Laura Quinn & Gemma Watson

Abstract:

Delivering high-quality residential care to children requires skilled, knowledgeable, and reflective practitioners who are supported to continuously learn and develop. In collaboration with Aberlour Sycamore Children's Houses, we explored how a practice profile of learnable, teachable, doable, and assessable residential child care practice could be used to support practice across two of the houses. We explored how a structured approach to observation and feedback could help to grow and develop residential childcare practice. In order to assess the impact of this work across house staff teams, senior managers and project team members, we undertook a series of 'sailboat retrospective' sessions. This highlighted how a whole system approach, leadership support, and a sense of shared ownership helped to cement this work, improving practice for young people and professional development for staff.

Introduction

Considering how high-quality residential child care can be delivered to children and young people every day by skilled, knowledgeable, and aspirational adults was a journey we embarked on together with Aberlour Sycamore Children's Houses.

Informed by implementation science, particularly the active implementation frameworks outlined by Fixen et al. (2019), we understood that to sustain high-quality practice over time, the practice has to be clearly defined so that it becomes 'teachable, learnable, doable, and assessable' (p.70). We thus aimed to shine a light on those components of practice that have a major impact on children's and young people's experiences and outcomes. We worked alongside a change team that included those Sycamore staff with extensive experience of direct residential child care practice, mid manager, and senior manager roles.



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Together, we considered the skills and knowledge of people across Sycamore to develop a practice profile, which is a tool that describes the core components of high-quality residential child care with practice examples aligned to each component. The tool offers a way for those caring for children to identify the strengths in their practice that should be sustained, as well as those where improvements in practice are needed.

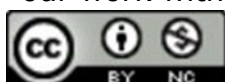
Having defined practice in a way that can be aligned to the day-to-day, the organisation was getting ready to move into a period of observing practice. But first, we supported the change team to carefully determine where they wanted to start their observations, knowing that readiness for change must be appraised (Aarons et al., 2011) to understand the extent to which there is capacity for and openness to innovation and learning. The change team carried out a readiness assessment of their houses, and two were chosen based on factors including how settled the staff and young people had been, the capacity and time protected for progressing this work, and the support from the management team to remove emerging barriers. Houses were selected where practice was appraised to be at a progressing level, with pockets of good practice, but also situations where practice was used inconsistently or in a limited range of contexts. The readiness assessment also looked for a strong learning culture, with openness to sharing and discussing learning.

There were two sets of observers, the internal team made up of staff within the houses themselves, and the external team made up of Sycamore staff who were part of the change team around this work. Observers spent time in the houses observing practice and offering positive and later developmental feedback as well as coaching to practice. A total of 77 observations took place during a pilot period of eight months, with feedback captured on observation forms.

Following the period of observation and feedback, it was crucial that we began to understand the impact of this on the staff and their practice. We were keen to understand in more detail not what had been observed, but what resulted from staff being offered feedback, and how this informed supervision and ongoing professional development.

Methodology

We used the 'sailboat retrospective' to support reflection and capture feedback on the observations. The 'sailboat retrospective' was borne out of the agile team approach, first used in the software development industry (McKinsey & Company, 2023). The idea was that a small team, made up of individuals with differing specialities, could work much more quickly and efficiently to find the solutions to big problems. Given the scope of professional knowledge, and with different team members often tackling diverse aspects of the programming, it is no surprise that teams needed a way to stop and take stock of their projects. In our work with Aberlour Sycamore Children's Houses we also diversified our



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approach with specific members of the project team, made up of our own staff and the provider's staff, taking the lead in different aspects of the work. As we reached the end of pilot phase we really wanted to stop, reflect, and learn as much as we could from the work so far.

The structure of the 'sailboat retrospective' allowed us to consider what made people feel good about the work (the sun on our faces), what helped push the work forwards (the wind at our back), what held us back (the anchor slowing us), and the risks ahead (the reef to be avoided).

We were keen to understand the views and perspectives of both the teams whose practice was observed and the change team involved in designing, supporting, and carrying out the observations. As such we carried out two sailboat retrospective sessions with the staff team at each of the two houses, and two with the project team and the internal Centre for Excellence for Children's Care and Protection (CELCIS) staff team. Some of the smaller sessions were conducted online, using a digital platform that creates a collaborative workspace, and the larger sessions took place in person, within the houses. The sessions were facilitated by CELCIS staff to offer a degree of independence.

A thematic analysis was then undertaken, focused on the quality and depth of the information captured. The data were coded in an inductive manner, allowing the data to define the themes, rather than any predetermined theoretical approach. We also considered some of the data captured through observing the delivery of the sessions, and the experiences and reflections of the facilitators.

Results

Our findings show that the collective approach to the work undertaken by Aberlour Sycamore Children's Houses had resulted in collective ownership of the common goal, across staff and manager teams, of improving experiences for children and young people. This was a significant driver for change and improvement within the service.

There was consistency across all groups involved in the 'sailboat retrospectives', that the experience of being offered both positive and developmental feedback had been well received. All groups agreed that the practice profile and observational feedback supported the development and consistency of practice, aided communication across teams, and enhanced supervision between managers and staff.

We also found that the familiarity of those in an observation role helped with preparing teams to feel comfortable and open to be observed, which was also a positive factor during observation periods. The staff spoke about feeling nervous, apprehensive, or worried prior to being observed and receiving



feedback. However, the way in which the internal observation teams carried out their role relationally, with respect and understanding of the team and children in the houses, alleviated these concerns.

Managers spoke positively about the impact having access to feedback collated during observations has had on supervision. According to managers, the content captured in the observation forms has made supervision more purposeful, supporting staff members to have manageable goals, aligned to the practice profile, and has personalised the time spent during supervision. It has allowed adults to focus on their own short-term and long-term development, all while supporting the annual review process across the houses.

The experience of observation was described as being positive and supportive, despite anticipation of the experience having created uncertainty, worry, and anxiety. This highlights the importance of preparation work and scaffolding for preparing staff, which led us to conclude that communication and storytelling about the work should concentrate in these areas.

When thinking about discussing the 'anchors' in the work, capacity was identified as one of the most significant barriers across all groups. There was dedication to the process of observation and feedback, but, at times, it was difficult to support this happening alongside competing demands in the houses. Recording observations often generated more paperwork for those in the internal observation team, but also for others to read, think about, and support developmental conversations.

When asked to reflect on what held the work back, staff focused on the emotional impact of being observed and offered feedback, while managers and the project team focused more on organisational and system barriers. This dichotomy, while not entirely unexpected, was helpful to enable us to effectively shape our communication and storytelling about the impact of the work for these two groups. Nevertheless, staff also shared that having access to laptops and software in the houses was an ongoing discussion during the pilot phase. This had an impact on the timely response to writing and reading feedback and observation forms.

Approach limitations and reflections

Some of the project team members were experienced and skilled in reflective practice, however we wanted to encourage participation from as wide a group as possible, so we knew we needed to ensure the retrospective learning sessions were inclusive and welcoming. The sailboat retrospective felt like a good fit, as it was a simple framework, presented in a light and visually engaging manner. We were able to evidence a depth and richness of response that enabled us to effectively stop and take stock of progress so far.



The initial sailboat session was carried out with the children's residential service management team, in-person using a single facilitator, who was also the note taker. The session went well, and the team took to the approach quickly, offering a great deal of depth within their reflections. After a debrief, the CELCIS team felt that they would have benefited from both a facilitator and a note taker, to free up capacity in the facilitator, strengthen the exploration, and ensure high quality notes could be captured to aid the analysis.

This dual facilitation approach also allowed more capacity for observation within the exercise itself. An example of this was that a real difference was noted between the two children's house sessions, with one house having more of the senior management team present, which led to a discussion more focused on what was hoped for in terms of service and practice development, and the other, with fewer senior managers involved, resulting in a much more staff-led session rich in reflections on their experiences of being observed and receiving feedback. Within facilitation debrief this was noted, which allowed us to explore the issue more fully. We reflected that having carried out a similar exercise with the senior staff may have left them feeling more prepared for and engaged in the session, leading them to role model for the wider staff group and inadvertently dominating the session. It was agreed that in future we would aim to avoid members experiencing session duplication to avoid this imbalance.

