

## *Children's Geographies*

### **Special Issue: Research Ethics and Working with Children and Young People**

#### **Working Title: Ethical Issues, Research and Vulnerability: Gaining the Views of Children and Young People in Residential Care**

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#### **Abstract**

Children and young people in residential care are some of the most vulnerable in our society. They may have experienced violence and physical, sexual or emotional abuse. They may be involved in offending or the misuse of drugs and alcohol. They are separated from their families and have to cope with living in a group situation with other young people and staff members. Children and young people in residential care also possess strengths, competencies and resilience. We have much to learn from their experiences and perspectives, both generally and surrounding their time in care. This paper will address the ethical issues which arise from gaining the views of children and young people in residential care, drawing on the experience of carrying out three studies in particular (Docherty, Kendrick, Sloan & Lerpiniere, 2005; Kendrick, Mitchell & Smith, 2004; Steckley & Kendrick, 2005; forthcoming). The paper will discuss: information, consent and choice about involvement in the research; confidentiality, privacy and safety. It will also explore some of the more complex issues of ethical good practice which arise from researching children in their own living space. The negotiation of children's time and space must be approached carefully, with consideration of their rights and wishes. Sensitivity to children and young people's priorities and preoccupations must be paramount.

#### **Introduction**

In the UK, approximately 10,000 children are in residential child care at any one time. They are some of the most vulnerable children in our society. They may have experienced violence and physical, sexual or emotional abuse. They may be involved in offending or the misuse of drugs and alcohol (Kendrick, 2005). The process of entering residential child care can itself be a stressful time for children and young people because of feelings of displacement, loss and lack of control (Hayden, Goddard, Gorin and Van Der Spek, 1999). There is a stigma to being 'in care' and in residential care in particular (Ridge and Millar, 2000; Who Cares? Scotland, 2004). Entering care can also lead to a sudden change in roles. From a position where children may have had a good deal of autonomy and responsibility (for example, in terms of caring roles within their own

family), they may now be treated as 'children' by social workers and carers, with little say in decisions or assessment of their competencies (Barry, 2002).

Significantly, in residential care, children and young people are now living in a group situation with their peers. In addition to the more general stresses arising from group living, this can have negative consequences in terms of bullying and peer abuse (Barter, 2003; Barter, Barter, Renold, Berridge, & Cawson, 2004; Sinclair and Gibbs, 1998). It can also, however, have positive aspects, and Emond highlights that young people 'regarded the resident group as an important force in their day-to-day lives, their view of themselves and of their social world' (Emond, 2003, p. 326). Children and young people also frequently cite the positive relationships with staff as central to their care experience (Dixon and Stein, 2003, 2005; Hill, 1999; Sinclair and Gibbs, 1998; Who Cares? Scotland, 2004).

Residential child care has suffered serious criticism following revelations of physical and sexual abuse by staff members over prolonged periods (Kent, 1997; Levy & Kahan, 1991; Marshall, Jamieson & Finlay, 1999; Utting 1991; 1997; Waterhouse, 2000). Children and young people have been 'silenced' because of their lack of status and power, their isolation, and because adults have not listened. These major concerns have had a significant impact on the development of regulatory systems which have impacted across all social services (Kendrick, 1998; 2004). Against this background, residential care has been marginalised and has struggled to maintain a professional focus in a policy context which gives primacy to the family and views residential care as a 'last resort'. It is interesting to note, then, that little attention has been given to the views of children and young people who have expressed their preference for residential care over other alternatives. Sinclair and Gibbs (1998) found that children are more likely to choose residential care than any other form of care; '... even those with experience of foster care chose residential care in preference to it by a ratio of three to one' (Sinclair and Gibbs, 1998, p. 46). In a Scottish study of children and young people either in care or who had left care, residential care was seen as providing 'a more secure, safer and longer-term environment' and therefore 'consistency of care' (Save the Children, 2001). This highlights the importance of viewing children and young people in residential care as experts in their own experiences, with strengths, competencies and valuable perspectives to inform policy and practice.

