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of residential child care

SIRCC provides education, training, research and service development to actively improve policy and practice for children in public care ('looked after children'). The organisation is a partnership of the University of Strathclyde, The Robert Gordon University, Who Cares? Scotland and Langside College.

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Introduction



At SIRCC, we're driven by the belief that **maintaining an awareness of relevant knowledge, theory and research should be central to our practice if we are to genuinely improve outcomes for children and young people in residential care.** Work in residential child care offers the potential to develop mutually formative relationships with children and young people, and have a lasting influence on their life choices. It is also a complex and challenging task. Those who have had the rich opportunity to work in residential child care will know this well.

In recognition of SIRCC's 10th year anniversary, and to celebrate both the success of SIRCC's partnership and its joint accomplishments with the sector of the last decade, **we looked to find a way to mark what we've learned about the essential components of residential child care practice.** SIRCC academic and support staff together have collectively created a series of articles reflecting key aspects of practice from across the sector. Some of the chapters have been contributed by experienced writers, while for others this is the first time they have written for publication.

It became clear early on in this project that 26 letters of the alphabet could never form an exhaustive guide to 'all you need to know about residential child care'. That being said, the SIRCC A-Z does aim to reflect some of the most crucial matters in providing effective residential child care practice: **the SIRCC A-Z is an introduction to key issues and concepts which have gained prominence over the last 10 years** and provides guidance for further reading.

Most importantly, **the articles reflect many of the key issues raised by young people themselves about the services they receive.** Our on-going commitment to listening and responding to the views and experiences of young people are reflected throughout this publication. You'll see that the editors have included relevant quotes and photos from a range of policy documents, research papers and participation projects which have collated the voices of young people.

A noteworthy mark of success of the past decade is the significant numbers in the residential child care workforce who have been or are currently involved in education and learning as they strive to meet the demands of professional registration. **We hope that this publication will act as a reference point for staff in their day-to-day work** as well as be a helpful resource for those staff undertaking formal qualifications.

A handwritten signature in black ink that reads "Jennifer Davidson". The signature is fluid and cursive, with a large initial "J".

Jennifer Davidson
Director,
SIRCC

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a Adolescent Development

ASPECTS OF ADOLESCENT DEVELOPMENT

is for...

Catherine Nalci
SIRCC SVQ Assessor, Langside College

The term adolescence can conjure up a number of stereotypical images for us all, such as the teenage character 'Kevin' portrayed by comedian Harry Enfield. Kevin is an exaggerated cameo, but nonetheless he does portray some aspects of adolescent development, including surges of angry feelings, defiance, and un-forthcoming communication with parents. Of course there are positive aspects associated with adolescent development, for instance beginning to adopt your own values and beliefs, and growing sensitivity to others. Many young people become very sensitive to the values of fairness and justice and may respond vigorously to what they see as unfairness, whether it be in regard to the way they or others are treated.

In acknowledging the different sets of changes that come about with the adolescent years, it must also be remembered that changes in one area have an impact on other areas of development, and that there are individual differences in the ways young people experience these changes. The biological changes of puberty can bring strong feelings and sudden mood swings, for instance of feeling attractive versus feeling ugly, or feeling grown-up and confident versus feeling self-conscious.

These feelings and doubts can create a time of turmoil in emotional development. There is often difficulty in controlling and regulating emotions, especially in unfamiliar situations, which can result in impetuous behaviour. In addition to this is the cognitive immaturity of adolescence, making it tough to keep things in perspective, and resulting in getting things out of proportion. Just as with children living with their parents, there are many instances when young people in residential care require a sanction due to inappropriate behaviour. For some young people, however, their reaction to the giving of this sanction is often more severe, more 'out of control'. Residential workers have to recognise both the 'normal' level of adolescent storms and deal with more extreme reactions.

A number of residential units make use of the 'life space interview' approach (see Suggested reading material 1) as a way of having a structured discussion after episodes

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of 'challenging behaviour'. However it is also important to think about developing a culture which is sensitive to young people's stage of development and methods of 'conflict resolution' that may prevent incidents escalating. One key issue for teams and young people to discuss is when a sanction is going to be applied. Generally speaking, sanctions that are imposed and explained to the young person as soon as is possible are more effective. If the sanction is presented to the young person by the staff on the next shift, or next morning it will be difficult with their immaturity to accept the sanction and it can therefore be a trigger to further incidents.

Adolescents on the whole are happier with their own age group, and will spend more time with their peers as opposed to spending time with parents, older people or younger children. But guidance from residential workers about dealing with friendships and relating to peer groups can be an invaluable support to a young person who has experienced disruption and loss of previous friendships. It is important that we do not stereotype the adolescents we work with, and individual care-planning should help to identify those aspects of development with which a particular young person may be struggling. Peer pressure in their community can result in negative behaviour, manifested in substance and/or alcohol abuse, which in turn can result in risks to safety and in offending behaviour. Late adolescence is unfortunately when certain mental health issues such as depression, anxiety, mood disorders, and eating disorders can emerge. Also when families have suffered trauma the young people will be at risk of developing psychiatric dysfunctional behaviours, including serious self-harm.

This chapter would not be complete without a mention of G Stanley Hall, a pioneer in the study of adolescent development. It is Hall who coined the term 'storm and stress' as a descriptor for the period of adolescence. Hall's work is described in the Suggested reading (3) below.

In Erikson's stage theory of child and adult development he suggests that the major challenge of the adolescent stage is to resolve the conflict, or tension, between 'identity' and 'role confusion'. The challenge and reward of the residential worker is the contribution that they make to helping particular young people 'move forward' in their development, and by drawing on their strengths and qualities, encourage the emergence of a clear and more positive self-image and identity.

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They say 'I don't like your attitude', and you ask 'what attitude', and they say 'you see what I mean?' Stuff like that - it's just typical. That's it, your're sanctioned.

(Male, 16)

I also wish people would explain rules more. It's always better to explain rules rather than just tell you that's the way it is, that's what you have to do. So sometimes when there are rules and I think 'I don't know why that rule's there', they just tell me 'that's just the rules', and you just have to get on with it.

(Female, 14)

Staff realise what I was going through, they understood what I was going through and I understood what I was putting other people through. They made me realise that if they've got to be fair to me then I've got to be fair to them. Staff are there for me.

from *Let's Face It: Care 2003: Young people tell it as it is*. Who Cares? Scotland 2003

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b

Bereavement & Loss

LOSS & TRANSITIONS:
FITTING THE PIECES TOGETHER

Janine Bolger

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is for...

'Loss' is the term used to describe the disappearance of something that has been treasured. Our experiences of loss may be diverse such as in the loss of a relationship, the death of a loved one, the loss of health or physical capacity, the loss of one's job. Some such situations may involve multiple losses such as the loss of a job and with it the loss of one's self-esteem. Loss and change are characteristics of all our lives and some changes come without warning while others occur after a long struggle. Whatever the nature of the loss the accompanying change usually results in stress and involves the person concerned in a process of grieving, reassessment and change (Currer, 1999).

The term 'transitions' is used to refer to changes such as moving in and out of care. The term may also refer to life changes such as puberty or even to explain particular and personal transitions such as divorce and family break-up, issues related to sexuality, adoption, pregnancy, disability or parental mental health or substance misuse etc. (Department for Education 2003). Multiple transitions can result in a cumulative deterioration in well-being if the individual is unable to recover before they are faced with another change. Although change is a necessary aspect of life we resist it in order to preserve the predictability of our existence (Marris 1986).

'Children entering, moving through and exiting the interim care system are faced with repeated separations and losses. They are frequently separated from their primary attachment objects' (Fahlberg, 1991, p 133). Everything in the child's world loses meaning. At times the trauma can be so great that the child feels helpless and flattens their affect (emotional expression) which leads to experiences of numbness and depression (Winnicott 1986).

Common physical responses to loss include fatigue, restlessness, insomnia, crying, pains in various parts of the body and changes in appetite. Emotional and behavioural responses include anger, panic, fear, avoidance, self-blame, longing, helplessness, meaninglessness and abandonment. To manage these responses is an important part of the process of adjusting to the loss.



Supporting children and young people through separation and loss

Each new loss that we experience will trigger memories of the past and communication is key to helping children manage transitions.

Children's fantasies are likely to be more frightening and damaging than the truth and so firsthand information should be shared. However abusive a situation the child has come from, they are likely to experience feelings of grief and loyalty. Yearning for a lost situation is normal. The age of the child is crucial in terms of their level of understanding and will help in identifying the level of support required. For example:

- In infancy the child will not understand the actual event that has resulted in loss but will sense that adults are upset or absent. It is helpful if routines can be kept as consistent as possible (Open Learning Foundation, 1999).
- Pre-school children are ego-centric and see events as caused by or related to themselves. Events are seen as reversible or temporary. Information should be given clearly and the use of euphemisms should be avoided (ibid).
- School aged children are beginning to understand the reality of events and so explanations need to be honest and straightforward with reassurances that their feelings are acceptable. Parental mistakes should be connected to the child's own experience of getting things wrong. The fact that responsibility for mistakes lie with the adults should be emphasised although if the change is occurring because of the child's behaviour, the unacceptable behaviour must be discussed (Jewett, 1997).
- Losses can be particularly difficult for adolescents at a time when they are searching for identity. Listening to their concerns and acknowledging their feelings is vital (Open Learning Foundation, 1999).

For all children and young people advanced warning of change (if possible) will assist them in preparing for loss. It will offer the opportunity to begin to grieve, to plan for goodbyes or hellos (however painful they might be) and for involvement in the change process (Jewett, 1997). The role of adults caring for children through transitions is to support them in coping with pain and loss and not to shelter them from the actuality of life.

When a person is unable to complete a mourning task in childhood he either has to surrender his emotions in order that they do not suddenly overwhelm him or else he may be haunted constantly throughout his life with a sadness for which he can never find an appropriate explanation.

(Fahlberg, 1991, p 163).

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Care Planning

CARE PLANNING

is for...

Brian Marshall
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As a SIRCC Associate I deliver training on recording and report writing and care planning assessment and review. It is on these particular courses that individuals express concerns that they are expected to deliver high standards in their written work while admitting to a lack of confidence in their writing ability. A common complaint of the staff that start their SVQs is that they are instructed to write reflective accounts but no one informs them how to go about this. It is a rather ironic assumption that they are all English literature students who will somehow magically produce written work that is both value-neutral and written to a professional standard. Therefore, in this short article I would like to outline the link between care planning and professional recording and writing.

Care Planning

The care planning process in residential child care is essential as it dictates the young person's journey through their time in care. Consequently, it is vital that practitioners approach the process of care planning in a child-centred way rather than a system-led process. A genuine assessment of a child should take account as all situations that will help the young person progress. A care plan should not be a one-dimensional mundane perfunctory piece of work, but should be a three-dimensional vivid portrayal of a young person's time in care. To do this professionally, a care worker will use all their skills and knowledge that they have acquired via their practice and qualifying courses. These courses cover areas such as child development, assessment, methods and models of interventions and anti-discriminatory values. Once equipped with both practical and theoretical knowledge of the young person in the context of his/her situation and development, the care worker can then record this in the young person's care plan.

Recording

A poorly written care plan can negatively affect a young person if the care worker does not record and write in a professional and appropriate way. There are however, many mitigating reasons why this can occur. Staff may not have enough time to complete the assessment. They may be dealing with the conflicting demands of social work, education or the family. Furthermore, staff may not get the support and guidance required or indeed may have had no training in this area. Staff sickness, rotas and timing of shifts can also play a part in preventing a professional approach to the writing of the care plan. (SWIA, 2010)

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Although not directly linked to residential child care we can learn from tragic events such as the death of Victoria Climbié and the Borders Report on adult abuse. A number of clear messages about report-writing were outlined in the reports' findings. It was noted that, the importance of recording was not always understood. Information was inaccessible, incomplete or out-of-date. Often facts and judgements were not distinguished, language used was discriminatory and oppressive, and there was little assessment and analysis. The final message was that managers were not fully engaged in the process and did not have the time to check work.

As the Spanish philosopher George Santayana informed us, 'Those who cannot learn from history are condemned to repeat it'.

A care plan should reflect anti-discriminatory practice with the fundamental values of respect for the dignity of the individual and for the uniqueness of the individual and their self-determination. Ensuring that staff work in anti-discriminatory ways should be addressed via good training, discussion and reflection in the work place.

It is essential that staff be given the appropriate training on how to record and write reports or care plans. Any training must be directed to help with the main concerns of the staff and their needs. Often training can be too generic. (SWIA, 2010) There has to be a level of importance placed on the discussions concerning the Data Protection Act 1998 and the Freedom of Information Act 2000. Both pieces of legislation are important particularly the Freedom of Information Act as we do not want our recording and writing/care planning to become the new form of abuse in residential child care. Staff need to be aware that any opinions or false judgments that are recorded may be deemed abusive and impinge on an individual's human rights.

In the care plan meetings they're always talking about all the positive things. It's never really negative. They're always telling your parents and the rest like your social worker, all the positive things. They try to always be praising what you've done.
(Female, 15)

from *Caring about success: Young people's stories*.
Who Cares? Scotland 2008

How we feel in reviews...

'[I was] sitting like a wee mouse,
nearly greetin'
(young woman 14-16)

'[people are] talking about him like
he's not here, you feel that big'
(group, 19+)

'Reviews are much harder for young people when there are a lot of people sitting e.g. social workers, relatives, minute taker. Some people find it hard to speak and say how they are feeling'

The above are taken from young people's postcards at a consultation event in the Evaluation Report on the Edinburgh Council Accommodated Children Review Team (2005)

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Furthermore, staff need to understand that the care plan is a legal document and as such could be used in a legal setting.

The introduction of registration has resulted in residential child care workers having to complete a HNC and SVQIII as a minimum qualification. As a result of this process staff will learn new skills, and hopefully have their confidence and knowledge base increased. It is imperative that this new-found knowledge is reflected in the care planning process. SIRCC is ensuring that staff are prepared for the important task of care planning, assessing and reviewing by making the links from the HNC and SVQ to the care planning process. In relation to the legislation, perhaps staff could ask themselves the following questions in order to ensure good practice. Is the information accessible? Is the information complete and up-to-date? Are the facts and judgements clearly distinguished? Does the plan include assessment and analysis? Is our language inclusive? Are our managers fully engaged with the care planning process?