Summary of factors that enabled observation of practice

There were consistent enabling factors of practice observation identified across the 'sailboat retrospective' responses. The whole system approach to change, aligned to Senge's (2006) systems thinking, which considers an organisation as a whole and pays attention to the interconnections between its different parts, as was evident in how the Sycamore change work had been prepared, delivered and evaluated. The key enabling factors included:

- **Leadership support and permissions**

Staff felt the presence of leadership support and the permissions granted for decisions to be made would further advance and benefit the work.

- **A dedicated senior manager aligned to the work**

Permissions and leadership support were critical to the pilot's success. However, having one dedicated senior manager aligned with the work created an internal feedback loop between practice and senior management. The staff involved had the autonomy to make decisions, but, at times, required support from different parts of the internal system of the organisation. Having a dedicated senior manager allowed this to happen in a timely and responsive manner.



- **A learning culture that places importance on honesty and relationships**

How the teams approached the work aligned with Aberlour Sycamore Children's Houses' vision of creating warm, loving homes where everyone laughs, learns, grows into their future, and is treasured always. The work confirmed the importance of creating spaces for not only the children but the adults caring for them to develop open and honest relationships focused on growth.

- **Observers who knew the work, the adults, and the children**

It was important that observations did not interrupt the rhythm of day-to-day life in the houses. Therefore, the selection of the observers was carefully considered, which the findings of the 'sailboat retrospective' confirming the criteria and approach required. The observers were staff who were familiar to the children and the adults caring for them in each house. They explained their role to the children and offered time for questions to ensure they understood. The project team reflected that the children appeared very comfortable with having the observers in the houses. The observers also spent time preparing staff and visiting houses more regularly in preparation for observation.

Conclusion:

The pilot phase of practice observations carried out by Aberlour Sycamore Children's Houses, with CELCIS support, has fostered a strong sense of shared ownership and commitment among staff, including managers, to impact the experiences of children and young people. Despite initial apprehensions, the respectful and relational approach of the observers alleviated concerns, making the process positive and supportive. The involvement of familiar observers and dedicated leadership has been crucial in creating a conducive environment for practice development. While capacity and organisational barriers posed challenges, the overall impact of the observation and feedback process has been overwhelmingly positive, highlighting the importance of scaffolding through preparation, communication, and a supportive learning culture. The 'sailboat retrospective' proved to be a valuable and accessible approach that supported engagement across staff groups, and enabled reflection and learning.

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CELCIS brings together diverse expertise to improve the lives of children and young people.

Mihaela Manole is a researcher with expertise in implementation, focusing on understanding how policies and practices can be effectively embedded, ensuring sustainable, evidence-informed improvements.

Gemma Watson is an improving care experiences consultant, who provides specialist knowledge and support to practitioners to enhance the quality of care for children living in residential settings.

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Short Article

Progress is not linear, it's cyclical: Old books and our field's enduring vision – a modest proposal for readers of the SJRCC

James Anglin

On discovering and collecting books

I love books. Perhaps you do too. My passion for books really took hold when I discovered the book stacks in the library of my university during my first undergraduate semester. I fell in love with walking the rows and rows of books, on all subjects and disciplines. I loved the musty smell, and the phantasmagoria of shapes, sizes and colours.

As an aside, on a recent Zoom call, I noticed a law professor had shelved her books by colour, not subject matter. When I commented, she confirmed this was her method, as she found it more soothing to look at. She had also noticed that publishers tended to use colours in a similar fashion: red for controversial subjects, dark blue for positive topics, light blue for family and children's issues, and so on. Who knew?

I have organized my books on child and youth work and residential care in order of publication date, thus (I presume) my tendency to feel somewhat unsettled as I peruse them.

At university, I learned not just to find and remove the specific book I was seeking, but to search above, below, left and right, where I discovered many more interesting texts on the same or related topics that never appeared on any course reading list. Many treasures were discovered and new areas of knowledge opened-up, which added to, or shifted, my perspectives on my work and life.

Today, I imagine this experience has become quite rare. Almost all articles, and many books, can be found on-line, from the comfort of home and a personal workspace. I fear that many contemporary students may never, in fact, even enter a library. And to my horror, libraries tend not to order very many books anymore; I guess they take up too much space and won't likely be taken off the



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shelves anyway. In my experience, libraries only consider donations of rare and valuable texts. (By the way, is there a young-ish scholar who might be interested in my lifetime collection? See more below.)

In terms of books published over the history of the child and youth work profession internationally, some of the early texts are now difficult, if not impossible, to find. This situation seems to be due to a combination of being published by small, private printers or being issued in relatively small numbers due to the “niche” nature of our field.

Many years ago, I decided to collect as many of the English language child and youth work (CYW) texts as I could, especially those focused on either residential care in child welfare or the development of the CYW profession itself. As a result, I have acquired approximately 400 books (including some government, agency and commission reports) published between 1925 and 2025 - the last one hundred years. This collection is largely comprised of books published in North America and the U.K., with a smattering from other countries in Europe and beyond (e.g., Israel, Brazil, Japan, South Africa).

But why read old books?

I know of several instances where post-secondary instructors have stipulated that students doing an assignment should only reference books and articles published over the most recent 10-year period. Certainly, one needs to keep up with the current thinking and research in the field, however I suggest an added criterion. In addition to these texts, “please read and reference at least 2 or 3 texts published at least 20, 50 or 100-plus years ago.”

But why? Because the evolution of thinking, practice and policy (at least in child welfare) is cyclical, not linear. It is simply not the case that the recent literature necessarily contains new, better or more important ideas and knowledge than in previous decades. I learned this lesson very clearly when I decided to research the evolution of parent education and support services in North America. Not only was *parent education* as a service modality not discovered or invented in recent times, I found that it was re-discovered and re-invented every 10 to 20 years or so, and had been for over 100 years (Anglin, 1985). The same or similar ideas and strategies were sometimes re-named, but many of the basic elements were often more or less identical to those in earlier decades, and sometimes useful notions had been lost or forgotten along the way.

An example in the child and youth work literature

Given the focus of this journal, I will offer a case in point in the field of residential child and youth care.



As far as I can determine, the first book published in North America on residential child care was *Wayward Youth* by August Aichorn (1935). However, this was an English translation of the German edition published in Europe in 1925, a full century ago now. According to accounts by some of his colleagues, Aichorn was a born youth worker who pioneered a new approach to working with delinquent young people. He seemed to have well-tuned instincts about what motivated young people and what he termed their 'dissocial behaviours'. To these talents, he added psychoanalytic training under the tutelage of Anna Freud, and the Foreword to his book is written by Sigmund Freud himself.

What I find fascinating is the number of contemporary issues and concepts that can be found in his text. These include, among others: love, therapeutic milieu, children's interests, intuition, pain, trauma and the fundamental importance of carer relationships with young people. To those readers familiar with some of the historical literature in the child and youth work field, a series of key texts published over past decades rediscovering these topics will likely come to mind. For example:

Love is Not Enough: The Treatment of Emotionally Disturbed Children, Bruno Bettelheim (1950)

The Other 23 Hours: Child Care Work with Emotionally Disturbed Children in a Therapeutic Milieu, Albert Trieschman, James Whittaker and Larry Brendtro (Aldine, 1969)

Before the Best Interests of the Child, Joseph Goldstein, Anna Freud and Albert Solnit (The Free Press, 1979)

Intuition is Not Enough: Matching Learning with Practice in Therapeutic Child Care, Adrian Ward and Linnet McMahon (Eds.) (Routledge, 1998)

Pain, Normality and the Struggle for Congruence: Reinterpreting Residential Care for Children and Youth, James Anglin (Haworth, 2002)

The Three Pillars of Transforming Care: Trauma and Resilience in the Other 23 Hours, Howard Bath and John Seita (University of Winnipeg, 2018)

Relational Child and Youth Care in Action, Heather Modlin, James Freeman, Christine Gaitens and Thom Garfat (Eds.) (CYC-Net, 2021)

Hundreds of books have now been published on CYW exploring issues of significant contemporary importance for practice, education, research and policy, and many of them echo messages published initially in 1925, or even before.

