In Residence

SIRCC

Scottish Institute for
Residential Child Care

This re-issue of 12 papers written over a period of six years has been produced to celebrate SIRCC's 10th anniversary – the organisation launched in April 2000. I'd like to express my appreciation to all the authors, who are drawn from SIRCC staff and residential practitioners currently working in various settings. The papers are circulated free of charge to all Scotland's residential homes and schools, and are available for download on our website. A recent survey told us that the papers are valued by those who read them, although that survey also prompted us to look again at how we promote them, and try to make sure they don't get stuck in a manager's office!

This re-issue has been substantially augmented with material for supervisors linked to each of the papers. We hope this will help workers look at how they can transfer the learning within the paper into practice, with the help of their supervisor. We have also asked subject experts to review the earliest papers and add their own foreword which provides a reflection on the original.

The idea behind the *In Residence* series of papers is quite simple, though not straightforward; it is to provide ideas about residential practice based on current research. It is not straightforward because the skills involved are in some ways quite diverse. To produce a useful 'practice paper' requires research skills on the one hand; seeking out reliable resources and summarising key findings. On the other hand it is also essential to have papers written by those who have first-hand knowledge about what it is like to be a residential worker. Practice papers do need to have credibility with the intended audience. The aim of this series is to help workers transfer the chunks of learning that are contained within the pages, into practice 'on the floor', as we say in residential work. If we are successful in that aim then the papers will also be useful to those responsible for training residential staff and managing them.

In recent years there has been a strong emphasis within social work and social care services on working in ways that are 'evidence-based'; to try to get people concentrating on doing 'what works' rather than just doing things as they have always been done. We hope, and believe, that these papers make a sound contribution to that endeavour.

The idea for the *In Residence* series came from Kirstie Maclean, the first Director of SIRCC, and she led by example in producing the first edition which was called 'Resilience'. The papers were initially released on an occasional basis; whenever Kirstie could persuade one of her colleagues to produce something. However since 2006 the responsibility for producing a more regular series has lain with Irene Stevens, who is based in the SIRCC national office. Irene is herself an active researcher who has produced many academic publications, but she is also passionately committed to the residential task and equipping workers to tackle the many challenges of their day-to-day work. Irene's role with the *In Residence* series has been to identify key topics and work with authors to produce the final product. This re-issue is thus a testament to her drive and effectiveness. I think that the series provides easily accessible material that both stretches and supports those who want to work in a more 'evidence-informed' way.

SIRCC's main remit is to provide training, research and consultancy to the residential sector. Books and journal articles produced by the academic staff play their part as well. Irene and I share the belief that if we can produce effective practice papers they will constitute an important SIRCC legacy. This re-issue celebrates, and hopefully delivers on, that aspiration in terms of the last ten years. We aim to continue responding to key practice issues and keep producing them in the years ahead.

The original papers and this re-issue package are also available on the SIRCC website (www.sircc.org.uk).

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FOREWORD

Contents

CONTENTS

Foreword

There are many aspects to this paper which are still relevant to current practice. While some may object to the use of language such as 'delinquent group', there are many aspects of this paper which assist us in understanding resilience in children.

In relation to activities, hobbies and useful tasks Maclean highlights that 'it is important to do a risk assessment but bureaucracy or over-protectiveness should not be allowed to prevent looked after young people from getting involved in the kinds of activities that many children living in their own homes take for granted.' The *Playing It Safe* report (McGuinness et al., 2007) and the practice guidance paper *Go Outdoors!* (SCCYP, 2010) echoes the above concern that within residential child care there continues to be a tendency for a risk-averse approach and many children are being denied the same opportunities for outdoor play as their peers.

Maclean highlights the work of Baldry and Kemmis (1988). Their sample showed that one in three children who had no contact with their birth family had no photos or mementos to assist them in relating to their birth family. This highlights the importance of life-story work with children. While in practice this may be difficult when there is a lack of such photos from a child's birth family, this highlights the need for residential practitioners to build up photos and items for a memory box.

Maclean discusses "meaningful roles..such as caring for siblings and domestic responsibilities, provided they are not excessive...are likely to have appositive effect in several ways." The key point to note here is "providing they are not excessive"; however, in reality there are many children who are taking on excessive responsibilities for their siblings owing to contemporary issues around parental substance misuse. For such children the tendency to assess them as having great resilience should be balanced with a real examination to make sure the child is not masking the true situation and perhaps not fully coping. In practice this appears to be the situation for many children who are living with parental substance misuse. The Hidden Harm Report (Advisory Council on the Misuse of Drugs, 2003) assists us to have a better understanding of the negative impact of parental substance misuse on children. When we examine the high number of children on the child protection register under the category of neglect, this is often owing to parental substance misuse and this is growing problem for residential child care practitioners. Such children are often assessed as having tremendous resilience, perhaps owing to them having at least one positive attachment figure who has assisted them during the times of adversity within their birth family. However, it may indeed be that they have become extremely skilled at masking their true emotions and appear as resilient.

Overall, Maclean's paper on resilience continues to be extremely relevant to today's practice and assists practitioners to understand resilience and assist young people in not only recognising resilience but how to build on the foundations of resilience to assist young people in building on their strengths, in order that they can overcome the adversities that they may have faced.

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- Scottish Commissioner for Children and Young People. (2010). *Go outdoors!* Glasgow: SIRCC.

RESILIENCE

Resilience

What it is and how children and young people can be helped to develop it.

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Introduction

The term resilience has become fairly commonplace in residential child care in the last few years but staff are not necessarily clear how to help children and young people become more resilient. This briefing paper aims to assist the development of a positive and hopeful resilience perspective and to provide some pointers as to how it might be put into practice. Obviously a short briefing paper cannot provide comprehensive information and advice and readers are urged to follow up their interest through accessing books and articles in the bibliography, attending a training course, or seeking consultancy and advice. SIRCC can provide all these services.

Resilience Explained

There are many definitions of resilience but most have similar components. Gilligan's (2000) definition – 'a set of qualities that helps a person to withstand many of the negative effects of adversity…….Bearing in mind what has happened to them, a resilient child does better than he or she ought to do' – is one of the more straightforward. Most authors consider that resilience is a mixture of nature and nurture. Attributes that some children are born with, such as good intellectual ability and a placid, cheerful temperament, are associated with resilience. Children who are born prematurely and/or with disabilities, who cry and cannot be comforted, who cannot sleep or who will not accept being held are more vulnerable to adversity and may be less likely to be resilient.

There are, however, many other qualities associated with resilience which develop through children's life experiences - the main ones can be summarised as follows:

- Good **self esteem** derives from being accepted by people whose relationship one values and from accomplishment in tasks one values. Praise, on its own, will not improve self-esteem; the child him or herself has also to ascribe value to the achievement.
- A belief in one's own **self-efficacy** means having the qualities of optimism, 'stickability' and believing that one's own efforts can make a difference. For children and young people who have had very damaging childhoods the creation of 'survivor's pride', i.e. the ability to value how far they have overcome huge adversity in their lives, is helpful. Young people's sense of self-efficacy is enhanced by taking responsibility and making decisions.
- **Initiative** is the ability and willingness to take action, including action to stop abuse occurring. Children and young people facing adversity are in a stronger position to deal with it if they are able to take the initiative in finding 'creative' responses. This sometimes combines with a strong sense of responsibility towards others such as siblings.
- **Faith and morality** can be described as 'a belief in a broader value system (which) can help the child to persist in problem solving or in surviving a set of challenging life circumstances. A sense of coherence in their experiences gives the child a feeling of rootedness; the conviction that life has meaning and an optimistic focus' (Daniel, Wassell and Gilligan 1999).
- **Trust** is believing in or relying on another person or thing. In order to trust others, you do not need to love them but you do need to experience them as reliable, feel respect for them, value them and not expect them to betray your confidences.
- **Attachment** is 'an affectionate bond between two individuals that endures through space and time and serves to join them emotionally' (Klaus & Kennell 1976, quoted in Fahlberg 1994). A secure attachment relationship creates a secure base from which a child feels

safe to explore the world. Many looked after children whose primary attachment figures have been unsupportive or unpredictable are able, fortunately, to find other attachment figures. In fact, one sign of resilience in children is the ability to 'recruit' caring adults who take a particular interest in them. This could be a neighbour, friend's parent(s), teacher, child minder, relative, mentor or befriender, foster carer or, of course, residential worker.

- The concept of a **secure base** originally related to the security provided by a dependable attachment relationship. However, in the context of looked after children it has developed a wider meaning i.e. the provision of a consistent and stable place to live and continuity of wider relationships which then allow the maintenance or development of attachment relationships. Where placement moves are absolutely unavoidable, strenuous efforts should be made to maintain continuity in other aspects of children's lives.

- **Meaningful roles:** Such roles include proficiency at academic and non-academic activities at school, sporting prowess, part time work, volunteering, caring for siblings, and domestic responsibilities, provided they are not excessive. Such roles are likely to have a positive effect in several ways – they can be beneficial in providing a sense of positive identity and a source of self-esteem, they may act as a source of pleasure and hope or distract young people from the adversity they are experiencing in other areas of their lives.

- **Autonomy** means the ability to make decisions. Young people who are autonomous know that it is OK to make mistakes and that you can learn from mistakes. They take reasonably well calculated risks. Autonomous children and young people are good at self-regulation – they gain increasing control over their own emotions and behaviour.

- **Identity:** Young people in care have a deep need to know and understand who they are, where they belong and to whom they are important. They may need help to find these answers. Children and young people's ethnicity, religion, culture and language form part of their identity. Preservation of their background and culture helps to create continuity and a secure base; it is also a legal right.

- Young people who have good **insight** into their own difficulties, including a realistic assessment of their own contribution and the contribution of others to those difficulties, are more likely to be resilient. Young people who are able to recognise benefits, as well as negative effects, from severe adversity are likely to be resilient. Insight helps people to take appropriate actions and make appropriate choices. It is therefore linked to self-efficacy and to initiative.

- **Humour** is the final building block of resilience. It can help young people to distance themselves from, and therefore reduce, emotional pain and it can also help them make and sustain relationships – humorous people are usually popular people. It may even be the source of a career.

Resilience Explained...

What are you doing to develop each of the core elements of resilience with the young people you work with? Think about each of the core elements in regards to the young people you work with. Examples of questions include:

- Do we give to young people opportunities to take responsibility and make decisions?
- To support the development of initiative, do we support young people to do things for themselves, as opposed to doing things for them?
- In regards to attachment, do we know who the young people's attachment figures are? (Who are their anchors?)
- How do we give meaningful roles or maintain young people's meaningful roles?
- Humour is important, however we need to ensure young people feel we are laughing with them and not at them. How do we do this?

Assessing Resilience

In order to develop a child or young person's resilience, it is important to know how far they have the above qualities i.e. where their current strengths and deficits lie. A number of authors, such as Daniel, Wassell and Gilligan (1999) and Grotberg (1997) have developed helpful assessment frameworks. Grotberg drew together the findings of an International Resilience Project which surveyed almost 600 children and their families in 30 countries. She found that the following aspects of resilience were relevant, to varying degrees, in all cultures:

I HAVE	I AM	I CAN
Trusting and loving relationships with others: parents, siblings, teachers, friends.	*Loveable:* the child possesses, or is helped to develop, qualities that appeal to others.	*Communicate:* the child is able to express feelings and thoughts, and listens to those of others.
Structure at home: clear rules and routines, comprehensible and fair sanctions when breached, praise when followed.	*Loving:* the child is able to express affection to others, and is sensitive to their distress.	*Solve problems:* the child can apply themselves to problems, involve others where necessary, and be persistent.
Role models: parents, other adults, peers, siblings, who model good behaviour and morality.	*Proud of myself:* the child feels they have the capacity for achievement and resists discouragement.	*Manage my feelings:* the child knows and understands emotions, recognises the feelings of others, and controls impulsive behaviour.
Encouragement to be independent: people who offer praise for growing autonomy.	*Responsible:* the child accepts and is given responsibilities, and believes that their actions can make a difference.	*Understand my temperament:* the child has insight into their personality and that of others.
Access to health, education and social care: consistent direct or indirect protection for physical and emotional health.	*Hopeful and trustful:* the child has faith in institutions and people, is optimistic for the future and is able to express their faith within a moral structure.	*Seek out trusting relationships:* the child has the ability to find people - peers or adults - in whom they can confide and develop mutual trust.

Table 1: Promoting resilience – action model (adapted from GROTBERG 1997)

This is a model that could be used with children and young people to help them consider their own resilience and the areas they might work on with you.

Assessing Resilience...

How could you use this table as an exercise / assessment?

Could you complete the assessment for the young person; complete it as a team; ask the young person to complete it with you; or ask them to complete it by themselves? There are many ways. Each may be different in each situation; however, it is interesting to discover where differences are. We can all appear different to different people and in differing situations. In order to work with a young person we must understand their perspective, as well as our individual and team perspective. We are working with what they believe, not what we believe.

Building Resilience

There is an increasing amount of research and practice literature on how resilience can be built. A small amount relates specifically to looked after children but much of it more generally to vulnerable children and/or children in adverse circumstances. The main building blocks described are:

- Resilient children are often those in receipt of social support. The term support is very widely used in social work but it is not always clear what practitioners mean by it and how well it is provided. Richman, Rosenfeld and Hardy (1993) helpfully suggest that social support takes eight distinguishable forms: listening support (just listening, not advising or judging); emotional support; emotional challenge (helping the child evaluate his or her attitudes, values and feelings); reality confirmation support (sharing the child's perspective of the world); task appreciation support; task challenge support (challenging, stretching, motivating); tangible assistance support (money or gifts); and personal assistance support (e.g. driving the child somewhere). Research undertaken by Richman, Rosenfeld and Bowen (1998) with disadvantaged school children found that those who regularly received the different types of social support were doing better in school on a variety of measures than those who did not receive them. The only type of support that did not appear to make a difference was tangible assistance.
- Many authors stress the importance of education and attainment for building resilience. Borland et al (1998) in a research summary concerning the educational experiences of looked after children stated:

'Schooling may be vital in enabling children to make the best of adverse circumstances like being in care, both through offering opportunities for academic success to compensate for the "failure" in family life and in affording access to alternative supporting relationships – with teachers and with peers ….. schools also offer opportunities for children to learn coping styles and gain a sense of self worth'.

The different outcomes in adult life between those looked after children who do well in school and those who do not is startling. Jackson and Martin (1998) in their comparisons of adults who had been in care who had achieved well educationally and a comparable group, in terms of their experiences of adversity, who had not done well educationally found the following outcomes:

	HIGH ACHIEVERS	COMPARISON GROUP
Unemployed	2.6%	72.7%
Single mothers	3.8%	41.7%
In custody	0%	18.2%
Homeless	2.6%	22.7%

Table 2: Educational achievement and adult outcomes
(adapted from JACKSON and MARTIN 1998)

It seems clear that educational success is a major tool in promoting resilience. However, recent research in Scotland (Dixon and Stein 2002) showed that only 40% of care leavers gained any Standard Grades at all. There is also, fortunately, evidence that success in non-academic subjects at school, such as sport or music, or social success, such as being popular, provided it is not popularity with a delinquent group, can also lead to resilience. In 2003 the Scottish Executive intends to publish quality indicators for assessing the educational richness of residential units and foster homes. It is important that residential staff use these indicators to try to improve the educational outcomes of the young people they look after.

- There is a growing body of research that shows that participation in activities, hobbies and useful tasks promotes resilience. For instance Mahoney (2000) found that young people who participated in extra-curricular activities at school were less likely to drop out of school early and less likely to be arrested for crimes than their fellow students who did not participate in activities. Other studies have found that adolescent work experience, provided it is not for long hours in stressful, dead end jobs, can help adolescents to develop a sense of self-efficacy and self-confidence and to acquire the skills and abilities required for successful transition to adulthood. There is a huge range of activities, hobbies and useful tasks in which looked after young people can be involved – these can be school based, community based, faith based, employment based, or based in the residential unit itself. Sometimes staff can be concerned about the risk to the child, or to other people, of participation in some activities. It is important to do a risk assessment but bureaucracy or over-protectiveness should not be allowed to prevent looked after young people from getting involved in the kinds of activities that many children living in their own homes take for granted.
- Gender has an effect on resilience. Pre-adolescence, girls are more resilient than boys but the situation reverses in adolescence. Different characteristics of the home environment are particularly protective for girls and boys. Girls benefit from an absence of over-protection, an emphasis on risk-taking and reliable emotional support. Boys benefit from greater structure and rules, adult supervision, the availability of a positive male role model and encouragement of emotional expression.
- In order for children to receive social support, develop trust, develop attachments and build a positive identity they need to remain connected to key figures in their lives. This will often include parents, step parents, siblings, grandparents, aunts, uncles, cousins, godparents, close friends, neighbours, past carers, past teachers and past youth leaders. Sinclair and Gibbs (1998) state, in relation to children in residential care: 'A system which provides them with a variety of adults to whom to turn is less likely to fail them than a system in which they are dependent on one'. For children who cannot have contact with close family members, the concept of family may need to be broadened, e.g. to include a befriender. Even where face-to-face contact is not appropriate, it is essential that children are helped to have a good knowledge and understanding of their family circumstances. Baldry and Kemmis (1998) found that over 20% of looked after young people in their sample did not have contact numbers and addresses for family and friends with whom they wanted to stay in touch. One in three did not even have photos or items to remind them of their family.
- Where siblings are unable to live together, sibling contact is very important. Our sibling relationships are usually our longest relationships in life and research shows that most of us view them positively. Staff should make every effort to maintain positive ties between siblings, particularly where they live apart, by, for instance, involving them in joint activities and celebrations, having overnight stays, and making joint videos and family books.

Friends are also important and 'it is particularly vital not to view peers as largely negative influences. Children help each other a great deal and all adults should be aware of friends and age-mates as actual or potential resources for resolving difficulties' (Hill 1999). Jackson and Martin (1998) found that one of the protective factors strongly associated with later educational success was having a friend outside care who did well at school. The parents of non-care pupils can often provide social support and academic encouragement. For a variety of reasons, abused children find it harder to make and maintain friendships than their non-abused peers. Experiments where they are paired at school with a more socially competent peer show that they can be helped to interact more positively. Close relationships with peers can increase self-esteem and reduce some of the negative effects of abuse on children's development (Bolger, Patterson and Kupersmidt, 1998). Although much of the literature encourages the maintenance and development of friendships with children who are not looked after, there is evidence that young people develop supportive and sometimes long lasting friendships with their peers in care (see for instance Horrocks and Milner in Mullender (ed.) 1999 and Emond 2002), and that these friendships should generally be supported, not discouraged.

Building Resilience...

How do we work to improve the educational attainment of young people?

Are we good role models in regards to doing homework academic courses, paperwork?

Do we have reading material readily available, play educational games, count money together, work on budgets for things we are doing or make learning fun?

How do we keep young people connected when there is little contact?

Do we encourage peer support?

Conclusion

A variety of ways in which residential workers can help increase resilience has been discussed. Children need to be treated as individuals; 'one size fits all' responses are not helpful. Remember that communication of your interest and concern in the child is essential; it is often the little things where, for instance, you have gone the extra mile beyond the call of duty, where you have bought something the child particularly treasures or you have just been there to listen and comfort, that matter and are remembered. Residential workers who have a determined resilience perspective will often make a positive and long lasting difference to looked after children's lives.

Conclusion...

How do we develop ourselves and our colleagues/staff to be resilient workers?

What supports are available and what supports do we need? How do the building blocks relate to us?

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Foreword

Working in the Lifespace written by Mark Smith and published by SIRCC in 2005 introduced the notion of lifespace in residential care. I would say that of all the terms introduced into the vocabulary of residential child care in Scotland in the last 10 years, lifespace is perhaps the most accessible and relevant. As a SIRCC student, being introduced to this concept for the first time was something of a revelation. Here was a way of beginning to think and talk about the residential child care environment that resonated with my experience. Little within my training had connected with the tasks undertaken in the residential setting. When asked to explain my role, I often struggled to capture in any meaningful way what it was that I thought I actually did – the 'getting alongside' children and young people and using a variety of everyday activities as a means to form relationships which then became the platform for aiding growth and development. Lacking any sort of conceptual framework upon which to hang my experience, I fear that I merely described playing with children and engaging in a range of other activities which sounded merely routine – using terms that reduced the task to a series of encounters that did not sound any different from any other form of child care.

Beginning to think about operating within the lifespace changed that. The notion of that play and everyday activities could be part of a planned programme of work connected to a care plan, where opportunities were seized to explore and develop, appeared more structured, concrete and professional. From this, concepts such as milieu, rhythms and rituals and use of self all began to come together, adding up to the potential for a meaningful intervention. Reflecting back now, I think I always realised this but struggled to express or explain it. I do not think I was alone as I have consequently witnessed staff teams, individual workers and students experience the 'light bulb' moment when beginning to engage with the concept of lifespace. It provides an overarching framework to explore the delivery of group care and individual care plans. Perhaps more importantly, it goes a long way to explaining clearly what it is that is distinctive and different about the residential child care task, where 'practitioners take as the theatre for their work the actual living situations as shared with and experienced by the child'.

In many ways this may be the most significant contribution of the concept of lifespace to residential child care. It has long been the case that residential child care has struggled to assert itself as a placement of positive choice, despite many calls and recommendations to the contrary. Contributing to this, arguably, has been the inability of the sector to establish and communicate clearly with a wider audience what it is that we do, or indeed do not do. As this paper concludes, lifespace can provide a language by which residential practitioners can do just that.

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Working in the 'Lifespace'

Mark Smith
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Introduction

The term 'lifespace' is one that many residential child care workers in Scotland may not have heard. Some will have heard of the 'lifespace interview,' a component of Therapeutic Crisis Intervention (TCI). In this context, 'lifespace' is likely to be associated with issues of care and control. The term however has a much wider applicability. Working in the 'lifespace' is what workers in residential child care do, on a day by day, shift by shift, minute by minute basis. It involves the conscious use of everyday events to promote the growth, development and learning of children and young people. An appreciation of the importance of the 'lifespace' offers practitioners a means through which they might articulate the way they think about and describe their jobs. It offers an opportunity to develop a coherent theory and practice base for work in residential child care settings. "Life-space work is neither individual casework nor group work, nor even individual casework conducted in a group context, but a therapeutic discipline of its own" (Keenan 2002). The distinctiveness of 'lifespace' work is well developed in other traditions of practice and in a North American context, it forms the core of the professional discipline known as Child and Youth Care. This paper outlines some of the literature on 'lifespace.'

A History of the Lifespace Intervention

Historically, in residential work with children and young people, treatment was conceived as being distinct from care. Those encountering particular emotional or behavioural difficulties would receive counselling from outside experts such as psychologists or social workers. The job of residential workers was to provide everyday care, a task that was viewed as a parenting one. As such, it was not professionally valued.

Bruno Bettelheim challenged this separation of care from treatment in the 1940s. Bettelheim, a survivor of the concentration camps, believed that the difficulties experienced by the children in his care were so extreme that they required a round-the-clock psychotherapeutic environment or 'milieu'. Bettelheim's ideas are subject to some criticism nowadays on account of their psychoanalytic orientation. This can make it difficult for workers to practice within the rarefied theoretical base demanded by his approach. However, many of his ideas provide insights into residential child care that remain relevant today.

The idea of treatment happening alongside care was further developed by Redl and Wineman in 'Children Who Hate' (1951) and 'Controls from Within' (1957). They were interested in the potential of the group as a medium for changing delinquent behaviour.

In the 1960s' a classic text on the lifespace called 'The Other 23 Hours' (Trieschman, Whittaker and Brendtro, 1969) was written. This book conveyed the relative importance of what happens in the hours of the day when children and young people are not involved in formal therapy or treatment. The use of the term 'treatment' derives from a North American tradition and reflects a pre-eminence of medical models of practice. In a Scottish context, rather than think about 'treatment', we might consider events like review meetings, keyworker meetings or the time spent on individual programmes around particular behavioural difficulties. While such planned interventions have their place, they are not the only times that we are 'working' with young people. Lifespace theory suggests that everyday life events, from getting children up in the morning to putting them to bed at night offer opportunities which can be as powerful as more formal interventions to enhance children's development.

Is the role of a residential worker now professionally valued?

Do you see your role as professional, equal to other professionals?

So What is Lifespace?

Residential child care is a unique environment in which "practitioners take as the theatre for their work the actual living situations as shared with and experienced by the child" (Ainsworth 1981). They share the lifespace.

'In Residence' summarises recent research on important issues pertinent to residential child care and draws out possible practice applications.

Lifespace can be described as "the therapeutic use of daily life events in residential settings. It recognises the potential for communication with troubled young people that is provided by shared life experiences. Daily life events, which are shared by care staff and young people in residential settings, are exploited by the care team to help the young people gain an understanding of their life experiences. This understanding then becomes the foundation from which support is given to the young person to help him/her gain control over his/her daily environment" (Murphy and Graham 2002). Working in the lifespace then, involves the conscious use of the everyday opportunities that present themselves in residential work, to engage meaningfully with children and young people about what is happening in their lives. It requires that workers connect immediate behaviour with the overall situations in which they are involved. Thus, a child's seeming misbehaviour in the here and now may reflect emotions or responses that have their roots in past experience. Workers therefore need to try and build up a knowledge and understanding of children's personal histories in order to make sense of their behaviours in the present. They also need to maintain an appropriate balance between understanding where particular behaviours might be coming from in terms of past experiences and presenting an authoritative adult response in the here and now, in order to set appropriate behavioural limits. (Anglin, 2001)

How would you describe the lifespace?

How do you build up a knowledge and understanding of children's personal histories?

Does this include feelings as well as facts?

Terms and Ideas Associated with Lifespace Approaches

1. Milieu

"The life-space is a mini society in its own right…it has a cultural life of its own."
(Keenan 2002)

The milieu is the overall environment of a home. It encapsulates what a place 'feels' like. The term is not particularly tangible. It has been described as the 'particles in the air' (Euroarc 2002) However, anyone who has set foot in a residential unit picks up very quickly on its atmosphere. They can detect whether there is a tension, or a sense of calm. The 'feel' of a unit is fundamental to how it is perceived, and will have a profound impact on the experiences of the children and young people placed there.

Practitioners need to identify the elements involved in shaping the milieu, in order that they can influence it for the benefit of children and young people. A range of variables will impact on the milieu; organisational design and culture, including that of the wider organisation, physical environment and the composition of resident and staff groups. The importance of physical environment is highlighted by Maier, who claims that "the space we create controls us." He goes on to suggest, quoting Redl and Wineman (1957), that the layout of a building should be arranged to ensure, "an area which smiles, with props that invite, and space which allows" (Maier 1982).

Healthy milieux are likely to promote positive growth for those who live and work in them. A sense of wanting to be there will be apparent in the fabric and furnishings, through the construction of the rhythms, rituals and routines and through the attitudes of staff and young people. Conversely, if these aspects of a unit are not given adequate attention and are not functioning effectively, the quality of care will be inadequate.

> How would you describe the milieu you work in?
> What attributes would you say support a healthy milieu?
> Are there areas for development?
> What aspects of the physical layout help or hinder the milieu?

