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Table of contents

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Editorial

Graham Connelly
Editor-in-chief

Welcome to the Autumn 2025 issue of the Scottish Journal of Residential Care.

Welcome to the autumn 2025 issue of the *Scottish Journal of Residential Care*. We publish this issue near the date of UNICEF's World Children's Day on 20th November which marks the adoption in 1953 of the UN Convention on the Rights of the Child. This year's associated awareness campaign focuses on listening to children talking about their lives, their hopes and their rights. Unfortunately, there are all too many examples of children's rights being undervalued, leading to children being ignored, harmed and even killed.

Our readers, especially those who are child and youth care professionals, may be involved in supporting events planned around Children's Day, including those aimed at helping children to express their views about how their rights can best be promoted. Children living in alternative care have rights to the very best standards of care, and rights are promoted in conditions where their caregivers are well informed and intellectually prepared for their challenging roles. We like to think that our Scottish-based journal with an international reach contributes to that sharing of information and the continuing professional development of child and youth care workers and others working with care experienced children and young people.

The autumn 2025 issue

This issue features a trio of long-form articles about different aspects of the Scottish residential care context.

Relevant to the theme of children's rights, the issue leads with Abbi Jackson's study of the use of restraint with children in residential care, in the context of 'The Promise' – the 2020 concluding report of Scotland's Independent Care Review - which set clear expectations that Scottish schools and care establishments should aim not to use restraint. Jackson, a social worker and charity CEO, summarises the main debates on restraint reduction, debriefing practices, and the policy framework in Scotland, finding limited research into restraint reduction and the use of debrief after an incident involving restraint in secure care. The study, based on an online questionnaire and focus groups, considers restraint from the perspective of Scottish child and youth care workers, and particularly the use of debrief following an incident where restraint was used with a child. The author identifies the need for a clear definition of

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debrief, potentially Scotland-wide, and argues for firmer policy about who should initiate and lead debriefs, suggesting there is scope for staff teams to undertake these themselves.

Jackson's research is set within a broader context of policy and practice work supporting the aim of minimising the use of restraint and upholding children's rights in care. Readers can find more information, including details of the work of the Reflection and Action Learning Forum (RALF) and the Scottish Physical Restraint Action Group (SPRAG), on the CELCIS website at this link.

Next is a research paper by Barry McGrath and Denise Carroll, specialist children's nurse practitioners at Kibble Education and Care Centre in Scotland. Their research is a study of the implementation of an electronic medication administration recording (eMAR) system in a residential school setting. The aim of this system is to reduce the frequency of errors, and to make identification of errors and their causes easier to identify. The authors say they are unaware of such a system being implemented in a children's or secure service elsewhere in the UK. The authors found considerable benefits in the eMAR system, including facilitating best practice in the administration and recording of medication, and a low rate of medication errors.

Finally, in the full-length article section, Ellie O'Donnell, a forensic psychologist in training, also working at Kibble Education and Care Centre in Scotland, has contributed a review of the literature on self-harm and suicide in residential child care exploring definitions, prevalence, risk factors, and interventions. She found that research highlights the need for tailored interventions, such as trauma-informed care, therapeutic interventions like Dialectical Behaviour Therapy, and staff training in suicide prevention techniques, as well as the importance of building supportive relationships and offering coping strategies to reduce self-harm.

We include one short article in this issue, contributed by Julie Garlen of the University of Toronto, Canada. Garlen's article about confronting Canada's colonial legacies of childhood care, invites the reader to engage in a broader critique of the colonial legacies of childhood care in Canada, highlighting the significant role of Indigenous counternarratives in decolonising representation in social institutions and the media.

In our spring 2025 issue, editorial board member James Anglin set a challenge to readers to contribute reviews of classic texts in the child and youth care field. Two of our readers have risen to the challenge - Bruce Henderson contributing a review of Virginia Axline's 'Dibs: In Search of Self' and Nicholas Campbell reflecting on the influence of Angus Skinner's 'Another Kind of Home: A Review of Residential Child Care' in the period since its publication more than 30 years ago. There are more historic book reviews in the pipeline, and we have an open call to our readers: Book Review Editor, Nadine Fowler, would love to hear from you.

The contemporary book review section has two reviews: Matthew Scotland reviews 'Working with Relational Trauma in children's Residential Care: A Guide

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to Using Dyadic Developmental Practice' by Kim S. Golding, George Thompson and Edwina Grant; and Leanne McIver reviews 'The Trauma Recovery Handbook: A Model for Navigating recovery for Professionals, Parents and Carers by Betsy de Thierry.

We will be back in spring 2026 with an issue that will include an article based on the 2025 Kilbrandon Lecture by Professor Carlene Firmin of the University of Durham. Meanwhile, keep sending your articles; our reviewers are standing by! You will find guidelines for authors and templates on the journal web pages on the CELCIS website. Happy reading.

About the author

Dr Graham Connelly is Editor-in-Chief of the *Scottish Journal of Residential Child Care* and a member of the editorial board of *Youth*. An interview with him to mark World Children's Day can be found at World Children's Day interview

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Original Research Article

'*Don't take it home with you*': Views of secure care staff on debrief after restraint

Abbi Jackson

Abstract:

There is a dearth of research into debrief after restraint in secure and residential childcare. This research sought the views of care workers on debrief practice across three secure centres in Scotland, using a mixed methods qualitative approach. It was found that the definition of debrief varied across participating centres. Overall, staff highly valued managers checking their wellbeing after a restraint. Other themes were discussion around antecedents, what went well, decision making, care planning and what can be learned from the incident. Focus groups considered who instigates debrief, when it happens, and who leads it. Ultimately it was found that debrief discussion after a restraint sits in a framework of discussions rather than a stand-alone conversation. Furthermore, it was concluded that debrief is not the sole corelate to restraint reduction. This is also influenced by the young person's needs, relationships, risk assessment and care planning, quality of supervision, and not least, leadership and culture. There are implications for workforce psychological safety. Restraint reduction work is incomplete without listening to workers' voices. Application of theory is proposed to support workers' understanding, and a reflective tool drawn together for workers and managers to adapt and use in debrief after a restraint.

Introduction

This article examines debriefing practices in the context of restraint reduction, with a primary focus on post-restraint debrief processes, while recognising their interconnection with broader restraint practices. A condensed literature review is integrated here to contextualise the study for international readers, summarising key debates on restraint reduction, debriefing practices, and the policy framework in Scotland.

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In the UK there have been concerns for a considerable time about physically restraining children (Davidson et al., 2005). Staff may also be traumatised after restraint (Allen, 2008) and experience moral distress (Morley, 2019). Inquiries into poor practice within residential establishments have often highlighted possibilities of restraint slipping into abuse (Utting, 1997) and being generally dangerous to young people (Kent, 1997).

If children are restrained when there are other less restrictive options available, their rights are also breached under the United Nations Convention on the Rights of the Child (1989). However, young people themselves have advised that restraining them at the right time, in the right way (self-perceived), can be better than failing to restrain them (Steckley et al., 2023). Restraint may also be necessary to comply with common law duty of care or duties of safeguarding young people looked after under the Children (Scotland) Act 1995. The debate is very complex.

Furthermore, The Promise (2020) has clear expectations that Scotland strives to become a nation that does not restrain its children. For secure care, this parallels Standard 30 of 'Secure Care: Pathways and Standards', which states that children are only ever restrained when this is absolutely necessary to prevent harm; they are treated with respect, dignity and compassion and held in the least restrictive way, for the shortest time possible, and should be supported after a restraint (Scottish Government, 2020). Debriefing practice is a contributing factor in reducing restraint and going some way towards resolving this 'wicked problem' (Grint, 2007, p.19).

Following a comprehensive literature review it was concluded that there is a paucity of research into restraint reduction in secure care, and less specifically into debrief after an incident involving restraint in secure care. Guidance documents and literature recognise the clear function of debrief but locate it in general support and the structure and culture of the agency rather than as a stand-alone intervention. Colton (2004) is an important overall document on readiness for restraint reduction, mentioning debrief, while 'Holding Safely', Davidson (2005) remains a key guide, noting that debrief may occur in supervision, team meetings, and with outside consultants. Although Huckshorn (2005) has a valuable reflective section on debrief using root cause analysis within the six core strategies, there is overall a distinct lack of debrief tools available across existing research. However, Scotland is beginning to place greater focus on debrief after restraint (Social Value Lab, 2023). There was consensus across most of the literature that debrief should take place no longer than 72 hours after the incident, which resonates with the views of participants in the current research. The wider attitudes of staff as key agents in restraint reduction need to be fully heard and openly discussed to reduce restraint (The Promise, 2020). This article highlights some of these views in the specific context of debrief practice. For clarity, the terms used are outlined below.

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Term 1 – Children

Children are defined in Part 1 of the Children (Scotland) Act 1995 and the Children and Young People (Scotland Act 2014 97[1]) as people under the age of 18. This is also the definition of the United Nations Convention on the Rights of the Child (1989). For the purposes of this research, these children will be referred to as 'young people'.

Term 2 – Secure care

Secure care in Scotland is a,

> …form of highly regulated residential care for a very small number of children who are deemed to pose such significant risk to themselves, or to others, that for a particular time they require to be detained in the intensely controlled setting of secure care (Moodie & Gough, 2017).

Children and young people can be placed in secure or residential care by a children's hearing or a sheriff if they deem that at least one condition under s.83(6), 87(4) or 88(3) of the Children's Hearings (Scotland) Act 2011 is met. These conditions are, a) that the child has previously absconded and is likely to abscond again, and, if the child were to abscond, it is likely that the child's physical, mental or moral welfare would be at risk, (b) that the child is likely to engage in self-harming conduct, (c) that the child is likely to cause injury to another person. Other options for available care must be considered before making a secure order. It is likely that the majority of children in secure care in Scotland are there for reasons of welfare rather than primarily due to the harm they have caused to others (Gough, 2016). In 2022-2023 it was recorded that 53% of young people in secure care were placed there for less than three months (Gibson & Whitelaw, 2024).

Term 3 - Restraint

The working definition of physical restraint for this research is drawn from *Holding Safely: A Guide for Residential Childcare Practitioners and Managers about Physically Restraining Children and Young People* as 'an intervention in which staff hold a child to restrict his or her movement and [which] should only be used to prevent harm' (Davidson et al., 2005, p.viii). This does not include chemical or mechanical restraint. This aligns with the Human Rights Framework for Restraint (Equality and Human Rights Commission, 2019), which states that pain techniques must not be used on a child. It should be clarified that methods like holding a door to prevent a young person hurting someone, albeit restrictive, are not considered restraint for the purposes of this research.

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Term 4 – Residential care worker (also referred to as 'worker' or 'staff')

The term 'residential care worker' is used to describe the paid adult working directly with young people in secure care as this is the professional registration term used by the Scottish Social Services Council (SSSC). All participants in this study were registered with the SSSC and adhere to this Code of Practice (SSSC, 2016). These are the people who have relationships with the young people. All legislation and policy change impacts, with respect to decision making in care planning and managing ethical tensions, are filtered through the values and direct practice of these individuals. Therefore, it is critically important to listen to those who are closest to the young people.

Methods

An inductive research model was required, whereby concepts were generated from emergent data (Becker, Bryman, & Ferguson, 2012). An interpretivist approach was adopted, as it is this epistemology that previous qualitative researchers have found appropriate for generating meaning (Crotty, 1998). The researcher made a commitment to see through the eyes of participants but is solely responsible for the interpretation. Responsibility is taken for construction of themes, concepts and knowledge contributed. This is an attempt at what Braun and Clarke (2023) would consider reflexive thematic analysis and was achieved by sense checking material as it was emerging. Themes were validated with participants.

Recruitment

Non-probability purposive sampling was employed as this does not require complex sampling frames and can be used for exploratory studies (Campbell et al., 2016). Those currently employed in secure care were invited by senior managers to participate. No restrictions were placed on gender or length of time employed. Those who had moved on from employment in secure care were considered to hold valuable opinions but were outwith the scope.

Data collection method

A mixed methods approach was deployed, via an online questionnaire sent to care staff, and focus groups. Focus groups were chosen as they lend themselves to sharing experiences and show how the participants view the world (Bryman et al., 2012). A questionnaire was included so that participants could still contribute (Bryman et al., 2012) if they did not attend the focus groups.

Two online group session dates were initially offered per care centre. Two centres eventually participated, one with one group and one with two. Focus groups were recorded and transcribed using MS Teams software. Transcriptions were tidied on the same day as each group was held, aiming to ensure accuracy.

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Focus groups were facilitated by the researcher with the help of managers and staff in the centres.

Ethics

Ethical approval was granted by the University of Stirling and the secure care centres. Given the sensitive nature of restraint, participant wellbeing was safeguarded through consent processes, confidentiality, and signposting to support services.

To protect participants, the care centres were not mixed during the focus groups. This ensured good ethical practice in several ways. Firstly, having staff present from single settings only, meant that there was no conflict of interest due to the politics around competitive tendering processes in secure care in Scotland.

Secondly, staff who would have known young people who have moved between secure care settings were not placed in the position of judging workers who represent another establishment. It is likely that traumatised young people had behaved in ways the care setting could not manage prior to a move. If care services were in mixed focus groups, this would risk workers experiencing shame when discussing the sensitive topic of restraint, where they may hold beliefs that they 'failed' with a particular young person. Care staff must bring their whole selves to work, and they are deeply emotionally invested in the care of the young people. They cannot do the job effectively without investment. Keeping groups separate was an attempt to protect against negative impact on staff confidence.

Thirdly, good ethics were upheld by not placing staff in a position of mixed groups where they might form views of other workers during the meeting, or of the care settings they represent. This would not be based upon a full picture and could distort reputations or relationships between services.

Lastly, underpinning all the above, and possibly the most fundamental reason for separate groups, was that services use different accredited models of restraint and have different thresholds and cultures of care. Mixed groups would necessitate clarification of models, which would draw the focus away from key questions.

Participants were reminded that they could withdraw consent at any time and leave the group without having to give a reason. They were directed also to the questionnaire as another opportunity to share valuable input they may not have been comfortable sharing in front of peers.

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Other ethical issues

The ethical issue of researcher disclosure of practice involvement in one secure setting was attended to at the outset by full transparency within participant information. All material was anonymised including locations.

Data analysis

Thematic analysis was undertaken following Braun and Clarke's (2006) five step process. Data from the questionnaire was read, and emergent potential codes considered using a grounded theory approach (Glaser & Strauss, 1967). The data was read again, tentatively applying these codes, following which codes were grouped. The data was read and re-read from the focus groups and codes were assigned (Bruan & Clarke, 2006). A relatively simple data set emerged. Themes were identified from both sets of data to determine patterns and any sub-themes. Themes were reviewed, similar themes merged, and one theme with weaker evidence was removed (Nowell et al., 2017).

Through this analysis, attention was paid to potential bias due to the positionality of the researcher. Coding was carried out inductively without trying to fit data into a pre-existing coding frame or the researcher's pre-conceptions (Braun & Clarke, 2006). However, reflexive decisions had to be made for inclusion and exclusion of data for codes, what constituted a pattern or meaning, or what prevalence made each code or set theme-worthy (Braun & Clarke, 2006). It is noted that subjective judgements by the researcher about when a code became a theme align with Braun and Clarke's approach (2023), wherein they discourage procedures being prioritised over reflexivity and theoretical sensitivity. One limitation of thematic analysis is that single occurrences of valuable data can be overlooked. This would mean a new idea from an individual would be discounted using this method (Nowell et al., 2017). Therefore, a sense check was applied so relevant practice could be included in the analysis, and key points to develop a tool were noted.

Findings

It was challenging to achieve attendance at the focus groups. Workers need to prioritise the complex care needs of young people, such that releasing them from duties was difficult. Deeper still, residential care staff are exposed to hostile and conflicting perceptions from external sources that can attack their sense of themselves as worthy people (Cooper & Lees, 2015), and this research was asking them to share their personal and professional selves. Demands on time may have been cited as barriers to attendance, but underneath, it may have been possible that putting oneself in a position of saying something controversial was a risk many staff may not have been willing to take on a psychological (or financial) level. Themes around risk to staff are precisely one of the reasons this research is so critically important.