It seems that much of our knowledge and writing is concerned with re-discovering and re-interpreting elements and dynamics that have been referred to elsewhere as our field's 'enduring wisdom' (Anglin & Brendtro, 2017). It



seems some old ideas and concepts need to be re-understood within an increasingly complex and ever-changing social, political and service delivery context.

As Winston Churchill has been quoted as saying (perhaps apocryphally): 'the farther backward you can look, the farther forward you are likely to see' (The Socratic Dialogue, retrieved March 15, 2025). Perhaps looking back in the CYW literature can help us to chart a renewed future for our field as well as for the children and families with whom we work.

A modest proposal

Do you have a book from over 10 years ago that has made a difference to your practice or your thinking about CYW? Perhaps others in our field could benefit from reading this text or at least might be inspired by your story of encountering it.

Most book reviews to date in the SJRCC are the result of publishers sending in newly published books. However, the SJRCC Editors have indicated that they would welcome reviews of older texts that have made a difference to readers and their contemporary practice. These reviews should be no more than 500 words, or so, and should emphasize the relevance of the texts to current CYW practice, preferably with personal examples of their impact in your own experience.

The SJRCC book review section is awaiting your submissions, and editors stand ready to assist those perhaps considering undertaking a book review for the first time.

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James Anglin has been struggling over six decades to understand how we can provide quality care for young people, wherever they live. He is Professor Emeritus at the University of Victoria, Canada, President of FICE-Canada, and a Research Affiliate at the Bronfenbrenner Centre for Translational Research at Cornell University.



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Public Lecture

22nd Kilbrandon Lecture: Who then, in law, is my parent?

21st November 2024

Kenneth McK. Norrie

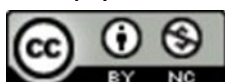
Strathclyde Law School

Introduction

It is an immense honour to have been asked to deliver the 2024 Kilbrandon Lecture. Past lecturers have included politicians, health care professionals, journalists, authors, and the occasional lawyer. Having recently retired from Strathclyde Law School after 33 years there as a child law specialist, I am pleased to note that two of the most eminent lawyers who have been Kilbrandon Lecturers – Lady Elish Angiolini and Lord Hope of Craighead – both have strong connections with Strathclyde. Lady Elish is a graduate of and a visiting professor in our law school, and Lord Hope for many years was Strathclyde University's Chancellor. 2024 is the year in which both the university and the law school are celebrating their 60th anniversaries, and there is a pleasing symmetry in the fact that 2024 also marks 60 years since the publication of Lord Kilbrandon's famous *Report*, which led to the establishment of the children's hearing system in Scotland.

I said that I specialise in child law, which is how the discipline is normally designated today, but in fact my major textbook on the subject carries the rather more traditional title *The Law Relating to Parent and Child in Scotland*, (Wilkinson & Norrie, 1992, 1999, 2013), which consciously refers back to Lord Fraser's important 19th Century work *Parent and Child*, (Fraser, 1866). This title I think better reflects the fact that for the vast majority of children their parents are the most important people in their lives; and the parent-child connection is the legal relationship that is most protected by our law.

That immediately raises an important and surprisingly difficult question: who, in law, *is* a parent? That is the question that I want to explore in this lecture tonight. The United Nations Convention on the Rights of the Child, incorporated this year into Scots law and containing a clear definition of 'child', avoids defining its other central concept, 'parent', which reflects the fact that there simply is no universal understanding of what a parent is that applies across the



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world, across cultures and across time. I was interested to note that in the recent Scottish Government consultation on the 'Redesign' of the Children's Hearing system¹⁶, one of the questions asked is whether the hearings legislation should include a definition of 'parent'. I answered that question with a resounding no, for many of the reasons this lecture will touch upon.

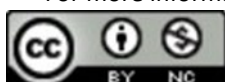
The artificiality of everything

During my long years teaching undergraduate law students I always emphasised to them this uncomfortable truth about lawyers: we are not a loved race. Amongst the many reasons for lawyers being so disliked is that we have a tendency to turn everything – including the most natural things in the world – into artificialities, from reality into abstractions. Lawyers do this because the law can only operate through a complex and interrelated set of classifications, which are human impositions onto the natural world. While these classifications may well seek to reflect reality, they can do so only imperfectly since the very process of classification acts to simplify the inherent complexities of life. However, this distortion is essential in order to make these complexities administratively manageable.

To give an obvious example, the law classifies human persons into children and adults (with an occasional intermediate category of 'young person'). To do so the law will often draw the line at particular anniversaries of the individual's birth: whether 12, 16, 18 or whatever. Later we do the same for age-related entitlements, pensions, bus passes, free TV licenses and the like. Now in reality of course every child grows up at their own pace and none of them wakes up on their 16th or 18th birthday with an intellectual or physical capacity that they did not have when they went to bed the night before. So, setting ages at which all young people acquire legal capacity is clearly artificial, though it is administratively convenient and indeed necessary for the efficient operation of the rules. It would be a nightmare to require the seller of alcohol or tobacco or fireworks (see Licensing (Scotland) Act 2005, ss.102-110; Tobacco and Primary Medical Services (Scotland) Act 2010, s.4; Fireworks and Pyrotechnic Articles (Scotland) Act 2022, ss.4-7), say, to assess the actual intellectual capacity of every young person seeking to purchase a restricted item.

Equally artificial, if perhaps less obviously so, is how the law identifies and defines a child's parents. Lady Hale famously said in the House of Lords decision of *Re G (Children) (Residence: Same-Sex Partner)* [2006] UKHL 43 that parenthood can be either genetic, gestational or social and psychological, but she emphasised that she was talking about 'natural' parenthood and was *not* suggesting that each of these concepts of parenthood makes an individual a legal parent, with legal consequences.

¹⁶ For more information on Scotland's system of Children's Hearings see <https://www.chscotland.gov.uk>



The law, indeed, has long recognised that there is a difference between legal parenthood and natural parenthood. The natural child of a natural father was what was called an 'illegitimate' child: a person whose father was not married to their mother. That relationship was 'natural' in the sense that it was recognised by nature rather than by the law, and it had minimal legal consequences: shades of that position survived in Scotland until as late as 2022 (or even 2024), when the last 'natural' child born before the Family Law (Scotland) Act 2006 attained the age of 16 (or 18). A more obvious circumstance today in which we distinguish between legal and natural parenthood is with adoption, which allows the parent-child relationship to be created by court process rather than anything found in nature. Parenthood in the eyes of the law is as much a construct of the law as is the adult relationships of marriage and civil partnership.

Actually, what is natural about the natural relationship? We are used to thinking today that parenthood naturally comes from the genetic connection between parent and child, but (becoming quite meta here) that natural connection is itself artificial, in the sense that it is human choice to give social and legal consequence to the fact of genetic connection. The Romans, with little understanding of genetics, did not make that choice and had no problem seeing fatherhood as a deliberate act of accepting one person as the child of another – Julius Caesar and Octavius, and Trajan and Hadrian, are only the best-known examples of sons who became so simply by declaration of older men. It was not until much later in history, during the medieval period, that blood came to be seen as the crucial and only determinant of fatherhood, for this was the time that Norman notions of primogeniture solidified into our law, and rights came to be devolved *iure sanguinis* – by right of blood.

An equally naturalistic way of looking at parenthood is to see it as a question of doing rather than of being. The word 'parent' can quite legitimately be used as a verb as well as a noun, and it is no grammatical solecism to identify a parent as the person who *parents* a child, in the sense of being the adult who actually carries out the tasks of caring for and bringing up the child. This is almost certainly how children, especially young children, perceive who their parents are. So, our legal system's choice, around 800 years ago, to locate 'parent' in terms of blood rather than care, is just as artificial as an adoption order. It is worth noting that that choice had nothing to do with the interests of the child: it was made because of feudal society's need for certainty in property succession in a male-oriented world.

We can see this in the language that we use. We use the word 'illegitimate' to describe the natural child, but what was legitimate or illegitimate was never the child's own existence but rather the child's claim to their father's estate (known in Scots law by the technical term 'legitim'). The child's claim was 'legitimate' if, being the child of the father's wife, there is a high probability of the child being that man's blood child; it was an 'illegitimate' claim otherwise. We used the



word 'adultery' to describe the civil offence (which continues to provide a ground for divorce in Scots law) of having sex outwith marriage. What was being adulterated was not the marital relationship itself, but potentially the male blood line (and gay sex, therefore, can never be adultery, even when occurring outwith marriage). All these rules served a social function: security of succession between males, which prevented disputes, and in extreme cases such as succession to the Crown, fratricide and war. These rules stabilised society, in other words.