2. Developmental Group Care

Developmental care has become a significant theme in residential child care and is synonymous with the work of Maier. In a key paper, 'The Core of Care: Essential Ingredients for the Development of Children at Home and Away from Home,' (1979) Maier identifies seven essential components of care; bodily comfort, differentiation, rhythmic interaction, predictability, dependability, and personalised behavioural training. Caregiving in this model is rooted in the developing, individualised and reciprocal interactions between children and young people and their caregivers. Developing a common rhythm or 'fit' and a sense of predictability and trust, facilitates the formation of enduring personal relationships between workers and young people, which in turn provide a platform from which to address problematic behaviours. Behavioural goals therefore need to be located within the ongoing relationships young people have with workers rather than in depersonalised books of house rules. The seventh and final component in Maier's Core of Care, care for the caregiver, acknowledges the need to support and nurture those who provide care, if they in turn are to be able to nurture the young people in their care.

Consider the seven core essential ingredients Maier highlights as the core of care, in regards to your work and workplace.

How are each met?

How do you create predictability and how do you care for the caregiver?

How are you as a caregiver cared for?

What is supportive and what could improve?

3. Rhythms and Rituals

The Core of Care introduces terms such as rhythm and ritual that have become central to child and youth care practice. Rhythm is the process through which worker and young person find a common and comfortable way of being together. The idea of rhythm can also be applied at an organisational level, to convey the sense of order and predictability in the patterns of daily living in a home. Rhythm is less rigid or prescribed than the kind of routine that might emerge from procedural attempts to impose order.

Rituals are those practices that become embedded in the fabric of a unit and which have a significance and special meaning to the workers and young people who engage in them. Examples of the kind of rituals that can develop between workers and children and young people might be behaviours like gentle nudging or 'high fives' on passing one another in the corridor. At another level, workers may be able to think of behaviours which are idiosyncratic to young people and which, on the face of it, the worker may consider to be insignificant. Particular ways and sequences of settling at bedtime for instance might appear to workers only as irritating habits, but may carry a particular significance and sense of meaning for the child concerned. An appreciation by the worker of such seemingly mundane aspects of everyday life speak of connections and a sense of care toward the young people with whom they work.

What are the rhythms and rituals of the house?

How are these created and adapted to meet the needs of different young people?

Who creates the rituals?

The Lifespace Intervention

What a worker does in response to a particular behaviour or event is called the lifespace intervention. The vehicle for the lifespace intervention is 'lifespace' or 'on the hoof' counselling. This should proceed from the basis of helping a young person make the connection between past, present and future. Lifespace interventions need to be goal oriented and related to the wider context of what is going on for a young person. They should be considered within the overall care plan. Care planning goals should be clearly identified and everyday opportunities within the lifespace used to reinforce these. Such an orientation dictates that working with young people on issues of anger management for instance, will be best undertaken in real life situations, For example, disputes may arise over carrying out chores such as washing the dishes. This opportunity can be used to help the young person use anger management strategies. Similarly, important messages of support and security can be offered to children who have been abused, through the ways in which workers deal with everyday aspects of practice such as settling them at night or in how they engage in physical touch. Getting this sort of intervention right provides opportunities to enter into meaningful dialogue with young people and to help them make the appropriate connections from feelings to behaviours. In this sense, the adult becomes the mediator between young people and their environments. To maximise the opportunities provided through the lifespace intervention, workers need to recognise and take advantage of the 'interventive moment.' They need to think through scenarios and identify possible opportunities in the everyday situations they face, to take a moment to consider the various dynamics involved and to prepare how they might respond. As part of this they need to 'check in with self' (Garfat 2003), to reflect on how their own personal circumstances may evoke particular emotions or lead them to react in a particular way.

In reality this preparation is often distilled into the moment and may seem to happen almost subconsciously. Ongoing reflection on situations and on their wider contexts may allow a worker to internalise what they have learned from past interventions and apply these to any new situations which they may meet. An appropriate balance needs to be maintained between reflection and introspection. A strength of lifespace approaches is that they de-emphasise the professional distance between workers and young people. Spontaneity and naturalness are hallmarks of the good practitioner. The dynamics of a situation or relationship should not become subject to 'analysis paralysis,' but practitioners do need to maintain a background awareness of these important factors.

> ### Reflect on your last shift and give examples of lifespace interventions you were involved in.
>
> On reflection were there opportunities you missed, or decided to avoid?
>
> Is the concept of 'analysis paralysis' one you can relate to?
>
> How do you differentiate between age appropriate developmental behaviour and behaviour relating to past experiences?
>
> Can you think of situations where you believe too much analysis has been focused on what you considered to be age and stage behaviour, or situations where behaviour was not analysed enough?

The importance of relationships and use of self

The most powerful moments in residential child care are when a personal connection is made between a worker and a young person. One of the most commonly referred to quotes in child care practice is that "every kid needs at least one adult who's crazy about him" (Bronfenbrenner 1977).
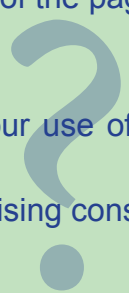
However relationships cannot afford to be indiscriminate. Fewster (1990) has suggested that the personalised relationship is the greatest challenge in residential child care. He refers to the difficulty that workers sometimes seem to have in developing a relationship with a young person in which the experience of intimacy and connectedness can be present, while appropriate boundaries are maintained. However, he goes on to assert that, in the absence of relationship, the worker's ability to affect a young person's values, beliefs, attitudes, or behaviours is extremely limited.

Residential child care is all about 'self in relationship.' This poses questions about the personal qualities and characteristics of workers, as these inevitably have an impact on the nature and quality of any intervention. Aspects of personal style become central to determining the appropriateness of an intervention. Garfat (1998), in his study of the effective interventions with children and young people, claims that "the style of the child and youth care worker in intervention should fit with that of the young person. It seems that this fit may have been instrumental in allowing the young person to experience the possible value of the intervention." This observation may help explain how some relationships in care settings seem to 'click.' Conversely, we can all probably identify workers who on the surface appear to do everything right, but just don't make the right connection with a young person. The answer may lie in their failure to get into a shared rhythm or 'fit.' Personal style is fundamental to good practice in residential child care.

This being the case, the values and beliefs which workers bring and the way they interpret these will be vital in determining the type of care they provide. Caring isn't merely an instrumental task but is what Phelan (2001) calls a 'self in action' task. The way that workers carry out their tasks in residential child care will depend on their own experiences of care, and on the views they attach to children and childhood. Ricks (1989) puts self awareness at the heart of residential child care practice, emphasising the need to consider workers' individual characteristics and ways of experiencing, as essential determinants of the quality of the care experience.

Putting 'self' at the centre of residential child care carries with it the inevitability that a powerful range of emotions and psychodynamic processes enter into the worker's relationships with young people. Supervision, debriefing and a culture of openness and dialogue amongst colleagues are important in ensuring that workers have the necessary support to carry out their jobs. The complexity of these psychodynamic processes must be appreciated in wider organisational structures.

What is your response to the Broffenbrenner quote at the top of the page?
Did you have an adult who was crazy about you?
Do the young people you work with have this?
Do the policies and procedures within your work support your use of self and developing close relationships?
Can you bring personal style into your work without compromising consistency?
How do you do this?
How do you get the support you require in your role?

Characteristics of the effective interventions in residential child care

Garfat (1998) explored workers and young peoples' views of what was meaningful in their experience of particular lifespace interventions. He identifies several themes in his study of what constitutes an effective intervention. These include adults having a high degree of care for, and commitment to, the young people with whom they work. The study also identified high levels of self-confidence and responsibility, and a general and immediate awareness of themselves as workers. Good practitioners also possess an awareness of the wider context, an understanding of the individual young person, and an intimate familiarity with the issues facing that young person. The latter is promoted by the ongoing process of sharing and working together in the lifespace. The ability of residential child care workers to prepare for an intervention and connect with the individual young person in a manner that 'fits' is also important. Effective interventions were related to the immediate circumstances of each young person. They enabled the young person to see their responsibility related to their situations, and challenged their perceptions and expectations. The importance of a young person's continuity in the relationship with the worker emerged as a final theme in the study.

Experiential Counselling

Phelan (2001) offers an interesting perspective on working with troubled young people. He suggests that the task should not focus on counselling them on past problems as this can merely serve to reinforce the negative experiences of the young person. He suggests that workers should become 'experience arrangers' offering a range of activities and experiences, which encourage young people to reframe how they perceive their circumstances in more optimistic ways. In this way, activities become more than just ways to fill the day. If purposefully planned, they become arenas for growth and re-learning. Workers need to be able to 'be with' and 'do with' young people in a range of ways, rather than simply feeling that they have to enter into counselling type relationships with them. This idea is best summed up by Trieschman (1982) who claimed, "When we do things to young people and not with them, it's not going to work so well." A similar sentiment is expressed by Garfat (1999) who describes the job of the residential child care worker as 'hanging out and hanging in.' By 'hanging out' he means simply being with young people and by 'hanging in', he means sticking by them through difficult times.

Conclusion

'Lifespace,' offers workers in residential child care a coherent theory base through which they might understand and explain the work they do. Through stressing the importance of everyday events, activities and relationships, lifespace allows them to put a framework around what they do and gives them a language with which they can 'name' and hence validate this.
How is working in the lifespace evidenced within your recordings, planned within care plans and shared with professional colleagues? Does this aspect appear within your job description and feature in your appraisal?

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In addition, access to a range of literature and ideas on working with children and young people can be found on the web site: cyc-net.org

Children's Rights:

How to Implement a Rights-Based Approach in Residential Child Care

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Introduction

Children's rights are often spoken about and discussed in residential units, but how do we use children's rights as a tool to do our work? This paper suggests some answers. It starts with basic information about the United Nations Convention on the Rights of the Child (UNCRC) and answers some common questions on children's rights. It introduces two models for   implementing a rights-based approach, and provides illustrations of their use. Residential workers might wonder why we need another method of working with children and young people. Taking a rights-based approach is not meant to be just another method, but is an overarching framework, which complements existing ways of working in child care. Discussions and reflections on the models presented in this paper will hopefully provide a better way to make decisions about children and young people in residential care.

Where did the UNCRC come from?

The UNCRC was developed by the United Nations, following a decade of work devoted to discussing why a separate statement about children's rights was needed. The final document was adopted by the UN General Assembly in November 1989 and ratified by the UK in 1991. Ratification means that legislation such as The Children (Scotland) Act 1995, the Regulation of Care (Scotland) Act 2001 and the Care Standards should incorporate the UNCRC. By doing this, the Government makes sure that children's rights are upheld by those who provide services for children and young people and that adults working with them, such as residential workers and other professionals, are accountable.

Relating Rights to Practice: what's the relationship between adults and children?

Everyone has human rights, including adults and children. Children's rights are simply specific human rights for all children and young people from birth to 18 years of age. They are needed because they reflect the special status of childhood - a period of rapid change and development during which this group experiences different vulnerabilities (e.g. physical weakness or lack of knowledge) and therefore has different entitlements from adults. Our explanation of what childhood is and recognition of this special status has been developed over a long period time. Aries (1962), and other theorists who have come after him, tells us that the idea of childhood is socially constructed. This means that people in western society tend to see children and young people either as potential victims who need looking after, or as potential threats who need to be controlled. One of the consequences of our current thinking is that children and young people are seen as passive and helpless and adults must 'do something' to help. This has been translated into the understanding that children and

young people in need of care should be 'taken away', 'be properly educated' or 'get the right kind of treatment.' This thinking focuses on children and young people's weaknesses and not their strengths. The UNCRC emphasises strengths and asks adults to see children and young people as active and not passive objects. Through the UNCRC, children are rights-holders. This point is important because unless the residential worker sees the child as a rightsholder and not a helpless object, any degree of participation will be, at best, tokenistic and at worst, meaningless. Residential workers are in one of the most important positions to promote children's rights, and therefore are also among the key groups of duty bearers. The tasks of the residential worker are complex, requiring many skills. Taking a rights-based approach to work is an important way to apply those skills in a proactive way. A rights-based approach is one where the worker has examined children's rights and tries to put them at the centre of their practice; however, applying a rights-based approach has been met with some suspicion. Some would argue that the promotion of children's rights has added to tensions in residential care, and undermined practitioner morale. The first Scottish Commissioner for Children and Young People, Kathleen Marshall, comments on a fear that our culture is becoming too 'rights-based.' She explains that there is a fear among practitioners that an over-emphasis on the rights of children and young people will create expectations that are both unhealthy and unrealisable in a democracy. Adults also sometimes comment that 'children and young people know too much about their rights already.' The truth is, however, as Marshall acknowledges, that children and young people know very little about their rights. What they believe they know is often only a fragment or even a caricature of the actual content of the UNCRC. Some studies about children have shown this to be the case. For example, in an interview with the Scottish Child Law Centre carried out by Save the Children, concern was expressed about how little children and young people in residential care attending children's panels know about their rights. Informing children and young people is a key responsibility for residential workers; however, given the fact that residential workers meet many problems on a daily basis, including verbal and physical abuse, they may have real concerns about their own rights. Some residential workers may feel that their rights are over-ridden by children's rights, or that they have more important matters to deal with than the promotion of children's rights. It is the intention of this paper to demonstrate that it is possible to implement a rights-based approach which makes both staff and children feel valued.

What is your perception of children – victims or threats or something else?

What is the perception of your colleagues?

Sometime the most basic discussions are useful to have; however what are the ones we miss?

How Do Rights and Responsibilities Relate To Each Other?

Kathleen Marshall emphasises that in any society, rights and responsibilities must go together. Sometimes, however, this is wrongly interpreted. For example, some people may say that unless a person takes responsibility, they cannot have rights. Marshall would say that a person can only be regarded as having a right if someone else has a responsibility to respect it; however, rights do not have to be earned by the exercise of responsibility. For example, most of us would acknowledge that babies have rights as have people with severe learning difficulties. Yet both these groups cannot exercise this right without help from others and are

very vulnerable to harm or exploitation. It is the same with children and young people in care. Marshall suggests that the more appropriate link should be responsibility and power, not responsibility and rights. Anyone exercising power of any description must do so responsibly. Our responsibility consists of knowing and being aware that in situations where we could have the power and moral capacity to jeopardise the rights of others, we have the responsibility to treat others with respect within a context of human rights.

How do you perceive the link between rights and responsibilities? How is power shared within your workplace?

Are the children at work different from other children you encounter within your personal life?

Do they have more rights or fewer rights?

Two Models for Implementing a Rights-Based Approach to Practice

The three core principles forming the three corners of the triangle are:

► Non-discrimination
All rights in the UNCRC apply to all children and young people. Children and young people have a right to be protected from discrimination. This is Article 2 of the UNCRC.

► Best interests of the child
In all actions concerning children and young people the best interests of the child should be a primary consideration. This is Article 3 of the UNCRC.

► Participation of the child
Children and young people should be free to express opinions in all matters affecting them, and those views should be given due weight 'in accordance with the age and maturity of the child'. This is Article 12 of the UNCRC.
The Fourth core principle in the heart of the triangle is:

► The right to life, survival and development
Children and young people have a right to life and the right to the development of their personality, talents and abilities to the 'maximum extent possible'. This is Article 6 of the UNCRC.

Using the Triangle of Rights in Practice

When a decision is made, the following questions relating to the core principles at each corner of the triangle should be addressed:

1. Participation
Were the views of the child sought? What are they and how can we take them into account? Does the child know how we have considered their views? Have we explored how the child can engage fully in decision-making, taking account of their age? Have we offered sufficient support to help them engage? Have we allowed time for preparation and created an environment in which the child is comfortable to speak out? Is the language used appropriate to their developmental level?

2. Non-discrimination

Have all options been explored? Are we advocating for this child as a rights holder and is he/she an equal partner in the discussion? Are all relevant persons included in the discussion? Are we making every effort to overcome difficulties, and/or prejudices, including our own, regarding the child or young person being an equal partner?

3. Best Interests

Are decisions based on the child or young person's background, future and best interests? Are we being guided by other considerations such as resource issues or organisational constraints? Are we making assumptions about the child based on issues such as our own experience, values and judgements? Are we regularly reviewing the decisions made, and have we taken the opinion of the child or young person into account?

4. Life, survival and development

Is the initial decision still safeguarding the survival and development of the child to the maximum extent possible? Is it subject to regular review?

A Case Study Using the Triangle of Rights

Neil is an 11-year-old boy with learning difficulties, living in a residential unit. His mother was not coping after Neil's father died. Neil lives in a group with older boys and is often the victim of bullying. Social Work decides he should move to a foster home and has found a placement for him. His mother agrees with the move; however, the foster placement is far away from Neil's home. His mother is concerned about not seeing him often enough and that he will lose touch with his school and friends. Social Work says that the move is the best option available as placements are scarce.

We can use the triangle of rights to see if this decision meets Neil's rights to survival and development 'to the maximum extent possible', as outlined in the UNCRC:

Participation (Article 12)

- Were Neil's views taken into account? Was he part of the dialogue during the decision-making process? Was he informed as to how his views were considered? Was he given sufficient information, choice and opportunity to make an informed decision?
- Has he been listened to and given time to explore this option (e.g. visit the foster family/explore the distance/given opportunities to continue regular contact with family/school options explored, given opportunity to talk to his family) as opposed to other options?

Non-discrimination (Article 2)

- Have methods of communication been used to ensure that Neil's learning difficulties do not constrain his participation in decision-making?
- Has the family been involved and allowed to express their views?
- Could work be done on anti-bullying strategies with the group and staff in the unit?

Best Interests (Article 3)

- What could residential staff do to safeguard Neil's interests? For example, is it really in his best interests to be placed so far away from his mother?
- How long has he been in the residential setting? Has he had the opportunity to settle and are we breaking this off too soon?

Survival & Development (Article 6)

- Does this decision support his current emotional and developmental needs? The questions which the Triangle of Rights prompts us to ask make us look at the bigger picture in Neil's situation. In this case, the decisions appear to be a reaction to a situation in the unit. Analysis of the situation using the Triangle indicates that the proposed foster placement

is perhaps not the best option. This decision was made on the basis of protecting Neil from an immediate problem in his current placement and is therefore not about what is best for his long-term development. It reflects a short-term intervention that could lead to further placement breakdowns. In addition, this intervention does not deal with some of the underlying causes (e.g. bullying behaviour). Alternatively, working with the group on bullying and finding a more appropriate placement would be a rights-based approach to practice which is further explained below. It would minimise the interruptions to Neil's development and maintain his family links. This decision would address his best interests, his development and participation, and not only the interests of the placing authority.

Would you consider using the triangle of rights in regards to decisions made for the children and young people you work with? What would be the advantages of using the triangle?

Would there be any disadvantages?

(B) Model Two: The Needs versus Rights Framework

Unlike a rights-based approach, a needs-based approach does not identify anyone who has a clear responsibility to meet needs. In other words, needs – unlike rights – do not create any valid claims on anyone to fulfil them, therefore the fulfilment of needs, instead of being a duty, becomes a charitable action dependent on the goodwill of powerful adults who cannot be held to account if they do not fulfil their duty as this duty is not recognised. By contrast, a rights-based approach focuses on the responsibility and duty of adults under the UNCRC to uphold the minimum requirements of care outlined in the Convention and the relevant legislation in Scotland. This approach also places a greater emphasis on the strengths of children and young people and their capacity to play an active part in the realisation of their rights. It encourages workers to look at underlying psychological, economic, political or institutional causes of the child's situation. It asks workers to make decisions which explore the bigger picture and challenge the causes of problems.

The Needs versus Rights framework

A NEEDS-BASED APPROACH A RIGHTS-BASED APPROACH

- Motivation: charity, voluntary, emotive response. Need met as concession or policy for the good of the state
- Short-term intervention/reactive
- Beneficiaries dependent on the goodwill of the more powerful
- One-way relationship perpetuating dependence
- Immediate outcome stressed over process
- Accountability undefined, charitable action of practitioner/worker, individualised responses
- Focus on resolution of present problem
- Concern for identified few
- Needs ranked in a hierarchy. Needs are met. Assumption: the need has been eliminated.

- Motivation: meeting of obligation, fulfilling responsibilities. A child has a recognised claim against the state.
- Longer-term intervention/proactive
- Beneficiaries as active participants in the realisation of their rights
- Two-way relationship promoting empowerment between worker and child
- Longer term process is important
- Accountability of duty-bearer clearly defined. Practitioners are representatives of the state with a duty of care under the UN
- Convention and local law
- Concern for underlying causes and wider analysis of the situation
- Universality of benefits
- All rights in the Convention are equal and indivisible. All rights must be fully realised. The four principles are a guide to addressing issues holistically and equally.

Practice Examples using the Needs versus Rights Framework

Two additional illustrations using the Needs versus Rights framework follow, using examples from the report entitled Lets Face It! which was produced by Who Cares? Scotland.

Bullying
One of the issues raised by the children and young people in this report was bullying. When dealing with bullying behaviour, the focus is often on assisting victims of bullying with their immediate needs. This falls under the needs-led approach. Working with the underlying causes for bullying behaviour, possibly by starting life skills training or creative drama sessions with children and young people, could help to address the issue in the longer term, and illustrates a rights-based approach.

Restraint
Misuse of restraint and sanctioning also concerned children and young people in the report. The UNCRC acknowledges the need for discipline but insists it must be administered in a way that is consistent with the child's dignity. It also acknowledges the need for some children and young people to be restrained, but insists that this must conform to the law and be a last resort. Before applying sanctions, staff should ask if these are really in the best interests of those being sanctioned. Helping children and young people to understand the consequences of behaviour and create an environment of reflection and learning is a longer-term solution and can give them valuable skills for the future. Inappropriate or unfair sanctioning might help the unit in the short term, but can lead to mistrust and the breakdown of relationships between workers and children and young people. Involvement in the process of sanctioning provides the young person with an opportunity to demonstrate their motivation to stay in the unit and work with staff. It also gives staff the opportunity to demonstrate their commitment to that young person, and clearly reflects a rights-based approach.

How do the examples relate to your practice?

What other examples can you think of from your practice or practice you have witnessed which would be relevant to the needs versus rights framework?

Using the LAC materials: A Rights-Based Approach in Practice

Residential workers should be familiar with the "Looking After Children materials (1999)." They were designed by the Scottish Executive and are usually called the LAC materials. This material consists of a set of forms describing the holistic care plan for the child or young person. The forms are intended to promote information sharing, communication and decision-making among the key people involved with the child. One set of forms records essential information, plans and reviews required for daily care and understanding of children and young people's identity. Other forms are concerned with assessment and action needed to promote the welfare of the child. The LAC materials reflect many of the dimensions addressed by the Triangle of Rights and the Needs Rights Framework. They can be a tool for reflection and can assist staff to ensure that the best interests of children and young people are constantly pursued and reviewed, in line with the UNCRC.

Conclusion

Hopefully, this paper will have outlined a practical and relatively easy way to implement a rights-based approach to work in residential child care. Residential workers are faced with making decisions about children everyday. By using a rights-based approach, decision making becomes more empowering, respectful and lawful for staff and children alike.

Has any of your practice or thinking been challenged by this paper?

Are there any changes to your or your service's practice required after reading the paper?

To whom would you make suggestions for improvement?

Where would you share your good practice which has been highlighted through this paper?

References

For the full text of the UNCRC please go to www.unicef.com.

Other interesting websites are:

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Historic Abuse in Residential Care:

Sharing Good Practice

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Introduction

The abuse of children and young people in residential care that happened in the past is now more commonly known as Historic Abuse. Allegations of abuse in the past, and apologies for this, have become topical in recent times. In Scotland on 1st December 2004, the First Minister took the unprecedented step of offering:

a sincere and full apology on behalf of the people of Scotland to those who were subject to such abuse and neglect and who did not receive the level of love, care and support they deserved and who have coped with that burden all of their lives.
(Scottish Parliament, 2004: 3)

However, what do we know about the nature of what is meant by historic abuse? How can agencies best respond to allegations of abuse in the past and what can they learn to help improve vigilance in the future? Sadly, the abuse of children while in the care of local authorities or voluntary organisations is still within living memory, as reports such as the Edinburgh Inquiry (Marshall, Jamieson and Finlayson, 1999) and Waterhouse Inquiry (2000) into abuse of looked-after children demonstrate. Therefore all residential child care practitioners should be aware of the issues involved.

This paper seeks to offer some guidance around this important area, and encourage discussion among practitioners at all levels. The paper was the result of work carried out by a short life group on historic abuse which was set up by SIRCC. The work of this group informed the debate at Scottish Parliament on 1st December 2004 on abuse in children's homes (Scottish Parliament, 2004).

What is Historic Abuse: A Definition

For the purposes of this paper, the definition of historic abuse is that used in The Lothian and Borders Joint   Police/Social Work Protocol on the Management and Conduct of Enquiries into Allegations of Historic Abuse:

Historic Abuse will include all allegations of maltreatment whether of serious neglect or of a sexual or of a physical nature which took place before the victim(s) was/were aged 16 years (or aged 18 in some circumstances) and which are made after a significant time has elapsed. Often the complainant will be an adult but some cases will apply to older children making allegations of abuse in early childhood. (Lothian and Borders et al., 2001: 5)

The term Historic Abuse is value laden and imprecise. For example, corporal punishment in schools, or physical chastisement within the home and community that were acceptable in the past are now perceived to be abusive. In addition, perceptions of acceptable child rearing practices have changed over time. This trend is recognised and Caring for Children Away from Home (Department of Health, 1995) proposes that:

A look over the last century would suggest that the threshold beyond which child abuse is considered to occur is gradually being lowered. (1995: 15)

However, while the abuse may have taken place many years ago and be regarded as 'historic' by the agencies involved, it is not 'historic' for the person who experienced the abuse, which may continue to have a profound impact on their lives.

The definition used in this paper has implications for practice. Decisions need to be made by those investigating such allegations as to whether the experience reported as historic abuse constitutes maltreatment or neglect in terms of the accepted standards of the time when it occurred. This is recognised in the Fife Council Independent Enquiry where Black and Williams (2002) emphasise the importance of setting the historical context (2002:7).

> Has care practice changed in the time you have been involved in residential care?
>
> If so, in what way?

The Legislative Background

While there have been Regulations for the operation of Children's Homes in England since 1951, there were no similar Regulations in Scotland until 1959 when the Administration of Children's Homes (Scotland) Regulations 1959 came into effect. Since then, it has become apparent that some of the standards of practice before the implementation of the Regulations were unacceptable. A number of children and young people suffered poor quality care and this was not detected or acted upon at the time by the responsible bodies. These are the types of experiences that are likely to be referred to as historic abuse. Reports of abusive care practices require to be considered against the existing legislative framework at the time, both civil and criminal, as well as agencies' general sense of ethical responsibility to former residents. Child protection legislation falls under criminal law, with the burden of proof being 'beyond reasonable doubt'. The Regulations in respect of residential care fall under civil law, with the burden of proof being 'on the balance of probabilities' which is less stringent than criminal law (Baillie, Cameron, Cull, Roche and West, 2003). In Scotland in recent years there have now been several convictions in cases of historic abuse. For example, in Edinburgh in 1997, two former care workers were convicted of serious abuse of children in the care of Edinburgh Corporation and Lothian Regional Council between 1973 and 1987 (Marshall, Jamieson and Finlayson, 1999). In Fife, David Logan Murphy was convicted in 2001 for the sexual abuse of children in residential care (Black and Williams, 2002).

Finally, it is important to consider allegations of abuse that would not be regarded as 'historic'. These are situations where abuse is more current and which are addressed by existing legislation, child protection procedures and disciplinary procedures within agencies.