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Out of a possible 24 meeting options only three groups were facilitated, with 30 participants overall. Important topics were raised which the researcher experienced as passionate and committed conversations. The survey ran for 182 days and received 26 responses. One response was removed as it was completed by someone outside of the target sample.

Focus group findings

Group 1 comprised of senior care staff. This group fit the criteria of inclusion as they had a role in direct care. They talked of staff compliance with process and how they delivered debrief and managed the rest of the shift. They identified practice they considered good, including offering 'safe space' for staff to speak after an incident. The desired element of views from first level care staff was somewhat missing from this group.

Group 2 was facilitated with the help of a learning and development co-ordinator. They described the conversation model used with young people after restraint. This group noted that their centre was about to engage with the Reflection and Action Learning Forum (RALF), which trains facilitators in an action learning set model (Steckley et al., 2024). They also noted that there are ongoing discussions, meaning debrief is not a one-off event after incidents.

Group 3 utilised the opportunity as a reflective discussion, with the researcher sensing that there was learning happening amongst peers. They drew out the nervousness they felt with newly experienced hesitation around restraint decisions due to The Promise's (2020) drive to reduce restraint. The group deferred to the manager facilitating the MS Teams call, which meant that some key data could have been lost as to individual views. Interestingly this may mirror power dynamics in debrief in practice, and speaks to the need for psychological safety, as referred to below (Edmondson, 2018).

Coding

During coding, the number of times the code occurred did not necessarily reflect the time spent on that topic, nor quality of discussion. For example, the number of times relationships were discussed appears few, yet it is central to good quality practice. Emotional support as a theme was reasonably strong, yet it naturally occurs in a welfare check with staff, so the data may be lighter in this aspect than in reality. The theme around the welfare check was strong, so these aspects were grouped together. Reflective discussion was not considered by the researcher as a theme in itself, but rather as foundational to good debriefing practice.

The strongest themes were physical and emotional wellbeing check, followed by 'what is the learning?' and decision making (with emphasis on earlier intervention).

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Participants also talked about the function and value of debrief:

> …one restraint I had […] I was so upset but I had the debrief, yeah, absolutely. That day I wouldn't have been able to go home and sleep. That's the importance of it… (P1)

> … emotions are high, adrenaline's high, people can have personal opinions about how they felt […] I think it is only healthy that people have that, that safe space to say, do you know what? I'm not ok… (P2)

> …I don't think I've done a debrief that's not been useful… (P3)

Longer-term and wider reflection and learning was also noted to be happening, as mentioned by participants 4 and 5:

> …so, discussions are happening all the time and reflection of practice and how we are, you know, practicing, you know, doing our job really. So […] it's an ongoing thing. We're always learning and trying to get better. (P4)

> …To make sure you know the whole team around the child has that awareness. (P5)

Group 3 went on to spend some time on a discussion about who instigates a debrief.

One person believed '…the need for a debrief is measured by the people involved' (P6), although this was challenged by others who believed that staff might not come forward and ask for managers to lead a debrief for fear of how they may be perceived by others. This was suggested by P7:

> …(we) talked about it separately and actually, I didn't feel I could have went, actually can I get the whole team together? And I'm quite a confident person, but I don't know, I don't know. I needed that, but I almost felt dismissed that the conversation I was having about that was enough. (P7)

> …it might be easier if every single incident […] was just debriefed […] It takes it away from xxxx being like, oh, does anyone want a debrief [...] three or five people involved […] one person says 'no, I'm fine'. […] Those people that feel like they need one might feel a bit weak. (P7)

This indicates a preference for the six core strategies approach, which promotes that, '[a] formal rigorous event analysis will follow every incident of seclusion and restraint and will occur within the first 24-48 working hours post event' (Huckshorn, 2005). However, other participants perceived there may be threshold decisions for managers about when to debrief with staff.

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All three groups shared values around the need for restraint reduction, although practice models were the lens through which the research questions were viewed. One centre understood the debrief to be a discussion amongst adults. The other understood it as a conversation firstly with the staff and manager, and then as a life space interview (Redl, 1966) between the manager and the young person. Participants using this model noted that alternative behaviours would be discussed with the young person, advising that increased ownership leads to behaviour change.

Framework of debrief

A framework of debrief began to emerge. This began with a physical and emotional welfare check soon after the incident. Staff expected managers to lead on this. Staff also held impromptu peer-to-peer discussion relatively soon after the incident, and again after the shock had subsided. There was no time limit placed on these reflective conversations led by staff. There were also more organised reflective discussions about the incident, which staff expected managers or senior care staff to lead. Best practice timing was noted to be after a welfare check, but not so long after that staff felt uncared for. Discussion with managers and staff was undertaken whilst embedding changes to the care approach and could also happen without a more organised reflective discussion post-incident. Reflective discussion between staff, managers, and young people were noted. After some time had passed broader discussions with wider teams to share learning were undertaken.

The framework of debrief will be returned to below as it is embedded in wider practice factors.

Theme analysis

The themes arising were the physical and emotional wellbeing check, antecedents, decision making, what went well, and what the learning was. The check that people were 'okay' (Davidson, 2005) dominated, being mentioned in every focus group and every questionnaire response. One participant put the value of it succinctly:

> …I think it [check in after incident] is really important […] I've always appreciated that because it feels like [organisation] cares about me as well as, you know, us caring for others. (P9)

These comments resonate with the Department of Human Services Melbourne (1997), who acknowledge that debrief after incidents is necessary to minimise staff stress.

Decision making was threaded throughout all discussion and survey responses. The possibility for earlier intervention was explicitly mentioned in groups 1 and 2

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and alluded to in group 3, where it was stated that nervousness had crept in due to scrutiny around restraint reduction.

What went well was one of the weakest themes. Perhaps, in practice, this was combined with the previous discussions in the wellbeing check, or it may be that debriefs purposefully allocate time and energy to solution-focused discussion. There was moderate mention of restraint techniques, which may indicate that the debrief is less used to review physical skills and more heavily concentrated on problem solving.

All groups were clear that they were part of a learning culture, and participants seemed motivated to bring new learning into care planning. The needs of individual young people were deliberated, especially in group 2, where neurodiversity impacted their approach to debrief with a young person. This stood out from the other data as it directly related to the care approach.

The timing of the debrief, who it's instigated by, and who leads it were given critical focus by group 3, and a lesser focus by group 1. Group 2 mentioned that they discuss the incident as a team first before going to their manager. This may happen in the other groups, although practice norms cannot be assumed from such limited data.

There was no mention in the groups of wider matters affecting the young person's state of mind or analysis of transference and counter transference contributing to antecedents (Klein, 1952). There was no acknowledgement that some experiences of young people would test anyone's self-regulation and resilience in a generally volatile environment. This lack of depth may be due to understanding, or normalising, but also perhaps staff are experiencing subjective trauma themselves alongside vicarious trauma.

Discussion

The workforce can be considered the greatest asset to young people, and as such, there is a fundamental duty of care towards them as people first. This was strongly evident in the primary theme of the wellbeing check. Workers in residential childcare settings often experience limited autonomy and less respect compared to other human service professionals, despite engaging daily with young people who present serious behavioural challenges (Seti, 2008) and who can compromise workers' capacity for compassion satisfaction (Hughes & Baylin, 2016). Research into burnout among residential youth care workers indicates widespread emotional exhaustion, depersonalisation, and low levels of personal accomplishment (Decker et al., 2002; Lakin et al., 2008).

The importance of supportive structures following incidents cannot be overstated. Service commitment to debriefing as a learning opportunity contributes to the protection and wellbeing of everyone involved. However,

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inconsistencies emerged across services, with respect to both the clarity and flexibility of debriefing practices. While formal debriefs can offer containment and reflection, they are not consistently practiced or defined.

Staff relationships—both with young people and with each other—play a crucial role in shaping outcomes and supporting recovery. Positive staff-young person relationships are known to mitigate the effects of relational trauma and to reduce the likelihood of incidents driven by power struggles (Hughes & Baylin, 2016). Despite staff expressing a strong commitment to young people, this is not always perceived by the young people themselves, some of whom believe certain staff lack necessary skills (Gibson & Whitelaw, 2024). This disparity highlights the importance of staff understanding the deeper psychological functions of young people's behaviour. For instance, some young people may internalise the need for restraint as part of their identity (Schwartz et al., 2015), potentially jeopardising opportunities for relational repair. Skilful interpretation of behaviour—including psychodynamic, psychosocial, and systemic perspectives—can inform more therapeutic responses and reduce reliance on restraint (Kor et al., 2021).

Critical decisions about restraint must be made quickly, and the implications of those decisions can be profound. Timely, effective, therapeutic interventions tailored to the young person's needs are essential (Gerhardt, 2004).Failing to intervene appropriately and resorting to police involvement can be traumatising and may contribute to negative identity development for the young person (Goffman, 1963). Debriefing practices that allow space to explore these complexities in relationships can support more thoughtful, preventative strategies.

Equally important are the relationships between staff themselves, which underpin a culture of mutual support and wellbeing. Knowing and backing one another up was highly valued by research participants, aligning with Steckley’s (2010) findings. Burns and Emond (2023) argue for safe, continuous opportunities for staff to reflect on themselves and their colleagues in pursuit of a therapeutic environment. However, tensions can arise when staff hold divergent worldviews or values, particularly under stress. Navigating group dynamics and managing transference and countertransference (Klein, 1952) are daily challenges in residential care, especially in high-risk situations such as restraint. Emotional intelligence, frequently referenced by participants, is therefore critical in practice, including during debriefs.

Though a single organised debriefing event may be helpful, broader reflective practice must also address individual learning and support needs. Supervisioncan serve this function. Defined as a one-to-one discussion covering development needs and case reflection (Morrison, 2005), supervision can include reflection on staff behaviours during incidents and consideration of how these influenced outcomes. While participants did not mention supervision as a form of

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post-incident debriefing, the Reflection and Action Learning Forum (RALF), currently being rolled out in Scotland through The Promise funding (2023–24), was referenced. Supervision from external sources was not mentioned. This may mean it is not offered, or that it is not seen as an option by participants.

Debriefing practices were often inconsistently applied or unclear. One participant noted, 'I think it would be helpful to point out if a debrief is conducted full stop' (P10), reflecting previous findings by Steckley (2010), who argued that debriefs often happen 'in theory' or only when time allows. Some participants felt that the emotional impact of incidents on staff was overlooked. While discussions frequently centred around care plans, there was limited evidence that debriefs promoted the construction of meaning or epistemological containment. Theoretical frameworks were notably absent from participants' reflections, and while the study did not explicitly ask about theory use, its omission in discussion is notable.

The application of theory could enhance debriefs significantly. For example, understanding attachment and abandonment dynamics (Bowlby, 1979) could illuminate behavioural patterns. Similarly, recognising the role of shame (Brown, 2006) and power dynamics (French & Raven, 1959) could help staff reflect on triggers and improve future responses. Frameworks such as the power, threat, meaning framework (Johnstone & Boyle, 2018) may support a richer understanding of both staff and young people's experiences. Appreciating how trauma reenactments unfold in relationships (Hughes & Baylin, 2016) may also help reduce staff self-blame—particularly for those with a high internal locus of control (Rotter, 1966)—and support staff retention, which in turn stabilises the environment for young people (Schofield & Beek, 2015).

Tools like the Care Inspectorate's self-evaluation guide on restrictive practices (Care Inspectorate, n.d.) encourage services to reflect on how debriefing sessions influence culture, practice, and restraint reduction, yet still do not define 'debriefing' clearly. While this flexibility can empower services to tailor practices, it also creates ambiguity around expectations and accountability.

Leadership and organisational culture fundamentally shape the effectiveness of debriefing and broader support mechanisms. Lessons from Winterbourne View (Department of Health, 2012) underscore the shared responsibility of leaders and staff in cultivating positive care cultures. Residential childcare is recognised as a distressing and complex domain, often undertaken by under-supported staff (Furnivall, 2018), which makes structured debrief and care essential. Trauma-informed cultures, underpinned by leadership values of kindness, empathy, and mind-mindedness (Siegel, 2011), are critical. Participants in this study emphasised their appreciation for compassionate leadership (West, 2021), which is associated with improved staff wellbeing and care quality.

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Who initiates or leads debriefing was also a recurring theme. Group 3 echoed findings from the Department of Human Services Melbourne (1997), noting that when staff must request or independently access debriefing, morale is negatively affected. Visible, proactive leadership (Stirling et al., 2017) was clearly desired. However, opinions varied on whether debriefs should be manager-led or self-organised. Huckshorn (2005) advocates for debriefing as a formal, solution-focused meeting led by trained managers not involved in the incident, integrated into quality improvement. While participants recognised the value of reflective leadership, they also highlighted the potential for self-organised learning spaces (Dean, 2023; Stoll & Louis, 2007), where staff take collective responsibility for growth and accountability.

For such approaches to succeed, services must foster non-judgemental, open learning cultures. Open group climates, characterised by flexibility, support, and responsiveness (van der Helm et al., 2009), are more conducive to reflective practice than closed ones defined by coercion, mistrust, and inflexibility (van der Helm et al., 2011). Ultimately, psychological safety is essential for staff to engage in reflection, take risks, and grow (Smith, 2016; Smith & Fulcher, 2013). While some staff reported feeling safe during debriefs, such experiences are subjective and shaped by the power dynamics inherent in group settings. Tools such as reflective question guides (Appendix 1), used without the need for formal training, may help structure debriefs and support transparent, learning-oriented cultures (Johnson, 2021).

Limitations

The definition of debrief as a conversation between adults should have been more clearly identified and articulated to participants at the beginning of this research. Another limitation was that the research was undertaken by a single researcher. Although data was checked four or five times, it is acknowledged that no data set is ever perfect as coding is subjective and it themes are at best filtered and organised through the worldview of the researcher (Bryman et al., 2012).

A further limitation arose with respect to accessing participants. Undertaking focus groups in the way that best suited the services resulted in somewhat detached online facilitation. Related to this, the facilitation through the manager's MS Teams login (whereby they stayed in the meeting) did not allow for the full freedom of participation intended.

Conclusion

This research is a contribution to raising awareness of the function of debrief after a restraint, to support secure care staff who are practicing in high-risk environments where they are under significant scrutiny with respect to decision making. The weight of this responsibility and work context was acknowledged as

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sometimes feeling heavy for staff, but participants who engaged in the focus groups seemed committed to practice improvement. Caring relationships are where change is seen and felt with young people (Steckley, 2010). As experts by experience, participants noted they also need to feel cared for to be effective in their role. However, Burns and Emond (2023) believe that research on caring for staff is slow to emerge. Although there is no clear debriefing model across secure care in Scotland, it can be concluded there are a range of appropriate methods in operation. However, it is noted that this research is a very small-scale study, and the views of participants do not represent the views of their service nor those of secure care provision in Scotland.

Implications for practice

There needs to be a clear definition of debrief adopted. It would make sense for this to be defined across Scotland, and possibly to sit within a recognised framework of discussions which fulfil various purposes.

Services may reflect on a firmer policy around who should instigate, who should offer, and who should lead debriefs. This paper concludes that although staff felt cared for and cared about when managers undertook debriefs, there is also scope for staff teams to undertake these themselves. The tool in Appendix 1 may be a starting point. This tool intentionally assumes the definition of debrief as an adult-to-adult conversation, acknowledging there are intervention models already in use for life space interviews with young people.

It is not possible for staff to achieve an overnight reduction in restraint however good the practice is. This is likely because the young people who need the highest level of relational and emotional nourishment to recover from past experiences take time to change their survival behaviours (Hughes & Baylin, 2016). This should be considered alongside dignity for care staff who wrestle with moral distress (Brend, 2020; Morley, 2019) and experience complex accountability on a daily basis. Application of research and theory across practice in secure care may support deeper understanding.