The artificiality of parenthood is at its most apparent with statute law and lawyers, being natural 'Humpty Dumpty's', are entirely comfortable with words in an Act of Parliament meaning whatever the legislator wants them to mean.

The word 'parent' was central to, for example, the Social Work (Scotland) Act 1968, best known of course as the Act that established the children's hearing system. The 1968 Act tells us (ss.30 and 94, as originally enacted) that the word 'parent' means (where the child is 'illegitimate') 'his mother to the exclusion of his father'; parent also includes 'guardian', and 'guardian' is defined to include 'any person who ... has for the time being the custody or charge of or control over the child' – the person who *parents* the child, in other words, is within the 1968 definition of 'parent': while some fathers are not. The key to understanding this complicated definition is to realise that its purpose was never to identify who the child's parents were but rather its purpose was to delineate who had what today we call the right of participation at a children's hearing. Parenting has always been seen within the children's hearing system as more important than genetics, which actually explains why the natural father was excluded – it was assumed in the 1960s that when the parents were not married to each other only the mother would be involved in bringing up the child: only the mother would be *parenting*. That assumption continued in law long after it had become palpably untrue: until, that is, the Children's Hearings (Scotland) Act 2011 came into force in 2013, a mere 11 years ago. We can see similarly wide definitions of 'parent' in the Education (Scotland) Act 1980, s.135, the Antisocial Behaviour etc. (Scotland) Act 2004, s.117 and the Criminal Justice (Scotland) Act 2016, s.23(4) – all of which are designed to identify the persons upon whom certain legal responsibilities are placed.

An even odder definition of parent is found in s.40(7) of the Age of Criminal Responsibility (Scotland) Act 2019: 'parent' is a person who satisfies three conditions: is 'aged 18 or over', 'has parental responsibilities ... in relation to the child' and 'is related to the child'. We are further told that being related includes 'being married to or in a civil partnership with a person who is related to the child'. Now, read in isolation this is pretty meaningless, and it makes sense only when you realise that what s.40 is doing is identifying a responsible person who can accompany the child at an investigative interview with the police. It is not about deciding who is a parent – it is using that word as a shorthand.



In other words, parenthood, like it or not, in law is a mechanism to achieve particular purposes, whether imposing obligations to attend children's hearings or police interviews, universal issues like bearing responsibility to bring up or educate the child, or more venal issues such as identifying who should inherit property when someone dies. Who, then, in law, is my parent?

Who is a 'Mother'?

Mater certa semper est, said the Romans – or motherhood is always certain. This was never quite true, for even before the development of IVF and other infertility treatments motherhood could be a matter of contention, for example if there were alleged to be a mix-up at the hospital and the wrong baby is sent home with the wrong parent; or where immigration officers refuse to believe that the child a woman is attempting to bring into the country is her child; or as in the 18th Century Scottish decision from the House of Lords where succession to land, wealth and titles turned on the question of whether Lady Jane Douglas had at the age of 50 given birth to twin boys as she claimed, abroad, or had instead sought to perpetrate a fraud on her aristocratic family: *Archibald Douglas v Duke of Hamilton* (1769) 2 Pat 143.

What the Romans really meant was that there was no room for dispute as to how we *define* a mother: the mother is self-evidently the woman who was pregnant and gave birth. There may be difficulties in proof, but these do not challenge that unquestioned fact.

However, the development of infertility treatment, and in particular egg donation, towards the end of the 20th Century challenged this age-old understanding of motherhood. Suddenly the law was faced with the question: if the egg comes from one woman and is inserted into the womb of another woman, who is the mother? The common law had no obvious answer to this, and it could be argued either way. In fact, there was a third choice available, one indeed that may better reflect the reality of the egg donation situation. Both women make absolutely essential contributions to the creation of the child, so the law could have chosen to allow the child to have two mothers.

Now, that third choice would have led to multiple social and legal complexities and it was never seriously considered. When the UK Parliament in 1990 came to make its choice, it determined without any real discussion or opposition that the woman who becomes pregnant and gives birth is for all legal purposes the mother of the child (Human Fertilisation and Embryology Act 1990, s.27 and then Human Fertilisation and Embryology Act 2008, s.33(1)). It is interesting to note in passing that the Supreme Court of Ireland in 2014, in the absence of any equivalent legislative guidance in the Irish statute book, came to this same conclusion on the basis of the Irish common law: *MR and DR & ors v An t-Ard-Chláraitheoir & ors* [2014] IESC 60.



The point I am seeking to emphasise here is that defining 'mother' as *one* of the women who makes *one* of the crucial contributions was a choice – it was artificial, though no less valid for that: it was a matter of human judgment and (not least) social and administrative convenience rather than a matter of the law reflecting nature. Motherhood is of necessity a legal artifice, but it is a powerful one.

The strength of motherhood is seen in the case of *Regina ex p McConnell v Registrar General*) [2020] EWCA Civ 559. Here a female to male transgender man, Freddy McConnell, became pregnant through infertility treatment and he gave birth after his transition. He wanted to be registered as the child's father, but the English courts insisted that the law regarded him as the child's mother, even although he had obtained, before becoming pregnant, a gender recognition certificate changing his gender from female to male. What interests me about this case is why Mr McConnell cared so much, given that the law never denied he was, in one form or another, a parent. He claimed that an official record (his child's birth certificate) revealing his transgender history was a breach of his right to privacy; he argued that the parental exception to the law's recognition of his change of gender in s.12 of the Gender Recognition Act 2004 was a disproportionate interference with his private and family life; he asserted that the law was incoherent in declaring him to be, in effect, a male mother: and he said that from the child's perspective the relationship was in reality a father-son relationship while the law insisted that it was a mother-son relationship. The Court of Appeal rejected all these arguments, and in doing so emphasised that while a child gains benefit from a second parent, irrespective of that second parent's gender, gender-identity or sexuality, a child *always has a mother* – even if that mother is for all other purposes of law a man.

Who is a 'Father'?

Fatherhood is no less, and indeed more obviously, an artificial concept, and has been recognised as such for millennia. For it is a fact that has bedevilled the male psyche since the very dawn of time itself that while women always know who their children are, men never do. Men have to rely on what women tell them and, shocking though it may be, sometimes women are not truthful in this matter. For at least 800 years the law has identified the father of the child with the provider of the male genetic material that led to the mother's pregnancy. Both legally and socially we give that value, which is the underlying premise of that fabulous film *Mamma Mia* (even although none of the three men who had had sex with Meryl Streep's character had ever been a father to the character's daughter in any sense that surely mattered). That film is set, of course, in the modern age so the daughter could identify her genetic father, but for most of humankind's history it was a factual impossibility actually to prove the genetic link between a child and any particular man.



The law since Roman times has got over this evidentiary gap by operating a presumption as to who the father of a child is. This is known as the *pater est* presumption: *pater est quem nuptiae demonstrant*, or the father is he to whom the marriage points. There is a logic to this. Most children come about by sex, and married women are more likely to have had sex with their husbands than anyone else, and so it is perfectly rational for the law to presume the connection between the husband and the child. Modern Scots law has an additional presumption: if a man's name is registered on the child's birth certificate, then he is presumed to be the father, because it is likely that he is. Both presumptions are now contained in the Law Reform (Parent and Child) (Scotland) Act 1986, s.5(1).

Though today the evidentiary gap can be easily filled by a DNA test, these presumptions, based on likelihood, apply even when we know that in a not insignificant number of cases, they will not be accurate. However, that is actually the whole point: just as the rules of legitimacy enhanced social and familial stability in the middle-ages so today family stability is enhanced by the pretence that the Register of Births is accurate in all cases, until proven otherwise.