Finally, in writing a professional care plan workers need to avoid using jargon, to write clearly, to provide balanced assessments including positives and negatives, and to be reflective in their comments. Even when under the numerous pressures that are part of working in residential child care you need to ensure you write objectively, not in anger, that you record what is required, that you avoid making assumptions and carefully weigh up what you know. (SWIA, 2010)

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d

Introduction to Disability

WORKING WITH CHILDREN AND YOUNG
PEOPLE AFFECTED BY DISABILITIES

Rosemary McCrae

former SIRCC Lecturer, Langside College

is for...

Many young people affected by a disability use residential services. Statistics on the exact number, however, are difficult to quantify as many young people do not have a concrete diagnosis of a specific disability (Stalker 2008). What is clear is that disability services form the largest part of the residential child care sector. A key practice that has emerged in this sector is 'person-centred' planning. More on more on this model can be found in Sanderson et al. (1997).

The key to person-centred planning is to ensure residential workers and others keep the young person at the heart of the process at all times and identify their strengths and aspirations as the starting point in our work with them. Often these young people's strengths and talents may appear small and indeed, in our busy day to day work, it can be all too easy to miss unintentionally identifying the capabilities and strengths these young people have.

Visual tools are very useful in *Person-Centred Planning* and when I worked with a young child, I focused on their fascination for balloons and used pictures of coloured balloons as captions round the picture of the child in the centre of the document. I also used pictures of CDs and musical instruments in a similar way for an older child who loved music. The possibilities are endless, however, and it is vital when using these visual tools to take the lead from the young person and let them choose the topics they are interested in to personalize their documents.

The *National Care Standards* also help us to focus on person-centred planning within the social model. The standards state that 'you have the opportunity to: achieve all you can; make full use of the resources that are available to you; and make the most of your life.' (Scottish Executive, 2005, p. 8). These standards provide us with an opportunity to assist the young person in developing a previously identified strength. We then work within the social model of disability to advocate for that young person's full participation to develop

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their identified strength in their community, and ultimately realise their full individual potential.

An example of putting the above into practice arose when I worked with a young person who was very keen on computing. He attended college; however he had repeated the same foundation course for three years. He was understandably bored with the same course and frustrated that he could not access something more advanced. The college seemed unable to offer him any other computer courses so I advocated for him to be included in the course of his choice. It took a long time and many meetings, however he was eventually allowed to join another course and only then did he achieve his potential in this aspect of his life as required by the National Care Standards.

Initially when introduced to theories and models of working with children and young people, care workers can struggle with the application of these to children affected by disabilities. I was teaching psychological and sociological theories to a class of residential child care workers, who worked in a variety of residential care settings. During the teaching sessions, two of the students working in a disability setting stated: "we can't apply these theories to the disabled young people we are working with".

These students had been unconsciously focusing on the 'medical model' of disability, with regards to the particular physical disabilities affecting the young people. They had become focused on the individual condition and become 'blinkered' to the fact that these young people actually had family histories, life experiences and unmet needs like any other young person in residential child care. A very positive outcome from this issue was that these same care workers later told me that the teaching from the course in areas such as 'attachment' and the effects of poverty had opened up a whole new perspective for them. As care workers they could now see the relevance of relating theory to practice for the specific young people they were working with. In effect, they moved from working primarily with a deficit approach (medical model) to working with the young person holistically (social model). For more information on the medical and social model of disability, see Thomas & Woods (2004).

It is important, however, to remember that the medical model of disability should not be completely disregarded by care workers. It will always be vital to consider the impact of the disability itself to some degree, thus we need to increase our knowledge and

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awareness of the actual conditions of the young people we work with. Naturally health personnel and research scientists will tend to focus on the 'medical' aspects of the condition itself in the search for improved treatments. This has to go hand in hand with listening to disabled people and empowering models of working, such as the person-centred planning approach.

In conclusion, the needs of the young people you work with will be extremely varied and often they cannot fully express how they actually feel to us. It is therefore crucially important to work in ways that put meeting these needs at the centre of the work and which, as far as possible, give the young person a voice for their feelings and wishes. Person-centred planning is one way of doing this.

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e

Education

SUPPORTING EDUCATIONAL ATTAINMENT

is for...

Graham McPheat
SIRCC Lecturer, University of Strathclyde

The task of supporting and improving the educational attainment of looked-after children has received increasing attention in recent years. Much of this has focussed on perceived shortcomings with practice and outcomes (Scottish Executive, 2007). Some of the problematic outcomes regularly cited for this client group involve poor attainment of standard grades and highers as well as higher rates of school absence and exclusion when compared to children who are not looked after.

Publications such as *Learning With Care* (Scottish Executive, 2001) and *We Can And Must Do Better* (Scottish Executive, 2007) have been particularly central in highlighting the corporate nature of improving educational attainment and the requirement for residential care services to work in partnership with other agencies, particularly education, in an attempt to improve outcomes. The challenges involved in moving this agenda forward are numerous. One of the most significant is the task of moving past the rhetoric of partnership working to achieving it in practice.

The relationship between residential child care services and educational provision has never been particularly easy, perhaps for obvious reasons as the needs of many children present significant challenges to our partner agencies. The task of introducing educational study and discipline to children experiencing crisis and chaos is complex. Attempting to do this in an environment where the needs of one complex individual have to be balanced alongside the needs of a full class of pupils is all the more demanding. It is perhaps not surprising that the relationship between the two services can often be fraught.



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So how can this be moved forward? There are many examples at both individual unit/school level, as well as at the wider agency level, as to how this can be achieved. Open and honest communication between different professionals is a prerequisite. This can then act as a platform to negotiate and clearly define professional roles. On first reading this may appear obvious, but is it so? Many of the most common tensions appear to involve confused expectations about what residential workers and teaching staff should deal with and respond to. Whilst practitioners and students still often express frustrations regarding such issues there is also evidence of practice improving within residential schools. Encouragingly, Connelly and Chakrabarti (2008) present figures which outline a rise in the mean achievement rates amongst students presented for exams within residential schools.

The task of measuring and assessing educational attainment is equally challenging. Whilst there are plenty of statistics relating to the educational performance of looked after children, however, questions require to be asked about the accuracy and relevance of these statistics in actually capturing the progress made by children whilst accommodated. For many this will simply involve increased school attendance or sustained preparation to enter further education past secondary school. For many children this will mark a significant development but it is not the type of progress that will be represented in exam marks or other methods regularly used to capture progress. Stein (2006) questions whether many of the traditional measures used to assess practice and progress within residential child care environments are accurate, given that many residents spend relatively short periods of time in care. As such many outcomes, especially educational attainment, are more likely to be shaped by their experiences in families, communities and schools as opposed to a brief period in care.

The *National Care Standards* (Scottish Executive, 2002) tell children they can expect to be accommodated within a unit which is an educationally rich environment. Indeed, spending initiatives on the back of both *Learning With Care* and *We Can And Must Do Better* provided resources to support the creation of such environments. Connelly et al. (2003) suggest that staff can contribute to this in a number of ways – including communication and collaboration with schools, building familiarity with qualifications and attainment targets, helping children with homework, the encouragement of intellectual activity and offering support, encouragement and enthusiasm for learning. The Scottish Government (2008) also outlines some of the key tasks to be undertaken by managers in residential and educational establishments which will support good practice and the creation of educationally rich environments.

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In concluding, it is perhaps important to emphasise that the task of creating an educationally rich environment will succeed or fail with the behaviour, attitude and enthusiasm of staff. If a culture which values study and academic achievement is not fostered then no amount of resources will succeed in delivering an educationally rich environment and the educational outcomes for accommodated children to which we all aspire.

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is for...

Functions of Residential Child Care

FUNCTIONS OF RESIDENTIAL CHILD CARE

Ian Milligan
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Introduction

During the 1980s residential care became more individualised and smaller units were developed in response to criticisms of institutionalised practice, and of children becoming detached from their families and staying for unnecessarily long periods in residential settings.

Aims and objectives

In order to make care more purposeful it was also recognised that these small units should have a written *statement of aims and objectives* which would include an outline of their 'philosophy of care' or ethos. The idea behind having a written statement was that it would help staff identify the particular purpose the home was working toward and promote consistent practice. Despite the fact that these statements have often been drawn in very broad terms, and not always adhered to, the principle of working to a recognised remit and all staff having something to guide their practice is a sound one.

The importance of a children's home having a clear purpose and philosophy of care was reinforced in a number of research studies produced in the later 1990s. In summary, these claimed that a good home is a 'small home run by somebody who has a clear idea about what the home is trying to achieve and how to do it and which encourages contact with family members while respecting the fact that many children do not want to live at home'. (Dept of Health 1998, p 44).

Use of daily events

Having established that good quality care requires a home or school which has a clear remit, a philosophy of care and a team working together, it is important to say something



about how individual workers should practice and how theory might inform their work. One starting point is the group home itself: its 'lifespace'. A professional and informed view of modern residential care rejects the idea that all group care is institutional in the negative sense. Good residential work recognises that the 'rhythms and routines' of a home can in themselves provide a secure base for the children who live there, just as regular routines do in a nuclear or re-constituted family. It is in this context that many researchers have recognised the importance of the purposeful use of *daily activities*. Routines for getting up in the morning or settling at night, meal-time patterns, washing dishes, shopping, watching TV or kicking a ball about provide the context within which purposeful work can be done. All these ordinary activities of daily living offer the sensitive and attuned residential worker the possibility of building a relationship through two-way communication with children. The provision of nurturing and boundary-setting care allows the children and young people to have an experience similar to ordinary family life. (See *In Residence* No.2, Working in the 'Lifespace', for a number of sources on this).

Children's on-going daily experience of being cared for and cared about can also provide them with a foundation on which they can begin to talk about their deeper concerns or worries with a residential worker they have come to like and trust. It is this possibility that can make residential care 'therapeutic' and is sometimes called 'counselling on the hoof'. Although it does not require professional training in counselling, it does require understanding of the basics of being a good, active listener, and the ability to reflect, non-judgementally, on what is happening. Many experienced residential workers will recall occasions when they have been side-by-side with a young person, typically when washing dishes, or perhaps when driving in a car, when the young person has surprised them by choosing to speak about a sensitive subject. There is no doubt that this has happened because the young person has been able to choose the time and place and when they do not have to have face-to-face eye contact.

Opportunity-led work

Making good use of unplanned situations and incidents is a crucial part of the residential task. One way of analysing and making good use of anything that 'just happens' within a residential context had been described as 'opportunity-led work'.

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Opportunity-led work is a framework that has been designed to help workers think through the stages of handling and responding to the many unplanned moments and events in a day's work in order to make their responses more productive and helpful.
(Ward 2006, p 64).

Ward encourages us to see that even in very brief events it is possible to identify four stages: observation and assessment, decision-making, action, and closure and evaluation. Initially it can be difficult for a new worker to separate out the stages. For example when a child suddenly refuses to go to school because their shoes are not clean and the worker manages to persuade her to do so, it can be difficult for a new worker to step back and think about what was going on. However with practice these skills can be learnt and the worker can develop the capacity to think about what is happening and develop a wider range of responses.

Conclusion

Making thoughtful use of the environment and daily life to provide children with an experience of warmth and emotional security and opportunities to develop and learn requires an interest in both theory and practice. This chapter has introduced a couple of theories and approaches to the group care task. There are many others, and a professional child and youth care worker needs to be curious about what works for children and why.

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Gender

GENDER ISSUES IN RESIDENTIAL CHILD CARE

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Is gender an issue in residential child care? You would be as well asking 'Does the sun come up in the morning?' The answer is a clear and unequivocal yes. So how do practitioners face the gender issues that affect their work? The first step is to acknowledge that there are gender issues and to try and identify these.

In recent years, there has been a great emphasis on gender equality. The easy way to deal with this is to say that we should treat boys and girls in exactly the same way. In general, it is known that females are disadvantaged by some of institutional structures of society (like employment). They are also disadvantaged by persistent attitudes (or stereotypes) which paint them as highly emotive or as sex objects. By the same token, males are disadvantaged by media representations which equate success with well-paid jobs or by attitudes which suggest that they should not show their emotions. However, simplistic ways of viewing gender miss the point about diversity. They also miss the point about the specific issues which affect children and young people in residential child care. In order to provide the best quality of care, it is important that staff understand and deal with some of these specific issues.

Gender itself is a complex concept which has been subject to debate in recent times. For the purpose of this chapter, gender is understood as the way of being a man or a woman, a boy or a girl. In our society, being a man or boy is aligned with the concept of masculinity, while being a woman or a girl is aligned with the concept of femininity. Gender expectations can be further complicated by race and culture. The scope of this chapter can only cover the bulk of the residential population in Scotland today, which happens to be white and from social classes IV and V. For a more in-depth discussion on race, see Kendrick (2008).

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Statistics show that 55% of looked after children are boys. However, this figure includes those looked after at home, in other care arrangements, or in residential care. The best estimate of children and young people who are cared for in residential establishments shows that only 38% out of a total of 1580 are girls (Scottish Government, 2009a). Most mainstream and disability units are mixed sex, while some residential schools or secure units operate a single-sex policy.

The SIRCC qualifications audit shows that the gender split in Scottish residential care is roughly two female staff to one male. This concurs with Scottish local government figures (SIRCC, 2007; Scottish Government, 2009b). So we can see that while the workforce is two-thirds female, the client group is two-thirds male. In practice, the low numbers of male carers can present an imbalanced experience (Smith, 2010). Many children in residential care lack positive male role models. There should be the opportunity for them to experience different types of male role model, from the traditional to the more nurturing. The role of male carers is further complicated by abuse inquiries, which tend to identify males as the main perpetrators. This can lead to defensive practice by males, where they are afraid to give physical comfort or act in a natural nurturing way to the young people with whom they work. Female staff members also face challenges. For example, there is often a gender split in roles, with females often taking on domestic-type duties, while males get involved with sporty activities. Such gender splits can reinforce unhelpful stereotypes and should be countered in everyday practice.

O'Neill (2008) pointed out that girls are usually brought into care as a result of placing themselves at risk, either through self-harm or through sexual vulnerability. On the other hand, boys will probably have a background of oppositional defiance, often associated with offending or violence, some of which may be sexually aggressive behaviour. In terms of general vulnerabilities, boys do less well in education and are more vulnerable to the effects of trauma in their early life. Girls are more sensitive to cultural pressures in adolescence which can lead to 'confused and contradictory feelings' (Smith, 2010, p 254) and may result in mental health problems such as depression or self-harm. In terms of relationships with staff, girls prefer staff who are willing to sit and listen, responding in

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a sensitive manner, while boys seem to prefer staff who have an overt sense of humour and who both encourage and join in activities and sport.