Finally, the debrief cannot be the sole correlate to restraint reduction. Although it is clear that skilled judgement is required from managers and others to capitalise on naturally occurring moments to reflect, teach, and learn, skills improvement does not sit in isolation (Paterson et al., 2005). Restraint reduction must also be supported by a tightly woven context of positive culture, good leadership, supervision and relationships, risk assessment, and trauma sensitive care planning - in essence what Steckley (2010) refers to as multi-layered investment.

To lay down the core conditions for staff to feel able to reflect at the depth the tool can offer (Appendix 1), services should seek to increase the subjective experience of psychological safety (Edmondson, 2018). In this respect, the

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conclusion of this research aligns with that in Reimagining Secure Care (Gibson & Whitelaw, 2024), in that a 'trained, nurtured and valued workforce' is imperative for the future of secure care. It is also critically important to note that the debrief tool may be used (in whole or in part) after any incident and is not restricted to post-restraint situations. Routine use and reflection prior to action (Edwards, 2017) may positively impact psychological safety in terms of embedding a learning culture as well as increasing confidence in staff and managers around the function of the debrief.

Recommendations for further research

The views of managers and leaders were not included in this research. This was intentional, albeit could be considered a limitation of the study. Young people were similarly not included, who likewise will have key views on debrief after restraint. Further research on managers' views is recommended, in addition to research on young people's involvement with their own 'debrief' or life space interview (Redl, 1966), and their perceptions of their own future care. Alongside this, it is recommended that the impact of the use of theory in supervision and debrief in secure care is further explored.

Thanks

Sincere thanks are extended to all participants and those who made this research possible. This article is dedicated to secure care staff and managers in Scotland and beyond who come into work every day with an open mind and an open heart ready to care. It cannot be overstated how crucial the relationships they make are to young people and their communities. This small contribution to research is hoped to encourage policy makers to stop and hear the views of these adults who are closest to the young people day-to-day. Scotland will not be able to achieve the aims of The Promise without valuing them as key stakeholders.

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About the author

Abbi Jackson is a social worker who has worked across all sectors in social services for over 25 years. She has an interest in intervention with young people presenting as high risk, which has developed from fostering and secure/residential care work. She has authored two books to support practice in social work and residential care and is an experienced social work practice educator and business coach. She has set up businesses and charities and is currently an interim chief executive officer for a national charity.

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Appendix

Debriefing discussion tool (Jackson, 2025)

This series of reflective questions is designed to be used in children's residential and secure care to facilitate discussion in debrief after a restraint. They can also be adjusted for use after any incident. They do not need to be used in any specific order and not every question needs to be included in every debrief. It is intended that residential childcare workers and their supervisors and managers decide which questions are useful. The model can be freely adapted by individual services who may wish to add other relevant questions.

This tool is intended to be used in adult debriefing discussions either before or after a conversation with a young person about the restraint. It is intended to be used alongside the direct practice with the young person which values their own subjective views.

Understanding young people:

1. What insight would the young person have about their own restraint?
2. What function does the young person's behaviour serve for them?
3. Where is this young person experiencing shame?
4. Where can we offer choice to this young person?
5. Where can we change our language to reduce risk?
6. What theories can help us understand the antecedents?
7. What strengths does this young person have?
8. Where do we need to be more curious about this young person?
9. Where could we experiment with something new to support the young person?

Working together as adults:

10. What decisions during the shift need to be discussed and clarified?
11. Where did it help that our views aligned?
12. What do we need to know and discuss about each other's triggers?
13. Where is power helpful and unhelpful?
14. How do we manage shame and psychological vulnerability in ourselves here?
15. What can we do to help staff feel safe?
16. How can we support each other?
17. Where do we need more training or different training?

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Understanding our relationships with young people:

18. What is blocking our individual relationship with this young person?
19. What counter transference is happening?
20. What boundaries are we recognising?
21. What theories can help us understand the relational dynamics?
22. Where is power helpful and unhelpful?
23. What can we do to help this young person feel safe?

Wider questions:

24. What organisational issues have affected the antecedent to the incident?
25. What suggestions for organisational change do we have?
26. What do we need to do to support the group of young people?

To conclude:

27. What questions need to be revisited to round off this reflective discussion?
28. What specific measurable achievable realistic and timebound (SMART) actions can be taken forward?
29. Who will do what?
30. Who can we ask for further help?

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Original Research Article

Use of technology to improve medication safety in residential childcare

Barry McGrath & Denise Carroll

Abstract:

To increase the safety and improve the health outcomes of the children and young people in our care, an electronic medication administration (eMAR) system was implemented. We explore our experience, focussing on the challenges and improvements made by implementing this type of system. Despite initial hesitance to change, the system has improved how we manage medication within this service. It has reduced our errors, and reduced resources for ordering and auditing of medication, as well as providing young people with more responsibility for their own medication and overall health. Despite challenges in implementation, there are considerable benefits to using this type of system within residential childcare. The resultant reduction in errors provides an indication that there is an improvement in overall health outcomes for the young people in our care.

Introduction

The authors are two registered children's nurses, whose role is to support young people to access health services. Working day-to-day with the young people, providing direct assessment and care, as well as offering advice to residential childcare workers who support the young people every day.

We discuss the features and advantages of the electronic medication administration recording (eMAR) system, and the benefits and challenges identified through the systematic implementation process. Unique challenges were faced due to the nature of the specific services, which will be highlighted in the sharing of our practice.

Electronic medication administration recording (eMAR) systems are designed to reduce medication errors, prevent harm to patients, and improve patient care and outcomes (Westbrook et al., 2020). The uptake in Scottish care homes is low – around 5% of registered Scottish care homes use an eMAR system (Care Inspectorate, 2020).

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There are limited sources of evidence with respect to medication errors within children and young people's services, with the focus of existing literature on elderly care homes, where medication errors are estimated at 8.4% (Barber et al., 2009). The authors used the limited literature to identify the process where errors are more prevalent. A review in 2015 (Elliot et al.) attributed 44% of errors to medication omissions. A more recent study included other factors within the review, identifying that the most common error occurs in the administration of medication, where 54% are due to the wrong dose, missed dose, or the wrong medication being administered (Elliot et al., 2021).The eMAR system hopes to reduce the frequency of errors, and to make identification of these errors, and the causative factors, easier to identify. The authors are unaware of this type of system being implemented in any children's or secure service within the UK.

Background

Medication errors are reported to be higher in non-nursing settings (Barber et al., 2009). Staff registered to work in residential childcare, known within the service as child and youth care workers (CYCW), will have, or will be working towards, qualifications in childcare to become registered child and young people workers, but do not always have formal qualifications in medication administration. Administration of medication to children and young people is undertaken by non-clinical staff, such that the system of training and assessment must be robust. Anecdotally within the service, staff often describe anxiety around the administration of medication.

The CYCWs must undertake four stages of training to be deemed competent to administer medication. Staff are required to read the safe handling of medication policy, to attend a four-hour face-to-face training session on the safe administration of medication delivered by a registered nurse, and to complete the eLearning training from the creators of the eMAR system. In order to conclude their training, the staff must pass a competency assessment completed by their line manager, which is repeated annually.

This training within the organisation follows the National Institute of Clinical Excellence (NICE) guidelines on the 'administration of medicines in care homes' (NICE, 2020).

CYCWs work within different areas in the organisation. The safe centre looks after young people who require secure care. Whilst others work between children's residential care on and off campus, and community based accommodation.

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Considering an eMAR system – Where to start?

Prior to planning the implementation, options were discussed with the Care Inspectorate's pharmacist and inspectors who provided links with establishments that had successfully introduced eMAR systems. The Scottish care sector, including residential and secure children's care, is regulated by the Care Inspectorate, who inspect these services to ensure they meet national standards, providing safe, high-quality care which supports children's wellbeing (Care Inspectorate, 2015). Medication is now one of the core assurances for these evaluations, where medication standards can affect the grading and reputation of an organisation.

Visits were arranged to those services identified by the Care Inspectorate, and in each, the key message was to implement eMAR in stages, or to 'start small'. Their advice is to be prepared for a significant increase in 'medication errors', due to the increased transparency and automatic identification, in addition to staff recording errors whilst they adapt to the new system.

Implementing an eMAR system comes with risk. The increased transparency may superficially lead to an increase in reported errors. We did not find a true increase in errors within the service, but did note that errors were more easily identified when using the eMAR system – initially causing concern for the implementation team. Many errors relating to the recording of time, dose and strength of medication in paper records may be missed due to the systematic review of paper records being time-consuming (Care Quality Commission, 2019). As such, it takes a confident leadership team to consider the change to an eMAR system, and one committed to improving outcomes for its residents. Early conversations with the Care Inspectorate and other stakeholders are key to this process.

The business case

The business case was proposed by the nurses to the organisation's leadership team. The eMAR system can enhance the accuracy of medication administration, stock management, and recordings of administrations, thus improving outcomes for young people with additional health needs. The eMAR system is in keeping with the organisation's digital transformation of its internal administration and recording systems.

One of the main considerations is the financial implications. The eMAR companies boast financial savings in staff time (Access Group, 2024). As with most digital systems, companies will present information that their system's costs are offset by reducing staff time in relation to medication and the organisation's reputation for accuracy in medication administration. The financial savings in staff time are important, but not easily quantifiable in residential childcare where medication usage fluctuates. There are no 'medication rounds',

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with young people having access to their medication in a more individualised and person-centred way. There are set-up purchase packages agreed with respect to licence costs, training and support, with the level required influencing the cost. This is in addition to the hardware that may have to be purchased to facilitate the operation of the system. Beyond the rollout, there is a monthly cost for the licence which must be maintained to continue use of the system. Prices are negotiable depending on the number of licences purchased, however there has been a substantial increase in this cost in the three years since first implementation.

Devices for implementation

Within the organisation there are 29 houses, each of which has its own laptop configured solely for medication administration and recording. In addition to the purchase of the laptops, there are additional costs for IT services to configure the system. In this organisation, the IT department configured the laptops to ensure that when young people access them it is only to administer medication. This measure was implemented to support GDPR compliance.

In this organisation, the decision was made to use laptops. Other devices such as iPads and phones do not allow a young person to check their medication with the staff. The young people are encouraged to take ownership of their own medication and to check it alongside the staff member – evidencing this by entering their own passwords into the system. Young people's involvement in their care is a key component of the organisation's ethos that it wishes to maintain. In addition, this system allows for recording by young people who self-medicate.

Electronic medication administration recording systems (eMAR)

Several systems are available, with more having emerged since the time of implementation. Some considerations used to determine which system is most suited to the service include; whether the chosen pharmacy can work with the system; the type of device the organisation would like to use for recording medication administration; whether the system will work offline; and the backup system. In addition, consideration should be given to the ongoing support options, from online databases to live chat and telephone support systems. In this organisation, the support was not fully utilised because nurses were available, and staff would tend to call on them to ‘sort’ problems.

Care assurances

The purpose of auditing is to assess, review, and make improvements (Care Inspectorate, 2019). Care inspectors now place greater responsibility on the organisation's quality assurance system, utilising self-assessment tools. Managers who audit paper systems must gather and review multiple forms of data which may not be accurate. Managers undertaking audits or investigations

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from paper systems cannot be assured of the accuracy, for example if paper sheets have been filled in retrospectively prior to the audit, or if administration times have been accurately recorded. This process is also time-consuming. Implementation of the eMAR system allows for accurate audits to take place, such that challenges to the safe administration of medication can be identified more easily and action plans can be created to address these difficulties.

Many managers within the service have commented on the reduction in time required to complete an audit using the eMAR system. Previously it was estimated it would take around two hours to complete a monthly medication audit. The eMAR system can automatically generate numerous reports to provide a more accurate and streamlined approach to the auditing of medication. In addition to time saving in auditing patterns in young people using their medication can be easily identified. This information can then be utilised to support medication reviews and ensure young people's health needs are monitored.

Live monitoring

Nearly half of medication errors are attributable to medication omissions (Barber et al., 2009). The specific eMAR system chosen allows for live monitoring via a dashboard screen where all staff can quickly identify where medications are due to be given or have been missed. This is augmented by an alert on the main screen, which identifies the specific young person and medication that is due to be given. Using the dashboard will allow staff to act 'rapidly' (a term used by the Care Inspectorate in their medication improvement project report, 2020) to prevent missed medication, which improves the outcomes for the young person.

If the eMAR system were to go offline, medications can continue to be given and recorded. The system updates as soon as it is reconnected to the network. The system has a backup for 14 days if the internet is unavailable, after that there is a 56-day backup on a main desktop computer.

Where do errors happen?

The care forum in June 2018 reported that two thirds of medication errors occurred at the point of administration (Care Quality Commission, 2019; Mulac et al., 2021).

The eMAR system has several features which attempt to reduce human error in the process of administering medication, including young people requiring a photograph on their profile page. We are aware that this is common practice in other areas, however there are specific examples where this has been helpful within residential childcare. For example, in a specific house multiple young people identified as a gender different to their sex and used a name other than their birth name. Medication labels and medical records within Scotland reflect the birth name and gender until legally changed.

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To prevent inadvertent additional administrations, when a young person is administered their medication they no longer appear on the administration screen, or they are 'greyed-out', preventing any repeated medication administration. Medications only reappear when an agreed time frame has lapsed, for example four hours can be set for paracetamol with a maximum dosage set for a 24-hour period.

In addition, the system allows for complex medication regimes to be entered, for example when titrating to a specific dose, which provides more accuracy and prevents errors where there are multiple changes to doses over a short period of time.

For medication in patch or injection form, there is a feature to record the site of the administration, and administration cannot be recorded without the staff member entering the site of administration. Changing the administration site is best practice (NICE, 2022). This feature within the system provides a reminder and safeguard to ensure this happens in practice. There have been no incidents where medication has been given on the wrong site or route in the past 12 months.

The above features support the six rights of medication administration: i.e. 'right resident, right medicine, right route, right dose, right time, and right to refuse' (National Institute for Health and Care Excellence, 2020). Patterns of young people refusing their medication can be identified, and using this staff can encourage young people to take responsibility and discuss their medication and health needs with the appropriate health team, ensuring they are fully involved in all discussions about their health (Scottish Government, 2020).

In the eMAR system there is a feature involving a barcode scanner, wherein the pharmacy will provide a barcode on each of the medication boxes and the staff scan the medication box to ensure it is the correct medication for the resident. However, this feature is only possible when a designated pharmacy is preparing the medication for the eMAR system. The use of the scanner was trialled in the first rollout, but over time the use of the scanner fell away and staff were reading the labels rather than scanning. Using a barcode scanner was found to be effective in reducing administration errors (Malson, 2015), however we were unable to gather enough data to identify whether the use of the scanner in practice in this organisation reduced medication administration errors.

Optimising medication monitoring in young people

When young people are prescribed pro re nata (PRN), or as required medication, for example by clinicians in Child and Adolescent Mental Health Services (CAMHS) to manage symptoms of emotional distress, the eMAR system requests a note at a set time following the administration to record the effectiveness of the medication. A report of the frequency of use of these medications, as well as

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the notes entered by staff, can easily be generated and provided to CAMHS clinicians on request. The information in this report is useful to consider within the formulation of the young person's difficulties, to identify specific times or patterns when the medication is required to manage symptoms, and to highlight areas where other supports should be used before administering medication.

Covid-19

The rollout of the eMAR system was put on hold during the Covid-19 pandemic, which increased the time that the organisation was utilising two different medication management systems, eMAR in secure services and paper recording in others. The public health agenda has moved on from Covid-19, but many care establishments are still recovering from the effects of the high turnover of staff and difficulties in staff recruitment (Coalition of Care and Support Providers Scotland, 2024). This turnover of staff led to less staff being competent with using the new system, which increased the time spent on ongoing training. Impressively, throughout the pandemic the electronic system was maintained.

The implementation process

The two registered nurses employed by the organisation were leads for the implementation, providing weekly progress updates and arranging monthly meetings. The team supporting the implementation included the clinical director, service director, IT manager, learning and development manager, quality assurance manager, and data protection officer. An implementation timeline was developed and shared with the group.