### **Constructions of Childhood and the Voice of Children and Young People**

Whether implied or explicit, a particular view of childhood underlies any piece of research about or involving children (Thomas & O'Kane, 2000). Children have traditionally been seen as weak, poor, needy, vulnerable and incompetent (Morrow & Richards, 1996; Moss & Petire, 2002). We have tended to study how children perform within the confines of a socially constructed childhood, a glass cage as Alderson (2004) aptly puts it, without critically examining either the cage itself or its impacts. A shift towards viewing children as social actors in their own right, who are differently

competent or even more competent is occurring and will hopefully lead to research designs which address ethical issues more fully.

While we do not deny children have needs and vulnerabilities, we question the “proportionality and perspective” (Moss & Petrie, 2002, p. 56) of the dominant discourse that portrays children simply as victims or villains. Our view of children resonates with aspects of two different sociological approaches to childhood: *the minority group child* and the *social structural child* (James, Jenks, & Prout, 1998). The *minority group child* approach acknowledges and challenges existing power relations between children and adults, giving voice to children’s perspectives. Their observations and analysis of adult care-takers’ conduct tend to be a dominant theme, and this model is particularly aligned with our research on physical restraint. Children as neither pathological nor incomplete, but rather as citizens and social actors, with legitimate needs and rights, strengths and competencies characterises the *social structural child* approach. In these approaches, there is a centrality to agency and voice.

There is on the face of it an acceptance of an ethical imperative that children have a basic right to be heard (Lloyd-Smith & Tarr, 2000, p.60).

While importance of giving voice to children has been gaining increasing prominence in the social sciences, there has been an established tradition in social work practice of focusing on the inner world of children and giving them support in expressing their views. The Children’s Hearings system in Scotland, for example, placed the views of the child as central well before the UN Convention on the Rights of the Child and subsequent legislation in England and Scotland (Kendrick, 2000; see also Balen, Blyth, Calabretto, Fraser, Horrocks & Manby, 2006; Thomas & O’Kane, 2000). Due to a growing participatory rights perspective, the perspectives of children are taking an increasingly prominent position in qualitative research and consultation (Hill, 2006). Additionally, there is a growing solidity of conviction in the epistemological justification for giving children voice; their reality cannot be well understood simply based on inference and assumption (Lloyd-Smith and Tarr, 2000).

While the rhetoric is strong and pervasive related to the importance of children’s voices, these voices continue to be excluded and belittled (Hill, Davis, Prout, & Tisdall, 2004; Lloyd-Smith & Tarr, 2000). Consistently, UN committees have concluded that Britain is not consistently implementing Article 12 in policy, legislation and practice (ibid). Research has highlighted adults’, and particularly social workers’, inaccurate interpretations of children’s perceptions (Christie, Warden, & Stevens, 1994; Butler & Williamson cited in Oakley, 2000; Harpham, Nguyen, Tran and Tran, 2005). . In a study examining children’s involvement in decision making while they were being looked after by local authorities, Kendrick and Mapstone (1992) found that participation of young people in child care reviews is constrained by boundaries and limits set by social work professionals. The rhetoric of participation needs to be viewed in the context of wider structures of power and control (see also Thomas and O’Kane, 2000).

In relation to residential child care, it is encouraging to note that the majority of the studies in *Caring for Children Away from Home: Messages from Research*, include the views of children and young people. Summaries of these studies were shown to young people and they were asked identify key messages for relevant professionals. Their responses confirmed that the research resonated with their own experiences, but their final message was telling in a different way.

Stop moaning and going over time and time again what in essence has been known for years through repeated pieces of research and is common knowledge... A song that frequently comes into my head when looking at the slow rate of change in residential care is Del Amitri's *Nothing Ever Happens*. "The needle returns to the start of the song and we all sing along like before!" (Dept of Health, 1998).

This reflects Hill's highlighting of children's disappointment and disillusionment when they see no change subsequent to them sharing their views (2006).

We have to acknowledge, however, that the impact of children's voices can be slow and subtle in their manifestation, as will likely be the case with the research on experiences of physical restraint. Some of what participants shared was poignant, powerful and challenging. After conference presentations we have been approached, on more than one occasion, by people who have been strongly impacted by their words. It is hoped that through wider dissemination this will result in shaping peoples thinking in a way that improves policy and practice, and more importantly, improves the experiences of young people in residential child care.