Responding to Allegations of Historic Abuse

Residential child care practitioners at all levels have a responsibility to be aware of the possibility of historic abuse in their agencies. They also have a responsibility to learn the lessons of the past so that the integrity of safe care is maintained. The following issues were identified by the working group as areas where practice may be improved.

1. Record keeping

One of the main lessons learned from investigations into historic abuse is that more attention should be paid to record keeping in the present with a view to the future. In cases of historic abuse, police reported that records necessary to pursue these allegations are often poorly kept and unhelpful for investigative purposes because they contained little factual data to corroborate witness statements. Some practice points were highlighted by the working group in relation to record keeping and storage.

a) Retaining and transferring records

Attention should be paid to how records are stored. All types of storage have their limitations. For example, the use of microfiche in earlier times was a leap in technology over paper-based storage systems. However, the subsequent use of microfiche in contemporary times has proved unhelpful in investigations due to its limited life span and poor reading quality. Tracking records once they leave the agency for investigative purposes could be problematic unless the transfer was recorded. When records are passed over to any other agency, details should be maintained on what has been transferred and to whom. A representative of the receiving agency should sign to record receipt and details of the transfer should be kept on file. The working group discovered that while some agencies had a policy in respect of the retention of records, fewer included a statement of standards of storage. One organisation which does have such a statement is NCH (2005). The overriding message was the importance of developing a high quality, standards based archiving policy that is regularly reviewed. Experience demonstrates the value of involving skilled archivists who can offer considerable advice in respect of safe care of records in a manner that ensures efficient retrieval. NCH's statement is based on the archiving industry. In all events, reasons should be given for retaining or discarding records.

b) Clarity about the purpose of record keeping

Decisions need to be made about for whom records are kept. Records often have a combination of purposes, for service users needs as well as organisations. Legal advice should be sought as to what material should be destroyed and why, dependent on how the information will be used in future. Useful records for providing corroboration and confirming memories are log recordings, young people's files, rotas, personnel files, diaries, building plans, photographs and complaints forms. These records should be dated and retained. Past records are also helpful as commentaries on previous expectations of practice and drawing comparisons to inform current practice. 'Soft information' can also be helpful in investigations. This includes documentation such as supervision records, policy guidance, child protection procedures and codes of conduct at the time. This is often required as a measure of the standards of practice within which staff operated. Again these should be dated. In the past, these types of records were often not retained, which has created difficulties for investigators of historic abuse.

c) Access to records

Former service users may seek access to records as they represent part of their personal history. This may take a low priority in organisations and can be time consuming for practitioners. However, this access is important for former children in care. As such, the records should be protected by agencies. In respect of storage and access to records, agencies in the public sector now have responsibilities under the Freedom of Information (Scotland) Act 2001 to provide information held to anyone requesting it, subject to certain conditions.

2. Passing on information about alleged abusers

Initial information alleging historic abuse comes to agencies in a variety of ways. It may come from another agency (including the police) already involved in an investigation where they

believe it is important to pass it on either for child protection purposes, or to further existing enquiries. Sometimes it is offered by people who want to remain anonymous or 'off the record', or the information given at this point may be unsubstantiated. The status of this initial referral informs subsequent action. If information pertaining to allegations of historic abuse is received in a covert or unsubstantiated form, it can sometimes be linked to other information, or an enquiry that is underway. The appointed person can then liaise with the source, asking them to 'go on record' with the information or allegations. This can create dilemmas if the staff member against whom allegations are made is still employed in a care setting. If there is no other relevant information, it has to be a matter of professional judgement whether the staff member is told of the unsupported allegation concerning them. The following points may help inform decision making:

- If they are told, and they are guilty, they might seek to cover their tracks.
- If they are innocent, they should be aware that someone is passing on malicious information about them.

There needs to be a match between employment practice (in respect of the investigation) and child protection practice, to ensure that all parties are dealt with fairly. The most effective way of managing such allegations is to involve the police at an early stage if there is any possibility that the allegations may be substantiated. They will then notify other relevant employers.

3. Supporting survivors

All agencies which have provided residential child care should consider how they would support survivors of historic abuse. Best practice indicates that agencies should be as supportive to survivors as possible while recognising that the investigative process might be drawn out and that the re-awakening of past experiences is likely to be painful. The working group sought the advice of a group working to support adult survivors. Survivors' needs and wishes for support vary, both individually and at different stages in their lives. Many did not wish counselling or other forms of medico-psychological help, but had their own preferred support systems. Some survivors simply wished periodically to talk through their experiences or to receive an acknowledgement that the abuse had happened. Survivors often seek an apology from the agency as a means of closure. This has been difficult for agencies to provide consistently, due to legal issues, and will be further discussed later in this paper. It is clear that some aspects of the support process could be facilitated by agencies sensitive to the survivors' experiences. Practical examples of this might be access to records or a consistent agency contact. It is important that agencies establish from survivors their own preferred form of support. Agencies should have a system and a contact, should survivors wish to refer themselves again without having to repeat their circumstances unnecessarily. This task can either be carried out by an allocated individual within the agency, or contracted out to a specialist agency. Some people find survivors' groups helpful. While there is a role for self-help groups, practitioners should also have a role in facilitating such resources where necessary. For example, staff in many organisations already have counselling skills. Additional training could ensure that their knowledge is specific to counselling survivors of institutional abuse.

4. Supporting current staff

A number of issues have emerged in respect of the impact of allegations of past abuse on current staff. Staff may need support if they have worked alongside an alleged perpetrator. They may feel disbelief at being 'seduced' by them, or guilty because of the consequent abuse of young people. The tension resulting from loyalty to the team as against 'whistleblowing' on bad practice can result in frictions. If this happens, then children's current needs for support and protection can be compromised. Lothian and Border's Joint Police and Social Work Protocol (2001) addressed issues around staff loyalties, pointing out:
Individual loyalties which impede [protection of children/vulnerable adults and the community

at large] are essentially misplaced. Collusion, however well intentioned, may only contribute to greater risk and prevent a just and satisfactory outcome for all concerned. (2005: 14-15)

The report emphasises that:

The Social Work Liaison Officer should ensure throughout the enquiry that employees who are potential witnesses are able to provide information freely and truthfully without feeling compromised. (2001: 15)

It is the responsibility of senior management to ensure that if current staff are to be questioned by police, they are briefed about the reasons why. However, staff should not be rehearsed to take a particular agency or personal view. Senior management should also take responsibility to debrief staff after a police investigation. Staff who work for a larger agency but who are not involved in the unit where the investigation is taking place need appropriate factual information about measures in place (such as insurance and media coverage) to be able to deal professionally with any questions directed at them outwith the unit. The overall impact of allegations could result in difficulty in recruiting in the residential care field, in particular recruitment of male staff. This heightens the need for dissemination of good practice in the safe care of children and young people in residential settings.

5. Dealing with False Allegations

The issue of false allegations is very complex, tied up with 'false memory' and the view that these allegations are motivated by a desire for compensation. Without wishing to minimise the very serious nature of historic abuse as well as the importance of all such allegations being taken seriously and followed up rigorously, there is increasing concern about some aspects of the investigative process as it exists, in particular the current practice of naming alleged offenders. Some people have been convicted, only to have their cases quashed and reputations upheld in court.

Such practice impedes justice for all victims, as well as those falsely accused. There was concern in the working group that current practices for investigating allegations of historic abuse use the same process as for child abuse. This may mean that there is a disproportionate response to poor practice. As previously indicated, some practices reported in the past do not meet the criteria of child abuse even by present day standards, although they do constitute poor child care practice. Such practice may include reported experiences in the 1970-80s such as staff bathing two unrelated children together at one time, units having communal (albeit clean) underwear for children and children being taken on family holidays by staff members. In an effort to move away from a climate of 'agency protection' to that of 'child protection', agencies should consider the establishment of a system which allows people with concerns to report and discuss these without triggering a child protection investigation. Such an initiative should come from a national level to ensure consistency in standards applied.

6. Apologies and the role of insurance companies

Residential child care agencies need to buy insurance. Insurance provides added protection for all concerned when problems arise, and can mean the difference between the continuation of a service or its demise. A particular frustration for agencies was the resistance by insurance companies to permit them to offer genuine support, empathy and apology to survivors. In insurance terms, an apology is an admission of liability and should not be made until all proper investigations have been carried out. This was contrary to the agencies' ethos as they often wished to extend such a response immediately. Given the importance of apologies to survivors of abuse, it is clear that discussions on this subject need to take place when insurance policies are taken out. Agencies reported that it had proved fruitful to take time with representatives of insurance companies to develop a mutual understanding of each other's

perspectives. In negotiating such a mutually agreeable response, it should be recognised that the survivors must be treated fairly, and believe themselves to be treated fairly. Advice was sought from the Institute of Business Ethics (2003) who suggested the following:

Our solution would be to make a distinction between sympathising and apologising. Until the facts are known, organisations should not apologise for something that they may or may not have done. Instead, they should make it clear that they have the deepest sympathy for the individuals concerned. They should take the allegations extremely seriously, launch a full investigation and promise to take action as necessary once the investigation is complete. Once the facts have been established and if the organisation is in the wrong, that organisation should make a full and complete apology to the individuals and take any other action as necessary (Hooper, S., Institute of Business Ethics, personal communication, 2003).

By sharing the ethics and practice of residential care as well as those of the insurance companies some agencies have been able to negotiate the message they wished to convey to survivors in a way which is acceptable to the insurance companies. These are known as 'agreed statements'. However it has to be acknowledged that at least in some cases survivors find these to be unacceptable and contrived.

Thinking about how you now record factual information, would it be easy to understand in years to come?

Do you consider issues such as the use of initials and jargon?

Does your organisation have a statement in regards to retaining and transferring records?

What are your processes and procedures? What information needs to be retained and what should be destroyed?

What is the policy in regards to access to records?

What would you do if an allegation was passed to yourself?

How would you be supported in this?

Do you know the procedures for supporting survivors within your own agency?

Is there a policy or procedure and if not is one required?

What dilemmas do you believe would exist when supporting current staff?

What issues would be there for you?

Does your agency have a way to highlight concerns and report or discuss these without triggering a child protection investigation?

Conclusion

All agencies should anticipate the possibility of receiving an allegation of historic abuse. In order that survivors can receive an immediate, genuine and constructive response, policies, procedures and standards documents should include the appropriate response to be given by the practitioner receiving the initial information and by the agency as a whole. This should include how to communicate with the individuals involved as well as with current and past employees, and with other agencies involved in the investigative process. It would be helpful to involve insurance companies in drawing up such a document. The deliberations of the SIRCC short life group proved to be very fruitful through the sharing of their experiences and the opportunity to learn from this.

Unfortunately there is a likelihood further historical child abuse issues will arise and it is easier to understand and discuss the processes when there is not an investigation underway, therefore planning for such an event may be required now. It is also worth considering how we record and protect young people and staff now and ensure information is available should incidents be raised in the future. From reading this paper have you thought of any aspects of practice or recording which could be developed?

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Foreword

Working with Younger Children in Residential Care written by Judith Hewitt and published by SIRCC in 2007 highlights one organisation's psychodynamic approach to working with younger children. Very little appears to have been written about this area of work in the intervening period. This is interesting since the Scottish and UK Governments are promoting Early Intervention policies and practice which endeavour to ensure that children have the best start in life and are able to contribute positively to our society as a result of improving their life chances. Although there is a developing evidence base around the successes of policies and practice which interrupt inter-generational cycles of deprivation, neglect and abuse, the outcomes for younger children living in residential settings are sadly neglected. Despite this, it would seem that the core themes underpinning the work referred to by Hewitt are as important as ever.

The article highlights methods of interacting with and supporting children in developing positive emotional competence. In practice one can understand how this serves to raise self-esteem. The most important outcome of engaging with children will be in the forming of relationships through which the child can be helped to achieve emotional integration and so develop internal controls to manage overwhelming feelings of anger and frustration. This assists, then, in preventing them from becoming either victims, bullies or both throughout their lives.

The development of trusting relationships involves creating dependency through attachment which can later be transferred to relevant family members or friends. Increasing resilience through relationships with competent and caring adults results in positive self image and motivation to interact positively with the environment. The care and nurture provided elicits attachment-promoting behaviour. Younger children have a primal need for emotional and physical holding and containment. Adults act as a temporary container for the child's turbulent emotions, supporting them through the developmental milestone of autonomy versus shame and doubt to become a well-established container with an inner reality and boundaries to self.

The article concludes that the building of positive human relationships is at the core of recovery from trauma. Where there is relationship there must be communication and involvement by adults who convey unconditional acceptance and support of the children in their care and who, in turn, are supported by their organisation. Taking note of these concepts once again seems timeous at a juncture when the residential child care work force is questioning risk-averse approaches to working with children and where the notion of 'love' in the residential setting is up for discussion.

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Working with Younger Children in Residential Care

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Judith Hewitt trained and worked as a probation officer in the Hulme and Moss Side areas of Manchester before moving into residential care. For 20 years, she worked in a variety of residential settings becoming a residential service manager for the Boys and Girls Welfare Society. In this role, she opened and developed several specialist children's homes and contributed to the development of a family placement service. She is currently supporting a group of residential managers working towards their Level Four vocational qualifications. This practice development paper is an adaptation of an article contained in the online journal childrenwebmag.com.

Introduction

While it is recognised that the majority of young people in care are over ten years old, Clough et al. (2006) reported that the number of younger children in care is on the increase. This paper provides a case study of how one organisation approached work with younger children. It is suggested that the principles involved are congruent with the needs of younger children and demonstrate how psychodynamic theoretical principles can be applied.

A Specialist Residential Service

Cathy was eight when she moved into our unit. It was her eighth placement since her admission to care at the age of five. All her previous placements had been with families, including an attempted adoption or as Cathy described it, 'You know, Jude - one of them where they change your name, and then when you're naughty, they change it back and send you away.' Cathy's background of neglect and emotional abuse combined with the succession of placement breakdowns had left their mark on her behaviour. She was so demanding that even the most experienced staff could only manage her for an hour or two. Cathy has been with us for two years now. Her behaviour has swung from demanding, hysterical screaming to tearful clingyness, and from 24-hour enuresis to pre-pubescent obsession with cosmetics. She has now started introductions to her new family. We are taking things slowly; another rejection would be a disaster for Cathy's fragile but burgeoning self-esteem. Cathy is not unique. Johnny has just arrived with us. Although it is his first placement in a children's home, it is his fifteenth placement. He is just five years old. The experiences of children such as Cathy and Johnny have left them with the classic symptoms of attachment disorder. On the one hand, they can be superficially charming and engaging and indiscriminately affectionate with strangers. On the other, they can be extremely controlling, destructive and hostile. Iwaniec (1995) outlined some of the other difficulties faced by younger children who come into care which include poor impulse control and apparent lack of conscience and remorse. Their profound distrust of adults means that finding a way to work with them requires an excellent understanding of psychodynamic approaches, staff commitment and much imagination. Despite the fact that many local authorities decided not to place children under twelve in residential care, the fact remains that younger children continue to be placed. Specialist younger children's units can be a positive choice for this group, as they recognise that for many children negative experiences of family life and the breakdown of their family placement creates feelings of rejection, loss, grief and guilt which can prevent successful transfer to a new family setting. The ethos of the specialist unit in this case study is influenced by theorists such as Winnicott (1965) and Bowlby (1953). Winnicott was interested in child

development from its earliest stages, and in the role of holding children, both physically and emotionally. Bowlby emphasized the importance of attachment. Tomlinson (2004) identified how the development of a 'thinking culture', where all staff were fully engaged in the process of intervention, was crucial to its approach. The primary purpose of the specialist unit is to create a realistic family setting in which children can be prepared for their move to a long-term family placement. The service provides safe, positive daily living experiences to ensure that each child's physical, intellectual, social, emotional and spiritual needs are met. The priority of the unit is to provide a comfortable and supportive everyday living environment, in order to maximize the positive effects of professional residential care. The small family group structure allows a flexible approach and a relaxed and informal atmosphere in which children can be treated as individuals. As Winnicott indicated, where care and nurture play an integral part of daily life, trust, respect and self-esteem can be developed. Working intensively with very disturbed younger children creates a level of emotional and physical exhaustion for staff which is huge, even compared to working with very aggressive dangerous teenagers. Hence it is important that such staff have sound models of work and good support. In the specialist unit the residential workers use Maslow's (1968) hierarchy of needs to understand that children cannot begin to grow and develop unless their basic needs are met with reassuring dependability. Theories also require to be demonstrated in practice. Hence, the environment of the home must be warm, nurturing and child-focused. The importance of providing high quality primary care cannot be underestimated. At one of Cathy's placements, she had been given all her meals on a plate, on her knee on the back doorstep, because she was not considered fit to eat at the table with the family. Sitting in the specialist unit's cosy dining room, enjoying good food and conversation (while being expected to maintain her table manners) makes a clear statement to her about her self-worth and belonging. The specialist unit aims to reflect the qualities of a warm and loving family and home as well as the deliberate and conscious offering of additional relationship security, unconditional acceptance and programmes of work to aid understanding and promote healing and development.

How many placements have the children you work with experienced?

What is normal to them?

Is moving, rejection and uncertainty of how long you will live somewhere normal for them?

How do we help young people feel safe and secure if they do not think they will be living with us for long?

From their perspective, is it worth investing in relationships?

Within your work, how does your service / team create a caring and nurturing environment?

How do you personally create a caring and nurturing environment?

Five Principles of Therapeutic Living

Campling and Haigh (1999) described the five universal principles that define a therapeutic community: attachment, containment, communication, involvement and agency. While the specialist unit does not claim to be a therapeutic community, it does strive to provide a healing environment. The five principles can enable children to come to terms with past experiences and prepare them to move successfully to a new family setting. The five principles form the framework of the thinking culture.

Attachment: A Culture of Belonging

The process of repairing attachment difficulties begins on admission. The specialist unit deliberately fosters dependency in order to help the child to develop an attachment to the home and to individual staff members. When a child arrives, all of their labels such as 'naughty boy' or 'dirty girl' are left on the doorstep. Each child is allocated a keyworker who will plan and develop a programme of induction. The aim is to promote ownership of the placement by encouraging the child to personalise their private space with their choice of decoration. Much time is spent learning about their preferences using child-friendly work books. Staff listen actively, and use the information given to support and enable the child. Staff must also maintain availability in order to develop trust. To do this, they must be caring, accepting and empathetic. Availability means there is someone always ready to play cards or cars, to tie shoelaces or bake biscuits, or to read a story and stay a little longer when bedtime brings back fear and distress. Caring means giving hugs, and sharing jokes, as well as wiping noses, drying tears and sticking plasters on grazes. Acceptance and empathy mean understanding that sometimes the anger inside can spill out and lead to kicking, hitting and spitting. Staff hold this behaviour as well as the child, and never take it personally. While encouraging dependence in all these ways, it is never an over-dependence. Encouraging individual activity and involvement in community activity ensures that the attachment fostered is both healthy and realistic.

Containment: A Culture of Safety

Routines, written menus and rotas for laundry may sound institutional but for children who have experienced neglect, abuse and chaotic lives, these can provide safety and security. Such children have high levels of stress, anxiety and insecurity. Knowing who is coming to care for you each day, that mealtimes will happen at the same time everyday and that bedtime will follow the same comfortable pattern, whoever is sleeping in, offer reassurance. The aim of routine is to contain anxiety, reduce stress and increase security for the staff as well as the children. Routine and consistency provide children with a place that is safe and secure because they know what is expected of them and those around them. There also need to be rules and boundaries in relation to the behaviour of both children and staff that clearly establish what is permitted and what is not. Children can be part of establishing those rules both for themselves as individuals and for the group. It is expected that children will test them out and may reproduce the inappropriate behaviour that has enabled them to cope in the past. This behaviour can be extreme and hugely distressing for staff. Teams need to develop ways to manage distress and disturbance so that children are not left isolated and rejected when they are feeling desperate. Positive rather than negative approaches to discipline and good order are encouraged. Good supervision is the basis for good control, but this should not be oppressive. Effective responses to children in crisis are developed when they are not in crisis. They are the little everyday things such as caring touch and shared humour. Staff try to catch the children behaving appropriately, however difficult this might be. For Cathy this sometimes meant praising her for brushing her hair when she was looking to pick a fight about wearing her school uniform. Positive reinforcements rather than emotively reactive responses are given by staff. In addition, love and care in these situations must be unconditional. Children need care and closeness most when they feel and behave at their least reserving and are

determined to provoke the rejection of past experience. Staff learn the importance of picking their battles. If they do get into a power struggle they think about how to structure the child's choices so that the child does not have to lose.

> How do you create a culture of safety?
>
> Do children know who is coming in to care for them each day - are rotas available/understandable?
>
> What are the rhythms and routines of the house?
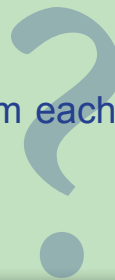
Communication: A Culture of Openness

Children coming into care rarely understand the process that has occurred or what will happen next. There are difficult facts and realities about their past that need to be explored. They need to be given the opportunity to fill the gaps in factual information. For example, Cathy did not know that she had an older brother and sister, both growing up in care. Giving her this information enabled her to lose some of the feelings of guilt that were preventing her from moving on. Sometimes, young children cannot recognise their feelings, or even put a name to them. Staff need to give children permission to have feelings, since, for most of their lives, the expression of feelings, through crying, screaming or acting out their anger, has led to problems.

Virtually every young child living in the specialist unit would rather be at home. However destructive their home may have been, it is what they know and value. If staff are to help children to move on, they need to maintain and respect the child's connections to early family and relationships of the past. Acceptance of his or her history reduces the power it has over the child and preserves remaining connections. It is important to work through children's losses without them feeling self-blame, destructive longing, the idealisation of the absent parent or feelings of rejection. In doing this, staff need to be painfully honest. Life story work begins on the first day of placement and provides the child with a clear, methodical understanding of all placement moves. It gives permission to express feelings while giving structure and control over the process to the child. In addition it can provide a formal yet user-friendly record of the child's history and life experiences. For Johnny the medium for this work was an eco-map in the form of a train track running around his bedroom walls. Each 'station' symbolised a placement move providing a visual aid for important memories. Residential staff are the guardians of children's memories. Records are important not only because they are a statutory requirement but also because they provide a context for their own future understanding of themselves. Care plans help staff to understand the work that is necessary to heal the damage of past experience but children need to understand and be part of this too. At the specialist unit each child has a 'Jobs List' which is a simple explanation of their care plan. Through this, children can understand the part that others play in their past and future and that being in care is not their fault. It also provides a clear framework for understanding what must happen before they can move to a permanent family placement. The culture of openness is not just about the children and their histories; it is about the everyday practicalities of group living. Children need to feel that they have some control over their environment and this is facilitated by regular group meetings to plan activities and address issues. For young children such meetings can be boring and uncomfortable but they can be made both meaningful and fun with a little imagination. Mini Mars Bars are a wonderful incentive to participation and contribution!
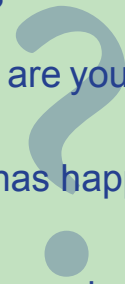
How comfortable are you in being painfully honest?

How do you decide when to soften the pain and who are you softening the pain for?

Often, but not always, children already know what has happened.

Do they just need it put in context?

How do you record life story work and ongoing life experiences?

Involvement: A Culture of Participation and Citizenship

When children are able to understand and make sense of their past and their present, staff can begin the process of weaning them away from the dependency that has been deliberately fostered. This begins by ensuring that they have the skills to manage in other settings. These can be basic practical skills like ensuring that an enuretic child can deal privately and competently with wet beds. Children are actively encouraged to develop any special interests or talents both within the home and the wider community. For Cathy this ranged from after-school French classes to Saturday morning disco dancing. The specialist unit promotes education and children are given every encouragement to take full advantage of educational opportunities. There is a clear expectation that all children will attend school. The keyworker will provide classroom support and, if necessary, attend parents' evenings, sports days and school plays.

The development of practical skills plays a major role in the movement of a child from dependence to interdependence. Helping to cook a meal for everyone or wash up and put away after a meal gives children confidence in their own abilities and also creates a sense of responsibility towards their fellow residents and the staff who care for them. A child can gain an enormous increase in self-esteem by the successful completion of simple tasks and the acknowledgement of the important role they have within the unit and community.

The environment should stimulate imagination and play, which the child has the opportunity to create and develop and over which he or she has control. Axline (1989) highlighted the importance of the therapeutic use of play. The programme to help Johnny explore his feelings uses the medium of an imaginary zoo. A frieze has been created on his bedroom wall that represents the zoo, with different enclosures, each inhabited by a different animal. Each animal is associated with a specific emotion, for example the lion represents anger and a penguin stands for loneliness. A box of three-dimensional tactile toys, which correspond to those in each of the animal enclosures, complements the frieze. Johnny, in planned play sessions with his keyworker, will be able to access these toys to demonstrate his feelings and can end a session by putting them away.

Agency: A Culture of Empowerment

When children's basic developmental and relationship needs are beginning to be met, they can begin to think about the origin of their own feelings, reactions and thought processes as well as those of others. At that point they are encouraged to take responsibility for themselves, their behaviour and their actions. This may involve beginning to walk to school alone or going to the local shop with their pocket money. It will certainly mean having friends outside the home and being trusted to come in at the right time. Most importantly it will mean praise and affirmation when children make the most appropriate choices. The specialist unit is committed to keeping young children for as long as they need to be there. Children normally stay for at

least a year. Some will stay for two or three years. For young children, this can mean that a significant portion of their lives has been spent in residential care. When they are ready to move into a family, this needs to be tested out by the process of 'normalisation'. For Andy and Tern, a brother and sister who came to the unit when they were aged just three and four, this involved taking them away with just one member of staff. With no other children or lots of staff to play with, they had to fall back on their own resources and start to behave as a family once again. This has proved invaluable in terms of the preparation for moving on.

Younger children can only be taken through the complex process of healing and moving on because of the commitment and passion of a dedicated staff team. There are no magic wands to make everything all right. Staff can only help children to learn to cope and find more positive ways to negotiate their way through life. Working directly with children in a focused way can be challenging, demanding, time-consuming, tiring and emotionally draining, and this must be acknowledged and recognised. The unit ethos defines the world of the young residents, and they live very much in the 'here and now'. They need staff who can be understanding and empathetic to their needs, and who are respectful of their struggle to survive and find a way through the trauma of their lives. Staff undertaking this difficult work need support to enable them to keep some perspective. They need time to reflect on practice and to share feelings, discuss ideas and concerns. Kendrick (2005) points to the use of external consultancy when researching the work of one such specialist unit. Effective supportive supervision is also a pre-requisite for good practice. Leadership at unit level is important. Managers must assemble and support a staff team to carry out this difficult work and they must lead from the front. By giving a clear message that the children should shine, staff are encouraged to follow and provide the love and care needed to help them develop.

In order to be able to give a high level of support to the children you work with, you need to be supported in your role.

How do you receive support for the work you do?

If you were to redesign the support available to you, what would you include/reduce?

What are your needs?