As with any change project, during the implementation process there were staff who were resistant to the change, which was anticipated, but the nurses identified managers and staff who were enthusiastic about embracing the eMAR system in each of the houses.

Staff were supported to visit other organisations that had implemented the system to observe it in action. This worked to alleviate staff concerns and allow for familiarisation with the system. One of the main fears staff raised was concern that they were 'not good with computers', rather than worries about the eMAR system itself.

On completion of phase one in the safe centre, there were requests from managers in other services keen to have the eMAR system implemented in their houses to reduce auditing time. This enthusiasm and staff familiarity with the eMAR system within the first phase built momentum, which helped drive forward the change process. This was particularly evident in the third phase, within the community setting.

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Training

The training itself takes place online, with specific modules to be completed depending on the responsibilities of the staff member. Modules for CYCW take around three to six hours to complete. Managers who have additional modules estimated four to eight hours for completion. Each module has three sections: demonstration, guided example, and unguided example. If there are more than four errors in each module, the section must be repeated. Initially, differential roles were established for the different grades of staff, however as time progressed this proved to be problematic, as staff were promoted and had additional modules to complete and then their user setup changed on the system. In reviewing the system it is now streamlined with two roles, CYCW and managers.

The training is thorough, but staff generally did not enjoy the training due to the level of accuracy required. The training itself was described as 'pedantic', due to staff being able to identify the correct answer but often failing due to not being accurate enough in clicking or typing. The training materials were standardised and not customised to the organisation, such that aspects of the training were not relevant to children's services. The training material is designed for elderly care homes, which was another challenge for staff as the language used in the training examples and medication were unfamiliar. This contributed to some staff feeling overwhelmed by the training.

Depending on the implementation package purchased there are live training days for staff where the trainer is online taking the staff through simulated examples. In the first phase this was face-to-face, with the latter two phases taking place online. It was reported that the face-to-face training was more helpful, where staff were set up with computers, in small groups with the trainer, and nurses supported the practical sessions. Online sessions mimicked this but the interaction and reported usefulness were reduced. It is licenced training, meaning that the organisation implementation leads are not able to access this and hold workshops, which is a significant drawback when considering how difficult it is to offer the training to staff working across services on various shift patterns, including night shifts.

That said, the eMAR trainer assigned to the organisation, with the support of the nurses, did develop examples relevant to the young people, for example with ADHD medication, contraceptives, acne treatments, asthma, eczema, and diabetic medication, typical medications prescribed to the young people in residential childcare. Staff did respond well when these examples were used making it more relevant to their daily experience. This form of training elicited questions that could be answered by the trainer prior to the system going live.

Access to the online training requires each staff member to have a login and password set up. In this organisation the learning and development department

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took on this responsibility, where in each of the three phases one week was allocated for the task of setting up and administering logins to each staff member. The senior management supported the request to make the training mandatory for all staff. However, there were still challenges in staff uptake and completion for various reasons. An additional factor, not relevant for this organisation but worth considering, is the use of staff who would not normally work within the service, such as agency staff. Such staff would not have access to the system, or the required training and competencies. The time for rolling out the training varied in the services, on average taking over six weeks for all staff in a team to complete the online training, which their line manager needed to factor into the weekly rotas. The live support training dates were booked in over two weeks, followed by the 'go-live' one week later.

The rollout

The three phases were carried out as follows:

Phase 1: Three houses in the safe centre,

Phase 2: Thirteen residential houses on one campus

Phase 3: Thirteen community houses.

Each phase followed the same format, where an implementation group was identified and led by the nursing staff. In this organisation the rollout was led by the nurses for the safe centre and residential houses, whereas for the community setting it was a CYCW under the guidance of the nurse who supported the implementation. The timeline for each of the services was established from a realistic 'go-live' date.

When the eMAR database is prepared for use in the organisation every member of staff is required to have their details inputted into the system and a login generated. Four weeks were allocated for this, for several hundred staff, with the support of administrators. Once the staff in the houses had logins to access the eMAR system, they were requested to complete a profile for each young person in their service.

Going live preparation with GP practice and pharmacy

There is a need to discuss eMAR with the GP practice associated with the service. For this organisation, it was a substantial task for the GP to coordinate the prescription requests for all young people's medication. For the eMAR system, all young people are on the same 28-day cycle for ordering and delivery of medication. This is common practice within other services such as elderly care homes; however, this is not generally the practice in residential childcare due to the frequent medication reviews and population changes.

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To ensure all young people started the 28-day cycle at the same time, multiple prescriptions were required for specific quantities of medication to allow for synchronisation of this cycle across all aspects of the service.

Re-ordering of medication

The eMAR system supports accurate monitoring of medication stock and re-ordering of prescriptions. The system works on a 28-day cycle where a re-ordering report is automatically generated. This report is populated with all the details required for the GP to provide a prescription for the young person, including the medication name, dose, and label details, and estimates the quantity required based on the previous month's usage. This report can be sent to the GP to request a prescription, thus ensuring the continuity of medication, and the automated ordering process reduces errors (Access Group, 2024). Having an efficient system to re-order medication reduces the likelihood of requiring emergency prescriptions and sourcing medication out of hours – this has a wider impact than the service itself, additionally reducing resources required within the health service (GP and pharmacy). There have been no instances in the last 12-month period where young people have not had access to medication due to there being no stock or expired stock. Use of the 28-day cycle also prevents overstocking of medication and reduces waste – this is a key driver currently in the local NHS health board, with Greater Glasgow and Clyde estimating that 10% of dispensed medication is wasted each year – in the local health board area this accounts for around £100,000 per day (NHSGGC, 2024).

Pharmacy involvement and support was essential in transitioning to the eMAR system, which was considered prior to purchase as not all pharmacies are compatible with all systems. In the first phase of the rollout in the safe centre, all the young people were in secure care, and as such did not go to local minor ailment services or go out to GP practices. Therefore, all prescriptions were able to be processed by a central pharmacy, who populated the details of the medication directly into the system, again reducing human errors within the service when entering medication information. This is the ideal situation and worked well in the secure centre. However, in the residential and community services where young people are encouraged to make GP appointments and go to the pharmacy as part of their life skills training, using only a central pharmacy is no longer possible. In this situation, when the pharmacist is not uploading the medication, it would be the CYCW who uploads the information onto the eMAR system. To reduce the risk of error within this process, the service enacted an additional safeguard to ensure a manager checks and approves the medication before it can be administered.

Negotiating with the GP and pharmacies in each of the phases was allocated six weeks to allow for meetings to be arranged/rescheduled. This was led by the nursing team to ensure a single point of communication between all services.

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Establishing this point of contact within the pharmacy and GP practice helps resolve any anomalies at the 'go-live' stage and moving forward.

The go-live date

At the point of the first go-live date the nurses rotated to provide comprehensive 24-hour support, in addition to the trainer being onsite to ensure all system questions and medication queries could be responded to quickly. The next go-live involved 13 residential houses on one campus. While each of the houses has its own staff team, collectively they are part of the same campus. All 13 houses went live on the same day and there was online support from the company, however staff appeared to prefer having someone on campus to 'show' them and therefore contacted the nursing team. This support was provided by the nurses, the CYCW, and managers from the phase one service. The nursing team supported the rollout, however this was difficult to sustain – on reflection, the nursing team should have signposted to the online help from the early stages to prevent reliance on the health team.

In the final rollout to the 13 community houses, a CYCW was recruited part-time as a health support worker for the duration of the implementation. Each of the houses was systematically set up and went live. Due to the geographical spread (across four local authorities and two health board areas), each of these community houses has different GPs and pharmacies. At the time of going live the week prior (or for as long as necessary), the health support worker was in the houses with staff supporting them to create profiles for the young people. During the go-live week, the health support worker provided daily support. This could be extended if required, as these services can feel isolated from the support of the larger part of the organisation. On average it took between one and three weeks to complete a house.

The quality assurance developments within the organisation

The organisation has a quality assurance department and the nurse links directly to this to ensure and evidence the highest standards. The young person's experiences and how their needs were met must be documented. The Looked After Children (Scotland) Regulations (2009) indicate that looked after young people's care records must be kept for 100 years, thus, digital medication records are much more readily accessible than archived paper documentation.

As the system is embedded in the organisation there are twice daily stock checks which are automated by the system, allowing for any irregularities in the stock to be followed up by the staff on shift.

The house managers complete a monthly audit: checking the profile of a young person is correct, reviewing whether medication labels and instructions match, any medication given late without reason, and any medication missed. The nurse then completes a parallel audit and categorises it using the traffic light system:

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- Green: no administration or recording errors and managers' audits completed.
- Amber: administration or recording errors but identified by the manager and appropriately followed up.
- Red: administration errors or recording errors that have not been identified by the manager.

For services in the 'red' the manager is required to have an action plan and would have support from the nurse and the head of operations within the organisation, thereby directing the support to those services that require it.

Summary timeframe

The timeline and actions within the table at Appendix relate to the organisation's internal processes. Other organisations may be able to implement over different timescales, depending on size, availability of hardware, and the implementation team.

Key questions to consider

Once the rollout commenced, one of the challenges was running with two systems in the organisation, where the old 'paper' system continued to run in some services whilst the eMAR system had been rolled out in others. This became challenging, with respect to ensuring policies and training were able to cater for both versions of medication administration.

Every service had unique challenges, and the authors found key themes across the three phases:

- There is a need to prepare senior management for an increase in error reporting, including recording issues but also highlighting previously unseen errors in practice. Pre-emptive discussions with the Care Inspectorate should be considered. The Care Inspectorate are in favour of the eMAR system, following the WHO in aiming for a 50% reduction in medication errors (Care Inspectorate, 2020; WHO, 2017).
- Additional features of the system include automated reports as to which staff are giving out medication. This allows the manager to identify staff who may be reluctant to give out medication and require additional support, thus increasing the competence and capacity within the team for safe handling of medication.

For the eMAR system to be sustainable in the organisation this requires ongoing commitment, for example, to remove staff who have left, to issue new logins for new staff, and to reset logins for staff who have forgotten their password. To facilitate the practice for young people to take ownership of their own medication, all young people required logins for the eMAR system, demanding a substantial number of resources to set up and maintain.

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The system has a help function that all staff can access, but staff were reluctant to use this due to having nurses available on site, leading to staff approaching them regularly rather than utilising the help functions within the eMAR system. Despite encouragement, staff continue to tend to favour seeking support where someone will show them in person. This has been difficult to sustain whilst continuing with core aspects of the nursing role.

To reduce the ongoing support required from the nursing team, the authors developed a quick reference guide with screenshots to respond to frequently asked questions and cover common processes within the system. This has been invaluable and is frequently referred to by staff and managers alike. More recently the managers requested that the nurses develop a quick reference book for the features specific to auditing, which has been actioned and utilised within the services.

Key recommendations

- Early conversations with senior management and the Care Inspectorate to support implementation.
- Ensure key stakeholders are also involved early, such as the GP, pharmacy, and IT and learning and development colleagues.
- Budget planning, being prepared for ongoing and changing costs.
- Identify clear support structures for staff early in development, to ensure system use is sustainable.

Limitations

The authors did not complete a formal qualitative evaluation of the implementation with young people or staff. Young people move within the service frequently; therefore, many do not have comparative knowledge of the paper system. Staff were asked for comments on their experience of the implementation, but minimal responses were returned.

Conclusion

There are considerable benefits to the eMAR system, ensuring best practice in medication administration and recording, as evidenced by its complete transparency and the low rate of medication errors. It has supported a standardised approach to the ordering, administration, and recording of all aspects relating to the safe handling of medication, and generates electronic reports on all of these processes.

There are additional aspects to consider, as well as those relating to the storage and retention of documents. Currently, within residential childcare, there is an onus on services to be able to provide detailed records of a young person's stay

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with them, often years later. The eMAR system provides ready access to medication records.

This article details the process specific to implementation and refers to the other departments involved, such as IT and learning and development, who within their role supported this transition, developing their implementation plans around the 'go-live' date, and offering ongoing support.

This requires planning and identifying who within the service has the capacity within their role to have an overview of the system and to take responsibility for the wider aspects of the safe handling of medication. Reflecting on Barber's research, this should have been identified prior to implementation.

The information in this article is anticipated to inform the planning and preparation for an organisation to implement an eMAR system.

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Appendix

Task	Actions	Timescale
System Choice Developing a business case	Business case costs to include: Hardware and software Ongoing costs Staff for implementation Staff for ongoing operation Initial Software costs Ongoing licence costs Training time/cost	4-8 weeks
Process of approval from the senior leadership team	Review and update the business case	2 -8 weeks
Establish the implementation group. Employ or allocate staff time to project Set weekly/monthly meeting dates in advance	House managers, health, IT, learning and development, GDPR officer, staff rep, admin Weekly summary report	2-8 weeks (dependent on recruitment)
Introduction of the eMAR system and process of implementation. Prepare for FAQ	Attend manager's meetings, team meetings, and development days	3 weeks (depending on size of the organisation)
Meeting with the company to discuss the training package and agree with your organisation's L&D	Agree on the training plan and timeline. Who will be organising the training access logins, online events, and updating the staff records on completion of training?	1 week
GP and pharmacy arrangements around the 'go-live' date and ongoing 28-day ordering cycle	Establish the number of young people and their medications Go-live date agreement Identify contact person at the pharmacy and GP practice If sourcing a pharmacy to input medication this will have been arranged in advance	2-4 weeks depending on availability of GP and pharmacy.

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		This will have been discussed at the prep stage as this will influence the type of eMAR system
IT department to purchase hardware and prepare for software installations	Ongoing IT support for software updates	4 weeks depending on the availability of software
Liaising with system provider re. specifics of database for roles and responsibilities of staff etc.	This will influence the training modules.	Commences when the contract has been signed
Prepare for the go-live date – when additional support is available for services	For example, avoiding months e.g. over holiday periods	Week before 'go-live' date
Set up and issue staff/users with logins	Admin task - will require ongoing updates with respect to staff turnover	Fortnight before 'go-live' date.
Prepare the system for use. Staff will upload profiles and medication orders onto the system.	Plan for who will review the input to ensure accuracy	Week before 'go-live' date
Arrange the stocks of medication for commencing the 28-day cycle	This will require reviewing current medication balances and requesting specific numbers of tablets for each young person	Within 1 week of the 'go-live' date
Transfer current medication counts from the paper system to the electronic system on the go-live date	This upload of the stock will follow the last medication administration on the paper system	Day and morning prior to the 'go-live' time.
Support go-live	Increased support for the first week	Support each shift team in administering medication using the system.

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Ongoing support to troubleshoot, update the users for changes in staff, coordinate the reordering of medication, install software updates, training support for new staff	Establish who will have the roles and responsibilities: IT for updates Training department Troubleshooting Coordinating medication orders Coordinating medication disposals Updating system users with new/leaving staff Negotiating license agreements	Ongoing
Updating policy and procedures will be required to reflect the responsibilities and process using the eMAR system	The roles and responsibilities Expectations on staff Outcomes of errors Link with management and HR policies	1 week
Review system of quality assurance	Review the manager's auditing systems and data analysis for action on areas for support, training, and noting excellent practice	Depending on the monitoring systems that are being developed or updated within the quality assurance dept.

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Original Research Article

Self-harm and suicide in residential childcare

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Abstract:

Self-harm and suicide behaviours in residential childcare require effective interventions, practices, and policies that ensure the safety and wellbeing of young people. This literature review examines current research on prevalence, risk factors and interventions, identifying inconsistencies in definitions and risk management. Trauma-informed care, dialectical behaviour therapy, staff training, supporting relationships, and adaptive coping strategies are highlighted as key approaches. The review highlights the need for developmentally appropriate and individualised care and safety planning, particularly for younger children and autistic children. Research gaps are noted, and policy recommendations include improved risk assessment, safety and care planning, and enhanced staff support.