Staff in residential child care need to be aware of the gender issues that affect their work. They should be ready to confront these and to accept that gender-sensitive practice means that girls and boys should be treated differently. They also need to look at the potentials within the staff group and to ensure that nurturing traits in males and strongly assertive traits in females are equally accepted and valued. Most importantly, 'macho' cultures should be challenged and practitioners should never be constrained into acting in a particular way just because of their gender. Factors such as age, experience, confidence and relationship are of equal importance.

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Holding

HOLDING

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Early experiences of being held are central to development and well-being. Winnicott (1965) wrote extensively about the importance of holding – both literal holding that occurs during the first few years of life, and metaphoric holding that refers to a child feeling held by an environment that is safe, predictable and nurturing. This whole experience of being physically and emotionally held is referred to as the ‘holding environment’.

Winnicott’s work on holding has clear links with Bion’s (1962) work on ‘containment’. Bion’s containment is not the ‘keeping a lid on things’ kind of containment that is currently often referred to in residential child care. His notion of containment also emphasises the importance of primary caregivers holding or containing the infant’s early experiences of distress by feeding their empty tummies, changing their soiled nappies and soothing all their various forms of upset. The care giver essentially absorbs the uncontainable feelings of the infant, and ‘gives them back’ in a more manageable – or containable – form.

Through the processes of containment in a holding environment, the infant begins to trust the world and adults around her. She learns to identify thoughts and feelings, she develops language and the ability to think in order to manage raw emotion, and she learns to play.

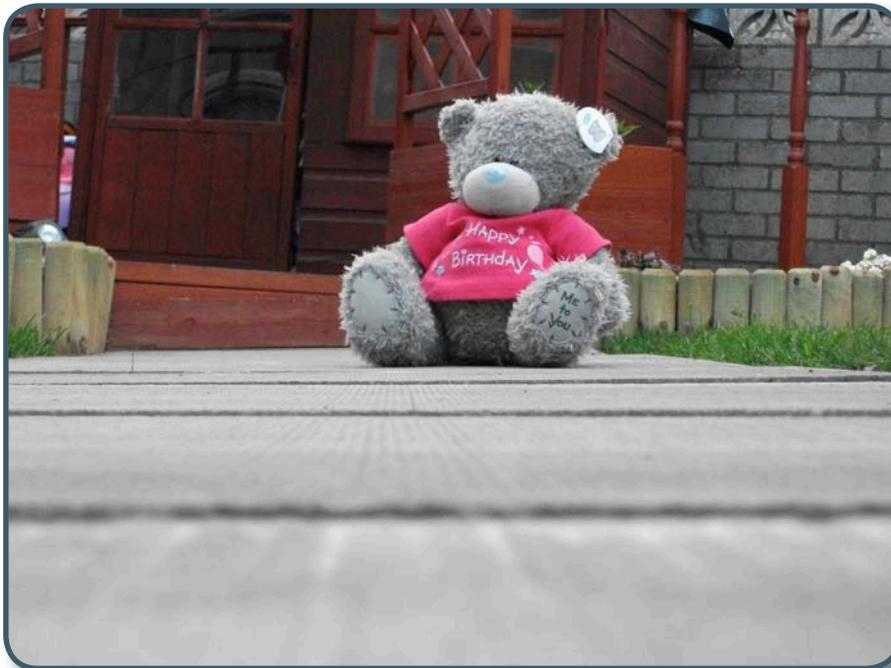
For many families, current and historic circumstances make the natural creation of a holding environment difficult or impossible. As a result, many children in residential child care have not experienced ‘good enough’ containment in their early years, and this has affected their development. These children will have difficulty trusting others and will have trouble managing their feelings and behaviour. They often carry deep, emotional pain related to their early experiences and their subsequent difficulties related to the delays in their development.

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Providing therapeutic containment and holding environments can be seen as the primary task for residential child care. While staff might not explicitly draw from the theories of containment and holding environments, teaching children to 'talk it out rather than act it out' will be familiar and resonates on a basic level with the work of Bion and Winnicott. A holding environment is provided through rituals, routines, clear expectations, use of activities, and most importantly, relationships – when they all come together to support a young person's healing and development.

The creation of a containing, holding environment, however, is complex and demanding. It involves helping children to feel safe and valued so that they can begin to make sense of painful experiences and emotions. This is not a free-for-all, where any and all behaviour is accepted because of the pain that underlies it. It also is not about creating a constricting environment where the primary aim is to keep behaviour under control. Sometimes a holding environment helps to 'poultice out' (bring to the surface) rather than to dampen down.

The most extreme form of holding in residential child care is likely to be 'physical restraint'. Physical restraint can be defined 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). A physical restraint should also only be used if there is no other practicable, less restrictive means of establishing safety.

Physically restraining a young person carries serious associated risks. Restraints have been implemented for the wrong reasons and in the wrong way. Staff and young people have spoken in research about very negative, even

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damaging experiences of physical restraint. In some cases, restraints can traumatise (or re-traumatise) the child (or, less frequently, the staff). Young people have even died during or proximal to being physically restrained.

At the same time, there may be some occasions when a young person's behaviour poses such a risk of harm and when other forms of intervening are not working that a physical restraint may be the best option. There is evidence that for some young people, being physically restrained is part of an overall, therapeutically containing experience.

For physical restraint to be used only in situations of imminent harm, when no less restrictive interventions are working (or can work), staff must be contained in a holding environment as well. Situations that tend to lead to a restraint can trigger controlling or counter-aggressive reactions. Staff have to contend with their own triggers and issues, while absorbing the young person's pain and anger. If they do not manage all of this effectively, it will interfere with their ability accurately to assess the risk of imminent harm and effectively intervene in less restrictive ways. This is extremely difficult in unsupportive environments that do not support staff to explore and make sense of the complexities of the work. It is almost impossible in environments that prize control or settled shifts over therapeutic relationships and young people's development. It is possible that by holding children emotionally, their need to be physically held by restraint is reduced or eliminated. It is also possible that when a restraint does occur, it can be part of a larger, therapeutically containing experience. Similarly, it is possible that by providing a holding environment for staff and children alike, physical restraint can be significantly reduced or eliminated.

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Inter- Professional Working

INTER-PROFESSIONAL PRACTICE

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*...we must all hang together, or assuredly, we shall all hang separately...
Benjamin Franklin.*

The terminology regarding 'joined-up' practice across disciplines is wide, including terms like 'multi-disciplinary', 'inter-disciplinary', 'inter-professional' and so on (Hammick et al. 2009). For our discussion, inter-professional practice might be taken to mean the purposeful sharing of thought, word and action across professional boundaries or 'collaborative practice' (Milligan & Stevens 2006), to achieve a common goal.

The world has become a complex environment and the way that we understand the world has become even more complicated. Whilst I may view the world through my lens - white, middle class, male, social worker, drawing conclusions as to the meaning of things from that perspective, it is not the only way to see things, nor necessarily the 'right' way to understand the world. Your perspective, influenced by culture, upbringing, experience and training, may provide different and equally valid, perspectives and meanings. If we then share our perspectives, and are open to new insights, then new horizons and understandings can emerge.

Whilst there are many theories of human development, arguably the *ecological model of human development*, proposed by Uri Bronfenbrenner (1979), is pertinent to this discussion. Bronfenbrenner suggests that individuals develop through 'reciprocal interaction' with people, objects and environments. Each individual has unique experiences and developmental opportunities, or lack of them, across a range of areas - family, immediate environment, social context, not forgetting national influences such as the economic climate, poverty and so on. For anyone to understand the 'other', or a young person who is looked after and accommodated, Bronfenbrenner's theory pushes us to consider this person's *unique development, their experiences, their meanings*. Numerous child death inquiries have pointed out that when we do not see the individual in context and pull together different perspectives, we only gain a partial picture or understanding of the young person, mediated by our own prejudice, professional perspective, culture and assumptions. When we then work with young people, can we really justify practicing with a potential 'understanding blindfold' on?

Bronfenbrenner provides underpinning theory to suggest that we require to think across a range of developmental 'domains' in order to understand individuals. This underpins the

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'My World' assessment framework, and indicates that practitioners need to be involved with a range of other professionals in order to gain the fullest picture that we can.

Inter-professional practice is not optional within residential social work. The social policy direction is towards joined up practice, as evident within the *Getting it Right For Every Child* policy stream. Social work's own review of the profession (Scottish Executive 2006a) soberly said that social work does not have all of the answers, thereby reinforcing the need to join up with other professions in delivering services.

Transforming Public Services (Scottish Executive 2006b, p 22) acknowledges much of the aforesaid, and suggests that barriers to effective practice should be demolished and also that there should be '*...work ...across common boundaries...*' (ibid). Policy recognises the theory, but acknowledges the need for change through which to promote collaborative practice. The law is also clear regarding collaborative practice, as evident within S21 (1) of the Children (Scotland) Act 1995 which provides the power for local authorities to request help from a range of people and organisations in order to carry out its work

Perhaps unsurprisingly no comfortable, procedural set of 'rules' has been established, which waves a magic wand and achieves good collaborative practice. However the issue of 'relationships' comes up time and again. We cannot collaborate unless some form of enabling relationship is established.

Bronstein (quoted by McLean in Lishman 2007, p 338) suggests that key components in successful collaboration are:

- *Interdependence*. In order to achieve tasks and fulfil individual and team roles, those working collaboratively are dependent on each other. In other words, we cannot achieve by going it alone!
- *Newly created professional tasks*. By joining and collaborating, professionals may need to undertake new activities. Whilst extending the skills repertoire of professionals, these new activities may achieve more than if collaboration was not present.
- *Flexibility*, arguably both flexibility of roles as well as flexibility in thinking. McLean (ibid) talks of 'role blurring', 'productive compromises', 'modification of roles', which in turn allows for the ability to respond creatively to new contexts.

Bronstein suggests (quoted by McLean in Lishman 2007, p 339) that a fourth component of her collaborative model is that of:

- *Collective ownership of goals*. Sharing responsibility and collectively owning the goals are crucial. If you do not agree, covertly or overtly, on the aim and therefore



the processes and methods of getting there, then achieving the goal will be fraught with difficulty.

- *Reflection on process.* In a busy working world it can be difficult to afford time to reflecting on the process of collaboration. Relationships and processes should be thought about and reviewed, allowing for feedback which can refine the process the next time.

In this very brief overview, I have introduced some developmental theory, policy, law and a broad framework of key components. Inter-professional practice requires hard work, persistence and a real sense of purpose, but the alternative is to fragment our understanding of the young people that we work with which at best means that any intervention can only be partially relevant to that young person, their life and potential outcomes.

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non- Judgemental

**HOW DO LESBIAN, GAY, BISEXUAL,
TRANSGENDER & STRAIGHT YOUNG PEOPLE
EXPRESS THEMSELVES?**

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At a recent Scottish Government-level meeting I attended, a representative of a leading Scottish equality organisation talked of a soon-to-be-released audio-visual aid on homophobic bullying. It features a young man who is effeminate being bullied by fellow school pupils for being gay. It turns out, to everyone's surprise, that he is not gay, however it is discovered that the school sports 'star' is.

The DVD means to challenge the stereotypes of LGBT behaviour and will do so; however it may unintentionally affix a greater value to one way of being gay over another, thus the 'masculine-acting' gay young person is valued differently from the effeminate and camp one.

The same can apply to lesbian young women when gender-conforming behaviours and expressions are regarded as more acceptable than those that do not 'fit' the expected norm for feminine behaviours. Thus the butch-behaving lesbian is valued differently from the more 'feminine-acting' one.

Society's need for individuals to 'fit into boxes' applies to sexual orientation and to gender also. We may expect young men and women to behave in particular gender-conforming ways, an expectation that will pose no difficulties for some but will restrict and inhibit others in how they wish to express themselves.

West and Zimmerman (1987) write about the way that gender is 'displayed' and that whilst this may appear 'routine' it nevertheless requires physical and emotional effort. Displaying femininity may require considerable body work (dieting, waxing, and tanning, for example) and also emotion work (working to adopt a caring attitude). Similarly, displaying masculinity requires that men work to embody certain physical attributes (e.g. muscular strength) and to display certain emotions (e.g., toughness).

What implications do these societal and cultural pressures on young people to gender-conform have for residential child care practices?

Residential child care environments can be particularly macho (Berridge and Brodie, 1998). External and internal managers may all be male. There may be a greater emphasis

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on control, and imbalance between control and care, and recreational activities may be geared more towards traditional, boys' interests. There tends to be a greater number of boys than girls in particular residential settings e.g., residential schools and secure accommodation (a point of interest in itself). These factors can contribute to the creation of such a 'macho' atmosphere.

How will the few girls who may be resident feel in such a male-dominated environment? Some of them will enjoy the traditional male activities and this particular masculine atmosphere. Others might feel that their interests are not being catered for.

Similarly how will any number of boys feel? Some will feel 'at home' and very comfortable in such an environment. Others may feel uncomfortable if they have to relate to men who express themselves in a very traditional way or if they would prefer to take part in activities that some might see as 'girly'?

Similarly staff may place different expectations on boys and girls when it comes to appearance and behaviour. Some staff will have particular views on how adolescent boys and girls should look based on notions of acceptable masculinity and femininity. Boys can be allowed to strut around in the home showing a degree of flesh but girls doing the same meet with disapproval. Likewise in behaviour, staff may accept particular behaviours in boys, the 'rough and tumble' play or the overtly sexual (male and heterosexual) posturing, that they would not accept in girls.

As good role models for young people, what roles are residential child care workers performing and is there a gender-conformity to these roles? Do they automatically take on roles and responsibilities that comply with gender role expectations? Who assumes the tasks of care and control? When confronted with challenging behaviours it may be assumed by male and female staff that the physically larger male, apparently more authoritative and likely to be in a more senior position, will undertake a physical restraint. Likewise assumptions are made about who is in a better position to comfort an upset youngster, to give the youngster a hug. It is assumed and expected that a female member of staff will undertake this task for two reasons: they are the 'natural' caregivers, and men are treated with suspicion and feel discomfort when attempting to touch young people (McLean, 2003).

Relationships between residential child care workers and young people may, or may not, 'work' because of the degrees of masculinity or femininity presented by or perceived by either group. This may not mean that workers need to alter how they behave as men or women, but it does mean that they need to be aware of self enough to enable an understanding of the effects of gender on young people.