Conclusion

All children, but especially younger children, desperately need us to listen to them, and to try to understand what they say. It is so easy to be too busy to listen, but inside each child, there is a story that needs to be told. It is through expressing themselves that children become self aware and start to resolve their pain and difficulties. They can then develop the self-esteem and sense of themselves which will enable them to relate effectively to others. Some things cannot be said to those who are too near, to family or substitute family. This is why residential care can provide the positive option for these damaged children whose experiences of family life have been neglectful, destructive and abusive. It can provide time and space for loss and grief to be acknowledged and understood and for learning the strategies for group and family living.
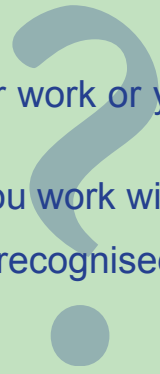
What for you are the main points in this paper?

Is there anything you would wish to adapt for your work or your own practice?

How does this paper relate to the older children you work with?

Are the needs similar, or are developmental gaps recognised?

Can all services learn from what is being said?

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Foreword

Conflict Resolution in Residential Care written by Neil Whettam and published in 2007 asks practitioners to reflect on the nature of conflict and how to use this. As Jung said

The most intense conflicts, if overcome, leave behind a sense of security and calm that is not easily disturbed. It is just these intense conflicts and their conflagration which are needed to produce valuable and lasting results

Conflict as actual or perceived opposition of needs, values and interests, infiltrates life at all levels and surrounds us, politically, socially and personally. It is present at home and work, within family and friends and is a feature of our internal world. As this useful paper points out, it is the resolution of conflict that we need to learn from, not its avoidance. Many young people in care have experienced disproportionate amounts of conflict and have had few experiences of positive resolution from which to learn. A primary task of caring / parenting is co-regulation or 'calming together' (Bath 2008). Children develop the ability to regulate emotions and reason through reliable and stable care-giving and adult role-modeling, not through threats and punishment. If as Cozolini (2006) suggests, 'the ability to absorb the rage of an angry adolescent is a gift' then the ability to help young people learn to turn anger and conflict towards resolution then becomes a gift that young people can also give to others.

Neil Whettam's idea of conflict partners is a helpful concept for everyday practice and resonates with some current residential theories and themes. For example:

• Real partnerships and participation of young people in service design where 'win-win' resolutions are sought rather than solutions that only meet the needs or interests of carers or organisations;

• The Social Pedagogy approach is grounded in the idea of learning and working together and enabling children to resolve their own conflicts. As one Social Pedagogy practitioner reflects, it may not always be what was expected or hoped for. "However, the process is important as it gives them the beginnings of developing the tools that will take them into adulthood. […]By me handing over the authority to the group to participate in [the resolution], the process was an empowering experience for all the children." (Holthoff and Eichsteller, 2009);

• Another model of therapeutic conflict resolution is Way of the Council, a group-work method where all participants have an equal say. Managed well, it can resolve conflict quickly and effectively in residential services (Stevens, 2010) When the opinions of children and young people are equally respected, it can begin to readdress the power inequalities that children in care may experience;

• This paper also discusses a number of practical methods, that are now part of restorative approaches piloted successfully in schools in Scotland (Kane et al., 2007). Here, skills-based training is given to support the notion that those best placed to resolve a conflict or a problem are the people directly involved, rather the behaviour being pathologised.

All of these approaches can conflict with 'deeply held beliefs about notions of discipline and authority' for staff and their perceived role as imposers of limits and sanctions. With a better understanding of the neurobiological model of stress and trauma that is linked to abuse and attachment, practitioners may be able to look behind the conflictual behaviour. These concepts are described very well by Perry and Szalavitz (2006) and Howe (2005).

Some children may well have developed challenging strategies which may be both unconscious and conscious methods of surviving intolerable stress. They are also likely to have developmental delays and differences that lead them into conflict situations A deeper understanding of the early experiences of young people seems key to identifying the conflict pathways and the development of positive conflict resolution strategies, as Neil Whettam suggests, would be steps in the right direction.

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Conflict Resolution in Residential Child Care

Neil Whettam

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Neil Whettam trained and worked as a residential child care officer in a residential school in Aberdeen before becoming a VSO volunteer in Belize. He became a social work trainer in the State Juvenile Detention Centre, where he developed his interest in conflict resolution. On returning from his VSO posting he worked for non-governmental organisation in the Balkans and Central Asian Republics providing services for children and families affected by war, genocide and displacement. More recently he has been involved as a UN consultant in projects for street and working children who are in conflict with the law. He works currently with Aberdeenshire Council as an Employee Development Officer (Social Work/Care) delivering and commissioning training for Social Work Children's Services.

Introduction

One of the main issues within many residential child care units across Scotland is that of conflict. As residential workers it is important to analyse how we manage it, help resolve it and how we assist a young person who is in conflict with others. Given the difficulties experienced by young people in care, it is not uncommon to find them in conflict with a wide range of people, who may include residential staff, peers, parents and professionals from agencies such as schools or field social work departments.

For many young people in care, conflict can dominate their life. The issues facing them have been well documented in research (for example, Clough, Bullock and Ward, 2006). Some young people have constant battles, both internally with their own situation and externally with their caregivers. This could eventually have a detrimental affect on their mental health. A study of young people living in care in Oxfordshire (McCann et al., 1996) highlighted that 67 percent of young people in care had mental health disorders compared to 15 percent in a controlled population. In a similar study of young people looked after by local authorities in Scotland (Meltzer and Lader, 2004), 45 percent of the young people surveyed experienced some mental health disorder. Research into the possible causes of the mental health issues for these young people is fraught with difficulty. This is mainly because it is so difficult to isolate causal factors. For some young people, it is strongly suggested that the constant conflict that may exist for them in their internal and external worlds could contribute to or exacerbate their mental health problems (Molgaard, 2005).

Taking this into consideration it may be helpful for practitioners to reflect on the nature of conflict for young people in care. This paper will provide some guidance on gaining a greater understanding of what is conflict, the signs and symptoms of conflict, and specific strategies to deal with conflict. It is also hoped that this paper will help practitioners to address some of the issues in the area of conflict during their day-to-day interactions with the young people they work alongside in residential child care.

What do we mean by conflict?

Conflict is a normal part of everyday life. It is also clear that conflict can make some people feel uncomfortable and can create difficulties when it occurs. People deal differently with conflict. Some will thrive on conflict as they feel it is a safe form of defence. Others will pretend it does not exist due to the immediate internal pain it may cause, or because it may lead to flashbacks to previous experiences which were uncomfortable. One definition of conflict describes it as:

A clash of interests, values, actions or directions (EEC, 1997 :8). Conflict may arise when more than one possible solution or course of action exists; conflict situations can be very complex and multi-layered, however, existing at one or more levels. In order to understand these complexities it is helpful to reflect about what happens for us as individuals when conflicts arise. What goes on for us when we think about conflict? What are our feelings? What are the possible effects of our ways of dealing with conflict? Take a few moments to think this through. This small degree of self-awareness and reflection can assist practitioners to understand how to deal with conflict in a more productive way. By spending a few moments thinking in this way, we can also see that conflict is something which affects not only the young people with whom we work, but ourselves as practitioners. Now, take a step back and think about yourself or a young person with whom you are currently working. What are the intra-personal and inter-personal conflicts in which you or they are engaged?

Intra-personal conflict

This is conflict that exists within our own self. Our initial reaction is to pursue one course of action whilst our 'inner voice' fights against this and advises something different. For young people in care, there is a high likelihood that they will have many sources of intra-personal conflict arising from their often disrupted or traumatic past. For practitioners, intra-personal conflict can arise if the role of residential worker clashes with deeply held personal values.

Inter-personal conflict

This type of conflict occurs between people and can often be negative, resulting in the deterioration of relationships, long-term resentment and a lack of co-operation. For many young people in care, this may be the norm as they may have been in constant conflict with others as a means of survival. This cycle of conflict can be difficult to reduce or even change. Conflict with long historical roots can be hard for a young person to let go of, as they may be in entrenched positions. They may find it harder to climb down, having made a stance previously. It may be that you interpret some action as a relatively small and minor issue of conflict. If you interpret something in this way, it can seem easier for you to manage. For the young person, however, these small issues may not be totally clear. They may be reading something else into the situation and the small issue becomes misunderstood. If this happens, a conflict between the practitioner and the young person can continue or escalate, purely because the practitioner has not acknowledged that the situation has a different meaning for the young person. At this point it may be useful to think of those in conflict as 'conflict partners.' This recognises that both sides have views and opinions and avoids setting up a blame culture. It may also be helpful to you to look at conflict in the following ways. Think about any conflict within your residential unit at present. Is it:

- Open – are the issues clear to all parties?
- Confused – are the issues unclear to any of the parties?
- Covert – are people pretending it does not exist and, therefore, are the issues not being acknowledged?

You can probably identify instances of open or confused conflict. Covert conflict, however, is a little more difficult. As a practitioner, you may have to draw from your own experience to gain some possible clues about whether or not covert conflict exists.

Sources and causes of conflict

It is essential for practitioners to understand the real issues within any conflict situation in order to resolve them. When you are experiencing conflict as a practitioner, some of the issues which the young person presents may appear to be trivial. For the young person, however, these may take on great significance and become the catalyst in what they see as an unravelling of their life around them. If a young person is feeling powerless, it may be these very small issues that become extremely important to them because those very issues may be the only things over which they feel they have any control. It is important that you gather

as much information and reflect on what is happening for the young person before making judgements or decisions on how to proceed.

Research indicates that the two most common causes of conflict are change and lack of communication. Other causes may include any or all of the following:

Differing aims: This may happen when the young person has not been fully consulted about aspects of their life. It may be, for example, that they have had little chance to have an input to their care plan. Alternatively, they may have chosen to have little involvement in their care plan. They may do this because they believe there is no point as no one has listened to them in the past, or they may perceive that consultation in the past has been a token gesture. This type of conflict is prevalent at a time of change, and is often experienced by the young person as a 'hidden agenda.'

Differing Aims

How much input do young people have when care plans are being developed?

What differing methods do you use to involve the young people and ensure you have a shared understanding?

Resources: The young person may want something to happen in their life, but there may not be the resources to facilitate this. One example might be supervised contact. This can escalate into a conflict situation whereby the young person wants to see their siblings or parents more often than resources or staffing will allow. Similarly, they may reside in a unit which is a long way from the family home as there are no local residential resources available. Practitioners must find ways to explain this to a young person while at the same time understanding how the young person feels about having to accept this situation. Alternatively they may feel that you have a role as an advocate for the young person in such a situation, and push for additional resources.

Have you experienced a situation where resources have been a basis for conflict?

How do we manage the separation of our own feelings of defensiveness or annoyance at the resource issue?

Are we honest about the issues?

Changes in role: It helps to be aware of the roles played by young people before they came into the unit. For example, if parents were unavailable to the child because of substance misuse, the young person may have taken on an adult or parental role within their family. If they are suddenly brought into a unit and this role is not recognised, conflict may result. Similarly, changes in role can occur once the young person is established in the unit. For example, a new young person may arrive within the unit and attempt to replace another young

person who occupies a leadership role, or even a 'scapegoat' role. Practitioners need to be sensitive to the dynamics of the group in the unit and the possible impact of change within the group. The whole unit should be addressing the changing relationships and what it means in terms of staff and young people.

What roles do the young people you work with have within the house?

Are the young people's roles discussed as a team?

Do we truly understand the roles?

The work of Dr Ruth Emond may enhance our understanding, a summary of the research can be found via:
http://www.sircc.org.uk/sites/default/files/understandingtheresidentgroup.pdf

Personality clashes: Like staff, some young people will express themselves strongly and assertively, whilst others will prefer to hold back. Young people should be given the space to voice their preferences about staff members and peers alike. If this space is not provided for and a view not allowed to be aired, conflict can arise or escalate.

How well do we recognise personality clashes?

What mechanisms exist within your workplace to allow for clashes to be discussed?

Lack of assertiveness: Some young people will avoid any kind of conflict, often to their own detriment. It is often the case that young people who are quieter may be overlooked, particularly in a volatile unit. Sometimes a lack of assertiveness can be linked to previous abuse or neglect. For example, the child who has been emotionally or sexually abused may not be able to be assertive for fear of repeated abuse, or because of learned helplessness (Garber and Seligman, 1980). In situations like this, practitioners need to be aware of the background of children in the unit. There may also be a need to train children and young people in assertiveness techniques.

Do we help young people become assertive?

Do we teach skills and help young people develop their ability to be assertive, or is compliance better rewarded?

Misunderstandings: It may be that some young people appear to be in conflict but, in reality, they are not in conflict at all. It may be that the perceived conflict is actually about poor communication skills, especially if the young person is unable to articulate exactly what they

are feeling. Practitioners can contribute to this misperception, especially if they do not fully explain what is happening, or what will be happening in the future, in an appropriate manner for each young person. Another source of misunderstanding can be when staff members have their own preconceptions about the situation or mindset of a young person without checking this out. In these cases, practitioners need to be careful that they have evidence for believing their preconception. Another well-known source of misunderstanding lies in the operation of the staff team. If every member of the staff is not consistent, a young person can be given different messages about the same situation. Consistency is extremely important in a residential unit and the team must have robust and open ways of communicating information from staff member to staff member. Consistency is also about quality of information as well as the way in which it is transmitted. Practitioners need to be clear about the content and reason for communication; providing space for discussion and clarification during handovers can help this.

How do we check out that our understanding is the same as our colleagues, managers or the young people we work with?

Is it okay to ask others to explain their understanding and to share our own?

Lack of Trust: For many of the young people in residential child care, the issue of trust is a huge obstacle for them to overcome. Given that the young people in residential care are among the most vulnerable and hurt young people in our society, and that they have probably been let down frequently by those charged with their care, practitioners should not be surprised that the young person will have constant questions like "Can I trust what this person is telling me is true?" or "How do I know I can trust them?" or "All adults tell lies anyway so why should I trust them?" If practitioners are not honest with the young people they work with, then conflict can develop. As a practitioner, it is important to avoid making judgements when looking at conflict issues, which arise from a lack of trust. It is also important that staff recognise the different needs that are arising, and provide hard evidence of their reliability in small but meaningful ways. Finally, practitioners should not take some of the comments made by young people as a personal attack. We should learn to see such comments within the context of the disruptions which have prevailed throughout the life of the young person.

What practical things do you do which helps young people and others build trust in you?

Is this more difficult in times of stress?

Unhelpful behaviour and ways to deal with it

This section discusses some of the unhelpful behaviour which arises in conflict situations, and gives some advice about how to deal with such unhelpful behaviour.

Avoiding Conflict

Rather than discussing something when it arises, some staff or young people may not say anything until their feelings explode in a hurtful and angry way. Much greater conflict may result. Try to discuss a potential conflict issue as soon as it arises, in a calm way.

Being Defensive

Defensive people will deny that they have made a mistake and avoid responsibility. This may alleviate the conflict in the short-term but will create long-term problems when others in the unit feel they are not listened to.

Address the conflict objectively and with a willingness to listen and respond to criticism. Overgeneralisation Some people make sweeping generalisations when faced with conflict. Avoid starting sentences with, 'You always…' or 'You never…' as in, 'You never agree!' Remain in the present, with the current issue and do not bring up old conflicts.

Being Right

Sometimes, people just assume that they are always right. This creates conflict through a refusal to see things in another light. Look for a compromise or agree to disagree, and remember that there is not always a right or a wrong way to resolve a situation.

Forgetting to Listen

Some people interrupt others before they have had a chance to explain a situation. Or they may be busy thinking of a response. Listen actively and empathise with the other person.

Blaming

Some people handle conflict by blaming others. This assists the person in abdicating responsibility for their role in the conflict situation. Try to view conflict as an opportunity to analyse the situation objectively and assess the needs of all participants in the conflict.

Needing to Win

Some people may feel that a conflict situation is almost like a game that needs to be won. Arguing how wrong the other person is or discounting their feelings can lead to increasing resentment. Try to encourage mutual understanding and come to an agreement that respects everyone's needs, including the need to save face.

Making Character Attacks

Sometimes people turn a negative action into a personality trait. For example, a young person or staff member needing assistance might be labelled as 'attention-seeking.' This creates negative perceptions and can become a self-fulfilling prophecy. Remember to respect the person, even if you do not like the behaviour.

Which of these behaviours can you most associate with yourself?

Which of these traits can you link to others you work with?

Can you share your perceptions on yourself and others with your team?

Do your colleagues know the behaviours you would like to develop and if so how can they help?

Developing a conflict resolution strategy within your unit.

Remember to look to the future and learn from the past. Do not dwell on negative past conflicts, or you will be unable to deal positively in the present or the future. Provide options for the young people making sure the options are workable for all. Set aside disagreements and focus on the options that seem most workable. In generating options, ask first for the options of the 'conflict partner' and then implement the following strategy:

- Offer new suggestions.
- Write all suggestions down so the young person can see them and where reference can be made to them throughout discussions or negotiations.
- Wait to discuss all of the options; this allows the young person to see the full range of options rather than becoming transfixed on the first one that you happen to choose for the discussion.
- It maybe helpful to group some suggestions together.
- Agree those options which you both feel are not workable, and note down the reasons why they are unworkable from both points of view.
- Predict the outcomes as you discuss them, and make clear both the positive and negative aspects. At this point you should also outline the risks involved if a particular option is chosen, remembering that there can be positive as well as negative aspects to risk.
- Ensure you look at all the options, no matter how unreasonable they may seem.
- Be creative and imaginative in your thinking, as this indicates to the young person that you are willing to assist in resolving the conflict and are able to listen to their options. When identifying key options and coming to a resolution which is satisfactory to all 'conflict partners' you should keep the following points in mind:
- Try to meet one or more of the shared needs.
- Generate options that will improve the relationship all of the 'conflict partners' involved.
- Choose the ideas that have the best chance at success.
- Arrive at a resolution which will increase confidence.
- Recognise the 'givens'.
- Look at each individual's responsibilities in relation to resolving the conflict and make these clear.
- State clearly that you see conflict resolution as a process in which you need each other.
- Focus on developing an 'our' power attitude rather than a 'my' or 'your' power stance.

Do you have a conflict resolution strategy, either informal or formal?

Do you need one?

What would you include?

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Bereavement

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Introduction

Bereavement is one of the last taboos in residential child care. Children may lose important people, and staff may lose children and young people for whom they cared. So how do staff and young people cope with bereavement? This paper suggests some answers and gives some helpful practice points.

Messages about bereavement: a brief review

Bereavement is probably the most serious loss a person will experience. It has been described as 'a state that is characterised by loss' (Herbert, 1996, p. 246). Yet despite its ubiquity, it is something for which people are often completely unprepared. As adults, we talk very little about death and bereavement. Although it is a natural and inevitable part of life, death is kept hidden away, particularly by Western cultural practices. Gatliffe, as cited in Mallon (1998) states that it is almost as though we have come to regard death as just another disease to be conquered. As a result it is often a 'taboo' subject, particularly around children. Western culture does not encourage children to talk openly about, and address the facts of, death and bereavement. People in our culture are not encouraged to grieve openly; therefore bereaved children lack knowledge and guidance in how to deal with their grief and loss.

Bereavement is a process which some children in residential care may have to go through and deal with. As a result, staff in residential child care units should be aware of the emotional, social, personal and educational effects this may have on the bereaved child. So how do staff fulfil their role in meeting the individual needs of bereaved children?

To understand the place of death in children's lives, we need to look at the beliefs and behaviour of adults around them. The attitudes and values of our society influence what we believe and how we think; they provide a framework for ordering the things that happen to us, for defining our purpose and place in the world. Death is a biological fact. What it means for us and what we teach our children about it are the result of socially shaped ideas and assumptions (Charmaz, 1994). Bereavement is an experience we must all go through when a death occurs, no matter whether we are children or adults. Someone who was important to us is no longer alive and we must somehow find ways of accepting that. Bereavement has also been described as 'a wound which needs time to heal' (Yule & Williams, 1990, p. 267). In a small scale study carried out by one of the authors (Duffy, 2003) it was demonstrated that in a school setting with children ranging from the ages of 4 to 11 years-old teachers failed consistently to implement work on bereavement or deal with the bereaved children in a sensitive and supportive manner that helped these children to grieve without feeling abnormal in any way. Indeed, bereaved children were often considered to be 'problem children'. Dying and death are not everyday topics of conversation, they are mostly regarded as morbid and best ignored and hence they are unfamiliar issues for many people. Talking about death elicits embarrassment and defensive attitudes, perhaps because it is often associated with pain, fear, ugliness and hopelessness. Every year, thousands of children face bereavement, perhaps through death of a grandparent, parent, friend or sibling. In these cases, adults may be so deeply engrossed in their own grief that the feelings of the children involved may not be noticed. The losses of children and young people in residential care can be profound before their care experience. Children in care who suffer loss through death are doubly affected, and may develop particular problems and needs that must be acknowledged and tackled if they are not to suffer unduly, perhaps into adulthood.

Children's perceptions of death

Children's understanding of death develops in parallel with the child's cognitive maturing through childhood. The development of the concept of death may occur at slightly different rates, but the developmental sequences seem to be the same. For younger children around five to eight years old, it has been found that this is also the age of fear and fantasy. A child may personalise death as a skeleton, monster or ghost. From the age of nine to twelve, greater cognitive ability gives the child an awareness of the finality of death: that it is common to all living things and that it is final, universal and inevitable. From twelve through to adolescence, children are searching for identity and meaning in their life. It is at this stage where 'the child's concept of death becomes more abstract, and they are able to understand more of the long-term consequences of loss' (Dyregrov, 1991, p. 12). Adolescents are able to grieve more as adults do, with appropriate crying, and with feelings of sadness, anger and depression.

How do you think the children and/or young people you work with perceive death?

Would the perceptions link with the age and stage of the group?

Effects of bereavement on the child

When a death or major loss occurs, a child will experience many different reactions and behaviours to cope with their grief. Grief is not expressed just in words; it is not answered just in words. Shock and disbelief are usually the child's first response to a death or major loss. A child's reaction may be a silent withdrawal or a wild outburst of screaming. A very young child cannot understand what is going on, but may be sensitive to an extremely disturbed, sad atmosphere in the home, and an upset of everything familiar to them. Dyregrov found that 'children may refuse to accept the death and firmly maintain this – thus keeping the painful fact at a distance' (1991, p. 13). Even though the child knows his or her loved one is dead, the child's every thought is so centred on that person that he or she cannot believe that the person is not around. The child has lost something and experiences a profound need to find that person again. The fact that they cannot find the person can lead to the child experiencing overwhelming fear, followed by despair. Anger is commonly expressed after a major loss, and this feeling may confuse bereaved children and young people. This anger may be directed at different entities. For example they may be angry at God for letting it happen, at adults because they exclude them from their grieving processes, or at themselves for not preventing the death. Another emotion that is common in a bereaved child is anxiety. 'Anxiety is an essentially adaptive emotion, in that it motivates us to initiate behaviours that prevent the anticipated harm being released' (Herbert, 1996, p. 271). One of the most common fears that children have is a sense of guilt, which may be associated with a specific aspect of the loss rather than a general sense of total self-blame. In the case of children and young

people in residential care, it is important to remember that bereavement may be closely linked to their attachment style. The attachment style of a child is based on their early childhood experiences. Based on the work of Bowlby and Ainsworth (in Tavecchio and van Ijzendoorn, 1987) attachments can either be secure, insecure, anxious or avoidant. Secure attachments arise when a baby has a warm loving relationship with its main carer at an early age. The baby knows it can depend on its carer and grows up to have a secure attachment style. Children who have main carers who are unreceptive or over-anxious will have anxious or avoidant attachment styles. For example, Wayment and Vierthaler (2002) found that those who reported having a secure attachment to the deceased reported greater levels of grief. Individuals with an anxious attachment style reported greater levels of grief and depression. Higher levels of psychosomatic disorders were reported by those with an avoidant attachment style.

Understanding the grief process

There are a number of ways in which the grief process can be conceptualised. The following is one of the best known models, based on the writings of Kubler-Ross (1969) and Murray-Parkes (1986). There is traditionally a five stage process to understanding grief.

Shock
At the point when the loss happens, it may be difficult to acknowledge that the event has taken place. The emotional state may be numbness and an inability to register that anything serious has taken place.

Denial
Eventually the state of shock gives way to one of denial. The individual may deny the emotional consequences of the loss or may even in extreme cases deny that the loss has taken place. For example, residents and staff of the unit may leave the absent person's favourite armchair vacant as though expecting the person to return. People may even report seeing or touching the absent person.

Sadness/depression
After a time the reality of the major event or change begins to dawn. Memories of the departed person and lost relationship may remain compulsively in the back of a person's mind. At this stage people may be tearful and miserable and be unable to get on with their work or other areas of their life. There is a possibility of sinking into depression. This stage may go on for a long time, with the person doubting their ability to manage the changed circumstances. Sometimes when a death occurs, the individual may take on all the blame for the situation and manifest severe depression and perhaps self-hatred. Sometimes the same person will also express hatred for the dead person for making them feel so hateful. It is not uncommon for people to swing between blaming themselves and blaming the person who has died for making them blame themselves, or between depression and anger.

Anger
Periods of sadness and depression may be interspersed with feelings of anger, often quite intense, directed at the person who has gone. Sometimes the period of depression is followed by a period of anger, sometimes the anger comes first. There is no fixed pattern for everybody. People will often move back and forward between stages. Anger may be particularly powerful if the loss is sudden and there has been no time to prepare for it. In such a situation there may well be unfinished business, things that one would like to have said to the lost person or issues that have not been resolved. Their sudden departure deprives the surviving person of the ability to communicate such thoughts or feelings directly to the person who has left.
Anger is particularly likely when the loss of another is interpreted as being a rejection or abandonment. In this situation people find themselves destroying letters or photographs or other memorabilia of the departed person. In terms of the grieving process it is easy to see how an individual can become stuck at the stage of anger and unable to move on to acceptance.

Acceptance

Finally, however, there comes a gradual acceptance that the death has occurred and that it is final. There is nothing left now apart from memories. Though there will be memories of the lost relationship, these are no longer compulsive or overpowering. There has been a kind of letting go. Eventually it becomes possible to remember what is lost without enormous amounts of emotional pain, and if what is lost was good, to remember it with fondness and love. What has taken place is a process of acceptance and emotional burial.

> Would these stages fit with your experience?
>
> How would you help a young person at each stage?
>
> What would be helpful and what could be unhelpful?
>
> **?**

The role of significant professionals in the life of a bereaved child

There is little research which deals specifically with bereavement as experienced by children in care. However, a small-scale study carried out by one of the authors looking at children in schools (Duffy, 2003) indicated some ways forward for residential staff when dealing with bereaved children. Some of the points with greatest relevance for residential practice are as follows:

- Practitioners have a significant role to play in the life of a bereaved child.
- They are in a prime position to recognise the signs of grief in children in their care.
- The creation of a unit policy can help to provide a framework for all staff to deal with death and all its eventualities.
- It is important that practitioners watch for changes in the bereaved child's behaviour and respond to this appropriately, especially when they have abnormal reactions grounded in their attachment styles.
- Staff can help a bereaved child by creating a supportive atmosphere where they feel able to talk and share their feelings openly.
- They should be ready for questions and always be honest. A child or young person often becomes burningly curious about death.