Introduction

Understanding self-harm and suicide behaviours in residential childcare is essential to developing appropriate interventions, practices and policies to ensure young people are safely cared for (Evans, 2018). This ensures those working within residential organisations have consistent training, understanding, and responses to self-harm and suicide behaviours (Paul & Hill, 2013). Research places importance on factors such as increased feelings of hope for the future and positive outcomes, and on reduced engagement in self-harm and suicide behaviours (Burnand & Johnson, 2022; Ngune et al., 2021). Therefore, this literature review aims to explore existing research on self-harm and suicide behaviours in residential childcare, including current interventions and supports. The review makes recommendations for policy, including risk assessment and management, safety and care planning, and staff training and support.

Language and definitions

The language used to describe topics such as suicide and self-harm, and looked-after young people's experiences, are complex. To ensure a consistent understanding of topics, the following section will provide an overview of 'residential childcare', 'suicide', and 'self-harm' within the context of this review.

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Residential childcare

In Scotland, residential childcare encompasses various settings, such as children's homes, residential schools, and secure care (Scottish Government, n.d.). Children may reside in residential care for a number of reasons, such as behavioural and emotional difficulties, exposure to violence in the family home, abuse or neglect (Pinheiro et al., 2024). As a result, children may be placed under a Compulsory Supervision Order through the Children's Hearing (Scotland) Act 2011, Section 25 of the Children (Scotland) Act 1995, or through permanence orders under Section 80 of the Adoption and Children Act 2007 (Scottish Government, n.d.).

Suicide

Although suicide has never been an offence in Scotland, until 1961 it was regarded as a crime in England and Wales (Suicide Act 1962; UK Government, n.d.). The act of suicide is often referred to as 'committing suicide', implying an offence has occurred, with phrases such as 'completed suicide' or 'died by suicide' being more compassionate (Padmanathan, 2019).

Self-harm

The definition of self-harm is often inconsistent due to differing understandings of the behaviour and motivations behind it (National Collaborating Centre for Mental Health, 2011). Descriptions such as 'parasuicidal behaviour', 'non-suicidal self-injury' and 'self-mutilation' have all been used to describe self-harm (Furnivall, 2023). For the purpose of this review, self-harm will be defined in line with the NICE guidelines (published in 2022): 'Self-harm is defined as intentional self-poisoning or injury, irrespective of the apparent purpose'. Common behaviours include cutting, burning, biting, scratching skin, and poisoning (Cipriano et al., 2017) However, '[t]he guideline does not cover repetitive, stereotypical self-injurious behaviour (such as head banging)'. Headbanging has been viewed as the most frequent form of self-injury among those with autism spectrum disorder (ASD)or those in a secure setting, due to it being a more 'accessible means of harm' (Mournet et al., 2024; Steenfeldt-Kristensen et al., 2020; Summers et al., 2017;). Research has uncovered that most individuals who engage in self-harm behaviours use more than one method, for example, cutting and ligature use (Cipriano et al., 2017). Frequent engagement is associated with mental health difficulties and increased risk of suicide attempts (Castellvi et al., 2017).

Method

To explore self-harm and suicide in residential childcare, a narrative literature review methodology was adopted. A systematic search was conducted across peer-reviewed databases for articles between 2008 and 2025, with inclusion criteria focusing on self-harm and suicide in residential childcare. Studies from

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similar systems, for example, youth justice, kinship, foster care, and inpatient mental health, were also included where relevant to draw transferable insights. Analysis involved thematic synthesis of risk factors, intervention models, and policy frameworks. This review is not an exhaustive exploration of self-harm and suicide behaviours in residential childcare.

Key findings

Measuring and recording risk of self-harm and suicide

Behaviour is described as having a temporal component, meaning it unfolds and develops over time. Therefore, tools have been developed to focus on risk factors, such as mental health and adverse childhood experiences (Stewart et al., 2020). An exploration of the Child and Youth Mental Health Screener (ChYMH-S; Stewart et al., 2017) found that the tool assesses varying factors, including mental state indicators, substance use, behaviours of concern, harm to self and others, communication, development, stress, trauma, relationships, and education. Stewart et al. (2017) found the ChYMH to be a strong predictor of self-harm and suicide behaviours within mental health organisations.

Additional tools, such as the Strengths and Difficulties Questionnaire (SDQ; Hall et al., 2019), the Revised Children's Anxiety and Depression Scale (RCADS; Baron et al., 2021), the Massachusetts Youth Screening Instrument – version 2 (MAYSI-2; Grisso & Barnum, 2006), and the Children Revised Impact of Event Scale (CRIES; Ossa et al., 2019), have also been validated for the assessment of mental health concerns. Such measures and tools should be repeated at regular intervals to continue to assess the risk and effectiveness of intervention (where appropriate) (Law, 2012). Qualitative designs, such as the 'ABC' model, propose that activating events or triggers, resulting in self-harm and suicide behaviour, which creates an emotional or behavioural response are also effective in monitoring risk (Fowler et al., 2021).

Self-harm and suicide behaviours require various measures to further understand them (Bateson & Martin, 2021; Madge et al., 2011). Residential organisations adopt their own data entry system for how self-harm and suicide incidents are monitored and assessed (Wadman, 2017). UK guidelines for young people who present with self-harm and suicide behaviours recommend comprehensive psychological assessments should be completed (National Collaborating Centre for Mental Health, 2011). Various scales, tools and measures are a key part of this assessment for predicting future risk. Available tools include: the Suicide Risk Monitoring Tool (SMT), Ask Suicide Screening Questions (ASQ), Self Harm Questionnaire (SHQ), Suicide Ideation Questionnaire (SIQ), Beck Hopelessness Scale (BHS) and Children's Depression Rating Scale-Revised (CDRS-R) (Erbacher & Singer, 2017; Harris et al., 2019).

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Safety planning

NICE guidelines state that young people who have engaged in self-harming behaviours should be supported through a 'safety plan'. This includes key coping strategies and sources of support for the young person during crisis, whilst highlighting warning signs for professionals to monitor (NICE, 2022). The guidelines further encourage a 'designated lead', to support staff and young people in implementing safety plans and ensuring these are adhered to. Research has placed further emphasis on the importance of safety plans using a Multi-Disciplinary Team (MDT) approach (Abbott-Smith et al., 2023).

The Centre for Suicide Prevention (2021) describes a safety plan as 'a written document that supports and guides an adult with suicidal ideation or behaviour to help them avoid a state of intense suicidal crisis'. Research has further described safety planning as a structured primary intervention between young people and professionals (Stanley & Brown, 2012). Safety plans are often developed in line with key aspects of the Cognitive Behavioural Therapy (CBT) model and have been found to lessen the risk of self-harm and suicide (Stanley & Brown, 2012; Mann et al., 2021). Research has identified that safety plans should include warning signs, coping strategies, social support, professional contacts, and environmental support (Bryan & Rudd, 2018; Mann et al., 2021).

Various approaches have been identified for creating safety plans with young people. The Stanley and Brown model (2009) utilises a CBT-informed safety plan. This approach was found to be positive in reducing suicide ideation, however, motivation to engage in the plan was low (Stanley et al., 2009). Therefore, motivational interviewing informed safety plans were developed (Czyz et al., 2019). Such studies found increased coping and engagement in safety planning but did identify a need for plans to be developmentally appropriate to young people (Abbott-Smith et al., 2023). OverCome (Muela et al., 2021) is a new intervention that focuses on self-harm and suicide behaviours. This intervention places foregrounds the development and implementation of safety plans that the young person can utilise during periods of crisis. Muela et al. (2021) also suggest professionals and care staff working with young people should have safety plans to reduce the stigma around self-harm and suicide and to normalise the need for support.

Further approaches, such as the SAFETY Programme (Asarnow et al., 2017), Family-Based Crisis Intervention (FBCI; Ginnis et al., 2015), the COPES model (Wolff et al., 2018), and the Adolescent Safety and Coping Plan (ASCP; McManama O'Brien et al., 2020), have been developed to explore family involvement for young people who continue to reside in the family home and for those who are transitioning out of highly-supervised environments.

Gaps within the literature have identified a need to develop safety plans suitable for autistic children, due to social barriers and differences in communication

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styles (Camm-Crosbie et al., 2019; Crane et al., 2019). As a result, Rodgers et al. (2023) developed a safety plan to support autistic individuals, the 'Autism Adapted Safety Plan'. This encompasses key elements required for a safety plan, however, with attention paid to communication styles. Strategies to support autistic young people in completing safety plans include visual aids, clear instructions, and recognition of sensory needs (Schwartzman et al., 2021).

Prevalence and risk factors of self-harm and suicide in residential childcare

Young people who reside in residential care have an increased likelihood of experiencing childhood adversity and trauma in comparison to those living in the family home (National Audit Office, 2015; Rosa, 2019; Rouski et al., 2021). Such experiences increase the prevalence of psychological difficulties and engagement in risk-taking behaviours, such as self-harm (Calvo et al., 2024; Cleare et al., 2018; Martin et al., 2016; Yates, 2009). Mental health difficulties, such as depression, anxiety, and post-traumatic stress disorder, are correlated with self-harm behaviours, particularly for those residing in residential childcare (Varley et al., 2022). Carter et al. (2025) reported the use of self-harm to cope with distress and negative emotions related to the young person's life experiences. Young people living in care can also experience social isolation, loneliness and victimisation due to the stigma of residential care, further perpetuating the risk of self-harm (Emmerich et al., 2024).

Research has identified that 35 to 40% of young people living in residential care engage in self-harm, in comparison to 15% of those living with family (Geoffroy et al., 2022). This is further evidenced by Hawton et al. (2022), who identified that those living in residential childcare are at greater risk of self-harm, thus emphasising the need for tailored prevention and intervention. Young people may be exposed to the distress of other's behaviours, contributing to what is often described as a 'contagion effect' (Chandler, 2016; Hawton et al., 2020; Papadima, 2019). For staff, frequent incidents can contribute to emotional fatigue, reduced tolerance, and reactive care practices, which in turn affect how well trauma-informed principles are applied (Brown et al., 2019; Clark et al., 2022; Friis et al., 2024; Grybush, 2020).

Research has highlighted the significance of adverse childhood experiences (ACEs) and mental health difficulties with respect to the prevalence of suicide (Stinson et al., 2021). An American study found experience of childhood trauma to be a predictor of suicide ideation and self-harm (Stinson et al., 2021). Further research identified each additional ACE increases an individual's risk of suicide by 123% (Dudeck et al., 2014). Muela et al. (2024) found that, of 185 young people in residential care in Spain, 26.5% had previously attempted suicide and 36.2% had ongoing suicidal thoughts. Only one-third of young people who had thoughts of suicide had sought professional support. Limited care staff knowledge and training impacted young people's confidence in seeking support

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from them (Muela et al., 2024). Burnand and Johnson (2022) identified the importance of relationships, talking interventions, practical support, and professional support for young people who engage in self-harm and suicide behaviours in residential care.

Deaths of care experienced children in Scotland

The Care Inspectorate (2020) conducted an overview of the deaths of care experienced children in Scotland between 2012 and 2018. They found that of the 42 children and young people who died, 14 died as a result of substance use, self-harm, and suicide. Half of these young people previously resided in secure care or settings with high levels of supervision. The review recommended the need for earlier identification of distress, effective multi-disciplinary team working, and available interventions.

Additional risk factors

It should be noted that trauma and adversity are not exclusive factors for engaging in self-harm and suicide behaviours, however, these are the most significant factors for young people residing in residential childcare (Calvo et al., 2024). Additional risk factors include interpersonal difficulties, grief and bereavement, financial difficulties, mental health difficulties, and sensory needs (Blanchard et al., 2021; Darol & Mishara, 2021; Elbogen et al., 2021; Ford, et al., 2021; Rasmussen et al., 2016; Reichl & Kaess, 2021). Research further states that young people with a learning disability (LD) or neurodevelopmental diagnosis (NDD) are at greater risk of engaging in self-harm and suicide behaviours (Blanchard et al., 2021). Such diagnoses can impact the individual's understanding, management, regulation, and communication of their emotions (Cibralic et al., 2019; Reyes et al., 2019; Sari et al., 2024).

There is limited research on the relationship between those who identify as transgender or gender diverse (TGD), or lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI), living in residential childcare and their engagement in self-harm and suicide (Cawley et al., 2019). Findings from the Life in Scotland report (LGBT Youth Scotland, 2022) indicated that 69% of LGBTQI young people had experienced suicide ideation and 43% engaged in self-harming behaviours. Those living in residential care, or who had unstable living environments, reported high levels of distress. Research has explored TGD individuals and their engagement with Child and Adolescent Mental Health Services (CAMHS), finding that those who identify as TGD had increased vulnerabilities to experiencing mental health concerns and engagement in self-harm and suicide behaviours (Whittle et al., 2024).

Criminal justice context: Young offenders

It is important to recognise that young people involved in the criminal justice system may be young prisoners. Since 2011, ten young people have died by

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suicide in HMPYOI Polmont (Judiciary of Scotland, 2025). Following the deaths of two young people, Katie Allan and William Lindsay, in custody, a Fatal Accident Inquiry (FAI) was conducted. The inquiry identified multiple systemic failings, including limitations in multi-disciplinary communication; inadequate mental health and suicide risk assessments; lack of trauma-informed practice; and misattunement to signs of distress and risk (FAI, 2025). Recommendations included in the FAI focused on the need for proactive risk assessments and management, including ligature prevention and suicide prevention technology, as well as the appropriate recording and communication of information (FAI, 2025; Judiciary of Scotland, 2025).

Although these deaths occurred in a custodial context, they highlight wider concerns about the safety and care of vulnerable young people across Scotland's systems, including residential and secure care. These concerns formed part of the broader policy and public discourse that contributed to legislative reform, including the Children (Care and Justice) (Scotland) Act 2024 (Scottish Government, 2024). While this is not a direct result of the FAI or the Children's Hearing System review, the Act introduces significant changes, including raising the age of referral to the Children's Hearing System to 18 years and ending the use of Young Offender's Institutions (YOIs) for children (Scottish Government, 2024; Scottish Prison Service, 2025). As a result, children are no longer placed in YOIs, and those requiring a custodial sentence are now accommodated in secure settings up to the age of 18, after which they may transition to HMPYOI Polmont if required.

Approaches to intervention and support

There are various interventions and supports which have been developed to support young people who engage in self-harm and suicide behaviours in residential childcare. These focus on trauma-informed care, relational factors, and evidence-based therapies. A key approach to supporting young people in residential care is the adoption of trauma-informed care (TIC) (Goddard, 2021). TIC promotes safety, connection, and trust within a caregiving environment, assisting young people to manage their emotions and behaviours safely (Bath, 2008). Research identifies that staff training in TIC improves emotion regulation in young people and reduces self-harm behaviours (Hodgdon, 2023; Nikopaschos et al., 2023). Burnand and Johnson's (2022) research found that giving young people the opportunity to discuss their engagement in self-harm and suicide behaviours is beneficial in the management of such behaviours. This discussion can take place with professionals or care staff.

Research emphasises the importance of stable and supportive relationships between care staff and young people in reducing self-harm and suicide behaviours (Burnand & Johnson, 2022; Epstein & Ougrin, 2020). Holland et al. (2020) found that young people in residential care were more likely to seek support from CAMHS, peers, and pets, rather than care staff. Research has

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identified positive outcomes for those who access online peer support groups related to engaging in self-harm (Joens et al., 2011; Rowe et al., 2014). This was reported to be due to the informal aspect of online forums, however, mitigations for potential risks were required, for example, professional facilitators, trigger warnings, and training (Abou et al., 2022). Peer-led support groups were also found to reduce self-harming behaviours by empowering individuals and providing them with access to information and support (Abou et al., 2022). Although there is limited research as to the effectiveness of family interventions in reducing self-harm behaviours, there is evidence of a positive impact on therapy attendance (Witt et al., 2021).