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Are residential workers agents of social change or control when it comes to gender and sexual orientation identity and expression? Are they concerned for young people to 'fit in' to the societal and cultural norms or are they prepared to support young people in, and by, challenging these?

In presenting a training course on Working with Lesbian, Gay, Bisexual and Transgender young people to a group of staff from a boarding hostel for young people receiving specialist education in music and dance, some staff raised a question: what should we do with the boys who pirouette up and down the aisles of the local supermarket?

What indeed? What would you do?

It is incumbent upon us as residential workers to support, nay, celebrate young people's self-expression and to embrace the diversity of their gender and sexual identities.

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Key

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Keyworking

KEYWORKING

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Introduction

There is no one view of the little researched keyworker concept, despite it being a common feature in residential practice for the past 25 years and more. Variations in the use of terminology reflect this, and keyworker practice varies considerably in definition, scope and purpose. In general the role may be defined as the named person who has a central role with a particular young person within an organisational context. Here we explore in brief its history, indicate three core models and offer an opportunity for comparison with your current experience of keyworking.

Background

The concept dates from the 1970s. For example, a joint Residential Care Association (now Social Care Association) and British Association of Social Workers (BASW) report, 1976, recommended a 'keyworker model' which accorded full responsibility for the young person received into residential care. The keyworker in this model was (and variously still is) a challenge to the current practice of the field social worker always having responsibility for the care plan. Therefore what is appropriate for the keyworker to do and where the boundaries exist have been recurrent themes.

Most of the literature focussed on keyworking as an '*internal model*' (Mallinson, 1995) probably most recognisable in practice today. However the ideal of the keyworker as the person responsible for progress through the care experience and who would span the boundaries, within and across disciplines, was rekindled in Skinner, 1992,

4.44: these developments (keyworking) are welcome and to be encouraged. In most homes there is considerable scope for further development of the role of keyworkers. Keyworkers may play a part before, during and after a young person or child is admitted to residential care and could develop their role in relation to families. In some instances the needs of individual young people can best be met by transferring full case responsibility from the field social worker to a qualified keyworker in the residential home.

In *Edinburgh's Children* (1999), which makes favourable reference to the practice and argues for integrating the keyworker more into the decision-making process with access to all relevant information and, whilst equivocal on the issue of full case responsibility, does uphold the value of the keyworker system (Recs. 76 and 77). The report also points to

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an alternative model offering a *co-keyworking* approach wherein the role is shared by two residential workers, one with a planning, coordinating role, the other emphasising relationship-building (and, crucially, emphasising choice).

Three definitive models of keyworking have been referred to so far, namely:

- internal, localised only
- with full case responsibility
- co-keyworking, with or without full case responsibility

Ma key worker, he's fantastic. If I've got a problem...he'll no just sit in ma room wi me and say 'blah, blah, blah'. We'll go oot and have a game ay football and talk about it... He'll find oot more 'hings and you'll tell him more 'hings... One thing leads to another and, before you know it, I've telt him everything I've got on ma mind. Basically I end up being successful.
(Male, 15)

from *Caring about Success: Young People's Stories*.
Who Cares? Scotland 2008

As confirmed by the limited research there appears to be widespread acceptance of the concept of keyworking. All three models require participation in decision-making and planning, the *variables* being the *degree* to which this participation is integral to working both within and across disciplines and the authority which accompanies it. Clearly further research would benefit the sector.

Enshrined in all models would appear to be the principles of individualised care, individualised care planning and a system for managing these arrangements. Whereas the *National Care Standards* generally uphold the first two of these principles, managing a keyworking system requires managers to ensure that there are:

- a policy in writing;
 - supervision, support and training;
 - clearly defined delegated authority;
 - clearly defined links between key workers and others including roles, responsibilities, communications and individual accountability.
- (Adapted from SCA Guide, 1991)

How favourably does your practice measure against these criteria for a unit policy?

Ward (2007) illustrates how the 'matching' of keyworkers to young people is especially important: who chooses whom and how? He suggests that the implications for a young person of being 'allocated' to a particular individual for keyworking support may be quite different from the message given by being free to identify a member of the staff team with whom he or she feels comfortable.



In a 'therapeutic' as opposed to a 'social' model of care matching is even more vital in the sense that it is not only the children and young people that bring their previous experiences of being parented, of adults and relationships and other experiences but also the worker's own parallel experiences which will determine the potential for good or not (if the worker's own unresolved experiences are a negative impact). Keyworker gender and ethnicity therefore may have a special bearing.

Future Developments?

From the foregoing it will be appreciated that much of the existing practice tends to emphasise the localised individual relationship aspects of keyworking. However variations in how the role is carried out strongly suggest the need to explore the potential of the role beyond the internal, localised model to creating a greater participatory profile as indicated above. A more holistic multi-disciplinary picture can be of much greater value than the narrower view of any one professional. Planning can therefore benefit considerably from the development of keyworking in the multi-disciplinary context.

Last words

It is acknowledged that greater commitment to participatory practice in a meaningful way rather than a vaguely expressed desire to do something, means challenging and reflecting on the way residential workers currently practice, with implications well beyond the residential workplace.

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is for...

Love is...

... a many splendored thing, or at least that is what all those 'happy ever after' stories would have us believe. In reality love is a multifaceted complex emotion. Whether as a child, an aged adult or at any stage of life in between, our internal emotional and intellectual landscapes change just as quickly as the external world around us does. Young people in care experience the rollercoaster of emotions that come with feeling love just as much as anyone else. For young people in residential care there may be a number of additional complications which may add to this quagmire we call love. Though it is difficult to pin love down, the lack of placement stability and of reliable and stable role models in a young person's life affect the ability to form trusting and lasting relationships. As residential care workers there are many ways that you can facilitate a way in which building blocks and foundations can be laid for young people in care that will enable them to love and be loved in return.

But what does 'love' mean? Love is not 'all or nothing' and can vary in depth and in the way it is shown within different relationships. Love can, and indeed does, come in a variety of different forms, so how do we recognize it when it's there? When brothers and sisters fight, is this not a form of love? When a mother scolds her child for running out into the road, is this not a form of love? And when a residential worker worries when a young person in their care gets into dangerous situations, is this also not a form of love?

Whilst the word is not explicitly used within the text, love is implicit within the Articles set out by the United Nations Conventions on the Rights of the Child, particularly Article 42. Article 42 states that children and young people have the right to develop healthily, to be properly cared for, to be protected from harm, to have a good standard of living and to be able to relax and play.

These can all be interpreted as acts of love, but as professionals we find it difficult to use the 'L' word. As professionals, love is not a word used very often and sometimes we are even scared of using the word when we clearly know what we are feeling. Within the current climate of residential care words such as corporate, professionalism, and bureaucracy all proliferate in the literature and words such as love do not. It is no wonder that both care workers and young people in their care find it difficult to acknowledge their love for others. Coming from difficult backgrounds it can also sometimes be hard for young people to open up, show vulnerability and love.

Love

LOVE IN RESIDENTIAL CHILD CARE

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Many young people in residential care have complex relationships with residential workers, social workers, health workers and even domestic staff. It can be difficult for them as they try to make sense of the personal and professional aspects of staff roles. Understanding what is going on in the relationships and recognising the associated feeling can be a struggle in itself. Putting these feelings into words can be even more of a challenge. There must therefore be a cultural change within the sector in order for language and situations to be open to this possibility.

In carrying out research with young people in care, Ruth Emond (2002) was invited by young people to live with them in order, they state, for her truly to understand what 'living in care' meant. After a year of living in two children's homes Emond indicated that young people looked after one another and cared for one another even when it was not obviously so. An example of this was the young people fighting like brothers and sisters. By living in a group setting with the young people, Emond found many examples of young people bonding, looking out for one another, covering up for one another, sharing secrets and educating one another. All of these are acts of care and love.

If the opportunity is taken, the residential child care setting can be an ideal setting for facilitating healthy loving relationships. Residential care workers are in a key position to help young people find and maintain these relationships. These relationships can be with family members, friends, other young people in care, girl/boyfriends, their social workers or with yourselves, residential workers.

Whilst I would not go as far as to say 'all you need is love' I also would not go so far as to say that just as regular food, warmth and shelter is a core physical must, love is a core emotional foundation that we would surely struggle without.

So, instead of love is... love can be... empowering, insightful, life changing, warming...

They were just there for me, and gave me a hug when I needed one, gave me support when I needed it, gave me love and attention when I needed it and that's what I wanted and needed at that moment in time. I really owe a big deal to them, to the staff in my unit I owe a lot to them for doing that for me. They were just there for me to understand me, listen and be there for me and I appreciate it very much. (Male, 14)

[It] is important for all young people to have people to listen to them. The one and only main thing to having a good experience and good relationships with staff, is trustworthy relationships, trust is the key part to any relationship. (Male, 16)

from *Let's Face It: Care 2003: Young people tell it as it is*. Who Cares? Scotland 2003

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Managing Staff

MANAGING STAFF: LEADERSHIP

is for...

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The importance of the contribution of effective leadership in the provision of good residential child care is widely noted in research. This is demonstrated by the link between what is achieved with and for young people and the process of care delivered by managers with and through their staff (Hicks et al., 2006). There is further evidence of the role of strong leadership, supervision and support in sustaining values, challenging poor practice and prioritising clients needs (*Kerelaw Inquiry Report, 2009*). However, whilst there is an extensive array of literature on leadership and management generally, there is limited material which contextualises these concepts to child care settings.

A helpful starting point to provide some context is the clarification of the difference between leadership and management.

A Leader:	A Manager:
• Innovates	• Administers
• Is original	• Copies others
• Develops	• Maintains
• Has a people focus	• Has a systems focus
• Inspires trust	• Relies on control
• Asks what and why	• Asks how and when
• Looks to the future	• Concentrates on the past
• Challenges the status quo	• Accepts the status quo
• Does the right thing	• Does the right thing

Some Common Leadership Styles – Can you spot your leader?

There are a diverse range of theories identifying various styles and systems of leadership some of which are outlined below. As with many theories these may be too sterile to reflect the approach of an individual manager but there will also be aspects you will recognise.

Autocratic

This leader is status-conscious and makes all the decisions. There is no degree of participation in decision making, no delegation of tasks and information is not shared. They are poor communicators and use coercive power.

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Assertive Persuasion

This style is characterised by the use of power of logic, facts and opinions to persuade others. This leader is articulate, persistent and energetic but often does not listen very well to points raised by others.

Reward and Punishment

This approach is characterised by the use of pressure and incentives to control the behaviour of others. Leaders using this approach need to communicate very clearly to others what they must do in order to get what they want and to avoid negative consequences. Effective use of this style means mainly using praise and little criticism.

Laissez Faire

A leader who utilises this style provides general guidance only. They adopt a hands-off approach and have very limited involvement. With this style there is no accountability for decisions and the leader is often absent.

Common Vision

This style is characterised by appeals to hopes, values and aspirations. It involves mobilising the energy, enthusiasm and emotions of others for a common goal. It is used by charismatic leaders and can be used for achieving high ideals or evil ends.

Participation

The style depends on good interpersonal skills and involving other people in the decision-making or problem-solving process. Leaders who rely on participation and trust tend to listen actively, drawing out contributions from others and sharing understanding and appreciation. This leader can effectively create and maintain team spirit and commitment.

The 'participation' style (also known as the democratic approach) relates directly to higher employee satisfaction, lower turnover and lower grievance rates. However it is important to note that not all employees want to participate in the management process and that there are different situations which require and demand different styles.

This is based on the belief that there is no one ideal management style or system and that it depends on various factors, including the environment. This has led to the development of the Contingency Approach to leadership. Within this style the effective leader identifies factors that influences the situation including:

- The relation between leader and group;
- The nature of the task undertaken by group;

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- The degree of authority vested in the leader;
- The similarity or diversity of the group.



This approach has been further developed into the model of 'situational leadership' which considers two components; relationship and task behaviour. Both of these models address the combination of relationships, tasks and situations which are important and applicable in the residential child care setting.

There is no universal agreement about the ideal style of leadership. The concepts of transformational or new leadership are also worthy of consideration in a residential child care setting. This approach brings together theories of style, personality and context with the aim of inspiring others to high attainment and is in line with the notion of a learning organisation (Hicks et al., 2006). By providing regular, consistent support and supervision and encouraging carrying learning into practice, leaders will create teams capable of leadership at all levels and make a significant impact.

The challenge is to develop leaders in residential child care with sufficient autonomy and unity with external managers to ensure they are in a position to provide effective leadership. This is vital as the evidence suggests that a leader with a clear strategy has a significant impact on staff morale and contributes to improved outcomes for young people (Hicks et al., 2006). The role of leaders is vital to the creation of an environment which supports staff and delivers the best possible care experience for children and young people.

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No to 'no language'!

NO TO 'NO LANGUAGE' DISABILITY AND COMMUNICATION

is for...

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In 1849 a Mrs. Jane Seymour wrote to Charles Dickens complaining of his mocking portrayal of 'Miss Mowcher', a character of restricted growth who appeared in the early serialised episodes of David Copperfield. She suspected that Dickens had modelled 'Miss Mowcher' on her and threatened legal action. Dickens apologised and subsequently developed the character in a more positive way in future episodes of the work (Shakespeare, 2006).

Historical perspective on disability

Since the 1970s there has been an increasing challenge to the 'traditional' understanding of disability, which saw the adverse experiences of disabled people as rooted in their physical condition. This is now described as a 'medical model' of disability. Disabled activists proposed that the disadvantage they experienced was because of social barriers, such as restrictive physical environments and social attitudes to disability. This is referred to as a 'social model' of disability.

The reasons for people being disabled and the provision made to support them and their families have also changed. At the time Dickens was writing, poverty and lack of appropriate and timely medical treatment was the underlying cause of impairment experienced by many disabled children. However, this has now changed. Premature birth due to medical developments and maternal drug and alcohol use during pregnancy are now the key causes of disability and developmental delay (Woods et al., 2005).

There has also been a move away from the institutional care model from the 19th Century. Disabled children are now far more likely to live with their families, attend local mainstream schools with appropriate supports going into the family home, and to have short breaks with family-based carers or in small residential units.

Communication and Inclusion

Communication is a fundamental human need evident from birth till death. For disabled children and young people, communication can be a particular challenge. It is helpful to separate the child's 'communication impairment' which is the fact that they cannot speak, from the barriers which may be put in their way by people not taking the time

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and trouble to learn how to communicate with them (Morris, 1995). The United Nations Convention on the Rights of the Child makes it clear that children have the right to give their views on matters affecting their lives and for these to be taken seriously (Article 12). The spirit of the UN Convention has been integrated to the Children Act 1989 and the Children (Scotland) Act 1995. Those involved in working with disabled children and young people are therefore obligated to promote communication.