Parenthood after infertility treatment

So, paternity always was a fluid concept, designed primarily to achieve social stability, and settled lines of succession, rather than anything else. However, stability depends on stable definitions, and the definition of 'parent' became far more fluid in law with the development of infertility treatment. This is because overcoming a couple's infertility often depends on using genetic material donated by a stranger, whom no-one intends to be the parent. Before the Human Fertilisation and Embryology Act 1990, the donor of sperm was excluded from paternity only by keeping his identity secret, and the man who was attempting to become a father did so only by relying on no-one challenging the presumptions I've already talked about: this was all very insecure. But the 1990 Act changed all that by removing the genetic link as the backstop determinant of paternity in cases of infertility treatment and replacing it with the notion of consent – either to the infertility treatment or to being treated as the father (depending on the relationship with the mother).

Having removed genetics from the definition of father, the logical extension of these rules to female couples came about with the Human Fertilisation and Embryology Act 2008. But the 2008 Act does struggle with terminology when dealing with same-sex couples. The woman who gives birth is always designated the 'mother'; if she has a male partner, he is designated the 'father'. However, the 2008 Act cannot quite bring itself to call the mother's female partner another mother: instead, she is designated as gender-neutral 'parent'. This makes little practical difference, but words carry emotional and political heft, as we have already seen in the case of Freddy McConnell. And there is a premium to be had from having the status of mother rather than parent.



Consider, for example, the case of *Re E (Assisted Reproduction: Parent)* [2013] EWHC1418 (Fam), which involved a female couple who wished to have a child together. They attended a licensed clinic where one of them was artificially inseminated with donor sperm; she became pregnant and in the fullness of time twins were born. The women were registered on the children's birth certificates as 'mother' and 'other parent'. Unfortunately, when the twins were still toddlers the women separated, and the fairly pedestrian contact dispute that followed soon became vicious. The mother opposed contact between the twins and her ex-partner with the devastating argument that the ex-partner was not a parent after all. She showed that the consent forms they had both signed had been given to the clinic *after* the insemination process had started rather than before, as the 2008 Act requires. The court held that since the conditions in the Act had not been fully satisfied the woman registered as the children's 'other parent' was not a parent of the children she had helped plan into existence and bring up in their early years.

Now, one of the major themes of this lecture tonight is that we shouldn't worry about the inherent artificiality of parenthood – but this is surely taking matters too far. The court's demands that the Act be followed in every minute detail, including when a form is signed, seems to me to preference legal technicality over social reality. And worse, it suggests that motherhood, a natural state, has a stronger claim to the law's protection than mere parenthood which is a creation of the law.

This is not a unique case. *P v Q* [2024] EWCA Civ 878 also involved a female couple, but this time they were married to each other, and married female couples don't need to involve clinics or sign forms. All they need is a blob of sperm and, frankly, the world is awash with the stuff. Through social media they contacted a man who was willing to provide the genetic material they needed, and one of the women became pregnant and gave birth to a child. The birth certificate again showed both women as the parents. As in the previous case the relationship broke down and the mother sought a declaration that her ex-wife was not in law a parent at all. Here the problem was not with the forms required by a licensed clinic, because no clinic was involved. Rather, the mother asserted that as well as attempting to become pregnant through artificial insemination she had also had sexual intercourse with the man providing the sperm.

Now, here is the problem. The 2008 Act only applies – parenthood is only transferred from the man who provides the genetic material to the partner of the mother – if the insertion of that genetic material into the mother is done *artificially*. But in this case the closeness in time between the mother attempting artificial insemination and having sex with the man providing the sperm meant that there was no scientific possibility of determining which insertion of his sperm – the artificial or the sexual – was the one that in fact led to this pregnancy. What was the court to do?



The Court of Appeal resolved the issue by utilising the ultra-legal concept of onus of proof. The onus lies, the Court held, with the party seeking to dislodge the common law and seeking to establish that the 2008 Act applied: the ex-wife in other words had the burden of proving that the conception was artificial. We already know – and the Court knew – that such proof was a scientific impossibility, so the decision on who had the legal onus to prove the impossible effectively decided who lost the case. Now, it seems to me that the court could just as easily have placed the onus on the mother. A man named in the birth certificate as a father is presumed to be so until this presumption is proven to be false; a woman named as other parent could equally have been presumed to be other parent until that presumption is proved false, by showing that the 2008 Act did not apply. Yet the Court of Appeal chose to place the onus on the parent rather than on the mother, and this I think is because the court conceptualised motherhood as something that trumps parenthood.

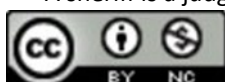
We can also see motherhood being treated as stronger than any other form of parenthood in the slightly unexpected location of a Scottish children's hearing case. *JS, Appellant* 2021 SLT (Sh Ct) 116 involved an unmarried (straight) couple, now separated, who had both been attending children's hearings for their child. After a couple of years, the mother declared that her ex-partner was not, in fact, the father. Since he had not been registered as the father, and the couple were not married, this meant that he could not rely on any presumption of paternity, and so the reporter¹⁷ indicated that he could no longer be regarded within the children's hearing system as a relevant person. The man offered to undergo DNA testing but the mother, who had put the issue in doubt, refused to allow the child to be tested, to have the doubt resolved.

The sheriff¹⁸ resolved this fairly tricky situation by attaching to the compulsory supervision order a condition that the child be DNA tested. Now, though her motivations were good, my own view is that the sheriff made a clearly incompetent order – for all sorts of reasons which I seek to explain in 'Paternity, DNA Testing and the Children's Hearing' 2023 *Juridical Review* 1. I mention the case here to show again the comparative strength of motherhood, in this case compared with fatherhood. The reporter's argument that he could no longer treat the man as father once the mother denied he was father was wholly inconsistent with his having previously treating the man as father simply on the mother's say-so.

The English High Court earlier this year adopted a much more pragmatic approach to a similar issue in *Re D (Parentage: Local Authority Application)* [2024] EWHC 305 (Fam). This involved a couple in England who were having difficulty conceiving and could not afford to access infertility treatment. So, the

¹⁷ The reporter is an official whose main function is to receive and investigate concerns about children and decide whether to refer them to the children's hearings system. See: <https://www.scra.gov.uk>

¹⁸ A sheriff is a judge presiding in a Sheriff Court and other tribunals in Scotland.



man mixed his sperm with the sperm of his own father, which was then inserted into the woman, who became pregnant. Some years after the child was born the local authority (for quite different reasons) instituted care proceedings and sought to have the child and the two men DNA tested to determine paternity. The application was dismissed on the ground that the local authority had no interest in the issue – in other words determining who the child's father was *in law* had no relevance to any issue that the local authority had to address in its child protection processes.

Now, I am not saying that finding out whose sperm had been used to create this child was unimportant: it may well be essential to the child's own developing sense of self-identity to know whether his father was actually his natural brother, and his grandfather actually his natural father. However, that was an issue for the child and not for the child protection process.

All of these cases show that the law gives a uniquely important status to motherhood which it does not confer on other forms of parenthood. This is perhaps no surprise, given that reverence for motherhood is hardwired into cultural traditions that transcend both time and place, from Ganga Mata (Mother Ganges) to Mary, mother of God, from the Egyptian goddess Nut to the Greek Gaia (Mother Earth).

Surrogacy and male couples

Yet sometimes the modern law allows a child to have no mother at all. The infertility treatment provisions in the Human Fertilisation and Embryology Act 2008 trace parenthood through the mother and as such, while they offer a route to parenthood for members of both opposite-sex and same-sex female couples, these provisions offer nothing to gay male couples. The 2008 Act did give male couples access to the parental order after surrogacy. Since 2008, surrogacy has flourished among the gay male community.

The law of surrogacy is a complex and fascinating study, but what is particularly interesting for our purposes tonight is how the law and the courts conceptualise the parental order after surrogacy. The order is only available to the couple who are in fact parenting the child: it is designed to reflect that social reality. However, the law does require that the genetic material of at least one of the intended parents be used, and that genetic link is the justification for rejecting adoption as the mechanism to transfer parenthood away from the surrogate: people should not have to adopt 'their own child'.