Therapeutic interventions, such as Dialectical Behaviour Therapy (DBT), have been shown to support a reduction in self-harm behaviours and suicide ideation (Asarnow et al., 2021; Kothgassner et al., 2021). DBT is a variant of cognitive behaviour therapy that can consist of individual psychotherapy sessions, group skills training, telephone consultation, and a therapist consultation team (Linehan, 2014). Research on the implementation of DBT within residential settings is limited, however, studies have found that where used young people have engaged in fewer incidents of self-harm and suicide behaviour (McIntyre, 2020). Witt et al. (2021) completed a study to assess the effectiveness of psychosocial interventions on incidents of self-harm behaviours. Interventions such as DBT, Cognitive Behavioural Therapy (CBT), Mentalisation-based Therapy (MBT), and family interventions were explored. This study found that DBT was most effective in reducing self-harm incidents post-incident in comparison with CBT, MDT, and alternate psychotherapies (Witt et al., 2021).

CBT allows young people to evaluate their thoughts, feelings and behaviours whilst supporting them to develop coping skills (NICE, 2024). Knowles et al. (2022) found that young people favoured developing coping skills supported by staff, and safe and accepting environments, over therapy as a way of reducing self-harm. They felt this risk would reduce once the young person had appropriate coping strategies and felt safe within their environment (Knowles et al., 2022).

Organisational considerations

Research has identified key factors to further reduce the risk of harm for those working with self-harm and suicide behaviours. These include the environment, training, observations, and technology (Care Quality Commission, n.d.; Slaatto et al., 2022). Healthcare Improvement Scotland (2019) developed guidance for those working within the National Health Service (NHS), especially when working with individuals who present with complex mental health difficulties. The guidance, ‘Observation to Intervention’, focuses on factors such as patient history, safe environment, safety and care planning, trauma-informed approaches, risk assessment and management, observations, and tailored training and supervision. Although this is not focused on residential childcare,

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the guidance provides key elements that can be adapted and implemented into residential organisation practice and policy.

Further consideration should be given to individuals' observations and how these are implemented. The National Confidential Inquiry into Suicide and Safety (2021) published data reporting that 40% of patients in hospital settings who died by suicide were subject to enhanced observation levels. As such, research has highlighted the importance of observations being carried out using therapeutic conversations (Barnicot et al., 2017; Insua-Summerhays et al., 2018). The 'Observation to Intervention' document (Healthcare Improvement Scotland, 2019) highlights the importance of using communication during observations. This has been found to reduce social isolation and immediate risk of harm. It is deemed a key factor for the individual's recovery as it provides an opportunity to communicate thoughts and feelings that may be related to their risk (Insua-Summerhays et al., 2018). Technology/artificial intelligence has been developed to monitor patients' physical wellbeing without the requirement for visual observations (Barrera et al., 2020). The technology monitors movement and heat changes, allowing for staff to observe any alterations in the patient's breathing that may indicate distress (Barrera et al., 2020). This is mostly used within hospital settings and is yet to be explored within residential childcare homes.

Additional factors related to risk include access to items. Research has highlighted that individuals who present at greater risk of harm to self often require certain belongings/items within their living space to be removed to create a safe environment (Bailey et al., 2024; Healthcare Improvement Scotland, 2019). However, research has highlighted the need for such risk management strategies to be proactive, due to the often-impulsive nature of self-harm and suicide behaviours (Asarnow & Mehlum, 2019; Wadman et al., 2019).

Staff training is a crucial component in understanding and supporting young people who engage in self-harm and suicide behaviours (Ervine, 2022a). Applied Suicide Intervention Skills Training (ASIST), SafeTALK, and Assessing Suicide in Kids (ASK) have been adopted by many residential childcare organisations (Shannonhouse et al., 2017). ASIST provides training to staff on how to connect, understand, and assist a person who is at risk of suicide (Rodgers, 2010). Although there is limited research on the effectiveness of ASIST in residential childcare, according to data from the National Suicide Prevention Lifeline, callers were significantly less likely to feel depressed, suicidal, and overwhelmed when an ASIST interview was completed (Gould et al., 2013). Due to training often focussing on adolescents, the 'ASK' workshop has been developed to support young people and children under the age of 14 (Mental Health Learning, n.d). This ensures developmentally appropriate resources and support are available for younger children.

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Definitions of self-harm and risk are often subjective due to being based on staff experiences and perceptions (Ervine, 2022a). Ervine (2022a) found that staff were more likely to support young people who did not voice suicide ideation over those who did, as this was perceived as 'care seeking' (Klineberg et al., 2013). Burnout and secondary traumatic stress additionally impacted staff's ability to understand and manage self-harm and suicide (Pintar Babic et al., 2020). To support staff with this, research has identified the need for appropriate guidance and policy (Burnand & Johson, 2022). This works to increase awareness and knowledge of how to safely manage and record incidents of self-harm and suicide, thereby limiting feelings of uncertainty and fear (Brown et al., 2019; Burnand & Johson, 2022).

As discussed previously, safety plans have been developed to suit individuals with LD and NDD (Camm-Crosbie et al., 2019; Rodgers et al., 2023), however, these focus on NDD-specific facilities, rather than generic children's homes or secure care (Bagshawe, 2023; Heady et al., 2022). Further consideration and research are required to assess the population of young people with LD and NDD who engage in self-harm and suicide behaviours in residential childcare.

There is limited research on preadolescents (under 12 years of age) who engage in self-harm and suicide behaviours (Bolger et al., 1989; Peyre et al., 2017). However, pre-adolescent suicide has increased in recent years, resulting in it being the fifth-highest cause of death for this age group (Peyre et al., 2017). A systemic review completed in 2022 found that approximately 17% of preadolescents who experience thoughts of suicide proceed to attempt suicide (Liu et al., 2022). Factors such as childhood trauma, limited parental support (Hostinar et al., 2015), mental health issues (May & Klonsky, 2016), and diagnoses including Attention Deficit Hyperactivity Disorder (Beh-Yehuda et al., 2012), showed a higher risk of suicide behaviours.

Policy implications

This review emphasises the complexity of self-harm and suicide behaviours of young people in residential childcare and highlights several key areas for policy development and organisational practice. In summary, there is a need for clear and concise guidance and policy when working with young people who engage in self-harm and suicide behaviours. Not only is this to protect the wellbeing and psychological safety of the young people, but also that of the staff caring for them. From areas identified within this review, self-harm and suicide policy should include the aspects outlined below.

Risk Management and Assessment

Accurate assessment and ongoing monitoring of self-harm and suicide risk is critical (FAI, 2025). Organisations should implement validated screening and assessment tools, as reported in this review; these should be repeated at

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regular intervals to monitor risk trajectories and evaluate interventions (Harris et al., 2019). Documents for recording self-harm and suicide behaviours should be accessible and clear to avoid missed information and assessment; this will likely reduce staff fears of wrong practice (Brown et al., 2019).

Policies should recognise the impulsivity of self-harm and suicide behaviours, whilst appropriately assessing and monitoring risk (Asarnow & Mehlum, 2019; Wadman et al., 2019). Consideration should be given to appropriate risk management, such as observation levels, safe environment, technology-assisted support, and safety and care planning (Bailey et al., 2024; Barrera et al., 2020; Healthcare Improvement Scotland, 2019).

Safety planning

Individualised safety planning should be central to organisational policy and practice, with it being recognised as a primary intervention to reduce incidents of self-harm and suicide behaviours (Mann et al., 2021). NICE (2022) guidance emphasises the co-development of these with young people, multidisciplinary teams, and families where appropriate (Abbott-Smith et al., 2023). Safety plans should be appropriately adapted to the young person's needs, including learning disabilities or neurodiversity (ND and LDD). Staff training could incorporate motivational interviewing and collaborative safety planning approaches to enhance engagement (Czyz et al., 2019).

Research has evidenced the need for trauma-informed and developmentally appropriate adaptations of safety and risk management for those with learning disabilities, neurodevelopmental disorders, and pre-adolescents. For example, communication aids, visual supports, and support with sensory needs (Peyre et al., 2017; Rodgers et al., 2023).

Psychological therapies

Policies should promote trauma-informed care, therapeutic relationships, and access to evidence-based psychological treatments such as DBT and CBT (Asarnow et al., 2021; Hodgdon, 2023; Witt et al., 2021).

Staff training

Tailored training, such as trauma-informed care, allows staff to understand how to safely assess and manage incidents of self-harm (Bath, 2008; Ervine, 2022b). Staff should complete specialist training in suicide prevention models such as ASIST, SafeTALK, and ASK (Rodgers 2010; Shannonhouse et al., 2017). To ensure appropriateness within residential childcare, continued use of such models should be coupled with evaluations and developmental adaptations. Consideration should be given to involving young people in the development of staff training due to their lived experienced. However, this must be approached ethically, safely, and through co-development, to avoid triggering distress

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(Knowles et al., 2022). Young people's involvement may include the development of key messages, staff responses, and support strategies. Those involved should be offered appropriate debriefing and support.

Staff wellbeing

Organisations should acknowledge the emotional demands on staff with respect to supporting young people with complex needs. Staff should have access to supervision, reflective practice, and psychological support (Brown et al., 2019; Burnand & Johnson, 2022; Ervine, 2022b; Pintar Babic et al., 2020). Staff should attend frequent supervision to complement training, thereby ensuring they meet the competencies required to work with such complex behaviours (Health Improvement Scotland, 2019).

Definitions

The subjective nature of self-harm and suicide definitions, and staff perceptions, may affect the consistency and accuracy of reporting incidents. Therefore, the definitions and language used should be that of guidelines, such as NICE, to ensure a universal understanding of the terms (NICE, 2022).

Addressing the gaps

Organisations should consider and address the gaps in current literature and guidance, particularly in relation to those who identify as TGD and LGBTQI, pre-adolescents, and young people with LD and NDD (Whittle et al., 2024).

Conclusion

This literature review examined self-harm and suicide among young people in residential childcare, exploring key definitions, prevalence, risk factors, and interventions. It highlights the challenges of inconsistent language and definitions, noting the influence of staff perceptions on the management of self-harm and suicide risk. Studies highlight the need for tailored interventions, such as trauma-informed care, therapeutic interventions like Dialectical Behaviour Therapy, and staff training in suicide prevention techniques. Additionally, it emphasises the importance of building supportive relationships and offering coping strategies to reduce self-harm. While safety planning and risk assessment tools are crucial for managing risks, there is a need for developmentally appropriate and individualised approaches, especially for younger children and autistic children. The review notes gaps in the literature, particularly regarding the need for more research on younger children in care and less intrusive monitoring of young people in crisis. It also explores the implications of organisational policy on supporting and managing self-harm and suicide behaviours in young people.

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Short Article

Re-educating representation: Challenging Canada's colonial legacies of care

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Abstract:

Building on a presentation I was invited to share for a Kilbrandon Children's Research webinar on media representations of children and young people in the care and criminal justice system, I discuss here the legacies of Canadian 'care' practices premised on violent assimilation and erasure. Those legacies include the overrepresentation of Indigenous children in state care and the underrepresentation of Indigenous voices in the media. Drawing on the language of residential schooling, which sought to 're-educate' Indigenous children through assimilation, I highlight the work of Indigenous creators to produce 'an epistemic dawn' (Claxton and Winton, 2023) of Indigenous knowing to imagine a potential 're-education' of representation.

Introduction

Across the world, Canada is associated with multiculturalism and bilingualism (Premat, 2024) even while its identity is often oversimplified as a nation of friendly (primarily white) hockey enthusiasts who enjoy a high level of wealth as well as abundant access to nature. (Marland, 2018). These stereotypes shaped my own perception of Canada before I emigrated from the United States in 2018 and, as a critical childhood scholar, sought to better understand the contexts of Canadian childhoods, specifically the mechanisms of cultural inequality. Although I was familiar with the Truth and Reconciliation Commission (TRC), established in 2008 as a result of a large class-action settlement to inform the Canadian public about what happened to Indigenous children in residential schools. I did not understand the extent to which these colonial institutions, the logics that supported their creation, and their modern manifestations, continued to shape the lives of Indigenous children and families. Canada's historical practice of removing First Nations, Inuit and Métis Nation children from their families and placing them under state care has impacted many generations of Indigenous

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families, and today Indigenous children continue to be significantly overrepresented in the child welfare system. In 2021, 53.8% of children in foster care in Canada were Indigenous, although Indigenous children only accounted for 7.7% of the child population (First Nations Child and Family Services, 2025). Indigenous children are also more likely to live in poverty and experience food insecurity than non-Indigenous children. These concerning statistics reflect the real conditions of too many Indigenous children's lives, which are not captured by long-standing white, Eurocentric stereotypes of 'Canuck' culture. While these conditions are often covered by news media, such stories about Indigenous peoples often lack context and perpetuate damaging stereotypes (Sison, 2022).

While my scholarship has taken up representations of children and childhoods across a variety of media, it has not specifically focused on representations of Indigenous children and/or communities. However, when I was asked to participate as a panelist in a Kilbrandon Children's Research webinar on media representations of children and young people in the care and criminal justice system, organised by the University of Strathclyde's Department of Social Work and Social Policy, I knew that I could not discuss such representations in Canada without bringing attention to the material overrepresentation of Indigenous in state care. As a white settler scholar, I was unsure whether it was my place to discuss these issues with an international, primarily white European audience. In keeping with the principle of 'nothing about us without us', I first spoke with my departmental colleague at the time, Carmen Robertson, a Scots-Lakota Professor and Canada Research Chair in North American Art and Material Culture in the Faculty of Arts and Social Sciences at Carleton University. Professor Robertson, who has a long history of scholarship on contemporary Indigenous arts and constructions of Indigeneity in popular culture, reminded me that many people outside of Canada are not aware of the history of residential schooling or the ongoing issues of representation that continue to impact the lives of Indigenous peoples today. As she shared in a news article about how Canadian media reinforces Indigenous stereotypes, mainstream news media tends to rely on 'stereotypical representations' of Indigenous people as drunk, troubled, childlike, or uncivilised (Lisk, 2020). As Robertson explains, 'There are nice features and stories that we see in the press today, but when there's a flashpoint moment, it just seems like they go back to what they know deep inside them, and that's often demeaning and destructive' (Lisk, 2020).

In our conversation, Professor Robertson encouraged me to use the webinar as a platform to expand awareness of Canada's colonial legacies and the contemporary issues of representation about which she has extensively written. In this short article, I build on that platform with the goal of further expanding international awareness of Canada's colonial legacies of childhood care and bringing attention to the work of Indigenous scholars who are leading the way in Indigenising the media landscape. Drawing on the language of residential schooling, which sought to 're-educate' Indigenous children through assimilation,

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I frame what Claxton and Winton (2023) call 'an epistemic dawn' of Indigenous knowing as a potential 're-education' of representation.

Canada's Colonial Legacies of Care

Formal child welfare organisations and policy emerged in Canada in the wake of a Child-Saving Movement that emerged from the Second Industrial Revolution taking place in Europe and the United States in the last decades of the 19th century. In North America, this time of rapid change that saw industrialisation, urbanisation, the emergence of a middle-class, and shifting race-relations, surfaced anxieties about the maintenance of elite political power and white supremacy fueled concerns about the conditions of childhood (Garlen, 2019). In response to these concerns, particularly those of white female Evangelical reformers who bemoaned children's factory labour and living conditions in the urban slums of England, new institutions including children's hospitals, orphanages, aid societies, schools, and correctional institutions were established to stave off moral decline (Garlen, 2021).

During this period, a number of 'protective' child-centered interventions arose in Canada. First, a new emigration programmes was launched in the 1860s to relocate impoverished British children to Canada, where they were put to work on farms, mainly in the province of Ontario (Bagnell, 2001). This was the same decade that Confederation occurred (1867), which formally joined the provinces to establish the Dominion of Canada and its parliamentary democracy. Then, in the 1880s, the new federal government became directly involved with residential schools for Indigenous children, which had previously been operating in the provinces as Christian missions. In 1876, The Indian Act made the education of First Nations peoples the responsibility of the federal government, which began funding the church-operated institutions. In 1891, the first Children's Aid Society was established in Toronto, Ontario, and soon after the Children's Protection Act of 1893 was passed. This law criminalised child abuse, gave Children's Aid Societies authority to intervene on children's behalf, established a government office to oversee child welfare and encouraged the placement of children in foster homes over institutionalisation, laying the groundwork for the modern child welfare system in Ontario and across Canada (Dunlop, 2017).