Usually quality assessments and information exist on how best to support a child's communication, but this is often held by agencies such as schools or speech and language therapists. Under policies such as *Getting it Right for Every Child* and *Every Child Matters* this material should be shared with all those involved in the child's care, but sometimes residential practitioners need to advocate strongly on the child's behalf to access this. It is, however, essential fully to support the child or young person.

Along with parents, residential practitioners are in a privileged position to promote communication with disabled children as they share the child's living environment and can therefore create opportunities. The routine activities of the day such as personal care and mealtimes give ample opportunity for communication using approaches best suited to the child's developmental level. It is helpful for many disabled children to use sensory experiences, objects included in the activity or a simple schedule of photographs or symbols to help them understand what is going to happen next. If an outing is planned, it can be helpful, and fun, to spend the evening before sharing a story or sings songs about the activity and after the activity, to make a collage of the outing using paints, photographs and sensory material gathered during the trip. The advent of digital photography means that children can take photos of activities home and to school thus sharing their experiences.

The views of children and young people with disabilities are often not sought at reviews or at important points of transition in their lives, particularly where meetings take place outwith the unit. It is then crucially important for residential workers to act as advocates for their views. Experienced residential practitioners have worked with other professionals to develop tools to facilitate this such as 'Talking Mats' (Talking Mats, 2010), 'MAPS' and 'PATHS' (Sanderson et al., 1997) to ensure the young person's voice is heard.

End note....

Since Dickens' time literary fiction has continued to draw on disabled people in plot development. Arguably their talents are now recognised and their different way of being respected, as is shown with characters such as Christopher John Francis Boone in *The Curious Incident of the Dog in the Night-Time* (Haddon, 2003), and Arthur and Esther in *Skallagrigg* (Horwood, 1987) Similarly the role of the residential care practitioner has changed and is now that of helping to give a voice to disabled children and young people in care.

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O Learning Organisations

LEARNING ORGANISATIONS

is for...

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The 21st Century Social Work Review identifies the need for social work organisations to develop as *learning* organisations if the social service workforce is to meet its future challenges (Scottish Executive, 2006).

Various public inquiries and reports (see for example Marshall et al., 1999) have made recommendations to improve residential child care practice. More recently the National Residential Child Care Initiative (NRCCI) puts forwards the view that residential child care should be “the first and best placement of choice for those children whose needs it serves”. To turn this rhetoric into reality the report suggests a programme of change and improvement is necessary.

Literature concerning how learning organisation theory relates to residential child care practice indicates that learning at an individual level alone is not sufficient to promote change in culture and practice. It suggests that learning at an organisational level, facilitated by systematic thinking and practice, will produce a learning organisation better able to respond to the challenges of the 21st century.

In 1978, Argyris and Schon published their book *Organizational Learning: A Theory of Action Perspective*, which helped to articulate the idea; however, the concept was not actually implemented until the 1980s.

A learning organisation can be defined as:

**...an organisation that facilitates the learning of all its members
and continuously transforms itself and its context
(Pedler et al., 1997, p.7).**

According to Pedler et al. (1997) interest in the idea of the learning organisation for many organisations has been driven by a range of factors including a failure of previous restructurings, a need to change the organisational culture, a desire to become more people-orientated, a need to link resources more closely with customer needs, and the increasing pace of change and competitive pressures resulting in a need to compete, survive and grow.

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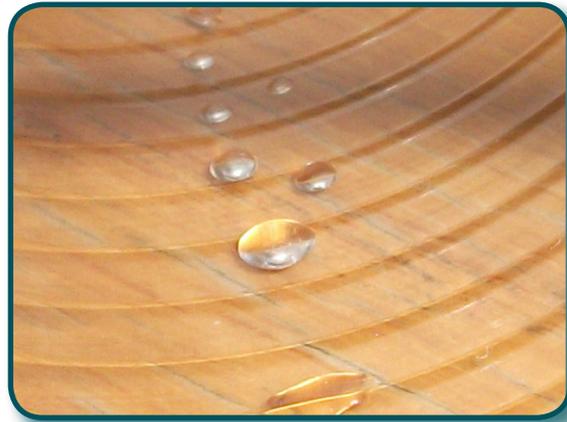
Dale (1994) suggests there are observable features which can be used to differentiate between a learning organisation and a non-learning organisation. Some of the key characteristics associated with learning organisations are: Team learning, shared vision, mental models, personal mastery, systems thinking, celebration of success, innovation, learning from mistakes, human potential, shared knowledge, trust, and learning from others.

Peter Senge (1990) considers 'systems-thinking' to be the key discipline of organisational learning. He suggests that writers on management theory tend to focus on the parts rather than seeing the whole, which does not allow for seeing the organisation as a dynamic process. Senge views the ability to see 'the whole' as a single entity as key to organisational survival and suggested that organisations suffer because of their inability to do 'joined-up-thinking'; he argues that organisations have to be able to learn how to cope with continuous change in order to be successful.

Research (Butler, 2009) found that residential child care organisations in local authority and independent sectors have many qualities associated with organisations that learn. Overall the sector was found to have a clear understanding of organisational values, goals and objectives. Encouragingly, training opportunities used to develop knowledge and practices were found to be strong features of residential child care practice. However, some areas of practice need to be developed to improve organisational learning across the sector, and these include: systems thinking, innovation and learning from mistake. A number of practices related to systematic thinking such as using communication structures to share knowledge across all levels, which Senge (1990) considers essential for organisational learning were found to be exhibited to a moderate extent. Effective communication systems and structures, a key area for development highlighted in public inquiries, continue to be less exhibited areas of practice.

To meet the challenges of the 21st century and to evolve as learning organisations, residential child care services need to develop innovative practice and encourage the use of mistakes as learning opportunities. Staff must feel free to take appropriate risks, and to try new ways of managing their work. To facilitate this process, mistakes made by individuals and teams need to be seen as learning opportunities, which will only be possible if the risk-aversion culture responsible for stifling innovative practice is addressed.

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is for...

Parents

WORKING IN PARTNERSHIP WITH PARENTS WHOSE CHILDREN ARE ACCOMMODATED AWAY FROM HOME

Kevin Pilkington
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Residential child care workers are mandated to work in partnership with parents, whenever this is in the best interests of the child (Scottish Office, 1997). It is my contention that parents who experience the benefits of this partnership approach are not evenly spread across the residential child care sector. While the reasons for this are complex, I intend to focus on two areas that indicate why working in partnership with parents has such significance. Firstly, it helps residential workers better understand the difficulties and disadvantages parents typically experience. Secondly, this understanding helps residential workers recognise discrimination, draw on the strengths parents have and support them through their difficulties.

A very important question we should first of all ask ourselves is: 'Who are the parents whose children are looked after in residential child care?' I began my social work career in residential child care before moving to field social work and I have been teaching on social care and social work courses for the past 12 years. I am frequently struck by the number of students who, while placed in a residential setting, write reports which fail to mention parents. There may well be legitimate reasons why parents are not considered but those reasons have to be clearly stated. More often than not, such explanations are absent, which in turn leads me to ask students: "Are these children orphans?" Of course, it would be quite wrong to assume this, or that their parents do not care, and more helpful to the parents to start from an understanding that their difficulties affect on their desire to provide complementary care alongside residential workers (Audit Scotland, 2010). In this context the often cited 'difficulties' in working with parents require both acknowledgment and qualification. While figures for the children looked after in residential child care for whom the local authority has parental responsibilities are not readily available, the general figures confirm that it is the norm for parents to retain rights in respect of their children. This places an onus on residential providers to demonstrate how they are working in partnership with parents, especially so, as current figures highlight, when care ended the child's main destination was returning home (Action for Children, 2009).

So, why then do we, however unwittingly, exclude parents from our considerations? Students are not alone in sometimes overlooking parents. There are concerns that while social work research should inform practice, research is patchy and not always available

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to practitioners (Scottish Executive, 2006). However, while residential child care benefits from a great deal of research interest at present, consideration of parents is really quite patchy (Scottish Government, 2008). This position is starker when you look at reports which have enquired into the circumstances of children who have been abused in residential child care. The inclusion of parents is absent or minimal despite parents often being the catalyst for investigation (Scottish Government/Glasgow City Council, 2009). I would therefore ask those of you who are joining the profession, and those who are seeking to update your skills and qualifications, to have a critical eye on how many times parents feature in book chapters, research journals or reports and begin to question why a profession which has such a strong commitment to social justice has such glaring inconsistencies.

This form of exclusion is important to acknowledge as we know that the parents whose children are looked after away from home are typically among the most disadvantaged in our communities. What requires additional emphasis is that the term 'parents of children in care' does not quite capture the reality of the situation as it serves to conceal that lone parents, and in particular lone mothers from working-class backgrounds, have always been overrepresented among those using social work services and in particular residential child care services (Burns and Pilkington, 2009).

It's quite hard when you're at school and everybody goes home to their mums and dads.
(Male, 15)

The good thing is as well that when you're in care away from your family, you realise the good points when you're in with your family, and sometimes it can bring the family closer.
(Male, 17)

In this home anyway you get outings, videos, wee treats like you wouldn't get in your family but even though you do get that you're still not happy because every human, no matter who you are, you still want to be with your family, it's just a human thing.
(Male, 15)

from *Let's Face It: Care 2003: Young people tell it as it is. Who Cares?*
Scotland 2003.

So then, how do we practice in a way which does not compound their already marginalised status? There are two important considerations attached to a partnership approach which represent quite a significant commitment from residential workers. Firstly, it means that you should be providing 'complimentary' care, that is, what you do should build on the important contribution and investment parents have in their child's care. Try and make sure in your contact with parents and care planning you are not adding to their difficulties but working with them. Secondly, we should not be providing 'substitute' care, except for those children whose parents no longer have rights or a positive contribution

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to make in respect of their children (Scottish Government, 2008).

Finally, when we do attempt to learn from parents, by asking them to tell us of their experiences, what do we find? We discover that they are generally happy with the care provided by residential workers, but, and this is crucial in a partnership approach, they would like to have more of a say, have more contact and have more support (Ofsted, 2008). And when we ask children and young people looked after what they want, they tell us much the same (SWIA, 2006).

So to conclude, let us not forget: few are orphans and few would not benefit from us working with their ma (and da).

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POVERTY, INEQUALITY AND RESIDENTIAL CHILD CARE

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Having been a lecturer and tutor on the HNC in Social Care for the last nine years, I have been struck by the extent to which 'poverty-aware' practice seems to have disappeared from social work/social care education and practice. It is my assertion that we must get it back on the agenda!

Childhood poverty is an on-going problem in Britain, with Scotland experiencing disproportionate levels of poverty. A child born in Glasgow has the lowest life expectancy in the UK and now has a lower life expectancy than children born in Iran or Puerto Rico. The level of inequality that exists within Scotland has a significant effect on the population. A recent study showed that Scotland's wealthiest suburb has a life expectancy of 87.7 years compared to the poorest areas of Glasgow where the average life expectancy is 54 (Hanlon et al., 2006).

The link between poverty/inequality and a range of social problems is well established. Poverty leads to decreased life chances and the harmful effects are evident in areas such as housing and homelessness, fuel poverty, debt and health. Poverty impinges on key aspects of residential child care practice as it is the financial and material consequences of poverty that will most frequently bring young people and their families into contact with social services (Bebbington and Miles, 1989).

Evidence suggests that the correlation between poverty and the likelihood of a child being looked-after in Scotland is as strong as ever. This is reflected in the numbers of children subject to supervision requirements. Nationally, children subject to supervision requirements account for 1% of the child population. In the least deprived wards of Edinburgh there were no children subject to supervision requirements whereas in the most deprived areas of Edinburgh this increased to 7% (SCRA, 2006). This is not the full picture however. Historically, children and young people are more likely to be

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accommodated if they originate from a lone parent household. Given that 90% of lone parent households are headed by women and that lone parents are twice as likely to be poor compared to couples, the link between gender, poverty and residential child care becomes apparent. For this reason, residential child care staff are most likely to come into contact with lone parent mothers who are attempting to cope with the debilitating impacts of poverty and inequality.

So, do young people and their families feel that we appreciate their circumstances? The research would suggest we still have some way to go. Service users often found that the stigmatising and labelling effects of poverty were *reinforced* in their interactions with social services. Social work staff frequently labelled them as 'difficult, feckless, deviant or responsible for their own poverty' (Beresford et al., 1999, p 259). This reflects dominant ideas about the nature of poverty which are largely based on ideas of pathology and anti-social values, evident in notions of the 'underclass' and 'social exclusion'. Historically, poverty has been viewed as the direct consequence of attitudes and lifestyles adhered to by the poor themselves underplaying the role of structural inequality. The power of such ideas allows the poor to be identified, not by their class position or due to inequality, but by their morality and motivation.

It would appear that social work/social care education has not been immune to this process. Despite a commitment to engaging in anti-discriminatory and anti-oppressive practice within social work education, the profile and status of poverty-aware practice appears to have been marginalised relative to issues relating to race, gender, sexuality and disability. This fails to locate oppression within a wider understanding of mass poverty and ignores the connection between poverty and other facets of structural inequality. Garrett (2002) describes this as the 'sequestration' of poverty from social work's agenda.

I would suggest, therefore, that poverty-aware practice is retained as a central element of any education programme offered to residential child care staff. Residential child care staff need to be able to reject explanations of poverty based on 'morality' and 'motivation' and instead create practice based on an awareness of the economic, social and cultural factors sustaining poverty, as well as the social, physical and emotional effects. This more comprehensive understanding of poverty will allow residential staff to

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look at cases of neglect and/or abuse in a broader way, recognising that parenting capacity is debilitated by the impact of poverty rather than the individual inadequacy of parents.

While we are powerless to cure poverty, we can try not to compound further the difficulties faced by those who have to live with it. Only by doing so will we meet the challenges set out in the *21st Century Social Work Review* which reinforced a commitment to the core values of inclusiveness and meeting the whole needs of individuals and families (Scottish Executive, 2006).

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R

Rights to Participation

YOUNG PEOPLE'S RIGHTS TO PARTICIPATION

is for...