In other words, the intended parents are seen as the 'real' parents even before the order is sought, and the courts have gone out of their way to ensure that the order is granted. I find it intriguing that while the courts have adopted an excessively strict interpretation of the infertility provisions in the 2008 Act (as we have already seen), they have at the same time adopted an extremely loose



interpretation of the surrogacy provisions in exactly the same Act – even to the extent of ignoring the clear rules set by Parliament in relation, for example, to the time-limits for applications (see for example *AB, Petitioners* 2023 SLT 893 (Lady Carmichael); *PM, Petitioner* 2024 SLT (Sh Ct) 33 (Sheriff Sheehan), both of which explicitly followed the English approach in numerous decisions to that effect). What the courts have consistently done here is to treat the parental order after surrogacy as a means to regularise the situation, or to reflect the parenting reality, rather than as a radical transference of parenthood from one set of parents to another, which is what, in strict legal terms, the parental order accomplishes. Legal technicality in this instance gives way to social expectation; it is a rare example of parenting trumping parenthood.

New family structures

Given the long history of same-sex couples establishing their own family units outwith the designs of the law, it is perhaps no surprise that even after the 2008 Act allowed same-sex couples to access both infertility treatment and surrogacy, a large number of female couples continue to prefer private arrangements than the medicalised (and expensive) options regulated by the Human Fertilisation and Embryology Acts. Also, the very much more limited options for parenting available to male couples have led men, in particular, to seek to fashion new styles or forms of parenthood which, by and large, women have resisted.

There have been a number of cases before the UK courts in which female couples have informally received sperm from gay men, in return for some involvement in the child's life. Often these arrangements work well, but very regularly cases come to court when relationships between the parties break down – the women on one side, the man on the other. We call them the 'known donor cases' and the breakdown in relationship is nearly always caused by the parties misinterpreting each other's intentions: they perceive the very idea of parenthood differently. When a female couple offer a gay male friend the chance to be a 'father' if he gives them some of his sperm, the man tends to interpret that as much more involving than the women mean. The first case to get to court was the Scottish case of *X v. Y* 2002 SLT (Sh Ct) 161 (see Norrie, 2002), but there have been dozens of similar cases in England since then. In for example *L and R v. W and W* [2011] EWHC 2455 (Fam) the women had advertised for a male couple who, in return for their sperm, would be offered the role of 'father' and 'step-father'. The men with whom they entered into an agreement to that effect understood these terms to have far more practical content than the women intended: they were using the words almost symbolically. Likewise, in *Re B (Role of Biological Father)* [2007] EWHC 1952 (Fam) the role the women offered the man was an 'avuncular' one, that of a benign, but distant, uncle; the man saw the chance (and perhaps his only chance) to become a parent in an involving sense.



What I find most interesting about these known donor cases is that in each of them the men are attempting to create a new form or style of parenthood where they have status recognition though less day to day involvement than expected (or demanded) of the traditional father: they are seeking to be a third parent with some involvement in the decision-making relating to the child's life, not to be the full-time carer but with more involvement than a typical non-resident father would normally have. Female couples, by and large, have preferred to replicate the nuclear model of family life, which excludes outsiders for all practical purposes except when they determine otherwise. The courts have resisted moving beyond the nuclear model because they reject out of hand the idea that a child can have more than two legal parents, even when that is the reality on the ground in these cases.

Yet many children are recognised to have more than two parents already. Adopted children have birth parents and adoptive parents; step-children usually have three or four parents, each with differing parental responsibilities. This leads me to wonder if actually the key to a better conception of parenthood is to see it in essence as a bundle of legal consequences which are normally held by no more than two people but which in some circumstances are spread more widely. The Children (Scotland) Act 1995, for example, easily accommodates more than two people having parental responsibilities and parental rights; the Family Law (Scotland) Act 1985 imposes a parental obligation of aliment on most step-parents in addition to birth parents; the Damages (Scotland) Act 2011 allows claims for wrongful death to parents and to those who adopt a parenting role in the child's life; the concept of the 'relevant person' in the children's hearing system has no limitation to a maximum of two. It seems to me that it is only in the field of succession law that there are strong policy reasons to restrict the number of our legal parents to two, but that area is properly governed by principles appropriate to property and succession law rather than child law.

Conclusion

Where does all this take us? I have described the various complexities in the law's approach to parenthood in order to make two fundamental points. The first I mentioned right at the start: parenthood, like everything defined by the law, is inherently artificial. However, we should not worry about this because it reflects the reality of many children's lives. By accommodating a variety of family forms, it avoids prejudicing children brought up in more unusual circumstances. Focusing on what is perceived as 'natural' serves no purpose today, and certainly offers nothing of benefit to the child. I am not arguing that the fact of genetic connection should be ignored, for it will usually have emotional and sometimes medical significance. I am questioning why in the modern world we continue to give significant *legal* consequence to its existence.



The second point that I want to make is that while every child is different and has different family circumstances, children are the same in one crucial respect: above all things they need stability in their lives, and the assurance that there are adults who love them and whose role is to put their interests first. Children are astoundingly resilient creatures and can cope with any family structure so long as it provides them with that stability and that assurance. The role of the law, it seems to me, is to seek to ensure that stability by regarding parenthood – in its many different guises – as an anchor for every child, which is immovable even if their life circumstances change due to the evolving relationships of the adults around them. I find deeply disturbing the cases I've talked about this evening where people who were originally regarded as the child's parents have had that status removed on legal technicalities in cases that are not primarily about who the child's parents are.

Professor Gillian Black (2018) has made a powerful argument that we in Scotland should adopt the approach common in continental Europe of severely restricting the mechanisms for challenging established parent-child relationships. I find this persuasive, if for no other reason than that cases where parenthood is challenged are all about serving adult interests – even if wrapped up in child-welfare language. Other than with adoption, where the child's interests are central to the whole process from start to finish, I would make it virtually impossible to remove a person's parenthood once they are officially recognised, by whatever means, as having some or all of the attributes of a parent. An individual attribute of parenthood, such as having parental responsibilities and parental rights, can of course be altered, but this should happen only when the child's welfare is the real issue at stake and not simply a mechanism to further adult interests.

Taking both these points together leads me, finally, to answer the question I set myself in this lecture: 'Who, then, in law, is my parent?'. And the answer I am afraid is that typical, frustrating, lawyer's response: it depends on the context and can have a different answer in different situations. If you find that unsatisfactory, then even more so is the typical, frustrating, academic's answer: the question itself is ultimately meaningless, because what is important to the law are the various consequences that flow from the recognition of a particular connection between a child and an adult: irrespective of what you call that connection.

Of course, I've already accepted that the words that we use to describe these connections do have social significance, but perhaps we need to leave it to children themselves to develop their own language to capture their own perceptions of who the adults around them actually are, and what *they* want to call them. That, rather than a focus on genetic inheritance, or legal technicality, or adult interests, seems to me to be a better recipe for ensuring the wellbeing of all children, whoever their parents are.



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About the Kilbrandon Lecturer

Professor Kenneth Norrie is a Scottish legal scholar and author. He is Professor Emeritus at the University of Strathclyde Law School, where he taught for 33 years until his retirement in 2023. He is the author of multiple textbooks, including *Parent and Child*, *Children's Hearings in Scotland*, and *A History of Scottish Child Protection Law*. Professor Norrie is a Fellow of the Royal Society of Edinburgh, was awarded 'Law Teacher of the Year' in 2007 and was a founding representative of the European Commission on Sexual Orientation Law. A video-recording of this lecture, and transcripts (and recordings, where available) of previous Kilbrandon Lectures and the related Children's Research Webinars can be accessed at the [Kilbrandon Lectures Archive](#).



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Book Review

In Harm's Way: The Memoir of a Child Protection Lawyer

By Teresa Thornhill

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Reviewed by: Kenneth McK. Norrie

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Teresa Thornhill is an English barrister who has had three decades of experience working in the field of child protection law. She has previously authored works about women, refugees, and vulnerable people in the Middle East. She writes engagingly, with a neat turn of phrase: at one point she describes an opposing barrister, whom she found smug and self-satisfied, as looking 'cool and calm as a glass of mint tea' (p. 5).

In Harm's Way is a coruscating account of the deep (and ever-deepening) flaws in the child protection process as it operates in England and Wales. The format of the book is a series of case-studies, interspersed with scenes from her own life. She sets out the aims of the book as making people aware of the miserable circumstances too many children are growing up in in contemporary England and Wales, and bringing to public attention how unsatisfactory – even dysfunctional – and grossly underfunded the system of child protection is. Years of austerity bear much of the blame for exacerbating these problems. However, few of the problems she identifies are unique to England and Wales.