These protective interventions grew into a movement in North America that focused on 'saving' children from moral and physical harm and controlling 'delinquent' youth (Platt, 1969). Under the guise of 'care,' public school systems, children's hospitals, orphanages, children's aid societies, and correctional facilities were established to rescue children from hard labour, poverty, and moral decline (Garlen, 2021). As Landertinger (2017) observes in her comprehensive history of child welfare in Canada, 'Child-savers and other social/moral reformers held that these suspect members of the empire had to be moulded into contributing citizens of the Canadian settler colony' (p. 12). The

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institutional structures that emerged from this movement were steeped in colonial logics 'through which Indigenous peoples are rendered subjects to be managed, and white settlers are re-inscribed as dominant, superior, and – despite the enormous violence that underpins their subject positions – as 'caring' (Landertinger, 2017, p. ii).

Residential Schools and Re-Education

Between 1831 and 1996, more than 150,000 First Nations, Inuit and Métis Nation children were routinely and forcibly taken from their families and communities to attend residential schools, often located far from their homes. Many of those children never returned. As the work of the Truth and Reconciliation Commission has revealed, the adults who were responsible for Indigenous children's care and education subjected them to emotional, physical, and sexual abuse (TRC, 2015). It is difficult, perhaps, to reconcile a proclaimed belief in child protection and innocence with such deplorable treatment. However, it is precisely this paradox that illustrates the insidiousness of innocence as a malleable hegemonic (and inherently racist) construct. The innocent ideal is a marker of white privilege that creates a hierarchy of humanity; the further away one is from that ideal, the more violently they are subjected to mechanisms of reform.

Assimilation, framed as re-education, was the explicit goal of residential schools and the theme of one of the most iconic images associated with their history in Canada. A pair of photographs from the 1890s illustrating the transformation of Thomas Moore Keesick of Muscowpetung Saulteaux First Nation continue to be widely circulated online and as a part of curricular materials in public schools (Brady & Hiltz, 2017). In the first photograph, an eight-year-old Thomas Moore (surname omitted) is said to be shown on his first day at Regina Indian Industrial School, in 'all the trappings of Indigenous identity that a majority audience at that time might have perceived as 'authentic' (braids, beaded loin cloth, fringes, etc.)' (Brady & Hiltz, 2017, p. 63). He is also holding a pistol, likely added for dramatic effect. In the second photograph, Thomas is shown a few years older, with short hair and neatly dressed in a military style-uniform. At the time of its initial circulation, the photographs were used by the Department of Indian Affairs to represent how successful residential schools were in assimilating Indigenous children into white Canadian culture.

Today, the widely circulated image, accessible through an internet search using the phrase 'Indigenous childhood Canada', continues to be used by educators when discussing Indigenous issues. As Brady and Hiltz (2017) point out, the contemporary uses of the image to illustrate the erasure of Indigenous culture through colonial power fail to contextualize or complicate the 'highly contrived photos,' and thus perpetuate further erasure by reducing Thomas to a 'poster child for colonial power' (p. 81). To foster more critical, contextualised

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perspectives, they point to 'radical recontextualizations' such as the documentary about Keesick called 'I am a Boy' (BigEagle et. al, 2015) directed by Louise BigEagle (Nakota/Cree, Ocean Man First Nations) that 'encourages Indigenous people and larger audiences to think more about who he was (including his Indigenous community)' (p. 81). BigEagle, who is not only a documentary filmmaker but also a journalist with the Canadian Broadcasting Corporation, is one of many Indigenous creators who are challenging colonial narratives and transforming the media landscape.

Re-Educating Representation

Considering the legacies of colonial violence justified by the 'protective' logics that drove the establishment of residential schools and considering how recently their consequences have come to light through TRC reports, class-action lawsuits, academic research, and heavy media coverage, it is not surprising that Indigenous children continue to be overrepresented in care in Canada. The effects of long-standing child welfare practices premised on racist, ethnocentric logics will be felt for generations to come. Although policies and practices have evolved to reflect an increasing awareness of these deleterious effects, and Indigenous sovereignty over child welfare has been written into Canadian law as of 2019, representations of Indigenous peoples in the media continue to perpetuate racist stereotypes. For example, in their analysis of news coverage in the Canadian media, Burns and Shor (2021) found that Indigenous community members were depicted as incompetent, drunk, and lazy. Similarly, Carmen Robertson (in Lisk, 2020) notes that 'there are far more Indigenous voices in the press, and stories are often more balanced, but we still see daily newspapers that have to fill those pages just fall back on what they already know, which continues to reinforce those stereotypes within people's minds' (para. 22). While, as Claxton and Winton (2023) observe, we are witnessing in Canada 'an epistemic dawn' of Indigenous knowing, in which Indigenous voices are leading in literature, medicine, politics, academia, and the arts, we still inhabit a 'shared ground where both settler nationalism and Indigenous sovereignty continue to wrestle with colonial ghosts' (p. 373). This is the same ground where Indigenous communities continue to lack access to clean water, internet access, and medical care, where First Nations women, girls, and gender-diverse people continue to disappear and die at disproportionate rates.

Although recent years have seen a surge of Indigenous storytelling in Canadian film and television (Randoja, 2024), Indigenous voices remain largely underrepresented, with settler stories and stereotypes continuing to dominate the industry. As Dana Claxton (Hunkpapa Lakota) and Ezra Winton observe in their volume on Indigenous media arts in Canada, 'despite organised Indigenous-led efforts to decolonize the media landscape, the media "insiders" in Canada remain a settler majority of European ancestry who are afforded, among

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many privileges, the space to create, tell, and share the stories of those who are not part of their kin, community, or shared narrative' (p. 3).

Given these challenges, what might it mean to 're-educate' representation – to dismantle stereotypes that were used to justify forced assimilation and cultural genocide? For white settlers, and especially those of us who are educators, a starting point might be educating ourselves on the ways that the use decontextualised images and statistics can perpetuate Indigenous erasure and epistemological violence. Rather than relying on the familiar or easily accessed materials to discuss Indigenous issues, we can look to Indigenous-produced media through which Indigenous people tell their own stories about their past, present, and future. However, the media industry, which is responsible for the images that show up in news feeds and internet searches, must also prioritise Indigenous representation. As Claxton and Winton (2023) observe, 'the dimensions of Indigenous representation behind, in front of, and beside/around the camera is vital for the non-Indigenous majority, including those of us yet unable to deprogram the pathological colonial circuitry from mind, body, and spirit' (p. 2). As part of that non-Indigenous majority, in a moment when decades of work to advance equity and fight discrimination across North America are being threatened, I am committed to the vital work of questioning assumptions, seeking out and amplifying counter-stories, and deconstructing the mechanisms of settler colonialism.

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Book Review

Dibs: In Search of Self

By Virginia M. Axline

Publisher: Houghton Mifflin

ISBN: 9780345303356

Year of Publication: 1964

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Professor Emeritus, Western Carolina University,
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In response to James Anglin's challenge in this journal's previous issue, to take an old book off the shelf and reread it, I immediately thought of Virginia Axline's *Dibs: In Search of Self*. When I became an undergraduate psychology major over 50 years ago and wanted to begin to work under my mentor, Jerry Levin, it was prerequisite reading. Jerry knew Axline from Teachers College at Columbia University. As a practicing clinical psychologist and academic, Jerry was not particularly wedded to the specifics of Axline's 'play therapy' method, but he thought Axline's approach to interacting with children provided an ideal model for his students. I think he was right.

Although *Dibs* was not published until 1964, it was based on the case of a five-year-old Axline worked with at Carl Rogers' University of Chicago Counseling Center in the 1940s. Axline had been a student of Rogers at Ohio State and moved with him to Chicago, although they eventually had a serious falling out (documented in a thorough and fascinating study of Axline by Stich [2020]). Dibs was uncooperative, uncommunicative and sometimes aggressive with his teachers, parents, and sister. His behaviour changed dramatically over a series of weekly play sessions with Axline. Dibs' behaviour was transformed at home and at school.

Interpreting this nearly 80-year-old study shares all the problems of any research generalising from a single case study. To this day, you can find arguments on social media about what was wrong with Dibs (in the Rogerian tradition, Axline made no diagnosis), and you can also find testimonies as to the effect reading the book had on budding teachers, psychologists, youth workers, clergy, and counsellors. Perhaps it is important that there is significant evidence that versions of Axline's play therapy are effective (e.g., Lin & Bratton, 2015).

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Yet, in some ways diagnosis and effectiveness are beside the point. Therapists from a variety of theoretical orientations, cognitive behavioural (Cochran et al., 2024), psychoanalytic (Jackson, 2010), and family systems (Redfern 2022) have documented what they have learned from reading *Dibs*. *That* is the point. What we learn from Axline is how best to work with children. We build relationships by being physically and psychologically available, respecting the child's space and voice, and by being responsive to their needs rather than our own. We learn from children through careful objective observation, not via inferences coloured by our own biases and presuppositions.

Rereading Dibs was like meeting up with an old friend. Over a half-century of working with children in a wide variety of settings, the lessons from Axline have served me well. And in a note to James Anglin, Dibs absolutely loved books. In his last session with Axline, Dibs remarked: 'And isn't it funny that little black marks on paper can be so good?'

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About the reviewer

Bruce Henderson is professor emeritus of psychology at Western Carolina University in Cullowhee, NC, USA. He is an advocate of high-quality residential care for children and youth, and author of *Challenging the Conventional Wisdom about Residential Care for Children and Youth: A Good Place to Grow* (Routledge, 2024). The review author was reviewing their own copy of this book.

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Book Review

Another kind of home: A review of residential child care

By Angus Skinner

Publisher: HMSO/Scottish Office

ISBN: 0114942358

Year of Publication: 1992

Reviewed by: Nicholas J. Campbell
Retired Senior Manager,
email: njc_1969@hotmail.com

In response to a call from this journal to review historic publications, I am reflecting on this groundbreaking report dated 1992, how it influenced my practice, its missed opportunities, and a view on how this plays out today.

Another Kind of Home: A Review of Residential Child Care by Angus Skinner, chief inspector of Social Work Services for Scotland, made 66 recommendations, which seemed at the time to be aspirational and exactly what was needed to reform and reframe residential child care in Scotland. However, many wrongly deemed it unachievable.

For example, upholding rights, giving voice, showing respect, and reaching for ambition were far-reaching concepts to some, yet, in my role I dared to challenge the norm and advocate for a robust improvement agenda. In this I discovered that the barriers were high and entrenched.

The mere thought of asking people who use and/or were supported by services and their families/carers for their opinions, never mind offering them any choice or control, seemed terrifying to those in charge when Skinner wrote *Another Kind of Home*. The perspective was that they knew best, even when clear evidence from the report suggested otherwise.

Being ridiculed, at best, for trying to even talk about, never mind implement, Skinner's recommendations for improvement felt like a daily trial in residential and child care services. This frustrated but never deterred me, often in fact fuelling my resolve to keep going.

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Established in 1978, Who Cares? Scotland is the only independent membership organisation for care experienced people. Initially, the organisation provided the opportunity for young people to comment on the care services they received.

Their support throughout the 1990s gave me and others even more motivation to continue, despite an often defeatist narrative, in an attempt to try and improve the quality and response of a broken and outdated system that was in tatters.

The reforms and recommendations suggested by Skinner became even harder to implement due to local government reorganisation in 1996, the uncertainly of funding, and the continuation of existing service supports.

Undeterred, Skinner gave me and likeminded others a roadmap to follow, endorsed by The Scottish Office of the day, which we could and would quote while fending off any resistance to the reform proposals.

Overall, Skinner set out these fundamental principles alongside his 66 recommendations:

- individuality and development
- rights and responsibilities
- good basic care
- education
- health
- partnerships with parents
- child-centred collaboration
- a feeling of safety

This has led me to reflect on recent developments, including Getting it Right for Every Child (GIRFEC) (introduced in 2006), The independent Care Review (beginning in 2016 and completed in February 2020), and the development of The Promise (published in 2020), alongside the implementation of new care and workforce regulators, numerous iterations of Centres for Excellence, the establishment of Care Quality Frameworks, and much more, since Another Kind of Home was published.

In doing so, it feels troubling to me that some 33 years later we are still trying to embed the principles and recommendations made by Skinner, let alone The Promise.

Would Scotland have needed a full independent care review that included residential child care if Skinner's recommendations had been carried out and achieved?

The former First Minister of Scotland, Nicola Sturgeon, stated that the 'root and branch' care review may be failing to deliver sufficient change. She told a BBC

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Radio 4 series 'Fixing Britain' that she blamed 'very vested interests that were pushing back against changes and institutional inertia [which] makes it sound more passive than it actually is' (Walker, 2024, para. 3).

Surely, then, it's reasonable to ask ourselves 'why?' Or do we fear that doing so would just create another social care/work review that seems to have become expensive, lengthy, and almost another industry?

Thankfully, it's not all doom and gloom, with many great examples of children- and young people-led ambition that have grown around Scotland as a result of The Promise. Additionally, there is currently political and financial support to try and meet all recommendations by the target date of 2030.

But we should remember that there is a Scottish election just round the corner, in 2026, with its outcome uncertain and the potential impact of political change unknown.

With this in mind, we must not allow progress to be left, once again, half baked. Historical examples have shown that not following through with *all* interconnected recommendations could lead to another implementation failure, similar to the struggles outlined within *Another Kind of Home*. We do not want to find ourselves in another 'root and branch' review if the ambitions of The Promise are not met.

I will leave you with a final thought from Skinner and urge you to read and reflect on his report: 'Effective change, however, requires commitment sustained over time. None of us should forget that' (Skinner, 1992, p.9).

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About the reviewer

A retired social work care professional for nearly four decades, who has never let go of the need to continually improve and innovate both public and charitable service's that provide support, advice and guidance to those in need.

I firmly believe that it is essential that the voice of those who use and are connected with services is genuinely heard, understood, and given the respect it deserves when planning and delivering any and all health and social work care in Scotland and beyond.

The review author was reviewing their own copy of this book.

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Book Review

Working with Relational Trauma in Children's Residential Care: A Guide to Using Dyadic Developmental Practice

By Kim S. Golding, George Thompson, & Edwina Grant

Publisher: Jessica Kingsley

ISBN: 9781787755598

Year of Publication: 2024

Reviewed by: Matthew Scotland
Support Practitioner, Children and Families Services, Crossreach, Matthew.Scotland@crossreach.org.uk

Working With Relational Trauma in Children's Residential Care is intended by its three authors as a training resource and guidebook that provokes thought and provides guidance for practitioners. The book's thorough treatment of trauma-informed child care complements our foundational Crossreach texts (Practice Model, TCI, and Beacon House), focusing specifically on dyadic developmental practice in residential settings. The opening chapters explain key DDP principles, applying familiar terms such as attachment theory, intersubjectivity, the window of tolerance, PACE, and storytelling. The book explains theory in an accessible manner, with its application to practice brought to life by an array of case studies, illustrations, and reflective exercises. The book's reflective and illustrative format prompted me to write a reflective review using its images as discussion points while considering my first year in residential child care.

Connection before correction

In chapter five, 'Co-Creating the Meaning of Love' (pp.109-128), Dan Hughes' axiom 'no correction without connection' is used in the image below (p.118) to demonstrate that connection comes not only before correction, but during and after as well. This is further illustrated in the composite case study of Aadesh (pp.119-123), a ten-year-old boy with significant developmental delay. DDP approaches Aadesh's pain-based behaviour (being unsafe in the car) as a

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learning opportunity, rather than triggering the adult 'into punishment mode' (p.124). By mutually reinforcing connection and correction, Aadesh progresses from shame to guilt (about endangering others), marking a crucial step forward on his developmental journey. This reflects my experience of residential child care as requiring soft, PACEful virtues on one side and firm boundaries on the other, described as a 'balance of boundaries and empathy' (p.126).

Figure 1 'Figure 5.2: Connection and Correction (Discipline)' in Golding et al. (2018, p.118).