A fundamental outcome of this small-scale study was to emphasise to staff the extent to which bereavement can effect the behaviour of a child in the unit or at school, and the role which they could play in the life of a bereaved child, in order for their individual needs to be met. Children can show signs of depression, withdrawal, regression and nervous anxiety. Others may push their feelings outwards in angry and aggressive behaviour as they struggle to make sense of their situation and try to handle their feelings. There may be a combination of these presenting behaviours as bereaved children live on an emotional 'seesaw' – up one moment and down the next. At times they may change their attitude to what has happened, swinging from displays of sadness to callous comments. These reactions may be further complicated by the attachment styles of the children. The challenge is for residential staff to recognise some of this as a normal reaction to grief and not to minimise this. If bereavement in childhood is handled with sensitivity, responding as soon as possible to a child's individual needs, residential staff have a far better opportunity to enable them to recover from grief and to integrate death as part of their knowledge base for life. They could prevent a child's grief from becoming prolonged or complicated later in adult life. Looked-after and accommodated children suffer bereavement like many other children, but their needs may be greater in that they have had to undergo a number of transitions and changes in their young lives. Children and young people with special needs often have short break experiences and here too the concepts of transition, change, loss, grief and bereavement apply as they do to all other

children and young people. The work of Dyregrov (1991) offers a series of guidelines in work and care of children and young people who have suffered a major loss:

Open and Honest Communication

- give age-adjusted explanations to children.
- reduce confusion by being clear in your communication.
- refrain from abstract explanations and keep things as concrete as possible.
- do not explain death as a 'voyage' or 'sleep.' This may serve to confuse the child or young person and, in reality, may be more about the practitioner's feelings than the child's feelings.

Give Time for Cognitive Mastery

- allow questions and conversations about death within the unit.
- accept short conversations.
- look at albums and photographs.
- let the children visit the grave.
- accept children's play.

Make the Loss Real

- let the child participate in rituals (seeing the dead or attending funerals).
- do not hide your own feelings.
- keep reminders of the dead person present.

Stimulate Emotional Coping

- work for continuity between the unit, school and home, if appropriate.
- avoid unnecessary separations.
- talk with children about their anxiety about something happening to other significant people in their lives, or to themselves,, as these are common anxieties.
- talk with children about eventual guilt feelings.

> Are there any of the recommendations you may find more difficult to adhere to than the others?
>
> How would you feel having an open discussion with a young person in regards to a death?
>
> Would you be able to attend a funeral with them, or show your own emotions?

Helping the helpers: staff and grief

This paper has focussed on working with children who have suffered bereavement. Another aspect of this topic is how staff themselves cope with death. There are two areas of work where staff have to deal with bereavement. One of these is working with the child or young person who has lost someone and dealing with any feelings that this may provoke for themselves as practitioners. The other is where staff members lose a child in their care. This can be a regular feature of work with severely disabled children with life-limiting conditions. It also happens in mainstream residential care, although it is not so common. In terms of working with a bereaved child, staff should have this acknowledged in supervision and they should be supported in this process. In terms of the loss of a child in the unit, the grieving process will apply to those staff who were involved in the care of that child. This particular staff group not only have their own grieving needs but also have to help other residents to cope with the loss. Managers have a

very important role to play here. Any grief experienced by staff and other young people should be expressed openly. The principles of open and honest communication, making the loss real, stimulating emotional coping and allowing ventilation of feelings, should apply.

While there has been very little research in this area, Katz, Sidell and Komaromy (2001) looked at the emotional and practical consequences of a death occurring in adult residential care. They found that most managers felt some responsibility for relatives of deceased residents, but rarely felt capable of providing what they perceived as appropriate bereavement support. They recognised the need for practical as well as emotional support for staff and other residents after a death, but felt that they lacked the skills and time to provide this. Certain types of home prioritised bereavement support, but many homes operated under considerable resource and staffing constraints. Even where support needs were recognised it was often difficult to put the requisite help into operation. This study identified a lack of training in communication skills and in particular little access to training in bereavement care. This area needs to be addressed if residents and staff in residential settings are to have their bereavement needs met.

Conclusion

Dealing with death in residential child care is a difficult and sensitive area. If handled well, it will have a positive outcome for children and staff. It is important that staff understand the grieving process and how it affects children and young people at different ages. It is also important, however, that staff receive the right kind of support to ensure the best outcomes for the children in their care. It is hoped that this paper may go some way toward equipping staff to deal with one of the 'last taboos.'

How confident would you feel supporting a young person through the bereavement process?

What support do you think you would require when undertaking this role?

Has the reading of this paper made you want any further information on any aspects, or changed your perceptions about working with children and young people through bereavement?

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Use of Self in Residential Child Care

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Introduction

It is often said that the best tool that a residential child care practitioner has is their own self. 'Use of self' is an umbrella term covering elements such as empathy, critical thinking and appropriate use of the personal within a professional child care context. It includes openness, self-reflectiveness, attunement to others, commitment and emotional maturity. Use of self is linked to relationships, which are of key importance for the residential child care practitioner. It has long been recognised that relationships form the basis of effective working, regardless of the theoretical orientation or organisational structures within which services are provided. For example, Dewane commented that the relationship is 'the cornerstone of change' (Dewane, 2006, p. 543).

This is particularly evident in residential child care where shared living adds to the potential depth of working within a relationship. The most meaningful work with children and young people takes place within the context of the relationship and 'no matter how knowledgeable, skilful or creative workers are, they can do nothing for their clients without a nurturing medium of human interchange' (Gilbert, Miller and Specht, 1980, p. 45).

In residential child care, the use of self is uniquely complex developmental work. It is undertaken by practitioners within the context of young people's past experiences and serves as the vehicle for developing attachments which help young people to heal. For many young people in residential care 'repeated painful interactions with a primary care giver' have led to 'despair about ever being known and understood' by themselves or by others (Mollon, 1996, p. 13). This may lead them to test relationships to the limit. If a practitioner can understand why this testing takes place, this can help him or her to recognise why it can be so difficult to manage the emotional responses of the young people. It can also help the practitioner to recognise the powerful responses evoked in themselves in response to the despair, anger and rejection of the child. Furthermore, it can allow practitioners to see behaviour as communication, giving cues about unmet needs and the unconscious search for these to be more adequately attended to (Casement 1990, p. 110).

No-one can ever come to a new relationship completely free of past experiences. In psycho-dynamic terms, transference and counter-transference occur. This means that present relationships are coloured by issues from other (often past) relationships, and it happens for both practitioners and young people. For instance, a child may respond to a staff member according to the way they were treated when their mother did not meet their needs. At times, because of this, they will unconsciously attempt to sabotage your work with them, which confirms to themselves that people do let them down. Mattinson (1975) sums this up as an unconscious need to make the present relationship fit into the psycho-dynamic structure of a previous one. The practitioner is 'invited' to behave in ways that others in the young person's circle have behaved in the past. If the practitioner does not understand the communication in this situation, he or she might become frustrated and angry at the young person's neediness and inability to do what they have agreed to do. The practitioner may begin to respond internally, and perhaps externally, in a dismissive or punitive way. If practitioners can learn to be more aware of this kind of process, they can consciously try to alter their part of the transaction and help the child or young person to move away from their older patterns of behaviour (Mattinson & Sinclair 1979).

It may seem an obvious statement, but all relationships involve relating and therefore have an impact on both participants. There is a danger, however, in relying on instinctual or natural responses. The danger is that the practitioner may not identify what comes from their own past experiences and how these operate within him or herself. Hence this may be lost as a way of understanding what is happening within the young person. As 'we influence and affect each other .... we need to be tuned in to what effect we have on others and to what effect they have on us' (Thompson, 1996, p. 11). Use of self as a way of working requires practitioners to strive to become aware of the feelings, thoughts, motivations and responses that are aroused in themselves by their work, and to identify their own issues and anxieties within these. Understanding the young person necessarily leads to further understanding of the practitioner's own strengths and needs as 'we strive, together, to make sense of what is going on, to interpret what we find and to discover meaning in what we do and what were are' (Howe, 1987, p. 111). This is the essence of 'use of self'.

Does the definition of use of self given in the introduction fit with your previous understanding?

What if anything is different?

The importance of being aware of the impact of the work.

Working in residential child care emphasises 'the closeness of the residents to the worker.... involving aggression, sexuality and dependency which arouse anxiety in everyone' (Ainsworth & Bridgford, 1971, pp. 458 & 461). The conscious use of self by practitioners, who invest themselves in the work and manage the relational aspects of it, can have a profound impact on young people. In addition, it can have an equivalent impact on practitioners themselves. Recognition of this impact is important if practitioners are to continue to thrive in the work rather than be overwhelmed by it or become distanced and shut off from it.

Clough (2000, pp. 61 - 62) lists a range of ways in which interventions with young people may affect practitioners and their ability to manage themselves. Among these are: exposure to pain and hurt, being touched or disturbed by the experiences, wishing to heal or resolve problems, the pressure to get tasks done, the management of risk and the impact of setting boundaries and assuming power and control. Working so closely with young people 'makes strong demands upon us.... and if we are to invest of ourselves so greatly we need to learn to do so without depleting ourselves in the process' (Ward, 1996, p. 231).

How do you recognise and record the impact on yourself from your work?

What enables or supports your ability to reflect?

Did you understand the possible impact of the work on yourself, prior to undertaking this type of work?

The developmental and self-protective nature of self awareness

Developing self-awareness has two key functions:
•   the development of more effective working practices.
•   a self-protective function in understanding and managing the impact of the work.

Managing the impact of the work and gaining deeper insight into the effective use of self requires a degree of self-awareness and an ability to reflect on practice. Thompson indicates that growing self-awareness helps practitioners to develop themselves as a tool for working. He states that 'much of what we have to offer comes from our own personality or our own personal resources. He noted that '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). This self-development is not an end in itself but a by-product of the creation of a more effective worker. Self-awareness is a skill that develops over time and does not necessarily come naturally. Keeping in touch with our feelings is important because unacknowledged feelings can distort work with children and young people. It can also have an impact on our overall functioning. It can be particularly difficult for those who have chosen to join a caring profession to acknowledge to themselves that they can have negative feelings towards some young people, particularly as this seems to contradict social care values. If these feelings are acknowledged and understood they are less likely to 'leak' out and intrude into our interactions with the children for whom we care. Thompson (2005) identifies three areas where it is important to develop self-awareness:

•   awareness of your impact on others and how others see you.
•   awareness of how others you are working with have an impact on you.
•   awareness of how the work you undertake has an impact on you.

Practitioners may find that they have a preference to concentrate upon one area of development rather than another. For example, some are able to enter the world of the young person and engage with the feelings of the young person, but are less able to reflect on and deal with their own feelings. The empathy and understanding that can come from this position can be positive but there is a danger that the practitioner may become too close to the young person to be able to step back and reflect on the case or to share it with colleagues. The pull of involvement and of making things better by being with the young person may get in the way of objective thinking. At the other extreme, those who take on a more distanced style of working may focus on planning and case management. Their ability to be aware of their own or the young person's inner world, however, may not be well developed. Both approaches have strengths, but in order to develop greater flexibility and ways of working, use of self-awareness in relation to preferred style and approach is essential. Self-scrutiny will only take you so far. Feedback from others is also required to ensure that you are obtaining a balanced and objective picture of yourself as a practitioner. Your attitude and responses to a young person may seem appropriate to you, but you may be missing vital elements of your responses that can be seen by others. A young person may make you feel protective and parental, or angry and disgusted. Teasing out where these responses come from may require supportive feedback from others, who are able to present a more objective stance to any 'psychological hijacking' taking place.

Feedback from your colleagues, young people themselves, or in supervision, can help you to examine areas where you have a blind spot. It is not always easy to accept feedback about yourself, especially when it does not seem positive. It is important to remember, however, that it can contribute greatly to your development if you can hear and respond to it. Of course it is much easier to accept feedback from those you get on with and respect and where feedback is mutual. Even if your initial reaction, however, is to reject comments from some colleagues and young people 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 to reflect on why they might see you as they do. Though this might be difficult to achieve in some teams, the aim should be to create a climate where comments can be made about one another's performance in a supportive manner.

Which of the three areas identified by Thompson do you feel most comfortable with and which areas do you feel least comfortable with?

Are there discussions within the team in regards to these areas?

How comfortable would you feel receiving detailed constructive feedback?

How confident would you feel giving detailed constructive feedback?

What mechanisms exist within your setting to support the feedback process?

Can you identify anything which may hinder the process?

Motivation for the work and its impact on use of self

There can be particular resonances evoked by the initial motivation to become a residential child care worker. Motivation for entering residential child care is, like all of our strong views, a complex mix of conscious and unconscious, personal, professional and political reasons. If you have chosen to become a residential child care practitioner, you have chosen to enter a sphere of work where who you are contributes considerably to what you do and how you do it. You are involved with the work you undertake both personally and professionally. It is one of the few professions where the whole person is engaged with the work and where the work undertaken requires scrutiny beyond the obvious surface level. Lishman (2002, p. 99) highlights the need for a personal element in our commitment to this type of profession as it can give us compassion, empathy, insight and a commitment to challenging injustice and discrimination. Though this positive empowering part of our motivation is important, we need to be aware of it and understand its impact on us, so that it does not lead to us undertaking work solely to meet our own needs.

It is particularly important to understand that residential child care is a profession that most people engage in, at least partially, because in some way it meets their own needs. It is unlikely that individuals would wish to become and remain residential child care practitioners unless there was some reward at a personal as well as professional level. The work can meet the need to be appreciated, to feel needed, to be involved in the lives of others, to make sense of our own problems (or to avoid them by working with those who have more difficult problems), or the wish to feel powerful and in control. It is important to recognise that there can be an 'attraction to working with people who may be, in part, dependent or disturbed. This attraction may lie in the potential to help or to heal, but this in turn has an element of power and control; others are in need of our services' (Clough, 2000, p. 33). Only by acknowledging and exploring the sources of these needs can practitioners stop them from intruding and distorting their work with young people. 'It is not wrong to get satisfactions from being in these situations', as Clough reminds us; 'the test lies in the way in which we manage this' (2000, p. 33). The test is also in how we continue to remain aware of personal reasons for undertaking the work while not being driven by them.

Why did you choose to work in residential child care?

What are your current needs and how are these met?

Have your needs changed over time?

Developing effective use of self: supervision

Lishman (2002) indicates that self-awareness hones the worker as a tool. She also stresses, however, that supervision should have developmental and protective functions. Not only is this important for ensuring good practice it also allows the practitioner to make sense of what is going on personally and professionally. It can allow them to process any feelings and difficulties they are having and help them to thrive within residential child care settings. Sudbery (2002) put it well when he stated that 'when feelings are suppressed or poorly controlled they are often communicated clearly in a relationship. (These feelings) have to be 'held' (neither suppressed nor acted out) until they receive appropriate attention in supervision' (Sudbery, 2002, p. 155). Supervision should help mediate the anxieties of the practitioner and provide support for self-esteem. A practitioner's ability to empathise and support young people should be echoed in an empathic warm relationship with their supervisor. Supervision as a relational and developmental process has parallels with the helping relationships that practitioners develop with young people. Just as supervision offers an opportunity for the practitioner to process and understand the feelings raised by their work, the practitioner then provides a similar experience to the young person. Effective supervision is essential for the development of use of self. There has been concern, however, that supervision sometimes emphasises management and appraisal of staff rather than support and development. The concern about this focus of much supervision was recognised in the 21st Century Review (Roe, 2005). The support and development aspects of supervision were highlighted as crucial factors in the development of a critically reflective analysis of practice. Supervision is a joint responsibility and it is important for practitioners and teams to be assertive in asking for supervision and contributing to the development of a positive supervision culture. It is important for supervision to provide you with an opportunity to reflect on your own knowledge and skills, and to support you in the development of new knowledge and skills. If you are unable to use this space to take risks, admit mistakes and ignorance, and suffer ambiguity over actions and values, your ability to grow and develop purposefully as a practitioner will be lessened. There is continuing debate about how appropriate it is to explore personal issues in supervision. The debate arises because of the fact that there is no neat divide between the personal and the professional. As stated previously, aspects of our personal selves are an inevitable and valuable part of residential child care practice. At a minimum, staff need to be prepared look at their past and their own needs. In this way, they can be sure that their responses to children and young people and to the work that they undertake are not driven by their own needs or past experiences. They can also be sure that their feelings and reactions are not driven by stress and anxiety. For example, falling back upon formal or institutionalised responses to young people has long been recognised as a defensive reaction to the anxiety generated by work with troubled individuals Menzies-Lyth, 1988). While issues such as this can be explored, supervision is not personal therapy, or counselling. Any discussion of your own life and personal reactions should have a purpose in contributing to your development as a competent, reflective and effective practitioner. Self-awareness combined with experiences of supervision can create your own 'internal supervisor'. This supervisor can be used in situations where you have to stop and think about what is going on and how you should act. Your 'internal supervisor' draws on your experiences of supervision and, by linking this with your growing self awareness and reflection on experiences, will develop to match your style of working. Self-questioning with 'the capacity to doubt one's ability more, rather than less, is an indication of a secure sense of self connected to the (practitioner's) ability to self reflect' (Brauer, 1991, p. 81). In linking reflection, knowledge and action, 'use of self' is the definitive integration of theory and practice through the lived experience of engaging with others.

What is your experience of supervision?

What different types of supervision do you experience (group, peer, individual, formal, informal)?

Does your formal supervision encompass management and appraisal and support and development?

What is the most important aspect for you within your supervision?

We are all different and so are our needs; however formal supervision systems can be developed for use organisation-wide.

What changes would you make to the way you are supervised?

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Reducing Offending in Residential Child Care

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Introduction

Public anxiety around community safety and the perceived rise in crime by young people is an issue that continues to cause concern across the whole of the UK. Young people who offend are continually highlighted as causing disruption, harm and distress not only to others but also to themselves. In response to these concerns the public have seen a variety of new legislation and policy initiatives introduced, such as Anti-Social Behaviour Orders, and an emphasis on the speed and effectiveness of interagency working and the youth justice system. Young people who are looked after and accommodated are three times more likely to offend than children in the general population (NACRO, 2003; Taylor, 2006). These findings are concerning. Not only are such young people living with the harsh realities of their past histories but they are also 'enduring the impetus of social exclusion by their criminalisation' (NACRO, 2003 p. 6). Many local authorities and voluntary agencies, backed by government policy, are already on the path of challenging this issue. Progress, however, remains inconsistent.

This paper aims to provide a toolkit from which to develop best practice in preventing looked-after and accommodated young people from being unnecessarily criminalised, by providing a series of checklists. It is based on research which involved a series of interviews and questionnaires with residential care staff, managers and police, from agencies that are already in the process of developing their practices in this area. The paper explores the challenges faced by residential child care staff when supporting young people who come into care, and suggests methods of working that seek to reduce the risk of young people being criminalised unnecessarily. It is recommended that this paper be used in the context of the specific aims of each individual care home and staff team. It is anticipated that the practice suggestions could be used over a series of team meetings or during a staff development day, to provide a base from which to discuss and develop best practice in reducing offending in residential child care.

Offending and young people – the wider picture

Of the 920,000 young people living in Scotland, 92% have no record of offending, yet youth crime accounts for one third of all recorded offences. Over the last ten years youth crime in Scotland has been on a downward trend, although the number of children and young people referred to the Children's Hearing System on offence grounds has been rising (Scottish Executive, 2006a). The vast majority of young people who offend have only one record of offending behaviour. There are, however, a small number who are responsible for a large amount offending behaviour (Scottish Executive, 2006b). In 2006, 33% of all young people with a criminal record were classified as Persistent Young Offenders, some with a minimum of five offending episodes during a six-month period (Scottish Executive, 2006c). The most common types of offending behaviour included assault, breach of the peace and vandalism (Scottish Executive, 2006d). As a consequence, youth crime and persistent young offending remain high on the public and political agenda. In 2002 the Scottish Executive published an action plan setting out five clear action points to reduce youth crime. These were:

- Increasing public confidence in Scotland's system of youth justice;
- Easing the transition between the youth justice and adult criminal justice systems;
- Giving victims an appropriate place in the youth justice process;
- All children and young people to be valued and encouraged to thrive; and
- Effective early intervention. (Scottish Executive, 2002, p.4)

In 2006, the Youth Justice Improvement Group was set up to build on this work. Their subsequent report highlighted an established link between children in local authority care and youth crime. It emphasised the role of the local authority as corporate parent to safeguard children and young people, giving them the same support and guidance that a reasonable parent would provide to their own child (Scottish Executive, 2006b). These findings echoed records from the Children's Hearing System indicating that '22% of the 2005/06 Persistent Offender group had their current status recorded as Children's Home or Residential Establishment' (Scottish Executive, 2006c, p. i).

> Why do you think these young people offend?
>
> Do the statistics reflect what you would expect, or are there any surprises?

Offending: Children and young people in residential care

Scotland is unique in the way in which it deals with young people who offend. This is because of The Children's Hearing System. The Children's Hearing System was set up to deal with children who have social problems or who commit crimes. The system is not concerned primarily with guilt or innocence. The welfare principle and the child's best interests are of paramount importance. It was set up initially to adopt an holistic approach, dealing with 'needs not deeds'. On first introduction, this system predominantly dealt with criminal cases. Over the years this has changed to dealing mainly with child protection issues, as the reporting of such cases has vastly increased. There is no national information concerning the reasons why young people become looked after, or where offending is one of the challenges that need to be tackled. Moreover, the initial scoping study for reducing offending in residential child care, led by the Scottish Executive, found that most local authorities 'do not have regular and systematic processes for measuring the profile of incidents within residential units and offending in the community by this group' (Scottish Executive, 2006c, p. ii). It is known, however, that looked-after young people are overrepresented in the population of young people who are identified as having committed offences and / or received warnings, charges or convictions (NACRO, 2003). Looked-after young people are also more likely to offend, more likely to end up in custody, and are disproportionably represented in the general prison population (Taylor, 2006). Such findings suggest that being looked after away from home is a risk factor in becoming involved in offending behaviour, or that such young people are predominantly criminal. The relationship between being looked after and offending behaviour is complex. Risk factors surrounding young people most likely to offend are similar to the characteristics of a young person who is, or has a history of being, looked after away from home. Risk factors associated with offending include hyperactivity, impulsivity, parental neglect, deprivation, truancy, exclusion from school, peer group pressure and parents and siblings who also offend (Scottish Office Central Research Unit, 1998; NACRO, 2003). Children and young people looked after in the public care system are increasingly recognised as some of the most vulnerable and damaged young people in society. Their lives have often been characterised by stressful life events such as the experience of physical, sexual and emotional abuse and neglect. They are often estranged from their local community, distant from their family, frequently unable to rely on any consistent support from any adults and achieve less in education (NACRO, 2003). The initial round of interviews for this paper suggested that going into care can be a risk factor in itself in becoming involved in offending in addition to pre-existing risk factors. Reasons highlighted included:

- Peer pressure;
- Increased scrutiny, resulting in young people coming into contact with the police for less

serious offences than that of their peers;
* Living up to labels such as 'young offender';
* The new experience of limits and boundaries;
* Increased vulnerability of becoming 'looked after'.

There is a considerable amount of anecdotal evidence surrounding the offending of looked-after and accommodated young people. This evidence often involves police being called inappropriately by residential staff, resulting in young people being criminalised for what are largely behavioural issues. Examples of this include a young person spitting at a staff member and being charged with assault, or breaking a photo frame and being charged with vandalism. Although these specific incidents may be based on a culmination of behaviours that may warrant a police call, they raise philosophical debates surrounding what parents would do in their own home versus how staff respond and the impact of policy surrounding the right to feel safe at work. They highlight the notion that young people can become unnecessarily criminalised as a consequence of being in care. During the research process, interviews with residential staff suggested that police involvement in residential care homes can vary owing to:

* Differing staff thresholds/tolerance levels;
* Level of staff experience;
* Individual relationships between young people and staff;
* Group dynamics;
* Individual personalities and backgrounds of the young people at any given time;
* Relationships with the local police;
* Organisational ethos and management styles.

Contrary to popular belief, criminal records do not disappear after the age of 16 years, and can therefore affect a young person's adult life. Based on the philosophy of the Children (Scotland) Act 1995, removing a young person from their home and placing them in a residential unit should equip young people with better life chances than they would have had if they were living at home. This means that all policies, procedures and professionals involved in residential child care have an obligation to protect young people from becoming unnecessarily criminalised.

From your experience, why do the young people you are aware of have criminal records?

Is the offending behaviour similar to that seen prior to coming in to care?

Is the threshold beyond which the police will be called different between work and home?

Is the threshold beyond which the police will be called different for different staff?

What would you identify as the reasons for this?

Moving forward: Reducing the risk of children in care becoming criminalised

Protective factors to assist in preventing offending behaviour include social bonding with parents and significant adult role models, a healthy environment, and involvement in community activities (NACRO, 2005). The main principles of the National Care Standards (Scottish Executive, 2005) highlight young people's right to privacy, dignity, choice, safety,

realising potential, equality and diversity. Coupled with building and enhancing protective factors, these care standards should underpin and inform any suggestions for working with young people in residential care. Several themes on reducing offending in residential child care developed from the research. These themes have been developed into checklists of suggestions to develop positive practice on the prevention of looked-after young people becoming unnecessarily criminalised. Eight checklists are provided and these are described later in this paper. The checklists cover eight main themes:

1. Setting and ethos;
2. Training, including formal de-escalation tools and techniques;
3. Debriefing;
4. Induction and care planning;
5. Risk assessments / Individual crisis management plans;
6. Daily structures and routines;
7. Consistency and teamwork;
8. Police involvement.

It was acknowledged throughout the research that many of these themes are affected by resource issues such as staffing, availability of appropriate accommodation and the impact of shift work. The research highlighted that there can be higher levels of police involvement when a young person is in an inappropriate placement that does not meet their developmental, behavioural, social and emotional needs. Moreover there is usually less police involvement in units that have a low turnover of both staff and young people. The research suggested that once a young person becomes settled in a unit, there are fewer incidents of offending behaviour. Likewise staff who feel supported, who have developed strong working relationships with each young person and are familiar with both individual, group and staff team behaviours are less likely to involve the police inappropriately. It should be noted that throughout the research there was difficulty in defining clearly the difference between challenging behaviour and offending behaviour. Challenging behaviour was generally described as including a wider scale of different behaviours, ranging from aggression to avoidance. Offending behaviour was commonly referred to as premeditated.

Using your own experience, do the links between relationships and offending confirm your understanding?

Is there anything else you would add to the equation?

Setting and ethos

An established and considered ethos and mission of a residential unit was found during the research to be the basis for a successful residential unit. This philosophy of care was highlighted as helping both staff and young people to understand why they are here. This can be particularly useful in informing staff interactions with young people and enabling young people to feel a sense of being informed and secure, when perhaps every other aspect of their life is unknown or in chaos.

Where will you find the philosophy of care for your workplace?

1. Setting and Ethos Checklist

- Is the ethos and mission of the care home clearly established?
- Is there an open dialogue about this mission of residential child care that both staff and young people contribute to?
- How does this ethos relate to offending behaviour?
- How does this ethos relate to police involvement at the time of an incident?
- Does each staff member know why they are working with the young people living in the care home (as a group and as an individual)? What does the care home hope to achieve?
- Does the care home focus on recognising, reinforcing and rewarding appropriate and positive behaviours?
- Are there clear policies and procedures for managing challenging behaviour and police involvement that relates to the ethos of the care home?
- Are all staff aware of these?
- Are all staff aware of their own limitations and values around offending behaviour?
- How does this fit in with the philosophy of the care home?
- Do the young people know why they are looked after away from home and why they are here?
- Do they know what the long-term plan is for their care?
- Have they been involved in this process?
- Do staff know what the long-term care plans are for each young person?
- How do they work towards this each time they are on shift?
- Is a culture of respect clearly established?
- When staff and young people first become involved with the care home are they clearly told the basic guidelines for acceptable behaviour, such as 'we do not yell at each other here'?
- Are such values modelled by management in how they interact and lead both staff and young people?