The book opens with the startling declaration that the cases she will be discussing 'are not real cases' (p. 34). The case studies are amalgams, obviously constructed to bring out the points that the author seeks to make, and she explains that she is obliged to adopt this approach in order to maintain confidentiality for the families (each of whose circumstances are so unique that identification would otherwise be relatively easy) – and, she might have added, for the other professionals she deals with (the more sensitive of whom might otherwise regard the book as actionable).

Though structured into four separate parts, the book naturally falls into two quite separate, and imbalanced, sections: the author's work representing



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parents, and her work as a local authority lawyer. The first of these sections, which makes up the bulk of the book, mostly concerns the frustrations the author feels at the deep and systemic unfairness faced by parents whose children local authorities are seeking to remove into care, who seldom understand the processes involved; the second focuses more on the frustrations local authority lawyers face with respect to the institutional processes by which their employers perform their child protection duties. Throughout the whole book, the author time and again returns to the devastation caused to local authority services in general – and child protection in particular – by years of austerity leading to unceasing reductions in funding. This has led to good outcomes being replaced as the primary goal of child protection by measurable process, accompanied by an across-the-board deskilling not only of social workers but of the lawyers who seek to support them.

The scenes from the author's own life (putting logs on a wood burner, walking holidays in the Pyrenees, seeing her son off to university) are distracting but do serve to underline one of her main points – the sheer middle-classness of child protection professionals. These scenes are inescapably alien from the life experiences of the families caught up in child protection processes, and the point is well made that it is vanishingly rare for abuse and neglect of middle-class children to lead to local authority intervention in family life. Sometimes however these scenes are clearly tendentious constructs. Chapter 10 consists of a chat over coffee the author had with a court-appointed guardian, which consisted of her asking her companion questions such as 'why has CAFCASS deliberately devalued the role of the guardian?' 'Why do they recruit people who are so green?' 'Has your case law risen in the past few years?' 'Don't you think, Naim, there's a huge problem with social work recruitment and training?' 'Do you think there should be a minimum age for people to become social workers?' Doubtless the author wanted to draw attention to matters which were outwith her own professional experience, but the artificiality of the conversation was grating.

The author identifies many aspects of the system which she considers broken beyond repair. She regards paying for psychologists to produce court reports recommending therapy as an immoral waste of money, when there are no resources to pay for it, and their large fees could be used to do so instead. She is angry at managerialism in the system, where judges and magistrates are more concerned with ensuring that their cases are dealt with within set timeframes than properly, and where CAFCASS reviews of guardians leave no space for personal initiative. She dislikes intensely the idea of lay tribunals making child protection decisions – at least as they operate in England and Wales. The Scottish system of children's hearings is not within her knowledge, where the whole structure is very different: the English system endows lay magistrates (overwhelmingly white, retired, financially comfortable) with the whole panoply of court ritual: 'All rise' the clerk will say when 'their worships' (the magistrates) appear (p. 9, p. 13). This is never likely to create an atmosphere in which struggling families can meaningfully engage in judicial proceedings.



The system is full of Catch-22s: parents often need to attend therapy to show they are working to get over their problems, but self-funding is out of the question, and the courts cannot order it if local authorities refuse (or are unable) to pay; a homeless young person without her child is low down on the list of social housing priorities, and both local authorities and judges feel unable to return children to homeless parents even when doing so would allow them to escape homelessness; the fact that recovery from addiction takes time means that children are removed permanently prematurely, applying the assumption 'that it's almost never in the interests of children to be made to wait while their parents try to change, even when the alternative is stranger adoption' (pp. 94-95).

The author describes one disturbing case (in truth, they are all disturbing) in which her client is the drug-recovering father of a six-year-old boy, whose mother has abandoned him and her two younger children. The father wants to care for all three of the children, but the social workers are clear that the younger two (who have only a social connection to the author's client) should be placed for adoption, with the six-year-old placed in long-term foster care. The author fails to persuade the judge that the best solution is to give the father more time to show he has properly recovered from his addiction, and to fund therapy to help him to do so – and she rightly worries that the outcome, involving more lost relationships, will be devastating for the six-year-old. This case illustrates so many things: that the best outcome for one sibling is not necessarily the best outcome for another; that what is best for the parent is frequently not best for the child; that time constraints place too many children on a trajectory that is virtually impossible to escape from once initiated; that funding constraints rob so many families of the support that they need, meaning that care proceedings invariably lead to much more extreme outcomes than would otherwise be necessary; and that middle-class decision-makers have little real understanding of the pressures and challenges faced by those at the margins of society.

The author's work was primarily either for or against parents, and she did not represent the children in any of the cases she discusses. At various points, she admits her doubts as to whether what her clients want – and what she was paid to argue for – was in fact the best solution for the child involved, but she points out that her job was to take instructions and to present these to the court in as effective a manner as possible: it was *not* to assess the welfare of the child. An analogous approach is adopted by criminal defenders, on the basis that everyone accused of a crime has the right to challenge and test the evidence offered against them, and to go free if that evidence is found wanting. This is right and proper in criminal law, but I am not convinced that the same argument works as well in child protection. Few criminal defenders lose sleep when the guilty go free, but from the author's own experience that almost certainly cannot be said for lawyers successfully representing parents in child protection proceedings. The ethical dilemma this poses is not explored to any great extent, given that the purpose of this book is not to show how the system is bad for children, but how it ill-serves parents at risk of losing their children. The usual



focus of most books on child protection law is the children, but this book serves as a very timely reminder that parents too are deeply involved and may face processes utterly destructive to their own wellbeing.

The final chapter of the book seeks to offer some solutions (or at least practical improvements). Most are utopian (by which I mean out of the question in today's reality): a reversal of the deep cuts the past 10 or 15 years have seen in local authority resources, and far higher pay for social workers, placing them on a par with doctors. Some identify deeper social and political problems which would not be addressed by even an ideal child protection process: lone parents struggling with lack of family support, too often with lives devastated by drugs and alcohol, low educational achievements, social exclusion, unemployment, homelessness. Rather more achievable, if requiring political and judicial will (and academic engagement), is her recommendation for vastly increased research into which outcomes delivered by the courts have worked in the long-term. The author would also welcome an expansion of the Family Drug and Alcohol Court and its more holistic approach (though she accepts that would be inappropriate for cases of physical or sexual abuse). The book ends with a plea for a massive increase in taxpayer money going into child protection, knowing that it will not happen, but few could disagree with the final sentence of the book: 'As one of the wealthiest countries in the world, Britain should strive to do better by its children' (p. 300).

About the reviewer

Professor Kenneth McK. Norrie taught family law at Strathclyde Law School for over 30 years, where he specialised in Scottish child protection law. He is author of a number of textbooks on that subject, as well as work on medical law, trust law, and defamation. He retired in 2023.

The publisher, Harper Collins, supplied a copy of this book for review.



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Book Review

Looked After, A Childhood in Care

Ashley John-Baptiste

Publisher: Hodder and Stoughton

ISBN: 139971192X

Year of Publication: 2024

Reviewed by: Chelbi Hillan

CELCIS Consultant with Lived Experience

Looked After: A Childhood in Care is a memoir of Ashley's experiences of care in England from the age of two to 18 years old. His reflections seem relevant for understanding care experience in many contexts, not simply England, and they are deeply personal. Since gaining his degree at Fitzwilliam College, Cambridge, he is now a broadcast journalist and presenter. Reading this book was an emotional journey, with some parts leaving me teared up, facing the reality of life in care for many, and at other points filling me with immense hope and joy, knowing that people do care.

I saw a lot of myself in this book. Ashley accurately portrays many of the challenges which young people face while living in care and under the rule of adults who make major decisions about their lives. A moving account of how difficult it is to leave home and start again reminded me of just how challenging the countless transitions can be for people in care. The way Ashley described intergenerational trauma and the emotional load we carry as children in care was spot on. It struck a chord in me when he described the pain of watching a parent struggle and reminded me of the scaffolding of support needed for children and their families to thrive.