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Who Cares? Scotland

We have an ethical and moral duty to involve young people in all aspects of their care and decision-making in their lives. This is also a legal requirement under the *Children Scotland Act 1995*, which governs social work and child care with children. Young people who are not involved in making decisions risk further marginalisation and exclusion – for example when young people feel they have not been involved in key decisions which affect their lives or do not understand the reasons why decisions were made. Facilitating effective participation enables young people to have a voice, gives them the power to make decisions in their lives, and assists service providers and policy makers to make sure that what they do is wanted and required, and so more efficient and effective.

Policy Context

This right to meaningful consultation and participation is enshrined in the *United Nations Convention of the Rights of the Child (UNCRC)*. As of November 2009, nearly every country of the world has accepted it as the basis for their laws and expectations around the place of children in society: 194 countries have ratified, accepted, or acceded to it. Article 12 of the *UNCRC* says that all children and young people have the right to say what they think should happen when adults are making decisions that affect them, and to have those opinions taken into account. The *UNCRC* states that the voice of the child should be the primary consideration; it does not, however, necessarily mean that the rights of the child are more important than the rights of others or that the child has the most adequate view. Rights as a starting point for dialogue implies that in every context, children and parents should examine together in dialogue (relational citizenship) whether their rights are given full play.

Particular to our settings are the *National Care Standards* that set clear baseline standards for young people's involvement in elements such as care/personal planning and an understanding how decisions are made. This is explained in the Standards as: 'You have the right to contribute to decisions made about your life and care, in ways that are suited to your age. You can expect support to help you choose and act on your decisions'. Participation needs to be meaningful, as there are always dangers that it will

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be tokenistic if adults are not committed to listening carefully to children and exploring issues carefully with them. We need to provide children with a genuine opportunity to influence decision-making while providing honesty and clarity about the extent and limits of the influence young people can have, for example when there are elements of risk or child protection issues.

We should especially encourage the involvement of socially excluded groups and victims of discrimination and ensure that their voices and experience are given equal opportunity to be heard and acted on as often they are the most powerless in society and least likely to have the confidence or skills to influence decisions which affect them directly.



Practical ways of creating a culture of consultation and participation

In order for young people to be willing to participate they must believe that change is possible as a result. This may sound obvious but in consulting young people it is important to avoid using jargon on the one hand and being patronising on the other. Young people want adults to be straightforward and direct in what they have to say. And whether the communication is written or spoken, finding the right tone of voice is important in convincing young people that their views are genuinely valued. Effective consultation takes time, effort and skill. If it is done in haste by workers who have neither the time,



commitment nor skills, it will be a waste and the whole process will become devalued. Methods used to engage and consult young people should be flexibly applied according to variations in age, ability and attitude. For example, a group of 14-year-olds with limited attention is unlikely to respond well to adult-led meetings and formal consultative arrangements. However, the young people are more likely to take up the opportunity to express their views through a chat-room, a web-based notice board or text messaging. There are many opportunities for organisations and individuals to be creative! Ideas such as big brother style diary rooms, agree/disagree run-around exercises, drama work, video projects where young people express their views to decision-makers on given topics, youth forums, peer-led projects where young people assist and mentor others and participative activities are more likely to succeed. The SCCYP website has some resources you can use for consulting with young people.

In order for young people to participate actively, they need good information communicated in a way that is relevant and meaningful for them and taking into account any multiple and complex needs which they may have. Residential workers will also be aware of the level of literacy and any communication difficulties that the young people will have. They need to take these factors into account, and when using documents or questionnaires try to make them as free of jargon as possible.

If young people take part in meetings it is important to make sure that they are well briefed beforehand about important matters that will be coming up. It will not be productive if they come to a meeting poorly prepared and informed. Somebody should be given responsibility for the briefing. Good preparation is necessary if active involvement is to work. This includes training young people in the skills needed for some of the tasks that might be involved, such as appointing staff.

References and further reading:

- Involving young people in social care www.scie.org.uk/publications/guides/guide11/toolboxes/practice11.asp
- National Care Standards www.scotland.gov.uk/Topics/Health/care/17652
- Participation Works – www.participationworks.org.uk/
- Scotland's Commissioner for Children and Young People (SCCYP) www.sccyp.org.uk/

S

Staff Supervision

THE SUPERVISION PROCESS WITHIN RESIDENTIAL CHILD CARE

is for...

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Social work and social care have a long tradition of promoting the importance of supportive supervision. However with the increasing focus on the regulation of services, supervision has tended to become a process which has been related to the auditing of work and is seen by supervisees as a task-orientated, tick-box process.

It can go wrong for other reasons too. Over the years I have heard staff members recounting tales of supervision sessions turning into counselling sessions for the supervisor and even of residential workers being told to go and write up minutes of supervision sessions which did not occur because of impending Care Commission visits. A good talking point within any new HNC class is, when was the last time you received supervision? To date the 'winner' of this dubious accolade has been a nightshift worker who said that he had not received supervision for the entire eleven-year period that he had been a residential worker.

The 21st Century Social Work Review and the Changing Lives agenda have put leadership and supportive supervision back on the agenda and we now should be experiencing a different emphasis on what supervision should be. The aim is to rediscover supervision as a regular, reflective process where the individual supervisee feels central to the entire proceedings. Supervision should be:

A quintessential, interpersonal interaction with the general goal that one person, the supervisor, meets with the other, the supervisee, in an effort to make the latter more effective in helping people.

(Hess, in Hawkins & Shohet, 2000, p 50)

Supervision should be educative and supportive as well as administrative (Kadushin, 1992). For example in order to be educative, supervision should allow the supervisee the opportunity to look at new policies and procedures and grasp the intricacies of working with such documents. The supervisee should also be allowed to reflect upon everyday tasks that they have been involved in and be given an opportunity to learn from these

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with the guidance and support of their supervisor. Finally, there can be no denying the degree of accountability which should form part of any supervision session. The supervisor needs to be assured that the supervisee is carrying out the administrative tasks that are essential when working in this field.

Supervision is also important in orientating the worker to the aims, goals and values that the agency upholds. In modelling the work within the units, the process of supervision should be anti-oppressive and anti-discriminatory. There is a clear correlation between the values that we uphold within residential child care and those shown within the context of supervision (Brown & Bourne, 2002). Confidentiality, respect and individualisation should all be paramount when undertaking the supervision process. There are various forms of supervision including direct, indirect, informal, formal, group and individual. The most commonly accepted and used form of supervision is individual.

Establishing the boundaries of supervision sessions is important. There should be protected space and time and the sessions should never be rushed. Due consideration has to be given to confidentiality in order for the supervisee to feel confident and relaxed enough to discuss issues, reflect upon incidents and practice they have been involved in, take on board feedback that they might receive in order to learn and move forward as a practitioner.



They need to be clear about the limits of confidentiality so that they can feel confident that nothing discussed will be shared with the team unless the worker agrees and it is relevant to do so. The session should be minuted with both parties signing the paperwork as a true reflection of the meeting.

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The advantages of this form of supervision are it allows for the supervisee to reflect without feeling threatened. It allows for working relationships to be strengthened and valued and it provides personal support for the individual.

Supervision is a valuable space within which residential child care workers can take the time to reflect on the impact of young people on them and their impact on young people. This reflection is crucial for healthy relationships to be maintained and strengthened between the worker and the young person.

Like any other relationship the supervisory relationship takes time to develop and consistency of supervisor and maintenance of the boundaries is an important part of the process.

Though it is important to establish an effective supervision system, this needs to be worked at as some supervisors may lack confidence in carrying out this role and this may lead to the supervision session lacking structure. Training for supervisors needs to be seen as essential for any supervision structure to be successful.

It is often suggested that the needs of the young people and the demands of the service may lead to supervision sessions being cancelled but this is a 'false economy'. Young people will be best served when their direct care staff are receiving regular supportive supervision. The supervisor and supervisee need to be jointly responsible for the session occurring. When there is a balanced and supportive focus on the three key aspects of supervision – educational, supportive and administrative — supervision should be a positive and beneficial activity which creates practitioners who are confident, effective and can carry out their role in a manner which demonstrates professionalism and commitment.

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t

is for...

Trauma

THE IMPACT OF TRAUMA

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Loss is a universal human experience. All of us by the time we reach adulthood are likely to have suffered some significant loss through death or some other disruptive event which will have caused us pain and distress. Trauma on the other hand is a psychologically distressing event that is outside the range of usual human experience. Trauma is characterised by a sense of intense terror and a feeling of helplessness. People who have experienced trauma may have severe and long lasting psychological difficulties that can affect every area of their daily lives.

Many children in residential care will have experienced traumatic events such as witnessing extreme violence or being abused themselves. Often the trauma they have suffered began very early in life. The emotional environment in which children spend their earliest months has a profound impact on their developing brains. In an environment characterised by anger and abuse, such as a household where domestic violence is the norm, infants fail to achieve crucial emotional milestones. These include the ability to regulate stress, impulse and rage. They also learn to view adults as a source of terror rather than as trustworthy protectors.

Skills in emotional regulation can enable people who experience trauma to recover most quickly and completely. Young people in residential care are therefore often doubly disadvantaged as they may experience multiple traumas and their early experiences impair their capacity to manage such trauma. In addition we know that children who experience chronic trauma in the first decade of life, particularly if the trauma has involved injury to the child or someone close to them, are most at risk of long term problems such as educational failure, impaired social functioning and continuing distress and unhappiness. These are the very children who are likely to be in residential care. The factors that can enable children to recover spontaneously from trauma, which include a supportive attuned carer, are usually absent in our children's families.

All of us have a built-in emergency system that can short-circuit the normal brain pathways when confronted with extreme danger. We can recognise this response when, for example, our bodies react to a loud noise or a sharp pain even before we

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are consciously aware of them. This is an extremely important response that enables us to manage threats and dangers very quickly. One of the effects of trauma, however, is that it increases our sensitivity to danger and therefore this response becomes activated more quickly than normal. Certain sensory cues such as particular smells, sounds, tastes etc., associated with the trauma can also trigger a strong reaction. These very extreme responses are often difficult to understand both for the individuals concerned and those who are close to them. Much of the inexplicable behaviour and seemingly 'mindless' violence of young people in residential care may well have its roots in traumatic events.

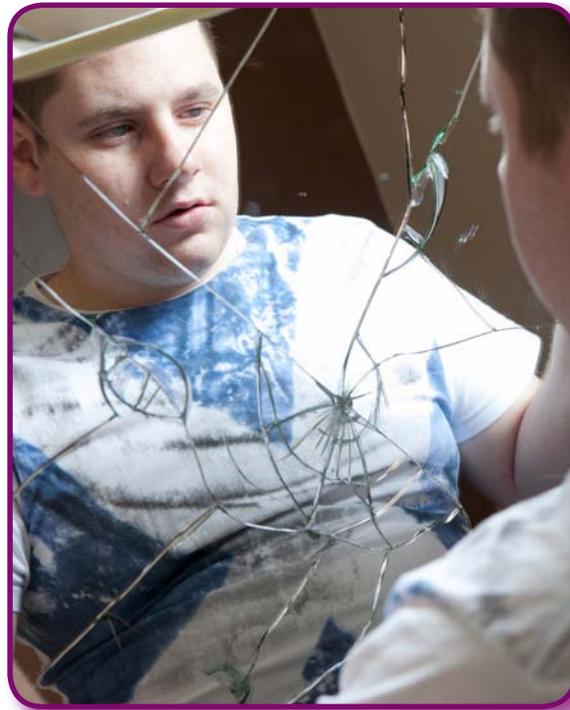
In situations of extreme terror human beings react physiologically in one of two very different ways. If there is the possibility of running or fighting back then the body will increase heart rate and blood flow to the limbs and secrete endorphins. This increased arousal allows the person temporarily to ignore pain and to respond with extreme physical effort to attack or run away from the source of the fear. If there is no possibility of escape the bodily response is to freeze and the heart rate reduces and blood flows away from the limbs to the central organs. This is intended to reduce the damage caused by injury by reducing blood loss and it ensures survival both physically and emotionally. Similar bodily responses of hyper-arousal and dissociation can be triggered in traumatised young people by a range of everyday events or cues. This can interfere dramatically with their capacity to manage normal developmental experiences such as school, socialising with peers, coping with change and transition and understanding their own and others' emotional lives.

How can we help? Firstly we all need to have basic information about trauma. This article is a brief introduction to the topic and suggestions for further information are included at the end. Not only should we understand trauma, so should the children we work with. People who have experienced trauma often believe that they are going mad and knowing that their experience can be understood can be very helpful. We need to help them to recognise the patterns behind their behaviours so they can begin to control their responses.

We also need to avoid relying too much on verbal interventions with young people. Trauma is often described as 'wordless terror'. We first of all need to create a feeling of safety for children. This may involve working on the physical and sensory environment just as much as talking to children. Using safe touch, pleasurable smells, soothing colours and textures, rhythm and music may all be very effective in enabling young people to

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relax and feel safe, which is the first step to recovery from trauma. We must help young people develop or regain emotional competence so that they can manage their own emotions and be sensitive to those of other people. Finally we need to remain optimistic and positive – our young people can recover from trauma but only if we believe that it is possible.



Further reading:

- Cairns, K. (2002). *Attachment, Trauma and Resilience: Therapeutic Caring for Children*. London: BAAF.
- Perry, B. and Szalavitz, M. (2008). *The Boy Who Was Raised As a Dog: And Other Stories from a Child Psychiatrist's Notebook - What Traumatized Children Can Teach Us About Loss, Love, and Healing*. New York: Basic Books.
- 'We can and must do better' training materials DVDROM (particularly the section on trauma and the film *Craig's Story*)
- www.childtrauma.org/index.php/home

U

Use of Self

USE OF SELF IN RESIDENTIAL CHILD CARE

is for...

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The term 'use of self' is more often spoken about than clearly understood. This is not surprising as it covers some very important but less tangible and quantifiable aspects of residential child care work. It reflects the fact that all residential child care work depends on developing, sustaining and using relationships with children and young people therapeutically. The therapeutic relationship is central and its effectiveness largely depends upon the worker's self-awareness, self-knowledge and self-understanding.

Who we are in residential child care is as important as what we do. Much of what a worker can offer comes from their own personality, personal resources and life history. As 'we are, in effect, a tool of intervention in our own right, it clearly pays dividends to have some degree of understanding of that tool or resource' (Thompson, 2005, p 89).

On the surface using our selves in relationships can seem simple as it is what residential workers do every day. However there are dangers in taking this for granted. The worker can end up taking behaviour at face value and responding to the overt behaviour rather than seeing it as communicating something about the young person's unmet needs and a plea to have these needs seen and met. There are no short cuts to understanding and responding to these needs; that understanding and response comes from the 'self-in-representation'.