Training

Regular high-quality training is considered extremely important in establishing a staff team that feels competent, valued and equipped to manage situations as they arise. As part of the Social Service Codes of Practice, training and development opportunities must be provided to equip staff with the skills and knowledge that they need to do their job effectively (Scottish Social Services Council, 2003). For residential care staff the research highlighted that training should include formal de-escalation tools and techniques (such as Therapeutic Crisis Intervention (TCI), Crisis Aggression Limitation and Management (CALM), Safe Crisis Management (SCM) or Team Teach), as a mandatory part of training for all staff. The guidance document Holding Safely (SIRCC, 2005) should also be available as a reference to all staff. Regular training on behaviours was also highlighted as a way of helping staff to understand what is happening for individual young people and how best to support them. It was also highlighted throughout the research that there can be high levels of anxiety amongst residential staff surrounding young people who come into care with a 'known' reputation for violent outbursts. This anxiety was strengthened by a perceived lack of knowledge about how to respond to certain types of behaviour as well as working with other staff, specifically agency or casual staff, who may not be trained in de-escalation techniques. Education, training, and formal and informal support were identified as methods in which to reducing staff anxiety surrounding challenging behaviour. These enable staff to feel prepared, informed and more comfortable in their working environment and therefore less likely to involve the police unnecessarily. The research findings emphasised that the most successful training can happen when it is tailored to the emotional and physical needs and behaviours of the young people that the staff team are presently supporting.

2. Training Checklist

Are all staff, including casual or agency staff, trained in conflict resolution, de-escalation skills and safe holding, such as TCI, CALM, SCM or Team Teach? Is there regular training and incident assimilation in conflict resolution and de-escalation skills? Is there staff training before

and after the admission of each young person, specifically relating to how best to support them? Are all staff trained and/or experienced in the needs of looked after and accommodated young people? Are all staff trained and/or experienced in group living and groupwork strategies? Are all staff aware of their role in keeping young people safe from all forms of harm, abuse or exploitation? Are new staff given opportunities for shadowing more experienced staff members? Are all staff trained in legislation that specifically relates to the area of offending, specifically around assault, breach of the peace, vandalism, and possession/use of drugs? Is there regular training on child development and dynamics of peer/family relationships? Does this training include providing specific skills and strategies for managing associated behaviours? Are staff trained and practised in restorative justice practices? Does each staff member have an individual training plan that combines and incorporates their own learning needs and the needs/ethos of both the care home and the young people that live there?

How is training/learning embedded in practice?

Is the impact of new knowledge in practice included in supervision?

Do you discuss how your learning can be shared with others in your team?

Debriefing

The importance of debriefing after an incident of challenging and / or offending behaviour was highlighted consistently throughout the research. Debriefing came under a variety of names and was also said to be incorporated into many of the formal de-escalation tools referred to in the training section of this paper. Research participants drew attention to the fact that debriefing is NOT about allocating blame or scape-goating. Instead, debriefing should be an essential part of residential life that places emphasis on safe care, accountability and best practise. It should recognise that incidents do not occur in a vacuum but in the context of historical events and contributory feelings and behaviours. The primary objective is about learning and developing for both staff and young people. It should emphasise what should or should not be done differently and should be built into agency protocols. Staff and young people should expect that debriefing will happen as part of the learning process for both individuals and the care home as a whole, regardless of whether or not something went wrong. During the research, ideas were raised around who should attend a debriefing session. It was suggested that both care staff and young people should be given an opportunity to debrief, either collectively or individually, either in one meeting or over a series of discussions, depending on the nature of the incident. Police involvement in debriefing sessions was also suggested as useful when appropriate. Restorative justice practices were also found to be useful as part of a debriefing session. Research participants recognised that organising a debrief can be difficult owing to shift patterns and finding time to engage with both staff and young people when all parties are calm and ready to reflect. Some agencies stated that it must happen within 24 hours, whereas other agencies stipulated two to three days. Interestingly, interviews highlighted that in different disciplines, such as the police, staff are not allowed to return home after a serious incident until they have participated in a debriefing session. It was acknowledged that setting a time limit was important in highlighting the importance of a debriefing session and ensuring that it is not skipped.

3. Debriefing Checklist

- Is debriefing after an incident of challenging and/or offending behaviour part of the agency protocol?
- Does a debriefing session happen as soon after an incident as possible?
- How is it ensured that this will happen? Who is responsible for organising the debriefing session?
- Who is responsible for chairing the debriefing session? Is this person a third party, i.e., someone who was not involved in the incident?
- Are all parties involved in the debriefing session?
- Are local police invited when there has been involvement during an incident and/or when appropriate?
- Is the debriefing session held in a place safe from interruption?

Does the debriefing session:

- Include an initial check on physical and emotional well-being?
- Reflect on what happened? (Where were you? What did you do? What went well? What could be done differently?)
- Address feelings, then and now?
- Involve observations from all parties?
- Keep to the facts
- Identify patterns from previous behaviours?
- Discuss alternatives?
- Develop action plans about what we can do next time to alleviate risk?
- Identify and pursue developmental or support needs?
- Identify any action that is still necessary?

Is the debriefing session recorded? Do all people involved in the debriefing session check and keep a copy of these recordings? Are there opportunities for both staff and young people to talk with external agencies, such as counselling services and/or external supervisors?

Induction and care planning

Keeping young people actively involved and informed throughout their involvement with residential child care agencies was seen as essential in contributing to reducing and managing challenging behaviour. Research participants highlighted the fact that young people who are seen to be settled and at ease in their care home show fewer outbursts of challenging behaviour and are less likely to offend. It was identified that a well-planned and thorough induction is essential in enabling a young person to feel settled. This induction should begin prior to the young person moving in. It was recognised that some young people have to move into a residential home on an emergency basis and therefore planning may not always take place. It was felt, however, that this was not only disruptive to the other residents but could also be an extremely frightening experience for the young person, often resulting in 'fight or flight' behaviour. Such transitions should be avoided where possible. It was also highlighted that staff inductions are extremely important. They can enable staff to feel comfortable and competent in their role, thus being able to focus on best meeting the needs of the young people in their care. It was also highlighted during the research that care plans are a tool that allows a young person to feel both settled and an active participant in their lives. It was stated that care plans should be completed with full involvement from the young person, their families and all other relevant support networks, and must have clarity about the purpose of the placement. The care plan should set achievable goals, realistic time-scales and specific outlines on how contact with significant others will be maintained. It should support existing involvements and school placements already developed prior to the young person coming into care. Is should also encourage young people to take up their own individual interests, outwith the residential unit and peer groups. This was felt to be particularly useful in discouraging copycat behaviour, while also enabling the young person to develop their own sense of self. Care plans should be reviewed regularly.

4. Induction and Care Planning Checklist

When planning a young person's move to a residential home are all professionals involved sensitive to the gravity of such a life event? How does this affect practice? Are young people, their families, and all other support networks fully included and involved in the transition to the care home? Is there clarity about the purpose of the placement? Has the young person and their family been provided with information about the re home prior to moving in? Has the young person been introduced to a key worker, or has an early formation of a positive relationship with another young person, perhaps through shadowing or buddy systems, been established? Have young people been given an opportunity to personalise their bedroom? Are all new young people and/or staff individually introduced to other residents and to each member of the staff team, including agency or casual staff? Are clear boundaries in terms of what is acceptable and expected behaviour explained to the young person as part of the induction process? Is the young person able to maintain regular contact with people (friends and family) from the home? Does the young person know how and when this will happen? Do young people know whom they can speak to if they have any questions or concerns? Does an identified person 'check-in' with the young person at regular intervals? Do young people know that bullying can sometimes exist and how they can get help/support? Are staff fully acquainted with each young person before they are admitted into the care home: their family, emergency contacts or other significant people? Is there transparency with staff at interview stage about the types of behaviour that they may encounter and have to respond to? Is a formal staff induction in place? Does this induction include:

- An awareness of all policies and procedures (such as absconding, fire, police involvement, time off, supervision, changeovers) as absconding, fire, police involvement, time off, supervision, changeovers);
- Sharing knowledge about the young people that live there;
- Training in de-escalation techniques;
- Introduction to, and awareness of, external agencies?

Are young people involved in putting together their care plan? Are the young person's family involved in care planning? Are care plan goals achievable? Does the care plan discuss how behaviour will be managed and supported? Does the care plan discuss police involvement? Does the care plan explore alternative methods to charging when an offence has been committed? Do both the young person and their family agree with and/or understand what is written on the care plan, and what this means? Are young people encouraged to be 'themselves' and develop their own sense of identity by doing separate activities inside and outside the care home?

Risk assessments / individual crisis management plans

Risk assessments / individual crisis management plans were terms that seemed to be used interchangeably throughout the research. Such tools were seen to be effective in helping to plan for and safely manage potential incidents that might involve challenging and / or offending behaviour. They anticipate what might happen when a young person is in crisis or under the influence of drugs or alcohol. This includes identifying what flashpoints/triggers may exist for individual young people and what behaviours may potentially be exhibited. Risk assessments / individual crisis management plans can help both staff and young people to feel safe, secure and with an element of control, that can prevent further escalation. They should work in line with the young person's care plan and within the ethos of the residential care unit. They are a tool that should continually be reviewed and modified, depending on what is happening for the young person and/or the staff team at any specific time. The research highlighted that the development of effective risk assessments / individual crisis management plans is aided by a referral system that involves placement planning and does not include sudden unplanned admissions of children.

5. Risk Assessments / Individual Crisis Management Plans Checklist

Is there admission screening that ensures that the placement is best suited to the needs of the young person? Do staff have a sound knowledge of each individual young person before they move in: their families, friends, associations, behaviours and contexts in which to set notion of risk? Are risk assessments / individual crisis management plans in place before a young person moves in? Are young people involved in developing and reviewing risk assessments / individual crisis management plans? Do risk assessments / individual crisis management plans include triggers that may result in a change of behaviour for a young person, what behaviours may be displayed and what both the staff and young person should do in such situations? Are young people told the acceptable and expected forms of behaviour when displaying emotion in a crisis situation? Are they given tools and support to do this? Are young people involved in discussions about how to gauge the consequences of any negative/disruptive behaviour? Are both young people and staff congratulated if a potential incident was alleviated? Are young people given attention and recognition for positive behaviour? Are incidents of offending behaviour tracked and recorded to monitor patterns of behaviour and the effectiveness of any action taken? Are risk assessments / individual crisis management plans reviewed regularly? How is this ensured?

Daily structures and routines

Interviews during the research highlighted that structure and routine can be an effective diversionary tactic to prevent young people from becoming involved in offending. Routine and structure can also enable a young person to feel safe and settled, allowing them a secure base from which to develop and explore other aspects of themselves, including their past, present and future. Examples included setting up regular activities either on a daily or weekly basis, such as football and computer gaming nights, attended and/or run by both care staff and local police. These opportunities can be useful in aiding young people to develop positive relationships with staff that will begin to enable trust and communication. Regular meal times were also highlighted as an opportunity to create sound relationships between staff and young people.

6. Daily Structures and Routines Checklist

Is there an established routine in the care home that includes meal times, cleaning, education, wake-up and bed times? Do young people know what this is and the reasoning behind it? Do all staff and young people eat together? Are there regular activities within the care home offered to young people that all staff support and are involved in? Are school holidays planned for? Are the young people involved in this planning? Are young people encouraged and supported to develop individual hobbies and outside interests? Are outside agencies employed to aid and support young people to develop hobbies and interests?

Consistency and teamwork

The research highlighted that consistent and effective teamwork with both the care staff team and other professionals involved in the care of a young person ensures that he or she is given the same message about acceptable forms of behaviour. In situations where effective communication systems are not in place between shifts and / or certain behaviours were overlooked by particular staff members, young people can be left confused and frustrated. This can potentially lead to challenging behaviour. Staff just 'being there' and developing relationships with the young people were also highlighted as being extremely helpful in not only monitoring group dynamics but also in modelling positive behaviour and conflict-resolution skills. Consulting external agencies, such as drug agencies and mental health services, to develop expertise and practice techniques can also be extremely useful and beneficial to the young person. Support from management was also highlighted as being an important factor in team morale and in affecting staff decision-making skills, specifically during incidents of challenging behaviour. It was emphasised that managers need to recognise the difficulties in the job of a residential staff member, and ensure that staff feel supported and empowered in a climate where they are constantly required to make split-second decisions.

7. Consistency and Teamwork Checklist

Are there regular team meetings? Do team meetings dedicate time to focus on providing a consistent approach to the care of each individual young person? Do all staff (including managers) have regular supervision? Does supervision allow staff, with their managers, to identify individual training needs? Do all staff feel that their opinions are listened to and decisions supported? Is the unit operating with enough staff? Is the staff rota effective? (For example, does it allow time for a proper changeover? Do staff have enough time off between shifts?) Is time allocated for team-building to develop a strong staff culture? Are all staff clear about their role in behaviour management? Are all staff clear about their role in intervening with violent behaviour? Do care home policies and procedures help staff to feel supported, enabled and empowered? Are 'changeovers' useful and effective?

Police Involvement

An established and positive relationship with the local police can allow for dialogue and discussion during and / or after an incident. This can result in police having an holistic approach when an offence has been committed, allow care staff to obtain an impartial opinion about defining offending behaviour, and enable a proactive multidisciplinary approach to future incidents. The research highlighted that a lack of awareness can sometimes exist between police and residential care staff about their different roles, skills, duties and powers. There was a notion that the police role can be misunderstood or misused by care staff. Police reported that they are often called when care staff do not know what to do in a certain situation. Likewise it was suggested that the police do not necessarily understand the mission of residential child care or the needs of the young people and how this may have an impact on behaviours that staff are faced with on a day-to-day basis. Building relationships and developing joint training with local police was found by some research participants to break down such barriers, ensuring effective, positive practice that works towards the best interest of the child. Charging and diversionary techniques, such as referrals to local projects, were seen as two processes by care staff and police working in partnership that should work hand in hand to reduce offending. There was disagreement between research participants as to what the process should be with regards to calling the police, specifically whether or not this should be a decision that any staff member can make or whether it should go through the manager. It was clear, however, that there should be a protocol for police involvement, outlining such decisions, that care staff, local police and young people are completely aware of. The development of protocols between police and residential units was also seen as a crucial aid in preventing the criminalisation of young people. It is worth noting that at several points during the research regular visits by the police to residential care homes were not regarded as being in keeping with the principles of 'normalising' the care home living environment. Communicating with the police on a regular and informal basis was, however, viewed as enabling young people to break down negative stereotypes of the police, and allow for dialogue about offending behaviour that would have wider benefits for the young person's future. The challenge between care staff not wanting to criminalise young people but also not wanting to collude was also highlighted.

8. Police Involvement Checklist

Is joint training in place for both police and residential staff? Are care staff knowledgeable about the law (including what constitutes breach of the peace, vandalism and assault) so that they know when a law has been broken? Do care staff know when police expect to be called and what is appropriate use of the police as a resource? Do local police understand the ethos and mission of residential child care? Are both police and care staff involved in making appropriate referrals to local schemes that provide a diversion from or support around offending? What mechanisms are in place for building relationships with local police?

Is there a clear protocol for police involvement that includes:

• An overarching statement about what the residential unit it is trying to achieve?
• A definition and clarity around when to involve police?

This should include but is not exclusive to:

• Type of behaviours,
• Any history of police involvement,
• Safety of a young person and/or others,
• If there is harm or threat of harm,
• Suspicion of drugs or weapons,
• If the problem has been ongoing or if it has calmed down,
• A consideration of 'pros' and 'cons'.
• Links in communication – who contacts whom and what to say (i.e. what law was broken)?
• A clarification of roles?

Is the protocol regularly reviewed and monitored? How is it ensured that this happens? Are all staff trained in this protocol? Is it part of staff induction? Is there an absconding protocol in place? Are calls to the police tracked and recorded to see when they are made, for what type of behaviours, and with what outcome? Are these records reviewed and evaluated? Do young people know when and why police will be involved? Do young people know what happens when they are charged?

Conclusion

The very nature of residential care means that young people come into care for a variety of reasons. They live with other young people, each with a different background, different needs and different personalities which can pose a variety of challenges in any living environment. Being looked after and accommodated can be an extremely positive experience for some young people, giving them stability, appropriate adult role models and a sense of belonging. Looked-after and accommodated young people are, nonetheless, amongst some of the most disadvantaged and socially excluded populations. The fact that they are looked after should not put them at risk of becoming involved in offending. If anything, it should prevent this. The quality of care that local authorities provide for their young people reflects how much they respect and value young people. Effective multidisciplinary practice, particularly between care staff and police, which involves sharing expertise, is integral to informing and developing best practice. As with all work with people, there is not a blanket approach. Different interventions work with different young people and are undoubtedly affected by the culture of the group living environment. The challenge of residential child care is meeting these needs while also ensuring the right of staff to be safe at work.

What is the plan from here? Has your reading influenced your understanding?

Are there any suggestions you would like to take forward?

How will you ensure your suggestions are given due attention?

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Supporting Lesbian, Gay, Bisexual and Transgender Young People in Residential Care

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Introduction

Lesbian, Gay, Bisexual and Transgender (LGBT) young people face a unique set of challenges as they progress through adolescence. Good practice is anti-discriminatory practice and such practice must be based on a greater understanding of homosexuality and heterosexism. Given this, it is important for residential child care workers to have a knowledge of and develop an expertise in working with LGBT young people, probably a sizable group overall within residential child care.

It is impossible to calculate accurately the number of LGBT young people in residential child care as this would depend upon all LGBT young people being confident enough and willing to identify themselves as such. An estimate, however, can be made based upon studies of both the general and the residential child care population. Recent research suggests that between 2-9% of young people have had some same-sex sexual experience (National Survey of Sexual Attitudes and Lifestyles, 2000). There are approximately 1660 young people in residential child care.

Jay and Young (1979) reported on age of realisation of sexual orientation difference, with 39% of the gay men and 20% of gay women studied realising this by the age of 12 years old. McMillen (1991) warns against arriving at firm conclusions from the evidence but suggests that 'youths who will later self-identify as gay or lesbian may be over-represented in the child welfare system, and thus in group care'(p.7); this is due to the greater possibility of LGBT children and young people being victims of physical or sexual abuse and / or to the inability of the family to accept its LGBT member and ejecting him or her from the home.

A further point to consider here is that it can be a common aspect of the normal developmental process for young people to have brief same-sex intimacy, emotionally and / or sexually, but not to go on to be lesbian, gay or bisexual. The residential child care worker needs to be aware of this and enable, if need be, any young person questioning this to understand its significance and to accommodate these experiences within a future heterosexual identity (Tasker and McCann, 1999).

Whatever the size of the population of LGBT young people in residential child care, they are present, and often confused about their sexuality. Some will be self-consciously visible and others will be safely invisible, as they perceive it, as lesbian, gay, bisexual or transgender.

Some definitions

For staff working in the field who may be unfamiliar with some of the terminology, the following definitions are provided.
Lesbian: the term used to describe girls or women who have an emotional and physical attraction to the same sex.
Gay: the term used to describe boys or men who have an emotional and physical attraction

to the same sex.

Bisexual: the term used to describe people who are emotionally and physically attracted to both sexes.

Transgender: an umbrella term used to describe a whole range of diversity of gender identity and expression, including transvestite (someone gay or straight who likes to dress in the clothing usually worn by the opposite sex) and transsexual (someone whose sex, which is biologically determined, and gender, which is socially determined, do not match up and who may seek a sex change).

Heterosexual/straight: the terms used to describe people who are emotionally and physically attracted to members of the opposite sex.

> What are your perceptions of lesbian, gay, bisexual and transgender young people in residential care?
>
> Have you recognised the need to be aware of the possible needs?
>
> What is your experience of working with any lesbian, gay, transgender of bisexual young people?

Growing up feeling different

How might the experiences of child and adolescent development differ from the norm for individuals who are LGBT? Baker (2002) utilises the useful framework of Erikson's life stages (1950) when contrasting the differences between heterosexual and LGBT development. Erikson's theory of psychosocial development is one of the best-known theories of personality in psychology. Much like Freud, Erikson believed that personality develops in a series of stages. At each stage, a psychosocial task needs to be resolved. Unlike Freud's theory of psychosexual stages, Erikson's theory describes the impact of social experience across the whole lifespan, from birth to old age. At the first of Erikson's stages, infancy, the task is a resolution between a sense of trust and mistrust. Baker (2002) suggests that 'certain attitudes about gender and sexuality may affect the way parents treat their infant,' and that any 'rigid ideas about gender....underlie homophobic attitudes in some people and parents.'(p.33). The same applies to the next two stages (Autonomy versus Shame and Initiative versus Guilt) when 'the feelings of a pre-homosexual child of being different, of being an outsider, may thus arise, at least in part from...early onslaughts of disapproval for gender non-conformity' (p.35). The reaction of significant caregivers to the girl who adopts 'male' traits, or the boy who exhibits 'female' traits can have long-term effects. In the next stage (Industry versus Inferiority), peer influence becomes increasingly significant. In the earlier years of this stage, it may be 'tomboyish' or 'cissy' behaviour that results in taunting, bullying and rejection. D'Augelli et al. (2006) suggest that feeling different at an early age can be a pervasive experience among LGBT youth who can recall that others noticed and remarked on these differences. This perception of difference came to them around middle childhood at around age eight years old. In the later years of this stage, some children develop an awareness of same-sex feelings, and that such feelings are likely to be unacceptable to their peers, parents and teachers. The failure to accomplish a sense of competence in social relationships and socially-valued skills, which is the key challenge at this stage, may lead to a long-lasting sense of inferiority and inadequacy. In adolescence (Identity versus Role confusion), gender nonconformity may make success with peers more difficult. It is in the adolescent stage that LGBT young people may experience the greatest of difficulties in terms of their development. This stage is concerned with the development of a strong identity versus a confusion about who one is, or will be, vocationally, sexually and socially. Peer acceptance is all-important but social isolation may ensue for the LGBT young person, opting out of the strictly heterosexual, culturally permitted norms which include, for example, dating or 'eyeing up' (Mercier and Berger, 1989). This lack of, or negative, connection with peers because of gender-different behaviour or

sexual orientation has been shown to be a strong predictor of mental health problems among LGBT youth (Christopher-Skidmore et al., 2006) Role identification is significant at this stage. Who are the predominant and culturally-accepted role models to be? Tasker and McCann (1999) refer to the problem of children having scant knowledge of LGBT people around them or in society as a whole and that this knowledge will be coloured with negative characteristics perpetuating particular stereotypes. The resulting stigma associated with being LGBT may result in low self esteem. Role identification requires to happen sexually, as a positive sense of personal identity must incorporate a sexual identity. The LGBT young person may lack positive role models of adult sexuality, through a lack of peers with whom to share sexual concerns and attractions or adults, who will understand and validate their emerging sexuality. Thus LGBT young people, in their identity development, frequently have to adjust to a socially stigmatised role, cope with developing a sexual minority identity in the midst of negative comments or jokes, and often have to live with the threat of violence. (Morrow 2004)

> Have you previously considered the issues in regards to the theory?
>
> Has your understanding changed?
>
> What other concepts do you think would be relevant?
>
> How would you support a young person developing through these stages?

The 'Coming Out' process

On top of the normative adolescent development then, how do young people cope with developing this sexual minority identity? Troiden (1989) suggests a sequential framework as follows:

Stage 1 - 'sensitisation' and the awareness of the feelings of being different.
Stage 2 - 'identity confusion' and the need to make sense of feelings, often without accurate information and based on negative stereotypes.
Stage 3 - 'identity assumption' with its gradual acceptance of an LGBT identity and social and sexual contacts being made with other LGBT people.
Stage 4 - commitment to the LGBT way of life.

This is a process that will start pre-puberty for some and may continue well into adulthood (Morrow 2004). D'Augelli et al. (1998) in a study of more than one hundred gay and lesbian youth found average ages for the stages of coming out. These were ten years old for awareness of orientation, 14 years old for labelling oneself as being lesbian or gay, 16 years old for coming out to a friend and 17 years old for coming out to a family member. Ryan and Futterman (1998) found that young people had a hierarchy of 'safe' individuals with whom to come out. These were other LGBT peers, close heterosexual peers, non-parental family members, and then parents. This is important for residential child care workers to understand because young people in care are often separated from family members, may only have imposed, superficial friendships with peers in their unit, and may have disrupted education which cuts them off from contacts with school-based peers. Troiden (1989) found that a common response to the confusion about sexual orientation was denial or avoidance. In attempting this, young people may find themselves suffering a number of other emotional and behavioural problems. These can include generalised anxiety, phobias, depression, suicidal thoughts or suicide attempts, school refusal or underachievement, prostitution and absconding from home, family or local authority (Tasker & McCann, 1999)

In what may be seen as a way of coping with emerging sexual orientation and/or homophobia, Rivers and Carragher (2003) refer to a number of studies from both the USA and the UK which provide evidence that LGBT young people enter into riskier behaviours disproportionately to

their heterosexual peers. These behaviours have included weapon-carrying, substance use/ misuse, anonymous and/or high incidence sex in risky, often public locations, and suicide attempts. Mental health may be at risk if feelings of self-worth are low because of being LGBT. If family support is lacking, the risk of depression may be higher (Morrow 2004). Where family contact is limited, it is a point to note that some LGBT young people in residential care may never 'escape' the violence and victimisation if they have little time away from the residential environment. It is worth considering also the effect on family relationships, possibly already problematic, when a young person in residential care comes out. Generally there will be a conflict or crisis when it becomes known that a child is LGBT (Borhek, 1994).

Would the stages of coming out fit with any experience you have? Can you empathise with the difficulties faced/experienced? Could you perceive there being issues if a young person 'came out' within the setting you work in? How would or do your colleagues react? How do other professions react?

One model of working with LGBT young people

This model, adapted from Mark-Ragg and Patrick (2006), is a strengths-based approach which encompasses three themes:

1. Vulnerability versus Empowerment
2. Stigmatisation versus Validation
3. Rejection versus Acceptance

1. Vulnerability versus Empowerment

Some LGBT young people will feel very vulnerable in residential child care if their sexual orientation becomes known to some people. LGBT young people are no more a threat to others than their straight peers. Indeed, research shows that the majority of perpetrators of sexual abuse are straight. Staff need to ask if it is really necessary to disclose the sexual orientation of LGBT young people to those who do not need to know. Staff can help monitor heterosexist bias by using neutral language. An example of this might be 'Do you have a partner?' rather than 'Do you have a girlfriend?' to a male resident who may be gay. They can also help by tuning into comments, listening out for hints from the LGBT young person about their identity (for example a reference to a particular TV programme and its characters) and by picking up on these comments, to communicate acceptance. Staff can also intervene with other staff and young people by challenging any homophobic remarks, jokes, and apparently innocent turns of phrase (For example, challenging remarks such as 'That's so gay!'). Young people should be enabled to control their coming out without feeling pressured to do so because staff and others may feel it is the right thing to do.