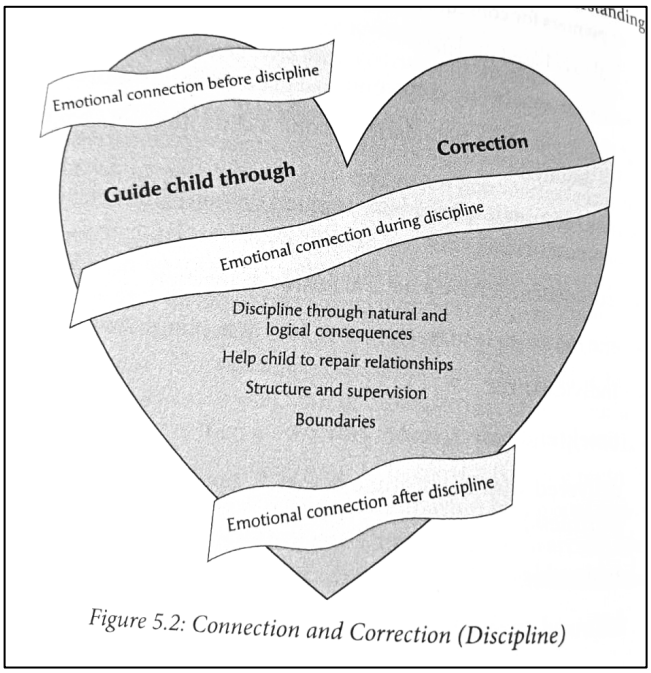

Figure 5.2: Connection and Correction (Discipline)

The two pillars

In the illustration below, 'The Pillars of Residential Care' (p.139), these soft and firm aspects are represented as twin supports, titled 'relationship' and 'structure'. The idea is that having one without the other is not feasible, and even a subtle elevation of one over the other would destabilise the whole system. Adults in residential care are described as cultivators of 'relational experience alongside structure' (p.139). While the book idealises the two pillars as co-equals, the reality is that, in practice, they can be viewed as a mismatch. Practitioners caught in the either/or of a dialectic, rather than the both/and of the dyad, may worry that being too PACEful compromises structure, or that being too structured stifles PACEful relationships. These tensions can escalate over the delicate matter of consequences, described in the book as 'a big deal in residential care! Indeed, they are one of the major causes of team disagreements' (p.116).

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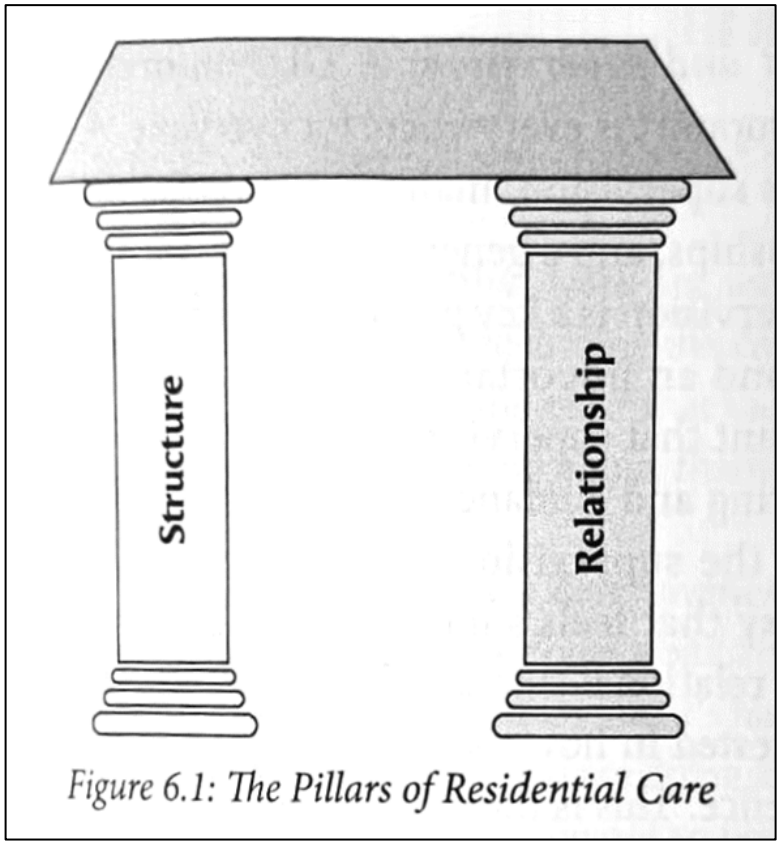
Figure 2: 'Figure 6.1: The Pillars of Residential Care' in Golding et al. (2018, p.139).



Chapter 6, 'The Pot Noodle Story' (pp.129-152), offers a light-hearted inroad into understanding team disagreements. A care manager complains about a team-meeting dominated by a 45-minute argument over how many Pot Noodles a child should consume. This in-depth discussion about an everyday snack demonstrates the uniqueness of a residential 'family' and its perpetual quest for balance, with consistency and unity commonly viewed as its key makers and markers. As a staff interviewee attests, 'the most important thing when you're working in a team is everybody's working in unison with each other' (p.135). While caregivers seek collective unity, the Pot Noodle Story suggests recognising that unity is frustrated by group diversity. How can a complex multiplicity of persons come together under one roof sharing a singular vision? And how can we cater for each child's unique personality within a single system of care?

Theoretically, team members could be arranged on a spectrum of positions between soft and firm extremes. At one end, a child could be permitted as many Pot Noodles as they please, while at the other end the snack could be banned altogether as a serious health risk. Edwina, a co-author of the book, places herself on the softer side, and interprets this as a reaction to her own childhood experience of firm parenting that 'tended to be over-boundaried with high expectations' (p.127). This section of the book observes a residential refining process in which overly soft practice firms up and overly firm practice softens.

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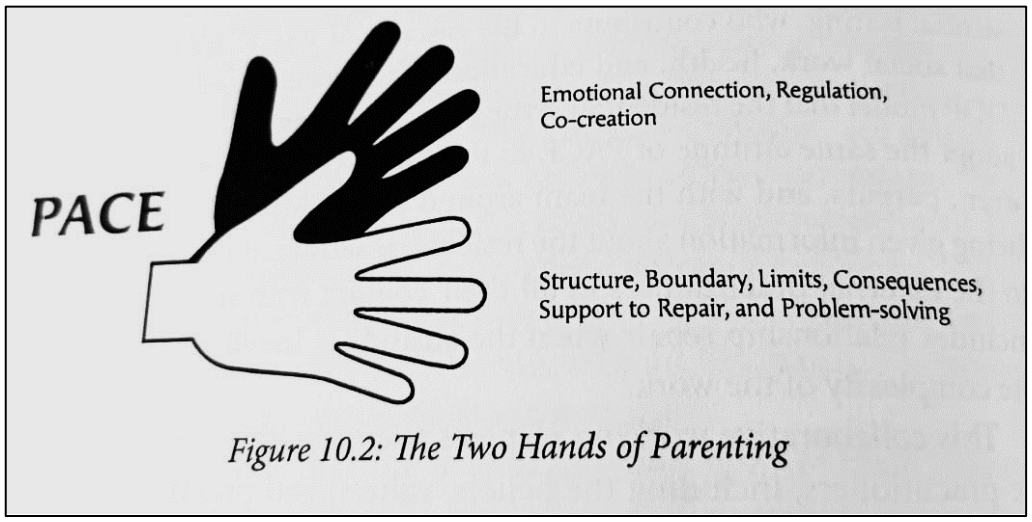
The two hands of parenting

While the two pillars portrayed perfect balance, it could be argued that the image was too abstract and unmoving to capture the flux of real-time developments on the ground. Dan Hughes' The Two Hands of Parenting (p.238) offers an ambidextrous solution to managing soft and firm virtues in complex environments.

Figure 3: 'Figure 10.2: The Two Hands of Parenting' in Golding et al. (2018, p.238).



The book features PACE as a mainstay of the DDP model, with its two-handed application brought to life in the case study of Andy (pp.212-213). When a stand-off develops between a young person, Andy, and staff members over access to gaming controllers, an on-call manager arrives and de-escalates the situation. Rather than revisiting Andy's behaviour, the manager prioritises connection by validating the child's feelings, 'this must be really difficult for you, Andy' (p.213). Having established connection, the manager guides Andy towards the intended location in a co-operative manner. In this way, 'hand one connected first with the young person's experience underlying their dysregulation. Hand two provided the boundary, structure, and consequence' (p.213).

The two hands illustration is subtitled, 'the cascade of PACE needs some containment' (p.238). PACE is metaphorised in soft terminology as an outpouring of water flowing 'down and through every tier of the organization. All can swim together in the tiered pools of PACE' (p.226). The water theme continues throughout the chapter, offering insightful dyadic scenarios such as a child learning to swim, where repetitions of holding and releasing in the pool models the bilateral patterns of care (p.227). 'Two hands are needed for the child to learn to trust in adult care, then to trust in adult authority, and, ultimately to trust in self as they mature into confident, independent, and autonomous adults' (p.239).

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The duality of theory and practice

The pairing of soft and firm virtues in the two pillars and the two hands highlights a further duality, that of theory and practice. This involves perceived tensions between the ideal milieu portrayed in textbooks and the day-to-day experience of practitioners. Staff reflecting on training 'noted how much sense the theory made to them in the room but how challenged they were to put some of what they were learning into practice' (p.221). In the either/or of a dialectic, theory makes sense in the training room but not always in the home. Scholarly ideals are easily overshadowed by the realities of practice, the orderly calm of the two pillars was all-too quickly disquieted by a Pot Noodle, and the interviewee's desire for collective unity implies that this remains unfulfilled. To imagine the milieu free of tensions would be as unrealistic as imagining a life or a world without challenges or inconsistencies.

Working with Relational Trauma in Children's Residential Care takes the pragmatic approach that 'tension in the team is both inevitable and necessary. From tension can arise creativity and change' (p.147). We cannot expect reality to mirror the ideal. By its very nature, an ideal transcends the real; if it were attainable then it would cease to be an ideal. Therefore, tensions between theory and practice are as inevitable as they are in human relationships. As role models, our handling of tensions and attitude towards disappointment can model resilience over dysregulation when people or circumstances fall short of our expectations. Our children are ever watchful, they 'notice how everyone relates to everyone else' (p.148). Our attitude is crucial given the profound disappointment they may feel at not having their ideal home. Many arrive with 'jagged stories of shame and terror' (p.103), which, using the metaphors in this book, could be described as piles of rubble instead of pillars, and clenched fists instead of PACEful hands.

By addressing the dualities of child care and embracing their tensions, the authors invite a broader application of dyadic principles to our whole system of care as well as human relationships. In a dyadic manner we can unify theory and practice along with soft and firm virtues. Conceptual pairings could progress dyadically, like strong human relationships maturing through tensions. This review followed my own train of thought while reading *Working with Relational Trauma in Children's Residential Care*, whilst others who spend time in the book will find their own avenues for reflection. For those seeking immediate practical value, a comprehensive index section provides a wealth of subjects for the busy practitioner to pick up and read for quick insights and ideas.

About the reviewer

Matthew Scotland studied at Glasgow University, initially focusing on psychology and sociology before his interests shifted to philosophy and theology, where he

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earned his degree. He now works as a practitioner in residential childcare with Crossreach, the social care arm of the Church of Scotland. Matthew has found his background in philosophy and theology resonates in interesting ways with the theory and practice of residential child care.

The review author was reviewing their own copy of this book.

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Book Review

The Trauma Recovery Handbook: A Model for Navigating Recovery for Professionals, Parents and Carers

By Betsy de Thierry

Publisher: Jessica Kingsley

ISBN: 978-1-80501-202-3

Year of Publication: 2025

Reviewed by: Leanne McIver
Research Associate, CELCIS. leanne.mciver@strath.ac.uk

Betsy de Thierry's name is well known in complex/developmental trauma circles. She's written a number of prominent books on attachment, trauma, and related ideas, and so I was excited to have the opportunity to review her most recent publication. Given her previous books, and the ever-expanding range of publications, YouTube videos, blogs and vlogs about trauma (by de Thierry herself and many others), I wondered what new content or insights might await me in this book.

The first thing that seemed notable to me was the title, *The Trauma Recovery Handbook: A Model for Navigating Recovery for Professionals, Parents and Carers.* Amongst all my previous reading and learning about developmental trauma, I've found many resources which explain what trauma is, how it occurs, how it can be expressed in children's behaviour, and even how we might address those behaviours if they're deemed unhelpful or inappropriate; but I've rarely seen something so explicitly focused on the idea of *recovery*.

It was also interesting to note the clear identification of the audience for the book – this is not a 'self-help' type book aimed at adults seeking to recover from trauma they have experienced themselves, but at adults seeking to support others who have experienced trauma – especially children. The book is aimed at the professionals who 'hold the hands of those who hold the hand of the child' (Independent Care Review, 2020, p.20), as well as the parents/carers doing the more direct handholding.

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This dual audience is also reflected in the structure of the book, which is presented in four sections. The chapters in the first two sections conclude with two sets of reflective questions, one for 'parents/carers/therapeutic mentors', and one for 'therapists', recognising the different perspectives within this broad hand-holding audience. These sections focus firstly on 'foundations'; that is, the basic understanding readers need to have before engaging with the remainder of the text. This includes highlighting the importance of those relationships and environments which can promote healing and recovery. The focus of the second section is 'general areas of impact', including the impact of trauma in areas such as the body, emotions, memory, and relationships. Within the chapters specific to different areas of impact are suggested techniques for 'in the moment' supports when trauma-driven responses occur; relaxation techniques are included in the section on impacts on body (p.156) and mind (p.196), for example, while ways to release anger are included in the chapter on emotions (p.174). This is an engaging and relatable way to present this information.

The third section of the book looks at different types of 'events' which may be experienced as traumatic, such as abuse and neglect. It was helpful and reassuring to see sections on medical and organisational traumas included here, since discussions of developmental trauma often focus on abuse and neglect, and less on other circumstances which can contribute to childhood trauma experiences. However, the chapters on emotional neglect and collective trauma are extremely short and mainly replicate content from de Thierry's previous books on these topics (2021, 2023). I would have liked to see a little more content in these chapters, rather than the implication that readers would have the wherewithal to access these other titles. Relatedly, the frequent use of extended quotes from de Thierry's previous publications was the one element of this book that I found a little jarring.

The fourth and final section of the book describes de Thierry's 'trauma recovery focused model' (TRFM®), which is mentioned throughout the book alongside several of the 'tools' which are part of the model. The section begins with an overview of the different professions which may be involved in supporting recovery from trauma; de Thierry is clear that recovery requires professional support and is not something that can be properly achieved by parents and carers alone. She presents the information in this section as useful to have 'as you wait for help'. While I agree that parents and carers should not be expected to take on the role of mental health professionals for their own children, access to help for care experienced children, who have often experienced developmental trauma, is known to be problematic (Education Committee, 2016; Kirkman, 2019), and not always in keeping with the child's individual needs and recovery journey, which their primary caregivers are uniquely attuned to. The model has four stages, and the importance of a foundational relationship with an adult whom the child considers safe and trustworthy is recognised in the first two, which focus on safety, hope, stability, and emotional regulation.

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Professional input is, however, recommended for the final two stages, which include processing and integrating symptoms, thoughts, and memories to progress towards recovery. From a practical perspective, I wondered how realistic this is for many of the children (and adults) who are on a trauma recovery journey.

Overall, much of this book is unsurprisingly familiar to anyone who has previous learning about developmental trauma. There are sections on concepts such as attachment, trauma types, shame, and their developmental impacts, and these foundational concepts build carefully towards the useful overview of the TRFM®. What is particularly helpful is the way in which these complex and inter-related topics are introduced, explained, and structured. For readers who are just beginning to learn about developmental trauma, the book is a good introduction, while going into a degree of detail in some areas which are overlooked in other books on trauma, and with a welcome focus on recovery.

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About the review author

Leanne is a research associate at CELCIS, with interests in adoption experiences, and the education of care experienced learners. She is also a therapeutic parent.

The publisher, Jessica Kingsley Publishing, supplied a copy of this book for review.

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