A relationship involves at least two people and, as well as understanding and working with the feelings of the young person, the worker needs to be able to manage their own feelings. Not only is it important that the worker recognise and understand the emotions picked up from the young person but also that they recognise and manage their own emotional reactions to the young person, to the work they are undertaking, and any incidental feelings and reactions that may be complicating the picture. Residential workers need to be close enough to recognise and respond to feelings and assess problems' but distanced enough to be able to reflect, analyse and intervene.

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This does not mean tolerating abusive verbal or physical behaviour; boundaries to acceptable behaviour have to be set. An individual's verbal and physical reactions are important sources of information and there is a skill in deciding where the boundaries should be set and assessing what is appropriate for each individual. The need for these boundaries is part of the information about what is being conveyed or enacted in the relationship.

Self-awareness is a skill that develops over time and does not necessarily come naturally. It can sometimes feel easier not to consider the impact that the work and people we work with are having on us, but the danger in not doing so is that we get out of touch with our feelings and responses. It can be particularly difficult to acknowledge negative feelings towards some young people, particularly as this seems to contradict social care values. However if these feelings are acknowledged they are less likely to 'leak' out in our interactions with service users at inappropriate times.

You need to be aware of how you feel but to be able to suspend judgement sufficiently to think reflectively before deciding how to respond. This links closely with what Kolb (1984), Schön (2003) and Boud et al. (1985) say about learning and reflection. It is a process involving space to think, reflection and action. Managing to create an internal space to think and reflect while engaging with a service user is a skill to be developed and monitored.

One of the challenges for the worker of 'using' themselves in the workplace is finding the right balance between physical and emotional distance and involvement. Each situation is unique and though there are some things that are clearly not acceptable the boundaries around what is acceptable vary according to the context and the individual. Giving some young people a hug may be acceptable and in fact essential to their growth and development, but will not be acceptable with others. Similarly expressing and sharing your feelings with a particular young person may be a useful and appropriate use of 'self disclosure' but with another service user may be felt as punitive, swamping or self indulgent.

Monitoring the boundaries of work should be ongoing both within yourself, in your discussions with colleagues, and in supervision. Not only is this important for ensuring good practice but it allows the worker to make sense of what is going on personally and

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professionally, to process the negative feelings and difficulties they are having and help them to survive and thrive within work. It is not always easy to accept feedback about yourself when it is not positive but it can contribute greatly to your development if you can hear and respond to feedback. Of course it is much easier to accept feedback from those you get on with and respect and where feedback is mutual. However even if your initial reaction is to reject comments from some colleagues and service users it can be helpful to take time later to think through what has been said. Sometimes it is possible to recognise some truth in what has been said or at least think about why they might see you as they do.

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V

Vatsalya

VATSALYA - LIFE IN AN INDIAN ORPHANAGE

is for...

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“There is no fixed time for volunteering. You can be here for one week, four weeks, four months....! Depends on your wish and your ability to feel comfortable here and work with children”.

These are the words of Jaimala Gupta the founder of Vatsalya, an Indian non-governmental organisation which works with children found orphaned or abandoned on the streets in India. Jaimala gave a talk at one of the SIRCC conferences about research she has undertaken in children’s homes in Rajasthan. When I discovered the organisation accepts volunteers you could not hold me back! I wanted to do something worthwhile and interesting and having spent four months backpacking in India it is top on the list of my favourite travel destinations. I love the culture, history and mix of religions.

The volunteer programme has been developed for many reasons. Jaimala believes that volunteers from different countries bring different energy, culture and colour to the rehabilitation programme for children. The ethos is about sharing and learning from each other and living as part of a community. This is reflected in the work of an international advisory committee which has recently been established to encourage the exchange of ideas and practice.

Udayan is Vatsalya’s ‘Children’s Village’. At the moment it is home to 56 children but since it began in 2002 it has accommodated over 200 children. It is in a rural area 40km north of Jaipur in Rajasthan. The land was donated by a Dutch organisation and is a large walled area approximately five hectares in size. The children at Udayan are privileged in the amount of space they have. The accommodation takes the form of dorms for 12 children with a residential staff member in a room adjacent. From a European perspective there is not much privacy but it seemed that the children would not have enjoyed having their own rooms as they were used to being and sharing with others. This

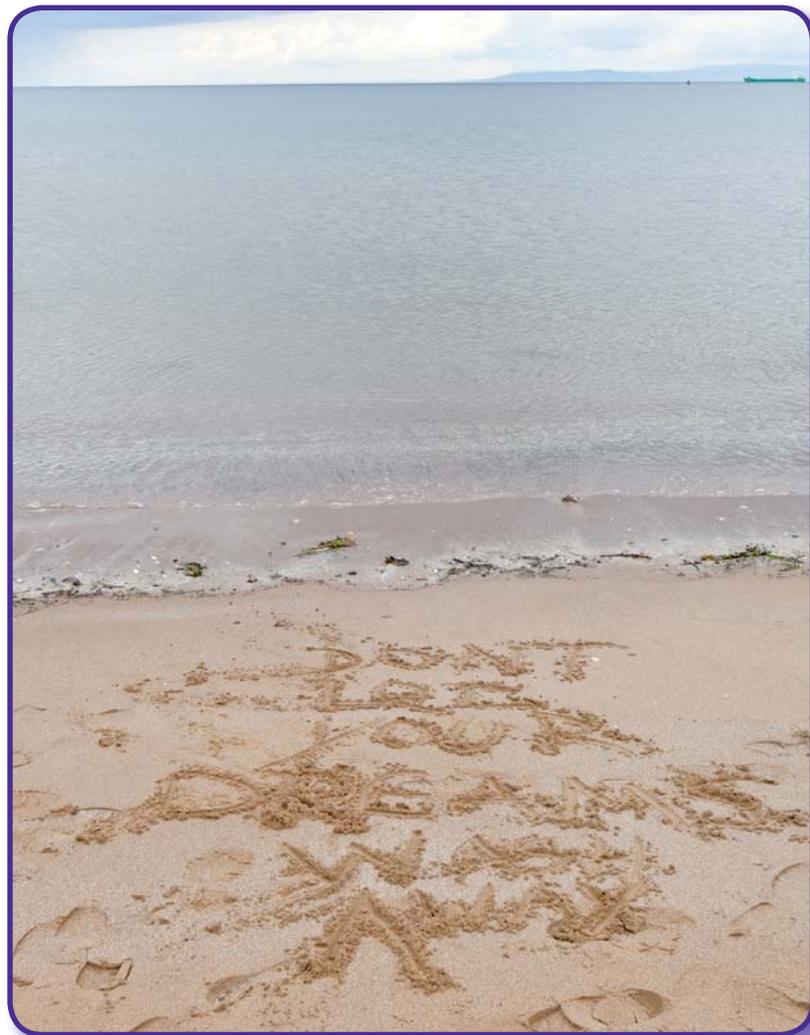
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is in contrast to how things are in Scotland where a very high value is placed on children and young people in residential care having their own space.

There were other significant differences to residential care in Scotland. When they have free time the children love to be playing outside and running around. They were not demanding of adult attention and the staff did not appear to be keeping a very close eye on them knowing that the environment was safe and secure. This is in contrast to the more risk-averse culture within our own child care system. The living conditions were basic.

Electricity was erratic, usually non-existent through the day and no showers - only buckets of water to wash with. They did however have Sky TV and a couple of laptops courtesy of donations. The children did not have many possessions and their clothes were donated mostly from overseas.

All children have their chores and responsibilities and are expected to contribute to the community. The older children help to look after the younger ones. Some of the older children were able to stay on in the community where there were jobs for them, for example working as



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teachers, helping on the farm or running the bakery. They see the orphanage as home and are welcome to come back and visit after they leave. The staff obviously genuinely cared about the children and their commitment was a positive constant in the children's lives. Perhaps there are things that we can learn about throughcare and aftercare from this setting.

Unlike Scotland, there is less of an emphasis on staff qualifications. Staff in Vatsalya are chosen because they are at a time in their lives when they can put the children first. Many of the staff live permanently at the children's village.

The children appeared to be happy and any frowns did not last long: they were quick to smile and laugh and very respectful to adults. I wondered why, considering the terrible backgrounds of neglect and abuse most of them came from. Is it because they have fewer expectations and actually are grateful for what they do have? Could it have something to do with their culture where meditation is an important part of their lives? Each day starts with yoga or breathing exercises for all children and staff in the meditation hall and ends with a group meditation when the sun goes down. This is not related to any specific religion but is for the development of peace and compassion. It is also clear that their own resilience, together with the support and love they receive at Udayan, helps the children to develop and grow and gives them some of their childhood back.

I felt honoured to have been there and share in the lives of these children and came away feeling truly inspired and hopeful for the future. One woman had a dream to change the quality of life for street children in India. I saw what she has created and what can be done if you have the determination. It may not be possible to help all 18 million children who live on the streets in India but over time it might be surprising how many lives have been changed for the better by the good work that Vatsalya does. It is interesting to consider what residential child care services in Scotland can learn from such a setting.

W Working Against Discrimination

WORKING AGAINST DISCRIMINATION: ANTI-RACIST PRACTICE AND RESIDENTIAL CHILD CARE

is for...

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Promoting anti-racist practice is the responsibility of all staff involved in residential child care across Scotland. Like other aspects of social work and social care practice, residential child care is governed by a distinct set of values which demand a commitment to anti-oppressive practice and social justice. Despite this, I often hear staff saying that 'racism is not an issue as we don't have any black or minority ethnic children in our units'. This is not a legitimate position: the national care standards state that all staff must show a commitment to promoting equality and diversity across the sector. Anti-racist practice is also essential to fulfilling our legislative requirements. The Race Relations (Amendment) Act 2000 states that all public authorities 'need to eliminate unlawful discrimination and be expected to consider the implications for racial equality of all their activities' (Miller and Gibb, 2010, p 10).

While the definitions of racism are numerous and complex, Chakrabarti (1990, p 74) describes racism as 'a set of beliefs or a way of thinking within which groups identified on the basis of real or imagined biological characteristics (skin colour, for example) are thought necessarily to possess other characteristics that may be viewed in a negative light....'

Racism is a multi-faceted issue that can take many different forms, taking place on a personal, cultural and structural level (PCS analysis, see Thompson, 2006). Racism on a personal level relates to the discriminatory attitudes held by an individual and the actions which may arise from this. An example would be the use of offensive or discriminatory racist remarks. Cultural manifestations of racism are concerned with the dominant belief systems that exist about what is assumed to be 'good' in a society (such as customs, religions and language) while simultaneously devaluing the cultures of minority groups. On a structural level, discrimination and oppression are recognised as being 'sewn into' the fabric and institutions of society and minority groups are disadvantaged by the continued existence of these institutions.

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The effects of racism on children and young people's development are well documented. Children from minority ethnic groups are more likely to experience bullying and this can often include elements of violence as well as racist name-calling (Barter, 1999). This can lead to diminished confidence, feelings of failure, withdrawing from others and increased feelings of fear and anxiety. Studies have demonstrated that children in residential child care from minority ethnic groups are more likely to have poor self-esteem as a response to a lack of positive racial identity attitudes (Robinson, 2000).

While Scotland is often portrayed as a friendly and tolerant country, racism remains a significant concern. Figures released by Strathclyde police show that there were 1,853 racist crimes reported in 2008 compared to 1,259 in 2002, an increase of 20% (Scottish Government, 2008). This acknowledgement of a recorded increase may be due to a growing awareness of racism but may also be due to the fact that Scotland has, over the last few years, seen an increase in the number of refugees, European migrant workers and asylum seekers who come to Scotland and experience racism. Studies have shown that 24% of the Scottish population felt it was justified to verbally attack asylum seekers who get housing and benefits in Scotland and 63% agreed that people from other cultures or ethnic backgrounds living in Scotland expected too much from the government (NFO Systems Three, 2001).

This has significance for the residential child care sector who are now charged with caring for an increasingly diverse group of young people, including unaccompanied asylum seekers. This term refers to those young people who arrive without a parent or other relative. These young people have often experienced traumatic events in their countries of origin, including war, political circumstances and the death or persecution of family members. Their journeys to Scotland may have been equally traumatic. Meeting the specific needs of this group are complex and challenging: they will have universal needs in accordance with their status as 'children' (e.g. physiological and safety needs); however, as unaccompanied asylum seekers, their needs are such that they may require additional support in relation to legal circumstances, adapting to a new/strange environment, the requirement for interpreters and issues of loss and trauma (Hill and Hopkin, 2006). This is encapsulated in the quotation below which reflects the experiences of a health worker supporting unaccompanied asylum seekers:

The ones that I've met and heard most direct accounts of ...they've been in a conflict zone and there's been a devastating event. Now, their experience of war or traumatic

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experience of other kinds have been very variable prior to the devastating event but it was usually something like soldiers coming into their family and setting fire to their house or capturing other family member or they themselves being captured and trafficked or sometimes given up to traffickers by family members trying to protect them or make money (Hill and Hopkin, 2006, p 34).

Residential child care staff, like all those who work in care services, need to be aware of the existence of racism and its potential impact on young people: this means being able to recognise and challenge our own attitudes and possible prejudices if we are to meet the ethical, professional (and legal) demands of the job. Equipped with respect for differences in ethnicity and cultural backgrounds will allow workers to be in a better position to offer authentic care for all children as well as attempting to provide a care environment which is as inclusive as possible and free from further oppression.

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X

SeXual Abuse

IMPACT OF SEXUAL ABUSE

is for...