What may depict a heterosexual bias where you work?

What depicts diversity where you work?

2. Stigmatisation versus Validation

Here, staff can help by individualising messages enabling young people to separate themselves from negative stereotypes and messages. They can help the young person to understand that these are not about this young person him / herself, but are often about the discomfort of other people about sexualities and sexuality in general. Residential child care workers can affirm the LGBT resident when the young person talks of his or her developmental struggles, as well as the positive achievements in his or her coming out. They can contribute to the support of the young person by 'reframing difference' enabling a young person to perceive differences as unique traits and giving these positive or at least neutral meanings. Staff can be influential in promoting pride, helping young people connect with affirming and supportive individuals and

organisations. LGBT young people will wish to be included in the whole range of activities on offer in a residential setting rather than being stereotyped by staff who might think that she or he will not like a particular activity because she or he is LGB or T. Workers could also include LGBT-related content when selecting DVDs, television shows and other entertainment.

3. Acceptance versus Rejection

Staff need to be aware of any negative changes they may show in their behaviour towards a young person who discloses an LGBT sexuality or identity and deal with these. Similarly staff may give the impression of acceptance but inadvertently see the young person as not quite 'measuring up' in the same way as straight young people who might be perceived as more highly valued by some LGBT young people. Staff can show a warm welcome to an 'out' LGBT young person coming into residence by acknowledging his or her sexual identity early on, in an appropriate, matter-of-fact way. Staff can remain open with a young person, avoiding the pressure to give advice, share opinions or judge. This will enable her or him to describe and explore the various aspects of their identity. Residential child care workers help if they maintain a 'curious position,' as opposed to one of knowledge or expertise, in that any young person's story of their developmental experiences is very individual. Staff can reflect and ask questions rather than advise and instruct. Ideally workers can get to the point of being able to celebrate a young person's difference and diversity generally, and watch him or her grow in self-acceptance and confidence in his or her sexual and gender identity.

> **In order to ensure we are aware of any changes we may have towards young people, we need to be aware of our own perceptions, feelings, opinions.**
>
> Where could you discuss these openly?
>
> Have you discussed your feelings on working with lesbian, gay, bisexual and transgender young people in learning, team or supervision sessions?

What else can be done?

Consider the physical environment. Are there safe zones for any potentially vulnerable LGBT young people? What about the imagery around in the residential setting? For example do magazines, posters, wall hangings or DVDs reflect a diversity of identities and relationships? What about the agency's policies and procedures? Are they inclusive of LGBT young people? Does the equal opportunities or diversity policy identify sexual orientation and gender identity? Is this the case also for any anti-bullying policy? Any admissions leaflets and welcome packs could give out a strong message to an LGBT young person that she or he will be valued, cared for and kept safe. Staff need to acquire specific knowledge of, and to access training in, working with LGBT young people. Training might be commissioned from within the residential child care sector or through local or national LGBT organisations. Some current organisations are listed as websites at the end of this paper. It is important for staff to have an up-to-date knowledge of local and national resources that they and young people can access for information and advice. This would include groups that LGBT young people might like to join in order to reduce any sense of isolation, or helplines they may wish to contact. Similarly any educational input to young people on site needs to be inclusive of particular information for LGBT young people. Consider recording practices and care planning. What, if anything needs to be recorded in day-to-day logs and individual care plans about someone's sexual or gender identity? There may be a dilemma for staff who are rightly concerned to record the individualised needs of a young person (for example, on particular social activities or

modes of dress) versus the young person's right to confidentiality. Where there are no child protection concerns, the young person's choice as to what is recorded is paramount.

A requirement and a desire

Residential child care workers in Scotland are required to adhere to the National Care Standards. These have six main principles which are dignity, privacy, choice, safety, realising potential and equality and diversity Individuals have a right to be treated with dignity and respect and to enjoy a full range of social relationships with whomsoever they please as long as they do not put themselves at risk. They have the right to have privacy and to have property respected, and to be free from unnecessary intrusion. For the LGBT young person this may be the privacy of their sexual identity. Individuals have the right to make informed choices, and know of the range of choices. They have the right to get help to understand fully all of the options and choose the one that is right for them. Consider what this might mean for a young person wondering about 'coming out.' They also have the right to feel a sense of safety in their environment. This includes safety from homophobic bullying and abuse with the knowledge that staff are there to protect and support them. They have a right to realise potential, to 'be all that they can be' and make the most of their lives, without the need for repression or hiding aspects of identity and personality. They have the right to equality and diversity, to live an independent life, rich in purpose, meaning and personal fulfilment; to be treated equally in a discrimination-free environment and to complain about treatment without fear of victimisation. Standard 14 states that 'Staff will respect your wishes about the private aspects of your life and your...sexual preferences.' Standard 14.2 states that, 'You know that staff are trained to deal with issues of diversity (for example, sexuality and lifestyle choice) sensitively and knowledgably. You have information about your lifestyle choices and can contact other people who can support them'. The National Care Standards promise a great deal for the LGBT young person in residential care in terms of enabling them to live fulfilling, expressive, confident lives. It is worth taking time to 'audit' practices against the National Care Standards, taking each specific standard in turn and asking how each applies and is applied to the LGBT young person. In addition to the above, social service workers are required by The Scottish Social Services Council to adhere to its Codes of Practice in which there are references to treating service users as individuals, the right to control one's own life and promoting equal opportunities and respecting diversity. From this it is clear that residential child care workers are required through legislation to work in particular ways with LGBT young people. Ideally residential child care workers will relish and wish for the challenge of promoting healthy and positive sexual identities in the young people they are working with and in the creation of an environment in which they live. Workers need to bear in mind, however, that while they may know for sure that none of the residents in a unit are LGBT, this is not a reason for not promoting an LGBT-friendly atmosphere and creating an inclusive environment. Workers themselves, parents and friends of residents may be LGBT. To provide the best service possible to LGBT young people in residential care, staff need to be raising their awareness continuously of LGBT issues and concerns and to question routinely their practice to ensure that it is best practice. Such practice should be inclusive, anti-discriminatory and anti-oppressive, and to be prepared to challenge other practitioners and organisational systems that are homo/bi/ transphobic. In conclusion, it could be that some LGBT young people will not need or wish for any specific LGBT intervention. This has to be respected. Furthermore, there is not one type of gay, lesbian, bisexual or transgender person. There is much diversity within and across all these groups and therefore intervention, as in all good residential care practice, needs to be very well informed and individualised.

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Useful websites

- www.biscotland.org/meetings.htm
- www.equality-network.org
- www.fflag.org.uk
- www.lgbthealth.org.uk
- www.lgbtmindmatters.org.uk
- www.lgbtyouth.org.uk
- www.schools-out.org.uk
- www.scottishtrans.org
- www.stonewallscotland.org.uk/scotland

Understanding Autism

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Bert Lawrie, Training Manager, Voluntary Service Aberdeen

Bert Lawrie is the training manager for Voluntary Service Aberdeen. For a number of years, he has worked with their social care and education staff to help them understand some of the issues facing individuals on the autistic spectrum. Trained in Applied Behaviour Analysis, a TEACCH facilitator at Linn Moor Residential School and an Instructor Trainer for Behavioural Support Strategies, Bert works with a small team of specialists at Linn Moor Residential School delivering assessment, training and qualifications to staff, carers and outside organisations, supporting individuals challenged by autism.

Introduction

Autism is a growing area of interest and concern in residential child care. The needs of some children who are affected by autism are met in autism-specific settings, or in disability units. It should be recognised, however, that children and young people affected by autism are appearing in all sectors of residential child care provision. As well as those who have a diagnosis, Myers (2004) suggested that there may be 'hidden' autism. This happens because children in residential care may have had multiple placements, and experienced such chaotic lifestyles that their health care monitoring has been disrupted. This paper will give a brief outline of what it means to be affected by autism and provide some guidelines for practice. It will also be illustrated by the voices of those affected by autism.

History, definition and prevalence

One definition of autism is 'a lifelong developmental disability that affects the way a person communicates and relates to people around them. People with autism have difficulties with everyday social interaction' (NAS, 2009). Another definition is given by Jasmine, an author who is also affected by autism.

> *A mysterious, unusual, potentially beautiful type of personality. To search the dictionary for a definition of autism is foolish, the definition will be incomplete and almost always negative. (O'Neill, 1999, p18)*

Autism is a condition which affects all aspects of a child or young person's functioning. The level of severity with which someone is affected can differ. For this reason, those working in this area tend to speak of an autistic continuum, and hence autism is more commonly referred to as Autistic Spectrum Disorders (ASD). The variations along this spectrum can go from mild anxiety to total disconnectedness or withdrawal. The situation of a child is often compounded by learning difficulties. In the next quote, Luke describes this continuum within his family.

> *Ben has massive problems with his senses. Everything seems extreme to him. He spends so much time with his fingers in his ears and now he can talk better he shouts 'too noisy' for almost everything. (Jackson, 2002, p17)*

If you work in a disability or autism-specific setting, you may have children and young people who have a profound type of non-verbal autism. This autism was first described by Kanner (1943). On the other hand you may have children and young people in your setting who are affected by high-functioning autism or Asperger Syndrome. Asperger Syndrome was named after Hans Asperger (1944, as cited by Frith, 1991). These children, whilst able to communicate verbally, have to routines and poor ability to develop social relationships. Statistics on the prevalence of ASD vary. The Scottish Society for Autism says that one in 110 people are affected by autism (SSA, 2009). The number of children and young people affected by ASD who come to the attention of social services and are being received into residential child care

has risen. It is suggested, however, that this is due to better awareness and diagnosis rather than a real rise. A study by Stevens (2008) found that social care students gained much of their perceptions about autism from newspapers, which led to an under-estimation of the types of challenges faced by children and young people affected by ASD. Also a study by Murray (2006) found that films about autism affected how the public understood this. While newspaper reports and the printed media have a grain of truth, the picture relating to ASD is much wider than this.

> From where is your knowledge and perceptions of autism drawn? **?**

Underlying issues facing the child or young person affected by ASD

There is ongoing research into the underlying issues which may contribute to ASD. At the moment we know that it is organically based, it often runs in families and tends to affect more males than females (4: 1 ratio). Some of the research which is most helpful for practitioners seems to suggest that ASD may be associated with difficulties in three key areas:

1. Executive Function
Executive function is a high-level mental ability which helps us to set goals, process information and plan activities. Interacting in our society requires an ability to understand and interpret complex social rules. If someone has problems with executive function, it is likely that they will experience problems in adapting to change, solving problems and recognising danger. Ozonoff (1997) suggested that if there are difficulties in this area, the child or young person may display challenging behaviour.

2. Theory of Mind
The development of Theory of Mind involves someone eventually coming to see that their thoughts are not shared by everyone else. In addition, as we develop a mature Theory of Mind, we come to understand that other people have thoughts and beliefs about us and the social situations we share. For example, in a social situation like a review meeting everyone will behave according to how they think that the other people will behave. This social process is like running a movie through your head before and during the social situation. Those with a mature Theory of Mind will know how to act in such social situations automatically. It is said that people affected by ASD have a poorly developed Theory of Mind which may rarely progress beyond what you might expect of a typical three or four year-old child. It is easy to see how such a child or young person could become frustrated if you do not understand what they need. Baron-Cohen (2008) called this mindblindness.

3. Central coherence
Central coherence is a mental ability to understand context and to understand that what may apply in one situation may not apply in another. Research indicates that people affected by ASD have weak central coherence. They pay attention to small or seemingly irrelevant aspects of a situation or object. Frith (2003) commented that this was like 'being unable to see the wood for the trees'.

> How would you describe executive function, can you give an example?
>
> In regards to 'theory of mind' think of the different social situations you are regularly in, what are the expectations in different settings?
>
> What challenges do you think a young person could face within your setting? **?**

What you might see in a child with ASD

The International Classification of Diseases, 10th revision (WHO, 1993) and Diagnostic and Statistical Manual of Mental Disorders, 4th edition, (APA, 1994) are the main instruments used by psychiatrists to diagnose autism. The ICD-10 and the DSM-IV state that the following criteria must be met before a person can be diagnosed with autism:

- Social interaction is affected, ranging from aloof and indifferent to making bizarre one-sided approaches;
- Communication is affected, ranging from no verbal communication to spontaneous, but repetitive, one-sided, and odd exchanges. These can also be characterised by extremely literal interpretations of events;
- Social imagination is affected, ranging from no apparent imaginative flexibility of thinking, to acting out one theme (for example, motor cars) repetitively;
- Repetitive patterns of self-chosen activities. These could be simple bodily movements (for example face-tapping or hand-biting to the level of selfinjury). On the other hand they might be more complex interests like being obsessed by train timetables. This may be accompanied by repetitive questioning or seemingly long-winded monologues on their self-chosen activity;
- Can be hyper-sensitive or hypo-sensitive to sensory stimuli such as colours, smells or textures;
- May have stereotyped movements such as flapping or jumping, ranging from very marked to minimal or absent;
- Very occasionally, they may have specific 'savant' skills such as manipulation of objects, music, art at a level above what may be expected for their chronological age.

Such classifications can be helpful allowing practitioners to understand the extent of the challenges faced by their young people in their autism-specific or their disability settings. They can also help practitioners to identify if a child with whom they work has an undiagnosed ASD. Every person will experience their ASD differently. In the next quotations, some autistic people describe some of the feelings in their particular cases.

> *When I get angry it's like an afternoon thunderstorm; the anger is intense but once I get over it, the emotion quickly dissipates. (Grandin, 1995, p88)*

> *Reality to an autistic person is a confusing mass of events, people, places, sounds and sights. There seems to be no clear boundaries, order or meaning to anything… Set routines, times, particular routes and rituals all help to get order into an unbearably chaotic life. (Joliffe, cited in Grandin, 1995, p76)*

Another simple way of understanding ASD is the Triad of Impairments (Wing and Gould, 1979).The Triad of Impairments recognises developmental challenges in three areas:

1. Interaction with others;
2. All aspects of communication;
3. Flexible thinking and imagination.

The Triad of Impairments will now be used to discuss some ways of working with the challenges presented by ASD.

Do the above criteria fit with your previous perceptions? **?**

Understanding and helping interaction

Soon I found my smiles were unreturned, my steps never followed and my place never called. Soon I saw I was invisible. (Wiley, 1999, p 44)

Children and young people affected by ASD seem disconnected with those around them. This disconnectedness may vary from a slight reluctance to initiate interaction, to total withdrawal from any involvement other than the meeting of needs. Such difficulty in building social relationships has an impact upon residential practitioners. If the child displays no interest in being reciprocal in a relationship, this can lead to practitioners thinking 'What am I doing wrong?' This is where anxieties come into play and the self-esteem of the practitioner may be challenged. Social stories are one way in which a practitioner can help interaction. The idea of using a story to describe common social situations was first put forward by Gray and McAndrew (2001). A social story describes a situation, skill, or concept in terms of relevant social cues and common responses of each person in the social situation. It makes the social situation more concrete and less abstract. Further details of social stories can be found at: www.thegraycenter.org.

Understanding and helping communication

Their words became a mumbling jumble, their voices a pattern of sounds. I could look through them until I wasn't there, and then later felt that I had lost myself in them. (Williams, 1999, p9)

Communication is central to our way of being. No more so than for practitioners working with or supporting a child or young person who is challenged by autism. It also takes a central place within the National Occupational Standards, upon which vocational qualifications in health and social care are based. If a child is non-verbal, this can create challenges for the residential practitioner as they struggle to find a way to communicate. For the verbal child, the practitioner must remember that the child's interactions can mask a lack of understanding of the meaning behind the communication. Such children and young people may become so highly skilled in the masking process that practitioners may find it difficult to discover the true level of understanding. There are basic assumptions regarding communication which can be difficult for the child or young person with ASD to comprehend. Social graces that do not satisfy any need other than the expectation of a particular culture at a given time may seem pointless to such a child. One common approach to helping with communication issues is Treatment and Education of Autistic and related Communication-handicapped Children (TEACCH). TEACCH was developed by Mesibov et al. (2005). It helps children with ASD to develop strategies to function in the culture that surrounds them, taking into account their characteristic cognitive and behavioural patterns. The principles guiding the TEACCH system have been summarised as:

- Improved adaptation: through the two strategies of improving skills by means of education and of modifying the environment to accommodate learning needs;
- Assessment for individualised treatment: personalised educational programmes are designed on the basis of regular assessments of abilities;
- Structured teaching: children affected by ASD benefit more from a structured educational environment than from free approaches;
- Skill enhancement: assessment identifies emerging skills and work then focuses upon these;
- Cognitive and behaviour therapy: the learning process is guided by theories of cognition and behaviour suggesting that difficult behaviour may result from underlying problems in perception and understanding;
- Generalist training: professionals in the TEACCH system are trained as generalists who understand the whole child, and do not specialise as psychologists, speech therapists or other professionals.

For more information visit: www.teacch.com.

Understanding and helping flexible thinking and Imagination

I happen to enjoy my self-stimulating behaviours. I love them and I enjoy them. I affectionately call them my 'stimmies.' Autistic people generally do enjoy their stimulations. They are comforted by them and are relaxed by them. (O'Neill, 1999, p73)

Stereotypical behaviour patterns and rituals in a child or young person affected by ASD can be challenging for practitioners. Such behaviours seem to get in the way of offering the child new opportunities. Yet it is important to understand that such rituals offer security, enabling a child to become utterly absorbed in that particular pattern of behaviour. For the child affected by ASD, stereotypical behaviour or rituals may be a response to a change in the environment with which the child is unable to cope. As McMillan said, 'Each of us could possibly see behaviour patterns within ourselves that offer security in times of stress or discomfort' (McMillan, 2009, p23). The key point here is not to deny the young person access to their rituals. The young person has the right to derive the comfort provided by their rituals. As a practitioner, you can use the rituals to encourage the young person to try something new, and then offer them some extra time indulging in their rituals as a reward. The main point of stress for young people affected by ASD is during transitions. Transitions happen at many points in the day. These transitions can be relatively minor (e.g from dinner table to sofa), or they can be major transitions (e.g. from school to home). It is not the length of the transition but the transition itself which is stressful for the child or young person. One way to help transitions is to use transitional objects. These can be objects, pictures or symbols which provide psychological comfort by helping the young person to understand that change will be happening, to provide an island of stability within the change. This helps the child to feel less stress during the transition to the new situation. You can also help transitions by offering some time for the young person to follow their routines or rituals when they have completed the transition. Transitions for young people who leave residential care or education can be even more difficult as the adult world is less structured with no set timetable for events or activities, times for meals or being in bed. Experience with adolescents affected by ASD has shown that it is too late to plan for their adult lives when they are on the point of leaving school or moving on to an adult placement (Mesibov et al., 2007). One tool to aid such a transition is the TEACCH Transition Assessment Profile which provides a comprehensive screening tool. This focuses on the strengths and interests of the young person, and takes account of feedback from family, school and social care staff. The integration of information from the individual assessor's observations, school and group care providers, and the family, offers powerful data to plan the transition to the adult world.

Assessment and intervention in challenging behaviour

Applied behavioural analysis (ABA) is one approach to assessing and intervening in challenging behaviour. ABA was developed by LaVigna (2007). At first it was applied more widely to services that support children or adults with challenging behaviour in general, but it has been found to work well with children and young people affected by ASD. Applied behavioural analysis helps a practitioner to identify what causes a particular behaviour in a child by focussing on what triggered the behaviour and what the consequences of the behaviour were. If a child screams at a staff member when they approach, it may cause the staff member to respond by backing off and leaving them. If the child's behaviour (screaming) obtained the desired effect (being left alone), they are likely to repeat this behaviour in future. By analysing this behaviour and recording its antecedents and consequences, a practitioner can understand what the communicative function of the behaviour was and can help the child to learn new behaviour which will help them to communicate their needs and emotions in a more helpful way. The goal of ABA is to teach skills and to tackle behavioural issues. Care must be taken to design opportunities for achievement that enables the child's progress to continue. The skills which might be the most important for the child to learn are attention, cooperation, and imitation. These skills are the basis of learning without which no other skill will be formed. Practitioners should offer opportunities for the child to display such skills and reward them in accordance with a graded reinforcement process. The reinforcement process will be specifically designed for the individual. They should be offered rewards that

corresponds to their stage of development ensuring that their interest is maintained. Further information about ABA can be found at: www.iaba.com.

> In regards to assessment, think of a behaviour shown by a young person you work with.
>
> What are the antecedents and consequences attached to this behaviour?

Some learning resources

This paper has provided some awareness about ASD and has highlighted some websites which may be of benefit. However, a practice development paper has limitations and it may be helpful to seek further qualifications in this area.

SIRCC offers a basic one-day course on autism awareness. Outwith SIRCC, the Scottish Qualifications Authority offers a Professional Development Award in Autism. It also offers an open learning pack supporting the Higher National Unit entitled Working with autism (McMillan, 2009). Further information on SQA publications can be found at SQA's Care Scotland webpage on: www.sqa.org.uk/sqa/3927.html. The National Centre for Autism Studies (NCAS), based at the University of Strathclyde offers a postgraduate certificate and diploma in autism studies. More information about NCAS can be found at: www.strath.ac.uk/autism-ncas. Finally, the National Autistic Society and the Scottish Society for Autism offer short course training and a range of publications to support practitioners working in this field. Their websites are: www. nas.org.uk and www.autism-in-scotland.org.uk.

Conclusion

Children and young people affected by ASD, whether they have a diagnosis or not, should have the same rights as any other child. The Scottish Society for Autism endorses a convention on the rights of people with autism which states :

People with autism should have the same rights enjoyed by all EU citizens (where such are appropriate and in the best interest of the persons with autism). These should be enhanced and enforced by appropriate legislation in each member state and include:

- The right to live independently.
- The right to representation and involvement as far as possible in decisions affecting their future.
- The right to accessible and appropriate education, housing, assistance and support services and to a sufficient income.
- The right to freedom from fear, threat, and from abusive treatment. (Autism Europe, 1996)

Given the confused public conceptions of autism and its growing prevalence in residential child care, it is important that those young people who are affected are ASD are not disadvantaged. Practitioners who suspect that a child may be affected by ASD should seek to have that child referred to a psychologist for assessment. The final words are left to the families of those affected by autism:

> *We often assume that because a person doesn't speak or act 'normal' that they have an impoverished life. Although I often wonder what goes on in my daughter's mind, I think she has a rich inner life…I wouldn't want Katie to be anyone other than who she is. (Dixon, p. 35)*

From reading the paper on autism do you feel you have a better understanding?

Myers (2004) refers to 'hidden autism'. Can you think of any people you have worked with who may have fallen into this category? Give reasons why you may think so.

Are there principles we can adopt which would be beneficial to all the children and young people we work with?

What adaptations would be needed in your practice and your team's practice if you were working with a young person with ASD.

What are the benefits of a diagnosis?

Do you believe there are any negative aspects to a diagnosis?

How and to whom would you refer a young person for assessment?

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Supporting Transitions and Throughcare:

Some lessons from secure care

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Introduction

Research in the area of throughcare and transitions has highlighted major problems (Dixon and Stein, 2002 and 2005; Stein, 2006). In response to such findings, regulations and guidance were published, outlining responsibilities for supporting young people leaving care (Scottish Executive, 2004). In spite of this, the development of good practice in transitions has been slow. The SIRCC stakeholder review of 2007 identified throughcare and aftercare services as key areas for development and in 2009, during consultations held in relation to the National Residential Child Care Initiative (NRCCI), this was emphasised yet again . This paper outlines the findings of a recent evaluation of practice in the secure sector and explores some general principles which can be applied across the residential child care sector.

The Throughcare Regulations and Guidance: What are young people entitled to?

The Regulations and Guidance includes duties to assess and review a young person's aftercare needs and to establish clear plans called pathways. In addition to this, reports and guidelines on best practice have been developed which offer support to practitioners (Scottish Throughcare and Aftercare Forum, 2006; Scottish Commissioner for Children and Young People [SCCYP], 2008). It is strongly recommended that residential practitioners make themselves familiar with the Regulations and Guidance. Here are some of the legal entitlements of young people in care:

- The young person should be prepared for leaving care (Reg. 6)
- The views of young people must be taken into account when leaving care and throughout the pathway planning and review process (Reg. 3)
- The local authority must provide suitable accommodation that meets the needs of the young person (Reg. 14)
- Young people should not be placed in unsuitable bed and breakfast or hostel accommodation (Guidance 9.3)

The local authority also has a responsibility to provide financial assistance. This assistance is important as young people may not be eligible for other state benefits until they are 18 years old. Under the Children (Scotland) Act 1995, the local authority can provide support up to the age of 21 years in some cases, and even beyond this if the young person is in education or training.

The Secure Transitions Evaluation: Some lessons for wider practice

The Secure Transitions Fund was set up by the Scottish Executive in April 2007 to help achieve better transitions for young people leaving secure care. Research showed that many young people leaving secure care were often re-admitted (Walker et al., 2005). The fund was set up to provide additional support for young people leaving secure care, in an effort to reduce the number of readmissions. The fund was only available for one year, but the innovative practice which developed served to inspire all who were involved. SIRCC was asked to evaluate the impact of the fund. This evaluation took place between August and November 2007. The key findings were:

1. Continuity of care is crucially important for positive outcomes;
2. Employment, college or job training are key factors in a good transition;
3. Proactive practice from staff improved, as they moved from asking 'Why are you here?' to 'Where are you going?'
4. Inadequate range of supported living units;
5. Poor pathway planning by throughcare and aftercare (TCAC) social workers;
6. A need for additional training of residential staff in TCAC regulations and guidelines;
7. A lack of family work.

These findings echoed research and literature on throughcare and aftercare and demonstrated that practice could be improved. The findings will now be described and their applicability to the residential child care sector in general will be explored.

Continuity of care

Practitioners felt that continuity of care demonstrated proper corporate parenting where young people were placed at the heart of their provision:

If your own teenager lives on his own and needs you, he will come home and you would look after him for a while wouldn't you? But if these kids are having difficulties, who looks after them? Who offers them a bed for the night? We need more opportunity for them to fall back on the relationships they know with the people they have connected with (Manager).

Most practitioners valued the opportunity to continue their relationship with young people beyond their departure date. In addition, staff engagement after departure made a deep impression on the young people. If a connection was made with a practitioner during the placement, it was recognised how important this relationship could be as a template both for future relationships as well as for continued engagement with social services in times of need.

Practice considerations

Services should look at ways to validate the connections that young people make while in care and offer continuity of those relationships during the transition time. Residential units could examine ways to structure group care duties alongside a reasonable level of transitions support. Visits back to the unit should be encouraged, in line with the National Care Standards.

How would you feel about a young person returning and/or continuing the engagement?

Is this familiar practice and if so how would you feel about not having contact?

How would you/do you manage young people returning?

Education, employment and vocational training

A variety of support mechanisms were implemented to encourage education, employment or vocational training. The evaluation found that most of the young people interviewed chose a vocational route. The support meant that young people were more likely to sustain their transition to mainstream education, college or work. In one example, a young person struggled to hold down employment on two occasions. The unit had a range of supported employment places within its services and the young person undertook one of these. This placement proved to be important in the young person's journey toward developing skills for work. After this period of initial support, a manager within the supported employment placement commented:

It means something if a young person comes through wind and rain and darkness and shows up for work on time every day despite all the travelling

Without exception, vocational training or being in employment provided a helpful focus as well as future aspirations for young people during their transition. The role of support during this time can be critical for the young person.