An important theme in Ashley's story is the complex relationship he had with the education system. Suspension, segregation and expulsion are common punishments for children in school and really do say to a child that they are different, other, and not good enough. It has always confused me that a place meant to be loving and nurturing would use such punitive measures against **children**, many of whom were simply struggling with the turbulent nature of their lives. Something that was clear to me as a child, and remains my opinion



now, is that the schools our children and young people attend need to have more support and resources to nurture all of their students.

Ashley wrote of feeling misunderstood, which also really resonated with me. I, much like him, wished that adults in my life would try to understand how the trauma we experienced affected us. Ashley also described feeling like he had to prove himself all the time, not only to professionals in his life but to those who cared for him, in order to be loveable. His description of this deeply complex relationship of being compliant and well behaved to receive love picked up on something important. It made me think that we need to show our children and young people love and acceptance in whatever stage of their journey they are at. His description of having outbursts and feeling out of control are so accurate. People who have experienced trauma can act differently to what is expected as 'normal', and having true trauma-informed practice in their daily lives can support children and young people, wherever they are at on their healing journey.

I remember some of the teachers who championed me in school, much like the teacher Ashley recalls in this book. Having trusted adults in your life is crucial as a child or young person dealing with the roller-coaster that is living in care. As a child or young person in care, you meet so many professionals who are constantly examining every detail of your life. This is an important part of record keeping and looking after children and young people, but it can be exhausting for them to have a revolving door of professionals in their lives. His story, much like mine and my peers', reminded me of the importance of continuity in relationships to allow for the development of trust. Safe people and safe spaces, in education in particular, can be a shelter during scary times of life.

Ashley also wrote of the challenges that care experienced people come upon when seeking to access higher education. He highlighted key issues, such as the need to financially support yourself whilst studying, and the precarious living situations during holidays. Thankfully, many universities recognise their corporate parenting responsibilities much better these days and have support packages for care experienced students. A challenging part of Ashley's story was hearing of the lack of support he received in university. It reminded me of the challenges we still face as care experienced students today, despite the support packages in place. Too many of us are facing homelessness, poverty, and a lack of mental health support. We have come a long way, but his story reminded me that we still have a way to go in supporting care experienced people. When Ashley described feeling excited and proud of himself for being at a prestigious university, but simultaneously feeling ostracised by the affluence around him, it spoke to me so deeply. Ashley was honest in the book about the feelings of self-doubt and shame we often feel as people who grew up in care. It can be really difficult to believe you are good enough when for most of your life people have not believed in your capabilities. After reading this book, I am thankful for the



communities of care experienced students around me who support and inspire me constantly.

Whilst reading Ashley's book, I heard of the many challenges he faced throughout his time in care, all of them familiar to people in our community. It served as a reminder that we must keep up the good work we are doing to keep The Promise, Scotland's commitment to ensure that children grow up safe, loved and respected. I recommend this book to anyone wanting to understand how it feels to grow up as a child or young person in care. It was a raw and beautiful expression of his experience, and I am so grateful to have read it.

About the reviewer

I am a care experienced person who works within the sector advocating for positive changes in practice and policy to improve the lives of children and young people in care. I study dentistry at the University of Glasgow and have a strong passion for addressing inequalities in healthcare. I don't usually like reading but this book was a page turner.

The Scottish Journal of Residential Child Care supplied a copy of this book for review.



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Obituary

Ruby Whitelaw

1963 - 2024

Neil McMillan

In Memory of Dr Ruby Whitelaw

It is with deep respect and gratitude that we remember Doctor Ruby Whitelaw, a dedicated and compassionate advocate for residential childcare, whose contributions to the field have left a lasting impact. Ruby passed away suddenly on 20th December 2024 and will be dearly missed by colleagues, friends, and all those whose lives she touched.

Ruby began her journey with Kibble, a Scottish charity for children and young people who have experienced trauma, in 1996 while pursuing her social work degree at the University of the West of Scotland. Even then, she had a remarkable ability to juggle responsibilities, a skill that would define her career. For 25 years, Ruby poured her heart and soul into Kibble, taking on a wide array of management roles that spanned residential and intensive services, foster care, day care, and secure care provision. In later years, she led quality assurance and child protection with the same level of dedication.

Ruby's work wasn't just a job - it was her mission. She was fiercely committed to the children and young people she cared for, always striving to improve their lives. Her passion drove her to continually enhance her knowledge, earning post-graduate qualifications in social work management, child protection, and social work practice teaching. She eventually achieved the prestigious Doctor of Philosophy - a testament to her quiet but immense pride in her capabilities.

At Kibble, Ruby will be remembered as someone who was feisty, firm, and fair. She was a brilliant mind who did not suffer fools lightly. If there was a difficult conversation to be had, Ruby never shied away. She was unapologetically honest, and her high standards inspired others to strive for better. Ruby believed in professionalism, not for its own sake, but because she knew it was the cornerstone of delivering the best care for children and young people.

In 2021, Ruby took her talents to the Children and Young People's Centre for Justice (CYCJ) at the University of Strathclyde, where she began sharing her hard-won wisdom, experience, and insights nationally across the children's care



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sector. It was a natural progression for a woman who spent so much of her life lifting others up. She became a respected academic, contributing valuable research and insights to the field. Her publications, including those in the *Scottish Journal of Residential Child Care*, have influenced both policy and practice, ensuring that her legacy will continue to shape the profession for years to come.

With a career spanning almost 30 years, Ruby was a tireless champion for children and young people in care. She worked to improve policies, practices, and outcomes for some of society's most vulnerable children. Her work was characterised by her unwavering commitment to child-centred care, her innovative approach to practice, and her ability to inspire those around her.

Ruby's ability to handle multiple tasks with ease and efficiency was legendary. As they say, 'If you want a job done, give it to a busy person', and Ruby embodied that saying to the fullest. It's no exaggeration to say that when Ruby left Kibble, it took a full-time person to do just half the work she had been doing.

But Ruby wasn't just about getting things done. At her core, she was guided by a profound sense of social justice and fairness. She was famed for having the moral courage to stand up for those who couldn't stand up for themselves, and her advocacy lifted countless people. She was a mentor, a coach, and a friend. As a manager, Ruby balanced honesty with genuine care, earning the respect and admiration of colleagues and students alike. Ruby's legacy is vast. It lives on in the countless lives she touched - children whose paths she helped brighten, colleagues she inspired, and students she mentored.

Ruby was a true humanitarian who had a keen interest global politics, particularly the politics of oppression. Growing up mixed race Bajan and Scottish in a small community with a 99% white Scottish population, and raising her children there as a single parent, she did not have her challenges to seek on that front. This carved her into a strong and feisty advocate of social justice, something that would remain a part of her for her whole life.

She had a keen interest in the civil rights movement. She also had a strong commitment to charity, particularly in developing contexts, and will be remembered for the large sums of money she raised to build schools for children in Malawi. Not content with raising money, she also travelled to Malawi where she participated directly in building projects and made lifelong friendships with several people from villages in Malawi.

Beyond her professional life Ruby was a parent and a grandmother. She raised two amazing children on her own and of whom she was immensely proud. Both went on to follow in their mothers' footsteps in a life of public service, with her daughter Lisa serving as a police officer, and her son Kevin in the British forces.



Ruby lives on in the name of her granddaughter 'wee Ruby' who was lovingly named in her honour.

Ruby was also an incredible friend with a huge social network. She will be remembered for her kindness, wisdom, and generosity. She was a mentor, a friend, and a source of guidance and support for many. She loved music and dancing and was deeply involved in the northern soul music dance and fashion scene, and the revivalist mod culture. She would regularly be seen out and about in her beloved vespa participating in scooter rallies across the UK or dancing the night away at northern soul nights and gigs.

Ruby taught us that making a difference is not about grand gestures but about showing up every day with dedication, courage, and heart. She was a force of nature - dedicated, determined, and deeply compassionate. She spent her life not just working but truly living her purpose: to make the world better for children and young people who needed it most. As we honour her memory, we also celebrate her enduring impact on the field of residential childcare. Her work will continue to inspire and inform future generations of practitioners and researchers, ensuring that her vision for compassionate, high-quality care lives on.

Our thoughts are with her family, friends, and all those who had the privilege of knowing her.

About the author

Neil McMillan is and Executive Director at Kibble Education and Care Centre in Scotland and was a long-time colleague and friend of Ruby.