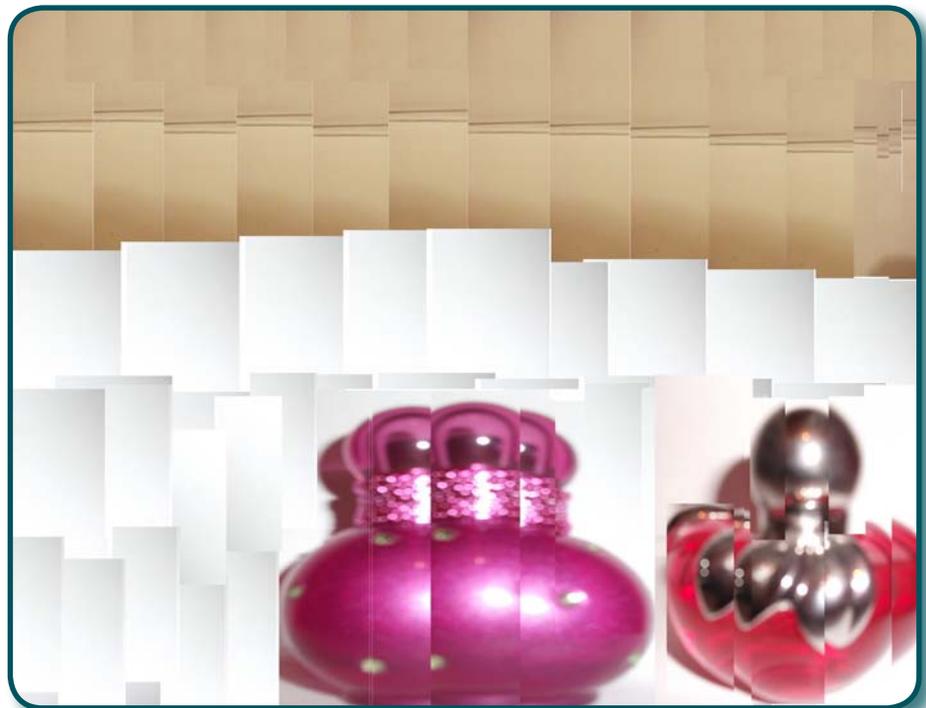
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The impact sexual abuse has on children and young people will differ for every child. There are, however, certain behaviour traits or signs and symptoms which may assist us in recognising when a child may have been sexually abused.

Signs and symptoms vary amongst children and young people and may be affected by their

cognitive abilities or the existence of a physical disability. Children with physical and / or learning disabilities are often targeted. This may be because they often need the assistance of a large number of adults particularly for their personal care. Their disability may leave them feeling trapped in a situation that they cannot physically flee from and where they are dependent on those who are abusing them (Marchant, 2001).

Signs and symptoms may present in very different ways. For example, some young people may smear faeces around their room or avoid showering in an attempt to repel any future abuse, while other young people become obsessive about scrubbing themselves clean. Often young people may harm themselves or misuse alcohol or illicit substances. In some instances young people have also attempted suicide (Corby, 2006).



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Disclosing sexual abuse is difficult in itself and the consequences of doing so may put additional pressures on the young person. In many cases of abuse within the family home disclosure results in the child's removal. As this is one of the common threats that perpetrators make, the young person may believe that all of the other threats that the perpetrator made will now come to fruition. Threats that if they tell anyone the perpetrator will move on to abusing their siblings or kill them are common. Fear of these threats being acted on can explain why some children later retract their allegations. In addition some young people come under pressure from others in the family to retract their disclosure.

Coming into your unit means that the child needs to adapt to living with strangers, possibly in a new area, and they may have to attend a new school. They may experience isolation from their natural support networks of family and friends, and this has to be balanced against the protection from further abuse.

Sexual abuse of children is extremely complex as the impact it will have on a child may depend on the relationship they had with the perpetrator, the age of the child, their understanding of the abuse and the manner in which the perpetrator groomed the child. Child sexual abuse by female perpetrators is now becoming more apparent, although there continues to be some denial of its existence and female perpetrators tend to receive more lenient sentences. This may be linked to the societal image of women as 'nurturer' and 'protector' which prevents a more widespread acceptance of the possibility of female abusers. Their role as primary care-giver, involved in personal care tasks, makes it easier for women to conceal their activities, as the child may not be able to distinguish appropriate and inappropriate touch in this context. All of the above makes it more difficult for children to disclose the abuse of a female perpetrator (Elliot, 1994).

Although more recently it has been easier for boys to disclose sexual abuse, it still remains difficult. For example, if a boy was sexually abused by a woman when he was 14 and the woman was 35 some people may wrongly see this as a 'rite of passage into manhood'. It is often much easier for society to identify a sexual experience between a man of 35 and a girl of 14 as sexual abuse. Therefore, boys experience difficulty in disclosing, as some members of society are unable to recognise this as sexual abuse.

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Another difficulty boys may have is if they have experienced physical arousal during a sexually abusive experience with a man. They may then begin to question their own sexuality and be confused about the sexual abuse. Similarly if a girl experienced some form of arousal she may also begin to question if this was abuse or if she in fact wanted this to happen. It is important that workers are able to explain to children that a robot could have touched them in that way and their body would have had that physiological reaction, and it is not that they asked for this to happen. The young person needs to know that physiological arousal in response to abusive stimulation is not, in itself, any indication of sexual orientation. The development of a sexual identity is a complex process itself, and young people who have been abused may need additional support in exploring and understanding their own sexuality.

An issue for some survivors of sexual abuse is that although they have disclosed abuse, the perpetrator is then not brought to justice through the criminal justice system. This can be extremely difficult for the young person to accept. It can be even more difficult if the perpetrator dies, as some children believe that they will come back to haunt them and have very disturbed sleep patterns and extremely high levels of anxiety.

There are two key points of good practice that come from the voices of young people who have been abused. First, always be careful not to intrude into the child or young person's personal space. Secondly, the two most important messages that survivors have told us that helped them overcome their pain are that we believe them and that they are not to blame.

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y

Involving Young People

INVOLVING YOUNG PEOPLE IN
LEARNING AND TEACHING

is for...

Janie Fraser
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Where did the idea come from?

SIRCC is funded by the Scottish Government to run an extensive programme to deliver the HNC in Social Care (subsequently referred to simply as the HNC) to residential child care staff in Scotland.

Course development discussions in 2009 raised the possibility of involving young people in the delivery of learning and teaching. With the growing acceptance in literature that participatory activities are beneficial to young people (Kirby 2004; O'Quigley 2000) as well as an effective way of bringing about sustainable cultural change in practice, we felt the participation of young people was becoming increasingly important.

Young people's participation is a right promoted under Article 12 of the *United Nations Convention on the Rights of the Child*. Rather than being passive recipients of adults' views, according to Lundy (2006), children need to be encouraged and have opportunities to vocalise their thoughts in a safe space. By inviting the young people into the college we were creating a neutral and safe learning environment for them and the students to listen and learn from each other. While we hoped that the young people would find the experience positive, we were aware that talking about their own experiences might be difficult at times. They were given help to prepare for the day and treated with sensitivity by the teacher bringing them in and the students participating in the event.

It was expected that both the students and the young people would gain from the involvement of young people in teaching and learning. Students will benefit from learning about topics from another perspective: the perspective of those on the receiving end of the care being provided. They will also see participation in practice – in a fairly new area. This will give them direct, practical experience of the 'participation' which has been so strongly emphasised in national policy. Crucially, they would experience the benefits and importance of listening to young people in a new way.



To ensure the experience for young people was valuable and not tokenistic, discussions took place with colleagues at Who Cares? Scotland who helped develop the programme in a way that ensured benefits for the young people, including learning new skills.

What did we do next?

Next, we had to decide on which units of teaching were most appropriate for the children to participate in. Again working with Who Cares? Scotland, it was felt that the Social Care Theory for Practice unit would be best with the teaching sessions concentrating on:

1. Social care values
2. Care programming.

For the students, being able to understanding the importance of participation in this process is vital, so who better to hear this from than the young people themselves? 'When involving children in making decisions about their own care and services it is necessary to understand their perspective of the world, their experiences, feelings and views.' (Kirby et al., 2003)

What happened on the days?

To date there have been five teaching and learning days: three looking at initial care programming and two involved with values. Although all involved were looking forward to the first session, on the day everyone was considerably apprehensive.

Prior to meeting, students were anxious, with one stating 'I feel quite nervous about this'. The two young people were also obviously nervous with one young women complaining about feeling physically sick. After being reassured by her support worker that she did not need to go through with it, she took a deep breath and said 'let's go for it'. The young man taking part was quiet, had his head down and made little eye contact but when asked, assured us that he was fine.

The young people were introduced, the aims of the session were outlined and the session was underway. The young people were initially quiet and allowed the students to do most of the talking. As they relaxed into the session they became more vocal and addressed some of their feelings and beliefs about their role in their care plans. They challenged some of the students' views regarding what should and should not be included in care plans and why.

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The next three sessions looked at values and as the young woman was unable to attend due to personal reasons, were led by the young man. With each session, he grew in confidence. His communications skills improved, he became more assertive and was clearly 'getting a buzz' from the session.

Although being quite clearly challenged on their views and values, student feedback was also positive. One student commented "no offence, Janie, but this has been the best day yet, I really got a lot from this."

Another student was going back to discuss how care plans are used in her workplace and to find out if they could incorporate some of the ideas the young people had discussed. One idea was that the care plan be about the 'here and now' and that historical information about their background and previous behaviour be recorded elsewhere – this way they were not being continually reminded of the things that had gone wrong in their lives.

Although early in the development of these sessions, feedback indicates that there has been a positive impact on both students' learning and the young peoples' self-confidence and esteem.

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Z

Zip & Vigour

ZIP AND VIGOUR: HEALTHY CARE

is for...

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The positive benefits of good diet and exercise cannot be underestimated in the lives of children and young people. Just as a good parent would endeavour to ensure that their child had all the advantages they could bestow in order to equip them for a full, healthy and happy life, so will residential child care workers want to ensure that the young people in their care are similarly nurtured. *The National Care Standards* make reference to 'Eating Well' and 'Keeping Well'.

We cannot fail to be aware, as adults, of the importance of both good diet and exercise. The media constantly bombards us with information on obesity, diet, fitness and food fads. However the importance of both a nutritionally rich and diverse diet and physical activity in the lives of young people has a plethora of other benefits. Not only for the impact on their physical well-being, but also for the positive effect that it can bring on a variety of other levels, including improved educational performance, behavioural improvements and better mental health (Bellisle, 2004).

So what are the specific benefits to children and young people in general?

The proven benefits to young people in taking regular exercise and having a healthy diet are too numerous to cover in this short chapter. However, some of the benefits include: increased energy levels, improved immunity to illness, reduced risk of serious disease, stronger muscles and bones, improved sleep patterns, increased life expectancy and better quality of life overall. Other benefits of exercise specific to children include a constructive channelling of excess energy, self-expression and more importantly – fun!

Recent media attention has also focussed on the 'obesity' epidemic in the UK and there is no doubt that the combined benefits of good diet and exercise also aids in combating obesity (Dixey & Wordley, 2010). This in turn can prevent obesity-related illnesses, such as cancer, diabetes and heart disease in later life. Research increasingly suggests that adult resilience to disease is closely linked to good nutrition in childhood.

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And what might the specific benefits be to young people in residential child care?

As already illustrated, there are a numerous benefits to children and young people in a healthy life-style, involving both diet and exercise. But there are other benefits, which may be of more specific use to children who may have experienced abuse, neglect, trauma, loss and many other challenges. Readers will be aware that some of the young people in residential care have experienced or are still experiencing very stressful life-events, some of which can lead to high levels of tension, depression, anxiety and mental health problems (Lader & Melzter, 2005).

Learning to relax and 'let go' of their worries can be a challenge for some of these children and as well as therapeutic interventions and day-to-day emotional support, strategies for improving diet and exercise can be very helpful.

Current research suggests that exercise can significantly assist in relieving anxiety and is also linked to decreases in depression. The current recommendation for children in the UK is one hour of exercise a day, in order to maintain physical health. However a commitment to supporting regular exercise in the lives of young people in care may offer significant benefits over and above the physical, in working towards more relaxed, happier and more emotionally resilient young people.

There may be other benefits in different kinds of exercise as well. Non-competitive forms of exercise, such as yoga, which focuses on gentle stretching with slow and gentle breathing, can help induce a relaxed state, release physical tension, calm nervousness and can be especially beneficial for children who are hyper-vigilant or anxious. It may also help them feel grounded in the moment, just experiencing sensations in their body (in a safe way), rather than being focussed on distressing thoughts. There are other types of benefit that can come through vigorous physical activity. For example, young people feeling angry/frustrated might benefit from releasing pent-up emotions physically in a safe way, and therefore releasing tension/emotion before it escalates.

Low mood can also be supported by diet and links have been made between junk food and low mood. Conversely a balanced, healthy diet has been shown to provide improvements in mental health. There are also well-established links between dips in mood and diet. Young people prone to mood swings or depression might very well benefit from foods which release energy slowly over a longer period of time, rather than the documented quick highs, followed by low mood and lethargy which can be brought on by processed foods or refined carbohydrates (Geary, 2004).

Conclusion

It is important in these areas of care that staff do not just tell children what is the right thing to do but get involved with them and become a good role model in terms of what they eat and by participating in physical activity with children and young people. A holistic approach to improving health in these and other areas has been developed for schools through the Health Promoting Schools initiative:

‘Health promotion in schools is not just about encouraging children and young people to eat well and to exercise; it encompasses a much broader holistic approach. This approach is called the ‘whole school approach’, which includes promoting the physical, social, spiritual, mental and emotional wellbeing of all pupils and staff.’

It might be a very positive way forward if residential services were to commit themselves to developing an over-arching ‘health promoting unit’ approach by building on the work that is already being done in schools.

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- Health Promoting Schools: www.ltscotland.org.uk/healthpromotingschools/index.asp

Further Reading

- Change 4 Life - www.nhs.uk/change4life
- How Food Benefits Mood - <http://news.bbc.co.uk/1/hi/health/2264529.stm>
- Physical Activity - http://hcd2.bupa.co.uk/fact_sheets/html/exercise.html

Photos...

The photos used throughout this publication were taken by young people from the Voice of Reason group in Aberdeen and Who Cares? Scotland*. Over the course of a residential weekend, the young people were asked to see the world through different eyes, using photography, to reflect on their journey through care. Some of these pictures are now part of a Scotland wide exhibition which began touring in November 2010.

Lisa

'Life is different now am settled. I can move on and enjoy the things that make me happy and make me the person I am.'



Feeling alone
Page 8



My favourite bear
Page 25



Perfume montage
Page 71

Fraser

'A lot of young people in care have very little; the few possessions and clothes are, in most cases, their life.'



Panoramic of the team
Page 15



Panorama
Page 40



Droplets
Page 46



Looking up
Page 32

Alex

'The hopes and goals of young people in care can get washed away.'



First excursion
with the camera
Page 43



Don't let your dreams
wash away
Page 66

Murray

'I'd sit in my room and play guitar... Music was an escape from being in care.'



Fooling around
Page 57

Jordan

'What can you do to stop shattering young people's hopes and dreams?'



Shattered
hopes
and dreams
Page 61



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A - Z of Residential Child Care

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