Practice considerations

Services should look at ways in which practitioners can provide practical active support for young people accessing job and college placements. In the initial stages of college or work, young people who have been in care may lack confidence or have poor self-esteem. Practical support from practitioners at the early stages of new education or employment experiences (e.g. accompanying young people to the setting, classroom support or arranging to meet them during break times) can create better outcomes. Practitioners should be aspirational for their young people in terms of their education and those who wish to pursue academic routes should be given as much support as possible.

What opportunities are available to the young people you work with?

What would improve the current situation?

Can you influence an improvement?

Proactive practice

A majority of practitioners in the evaluation indicated that, by focusing on continuity of care, they changed their thinking from 'where did you come from and why were you placed here?' to 'where are you going?' This shift resulted in care plans with a stronger aftercare focus. As one practitioner said:

We want to help young people to be better prepared for what it's like to really be alone, and not to have the back-up of, for example, the close support unit… like when you run out of milk, you just walk over to (the unit) and ask. Or when your electricity meter runs out, to make sure you have money to put in the meter

While it is important for practitioners to have an appreciation of the young person's history, young people should also be given an opportunity to explore their hopes and fears for the future. Encouraging the young person to look at where they want to be in ten years time and focusing on their future life path reflects the approach of Social Pedagogy. In the Netherlands, time in care was used for learning, evolving and moving on. Practice involved mentoring, coaching and empowering young people and their families to do things on their own again. It encouraged young people to be aspirational in all realms of life, to explore their talents, and not simply to define themselves as a troubled young person. This approach mirrors Getting it Right for Every Child (GIRFEC) (Scottish Government, 2009). The importance of building a healthy relationship with young people is emphasised strongly in Social Pedagogy while learning, empowerment and aspirations are key themes for practice. Services should seek to engage with the Social Pedagogy agenda in Scotland.

> How aware are you of social pedagogy?
>
> If you are not aware, how may you find out more?
>
> If you are aware how would the approach fit with your own practice?

Practice considerations

Meetings could be set up to discuss transition plans and support services for young people. This focus on a young person's future development and how to support them to benefit from this, is highly motivating both for practitioners and young people. The evaluation also highlighted the role of the transitions coordinator, who ensured that transitions remained a priority. Units or organisations could look at developing such a service.

> Who co-ordinates transitions, sets up transition plans and chairs discussions on the support services and needs of the young person moving on?
>
> Is there scope to develop such a role, or make it an explicit part of a current role?

Appropriate accommodation for care leavers

The Sweet 16 report (SCCYP, 2008) described the inadequacy of accommodation for care leavers. This evaluation confirmed these findings. Practitioners reported that young people were often discharged to inappropriate accommodation such as hostels or bed and breakfast facilities, often when they had just turned 16 years old. There were no specialist services for young people with problematic substance use, in spite of this being a growing problem. The majority of practitioners and managers expressed concern about the expectation that care leavers should function independently at an earlier age, and with much less support than the average young person in Scotland. According to the Sweet 16 report, the average age that young people leave home is 22 years old. Yet the residential sector in Scotland generally expects young people to be leaving the unit much earlier than this. As one practitioner put it:

Why are we sending such vulnerable children out there on their own?

Without exception, every practitioner who took part in the evaluation felt a real sense of anger, sadness and frustration over this.

Practice considerations

There is a need for a range of appropriate accommodation for young people when leaving care. Although individual practitioners and services cannot provide this, it is useful to find out exactly what might be available in the area. This is especially the case for special need housing associations as well as organisations offering supported accommodation. It also demonstrates a need for practitioners and services to advocate actively on behalf of young people if they are in danger of being discharged into inappropriate settings. There is also a role for organisations to look at retaining its young people until they are old enough to cope with life outside the group care setting. Finally, organisations could look at providing off-site supported accommodation.

> What do you think of the accommodation offered to young people leaving your service?
>
> Do you have supported accommodation as part of your service or which you can link in to?
>
> Would there be scope to link with another service to provide the best for the young person?

Poor pathway planning and a need for training

The evaluation showed that practitioners had to remind social workers or TCAC staff to develop pathway plans. In all but two units, the majority of young people left secure care without a pathway plan in place. Sadly this reflects the residential care sector in general, where the latest statistics indicate that only 55% of young people leave care with a pathway plan in place (Scottish Government, 2008a). In many cases, release from the unit was unanticipated. Practitioners felt that young people leaving secure care were not a priority for social workers. They stated that some social workers did not expect young people to succeed. Some social workers minimised their involvement as they felt they were wasting their time, according to staff. Individual social workers cannot be blamed for the size of their caseloads. Also, many young people in secure care are placed outwith their own authority, so there can be complications in the support and coordination of pathway plans. Nevertheless, the fact that

pathway plans were the exception and not the rule was worrying. It demonstrates a failure in the corporate parenting of young care leavers. The evaluation also showed that issues which should have been addressed in pathway planning, such as mental and physical health problems were often not followed up when a young person left the unit.

What is your experience?

What would you expect?

?

Practice considerations

Practitioners must advocate strongly for pathway planning to take place. Some practitioners are unclear about the regulations and guidance which govern throughcare and aftercare. Services should address this, and provide training on the legislation and guidance, and on advocacy skills. The importance of well-developed advocacy skills cannot be stressed enough. Practitioners are often in the best position to advocate for the children in their care and ensure they receive the services and benefits to which they are entitled.

How do you advocate for the young people you work with?

What good practice would you share with others?

What areas of development can you identify?

?

The need for family work

Home placements after a period of care seemed to fail frequently. This emphasises the importance of family work while the young person is in the unit. The Children (Scotland) Act 1995 and guidelines such as GIRFEC encourage partnership with parents. In practice, however, this can be difficult. This evaluation found that family work was not done. Informal family work consisted of seeing parents at visiting times and briefly updating them on their child's activities within the unit. Contextual methods of family work emphasise inclusive approaches which lead automatically to seeing children as a natural extension and reflection of their family system (Nagy and Krasner, 1986). As such, if you want to understand what is going on for a young person, you have to include the whole family system. Most young people report that their family remains central to them. Practitioners should make sure that opportunities are created for family issues to be resolved. Many practitioners in this evaluation felt that this was the job of the social worker and also that units were not the most welcoming environments for families to visit. Due to this and the absence of any formal joint work between the parent(s) and young person (including siblings), issues within the family are not dealt with, and opportunities for closure and moving on were not created. This could result in a recurrence of earlier problems within the family that were witnessed before the placement. Parents felt powerless to deal with their child which could result in another placement. In response to this, Stepdown, an organisation offering transition support to young people in secure care, offered a parenting course that focused on practical skills for rebuilding relationships. It encouraged parents to have realistic expectations around house rules, as well as providing some ideas for dealing with challenging behaviour. Parents who undertook this course felt more confident and able to make choices about their responses to the child's behaviour. They also reported a better understanding of their child's internal world.

> What family work do you do?
>
> What would you like to do?
>
> How confident would you feel to do family work?

Practice considerations

Research demonstrates that the judgemental attitudes of practitioners toward family members can be a factor in the lack of parental contact with young people in care (Pilkington, 2005). In negotiation with social workers, family work could become a greater part of the placement plan for a young person, where circumstances permit. The skills of residential practitioners and their knowledge of the young person can be invaluable in these circumstances. An action plan could be developed when the young person is admitted, which actively addresses how the unit and practitioners will engage with the family, if this is appropriate. It may also be helpful for the unit to have a statement about how it will welcome parents into the lives of their children.

> Do you have a statement outlining needs for family work within the care plans you develop?

Some transferable initiatives

Different initiatives were undertaken in the secure units to support transitions. The initiatives outlined are transferable to the wider residential sector.

Fitness
Young people were offered opportunities to develop hobbies, fitness activities and access to places where they could meet other young people. Practitioners accompanied them to fitness centres for the first few times until the young person felt more settled. Memberships were provided which could be used when the young person moved on.

Singing
A priority area was to introduce young people to age-appropriate activities and peers. One example was of a young girl admitted due to severe self-harm. While in the unit, staff organised singing lessons for her. On her departure, she joined a local music school's gospel choir where she made new friends.

Sports coaching
A sports coaching course for a talented young football player helped him develop his skills and meet other people. This young person left with a range of football coaching certificates, which increased his self-esteem and helped him to make connections in his new community.

Building family relationships
A young person and his step-dad were provided with a football season ticket to create an opportunity for relationship-building. The young person had identified this fraught relationship

as a reason why he had run away from home and got into trouble. The young person wanted to make the relationship work. Football was the interest they had in common.

Managing stress

A young woman with problematic substance use was supported to find alternative stress management techniques. She was introduced to the gym, sauna, and aromatherapy massage, saw a pantomime and took part in a Women's March in Glasgow. She indicated that the practitioner had introduced her to new possibilities of which she had no awareness. After undertaking a course as a nail technician, she progressed to a hairdressing course and living independently. She had no doubt that without this support she would have returned to secure care.

Practical skills for living

One unit set up a skills training group where young people learned how to build furniture from a DIY flat-pack, check for electrical wires in the wall when hanging pictures, what to do when your tap is leaking, minor clothing repairs and other basic skills. The topics were identified by both staff and young people.

Beyond the black bin bag

On leaving, the units provided young people with the following:

1. An information folder with their birth certificate, contact details, SQA candidate number and Young Scot card;
2. A proper suitcase;
3. A wash bag with basic toiletries for a month;
4. A mobile phone package with pre-programmed numbers topped up by £10 per week for the first 12 weeks as long as it was used appropriately;
5. A bank account;
6. A travel card;
7. A laptop with educational packages for those who were undertaking training.

The regulations on throughcare and aftercare provide some of these items on a discretionary basis. While these items should be advocated for, residential services should recognise that they may not be forthcoming, and look to see what can be provided within their budgets.

> What initiatives does your service provide?
>
> What could you provide?
>
> **?**

Concluding remarks

The building of relationships, trust and attachments in care can be a difficult task (Boendermaker, 1998; Buchanan, 1999). Such relationships, however, are extremely important. Different pathways of care leavers (moving-on, survivor and victim) are associated not only with the quality of care they experience, but also on their transition from care and the support they receive after care (Stein, 2006). This evaluation recognised the value of relationships that young people built with practitioners while in the unit. This was especially the case for those young people who had poor family engagement. Good practice in transitions is crucial to positive outcomes for young people. A real commitment to corporate parenting as laid down in the document These are our Bairns (Scottish Government, 2008b) should be followed up by ensuring that services have the resources to make good transitions a reality, and that practitioners learn as much as they can about the legal rights of those who are leaving care.

How would you evaluate your service in regards to managing transitions (good, bad, average)?

What improvements would you make?

What good practice would you share?

To whom would you make suggestions for improvement in order to develop practice?

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In Residence

Notes for supervisors on how to use the reflective questions

The creating and maintaining of a learning culture within residential services is a vital task in developing a successful environment where young people and staff wish to be, grow and learn together. The ability to reflect upon and question practice is essential in such a culture. To help you, as a supervisor, to encourage and support the reflective process, we have incorporated some reflective questions in the new edition of the In Residence papers. These questions are not designed to be undertaken as an assignment; they are prompts to start the reflective process, by asking some questions to be thought about honestly. The answers may be positive or highlight areas for possible development. The important point is that they give the opportunity to have discussions within a learning culture. These should be discussions where the aspect of blame is not at the forefront; understanding, learning and development are. Reflective discussion provides a venue where questions can be asked and situations analysed without a need for individuals to be defensive about practice, policy or agency. It is recognised that the questions that have been added are not exhaustive and you will have many more which you can customise to your own service. The questions are often phrased as how do we, as well as how do you, with the intention to create that climate of learning where we work together. We may have different roles but we will always have the same goal. Some of the papers were written a few years ago. To recognise this, new forewords have been added to the older papers. This means that the practice described remains relevant today. Where there may have been some changes in your own practice or service, then there is the opportunity to discuss the differences and the reasons for the change.

The way in which the papers are used will be different for each situation. I know of managers who have used individual papers as prompts for discussions in supervision sessions, while others have used the paper as a starter for a whole team discussion. Some supervisors have simply left them lying around for staff to pick up and think about. I would suggest most learning occurs when there is discussion and the opportunity to exchange perspectives and understanding. You will know your team and how best to achieve this. All we at SIRCC can do is ask that you use the papers to recognise and reinforce good practice, to further develop practice and to help create a healthy environment for learning.

There now follows a summary of the questions which are incorporated into the papers.

Resilience

What is it and how children and young people can be helped to develop it.

Resilience Explained

What are you doing to develop each of the core elements of resilience with the young people you work with? Think about each of the core elements in regards to the young people you work with. Examples of questions include:

- Do we give to young people opportunities to take responsibility and make decisions?
- To support the development of initiative, do we support young people to do things for them self, as opposed to doing things for them?
- In regards to attachment, do we know who the young people's attachment figures are? (Who are their anchors?)
- How do we give meaningful roles or maintain young people's meaningful roles?
- Humour is important; however we need to ensure young people feel we are laughing with them and not at them. How do we do this?

Assessing Resilience

How could you use this table as an exercise/assessment?

Could you complete the assessment for the young person; complete it as a team; ask the young person to complete it with you; or ask them to complete it by themselves? There are many ways.Each may be different in each situation; however, it is interesting to discover where differences are. We can all appear different to different people and in differing situations. In order to work with a young person we must understand their perspective, as well as our individual and team perspective. We are working with what they believe, not what we believe.

Building Resilience

How do we work to improve the educational attainment of young people? Are we good role models in regards to doing homework, academic courses or paperwork? Do we have reading material readily available, play educational games, count money together, work on budgets for things we are doing or make learning fun?

How do we keep young people connected when there is little contact?

Do we encourage peer support?

Conclusion

How do we develop ourselves and our colleagues/staff to be resilient workers?

What supports are available and what supports do we need?

How do the building blocks relate to us?

Working in the 'Lifespace'

A history of lifespace intervention

Is the role of a residential worker now professionally valued? Do you see your role, as professional, equal to other professionals?

So what is lifespace?

How would you describe the lifespace?

How do you build up a knowledge and understanding of children's personal histories? Does this include feelings as well as facts?

Terms and ideas associated with lifestyle approaches

Milieu: How would you describe the milieu you work in? What attributes would you say support a healthy milieu? Are there areas for development? What aspects of the physical layout help or hinder the milieu?

Developmental Group Care: Consider the seven core essential ingredients Maier highlights as the core of care, in regards to your work and workplace. How are each met? How do you create predictability, how do you care for the caregiver? How are you as a caregiver cared for? What is supportive, what could improve?

Rhythms and Rituals: What are the rhythms and rituals of the house? How are these created and adapted to meet the needs of different young people? Who creates the rituals?

The Lifespace Intervention

Reflect on your last shift and give examples of lifespace interventions you were involved in. On reflection were there opportunities you missed, or decided to avoid? Is the concept of 'analysis paralysis' one you can relate to? How do you differentiate between age appropriate developmental behaviour and behaviour relating to past experiences? Can you think of situations where you believe too much analysis has been focused on what you considered to be age and stage behaviour, or situations where behaviour was not analysed enough?

The importance of relationships and use of self

What is your response to the Broffenbrenner quote? Did you have an adult who was crazy about you? Do the young people you work with have this?

Do the policies and procedures within your work support your use of self and developing close relationships?

Can you bring personal style into your work without compromising consistency? How do you do this? How do you get the support you require in your role?

Conclusion

How is working in the lifespace evidenced within your recordings, planned within care plans and shared with professional colleagues? Does this aspect appear within your job description and feature in your appraisal?

Children's Rights

How to implement a rights based approach in residential child care

Relating rights to practice: what's the relationship between adults and children?

What is your perception of children – victims or threats or something else? What is the perception of your colleagues? Sometime the most basic discussions are useful to have; however what are the ones we miss?

How do the rights and responsibilities relate to each other?

How do you perceive the link between rights and responsibilities? How is power shared within your workplace? Are the children at work different from other children you encounter within your personal life? Do they have more rights or fewer rights?

A case study using the triangle of rights

Would you consider using the triangle of rights in regards to decisions made for the children and young people you work with? What would be the advantages of using the triangle? Would there be any disadvantages?

Practice examples using the needs versus rights framework

How do the examples relate to your practice? What other examples can you think of from your practice or practice you have witnessed which would be relevant to the needs versus rights framework?

Conclusion

Has any of your practice or thinking been challenged by this paper? Is there any changes to your or your service's practice required after reading the paper? Who would you make suggestions for improvement to? Where would you share your good practice which has been highlighted through this paper?

Historic Abuse in Residential Child Care:

Sharing Good Practice

What is historic Abuse: A definition

Has care practice changed in the time you have been involved in residential care? If so in what way?

Responding to Allegations of Historic Abuse

1. Record keeping- Thinking about how you record factual information, would it be easy to understand? Consider issues such as the use of initials and jargon.
2. Does your organisation have a statement in regards to retaining and transferring records? What are the processes and procedures? What information needs to be retained and what should be destroyed? What is the policy in regards to access to records?
3. What would you do if an allegation was passed to yourself? How would you be supported in this?
4. Do you know the procedures for supporting survivors within your own agency? Is there a policy or procedure and if not is one required?
5. What dilemmas do you believe would exist when supporting current staff? What issues would be there for you?
6. Does your agency have a way to highlight concerns and report or discuss these without triggering a child protection investigation?

Conclusion

Unfortunately there is a likelihood further historical child abuse issues will arise and it is easier to understand and discuss the processes when there is not an investigation underway, therefore planning for such an event may be required now. It is also worth considering how we record and protect young people and staff now and ensure information is available should incidents be raised in the future. From reading this paper have you thought of any aspects of practice or recording which could be developed?

Working with Younger Children in Residential Care

A Specialist Residential Service

How many placements have the children you work with experienced? What is normal to them? Is moving, rejection, uncertainty of how long you will live somewhere normal for them? How do we help young people feel safe and secure if they do not think they will be living with us for long? From their perspective, is it worth investing in relationships?

Within your work, how does your service / team create a caring and nurturing environment? How do you personally create a caring and nurturing environment?

A Culture of Safety

How do you create a culture of safety? Do children know who is coming in to care for them each day- are rotas available/understandable? What are the rhythms and routines of the house?

A Culture of Openness

How comfortable are you in being painfully honest? How do you decide when to soften the pain and who are you softening the pain for? Often, but not always, children already know what has happened, they may just need it put in context. How do you record life story work and ongoing life experiences?

A Culture of Empowerment

In order to be able to give a high level of support to the children you work with, you need to be supported in your role. How do you receive support for the work you do? If you were to redesign the support available to you, what would you include/reduce? What are your needs?

Conclusion

What for you are the main points in this paper? Is there anything you would wish to adapt in your work or your own practice?

How does this paper relate to the older children you work with? Are the needs similar, or are developmental gaps recognised? Can all services learn from what is being said?

Conflict Resolution in Residential Child Care

Sources and Causes of conflict

Differing Aims: How much input do young people have when care plans are being developed? What differing methods do you use to involve the young people and ensure you have a shared understanding?

Resources: Have you experienced a situation where resources have been a basis for conflict? How do we manage the separation of our own feelings of defensiveness or annoyance at the resource issue? Are we honest about the issues?

Changes in role: What roles do the young people you work with have within the house? Are the young peoples roles discussed as a team? Do we truly understand the roles? The work of Dr Ruth Emond may enhance our understanding, a summary of the research can be found via:
www.sircc.org.uk/sites/default/files/understandingtheresidentgroup.pdf

Personality clashes: How well do we recognise personality clashes? What mechanisms exist within your workplace to allow for clashes to be discussed?

Lack of Assertiveness: Do we help young people become assertive? Do we teach skills and help young people develop their ability to be assertive, or is compliance better rewarded?

Misunderstandings: How do we check out our understanding is the same as our colleagues, managers or the young people we work with? Is it okay to ask others to explain their understanding and to share our own?

Lack of Trust: What practical things do you do which helps young people and others build trust in you? Is this more difficult in times of stress?

Unhelpful behaviour and ways to deal with it

Which of these behaviours can you most associate with yourself? Which of these traits can you link to others you work with? Can you share your perceptions on yourself and others with your team? Do your colleagues know the behaviours you would like to develop and if so how can they help?

Developing a conflict resolution strategy within your unit

Do you have a conflict resolution strategy, either informal or formal? Do we need one? What would you include?

Bereavement

Messages about bereavement: a brief review

Do you have experience of working with children or young people who have suffered bereavement? Do you have experience in your own life of bereavement either as an adult or a child? Is death a taboo subject within your workplace or openly discussed?

Children's perceptions of death

How do you think the children and/or young people you work with perceive death? Would the perceptions link with the age and stage of the group?

Understanding the grief process

Would these stages fit with your experience? How would you help a young person at each stage, what would be helpful and would could be unhelpful?

The role of significant professionals in the life of a bereaved child

Are there any of the recommendations you may find more difficult to adhere to than the others? How would you feel having an open discussion with a young person in regards to a death? Would you be able to attend a funeral with them, or show your own emotions?

Conclusion

How confident would you feel supporting a young person through the bereavement process? What support do you think you would require when undertaking this role? Has the reading of this paper made you want any further information on any aspects, or changed your perceptions about working with children and young people through bereavement?

Use of Self in Residential Child Care

Introduction

Does the definition of use of self given in the introduction fit with your previous understanding? What if anything is different?

The importance of being aware of the impact of the work

How do you recognise and record the impact on yourself from your work? What enables or supports your ability to reflect? Did you understand the possible impact of the work on yourself, prior to undertaking this type of work?

The developmental and self protective nature of self awareness

Which of the three areas identified by Thompson do you feel most comfortable with and which areas do you feel least comfortable with? Are there discussions within the team in regards to these areas? How comfortable would you feel receiving detailed constructive feedback? How confident would you feel giving detailed constructive feedback?

What mechanisms exist within your setting to support the feedback process? Can you identify anything which may hinder the process?

Motivation for the work and its impact on use of self

Why did you choose to work in residential child care? What are your current needs and how are these met? Have your needs changed over time?

Developing effective use of self: supervision

What is your experience of supervision? What different types of supervision do you experience (group, peer, individual, formal, informal)? Does your formal supervision encompass management and appraisal and support and development? What is the most important aspect to you within your supervision?

We are all different and so are our needs; however formal supervision systems can be developed for use organisation-wide. What changes would you make to the way you are supervised, to improve supervision for you?

Reducing Offending in Residential Child Care

There is a lot of reflection asked for throughout the original paper, hence there are fewer additional reflective questions offered.

Offending and young people – the wider picture

Why do you think these young people offend? Are the statistics what you would expect, or are there any surprises?

Offending: Children and young people in residential care

From your experience, why do the young people you are aware of have criminal records? Is the offending behaviour similar to that seen prior to coming in to care? Is the threshold beyond which the police will be called different between work and home? Is the threshold beyond which the police will be called, different for different staff? What would you identify as the reasons for this?

Moving forward: Reducing the risk of children in care becoming criminalised

Using your own experience, do the links between relationships and offending confirm your understanding? Is there anything else you would add to the equation?

Setting and Ethos

Where will you find the philosophy of care for your workplace?

Training checklist

How is training/learning embedded in practice? Is the impact of new knowledge in practice included in supervision? Do you discuss how your learning can be shared with others in your team?

Conclusion

What is the plan from here? Has your reading influenced your understanding? Are there any suggestions you would like to take forward? How will you ensure your suggestions are given due attention?

Supporting Lesbian, Gay, Bisexual and Transgender Young People in Residential Child Care

Introduction

What are your perceptions of lesbian, gay, bisexual and transgender young people in residential care? Have you recognised the need to be aware of the possible needs? Do you have any experience in working with any lesbian, gay, transgender of bisexual young people?

Growing up feeling different

Have you previously considered the issues in regards to the theory? Has your understanding changed? What other concepts do you think would be relevant? How would you support a young person developing through these stages?

The 'Coming Out' process

Would the stages of coming out fit with any experience you have? Can you empathise with the difficulties faced/experienced? Could you perceive there being issues if a young person 'came out' within the setting you work in? How would or do your colleagues react? How do other professions react?

Vulnerability versus empowerment

What may depict a heterosexual bias where you work? What depicts diversity where you work?

Acceptance versus rejection

In order to ensure we are aware of any changes we may have towards young people, we need to be aware of our own perceptions, feelings, opinions. Where could you discuss these openly? Have you discussed your feelings on working with lesbian, gay, bisexual and transgender young people in learning, team or supervision sessions?

What else can be done?

Have you received any learning opportunities in regards to the topic? Do you feel some learning would be beneficial, if so on what specific topics?

Understanding Autism

History, definition and prevalence

Where is your knowledge and perceptions of autism drawn from?

Underlying Issues

How would you describe executive function? Can you give an example?

In regards to 'theory of mind' think of the different social situations you are regularly in, what are the expectations in different settings?

What challenges do you think a young person could face within your setting?

What you might see in a child with ASD

Do the above criteria fit with your previous perceptions?

Understanding and Helping

In regards to assessment, think of a behaviour shown by a young person you work with. What are the antecedents and consequences attached to this behaviour?

Conclusion, overall

From reading the paper on autism do you feel you have a better understanding?

Myers (2004) refers to 'hidden autism'? Can you think of any people you have worked with who may have fallen into this category? Give reasons why you may think so.

Are there principles we can adopt which would be beneficial to all the children and young people we work with?

What adaptations would be needed in your practice and your teams practice if you were working with a young person with ASD.

What are the benefits of a diagnosis?

Do you believe there are any negative aspects to a diagnosis?

How and to whom would you refer a young person for assessment?

Supporting Transitions and Throughcare:

Some lessons from secure care

The Throughcare Regulations and Guidance

How familiar are you with the regulations? Where would you find them in order to make yourself more familiar or help a colleague become familiar with the regulations and guidance?

Continuity of care

How would you feel about a young person returning and/or continuing the engagement? Is this familiar practice, if so how would you feel about not having contact? How would you/do you manage young people returning?

Education, employment and vocational training

What opportunities are available to the young people you work with? What would improve the current situation? Can you influence an improvement?

Proactive practice

How aware are you of social pedagogy? If you are not aware, how may you find out more? If you are aware how would the approach fit with your own practice?

Proactive practice (practice considerations)

Who co-ordinates transitions, sets up transition plans and chairs discussions on the support services and needs of the young person moving on? Is there scope to develop such a role, or make it an explicit part of a current role?

Appropriate accommodation for care leavers (practice considerations)

What do you think of the accommodation offered to young people leaving your service? Do you have supported accommodation as part of your service or which you can link in to? Would there be scope to link with another service to provide the best for the young person? Poor pathway planning and a need for training - What is your experience? What would you expect?

Poor pathway planning and a need for training (practice considerations)

How do you advocate for the young people you work with? What good practice would you share with others? What areas of development can you identify?

The need for family work

What family work do you do? What would you like to do? How confident would you feel to do family work?

The need for family work (practice considerations)

Do you have a statement outlining family work needs within the care plans you develop? Some transferable initiatives – What initiatives do your service provide? What could you provide?

Concluding remarks

How would you evaluate your service in regards to managing transitions (good, bad, average)? What improvements would you make? What good practice would you share? To whom would you make suggestions for improvement in order to develop practice?

NOTES