This raises questions about the ethics of asking for the views of children and young people in the full knowledge that they will be unlikely to enjoy any positive changes as a result of the research. The answer is not clear cut but is bound up in issues of clarity of informed consent, the potential intrinsic and even healing benefit of 'telling ones story' (Roberts & Taylor cited in Hill, 2006), and the value of being listened to (Munro, Holmes and Ward, 2005). While the benefit resulting from the process of participation may be adequate for some young people, it is important that they fully understand the probable impacts of the research before deciding whether to take part.

### **Research Methods and the Three Studies**

In terms of methodology, researchers need to think carefully about the standpoint from which they are studying children, and the ethical implications of that standpoint (Morrow & Richards, 1996, p.100).

Hill (1997) outlines the development of research concerned with children; early research tended to be about children rather than involving them. He highlights the range of methods which have been used to involve children in research. Participatory techniques have often been used with vulnerable individuals and societies, including children and

young people who are looked after (Abbott, 1999; Clark and Statham, 2005; Nieuwenhuys, 1997). Particularly where children and young people have not been involved in designing the research, participatory techniques provide participants with control over the agenda and how information is provided (Clark and Statham, 2005; O’Kane, 2000).

Participatory methods are those that facilitate the process of knowledge production, as opposed to knowledge gathering, as is the case with methods such as individual interviews, surveys or checklists,” (Veale, 2005, p. 254).

These methods do not require an individual’s ‘story’ to be told which allows young people to retain privacy in relation to their lives, but still an opportunity to offer their views. Participatory workshops, for example, have developed as an approach to facilitate the involvement of children and young people in the research process using a range of methods that they feel comfortable with (Punch, 2002; Veale, 2005).

Vignettes can also offer a range of potential benefits in qualitative research with young people (Barter & Reynold, 2000). They can afford participants greater control by providing them the space and flexibility to construct the scenario according to their own experience. Discussing scenarios can often be experienced as less threatening than being asked direct questions, particularly when discussing a sensitive subject. They provide a more varied interview format which can make participation more interesting, and their use alongside semi-structured questions can increase the likelihood of capturing beliefs, meanings, judgements and actions more deeply and comprehensively (Steckley & Kendrick, forthcoming).

Children and young people who are not used to being formally questioned may find questionnaires and interviews intimidating. Participatory techniques are more informal which may help to reduce anxiety for young people, and encourage them to participate in the research (Barker and Weller, 2003; Nieuwenhuys, 1997). This can be particularly important for young people who are anxious about their reading or communication skills (Clark and Statham, 2005) which, given the often lower academic achievements of looked after children, is of significant concern in residential child care research. Children and young people often derive more enjoyment from participatory techniques which can use media, especially photographic and computer technology, with which they are comfortable (McCluskey, Lloyd and Stead, 2004). Barker and Weller (2003), however, caution that what adult researchers consider to be fun and child friendly may not be viewed as such by children. Punch (2002) and Clark and Statham (2005) recommend using a combination of traditional ‘adult’ methods and child-centred methods with children and young people in order that they are not patronised by using only child friendly techniques.

Adults carry out the majority of the research, but there are issues around who is best placed to research children’s experiences (Hill, 1997). Peer research projects have successfully involved children and young people as fellow researchers. One example is The Looked After Children in Education (LACE) project, which recruited and trained

young people who had been looked after to interview other looked after young people (Hannan et al, 2002; see also Broad and Saunders, 1998).

The three studies described here have used a range of research methods; one-to-one interviews, participant observation, vignettes, and participatory workshops.

The first study [*evaluation study*] involved a pilot project of a residential unit for sexually aggressive young men (Kendrick and Mair, 2002; Kendrick, Mitchell & Smith, 2004). The research evaluated the first three years of the project, focusing on a number of issues such as: safe caring in working with sexually aggressive young males in a residential context; the outcomes for young people; development of personal change programmes; and confidentiality and individuals' rights. Data collection consisted of four main methods. Relevant documents were reviewed and information collected from the case files of the young men in the unit. Semi-structured interviews were carried out with residential staff over the period of the research. Telephone interviews were undertaken with the young men's social workers where possible. In addition, a number of young men were interviewed about their experience of living in the unit and undertaking work on their sexual aggression. Fieldwork at the residential school allowed observation of school events, groupwork, staff team meetings, and unit meetings involving the young men. It also allowed time to be spent in the unit at different times of day, for example, mealtimes, recreation times, and night-time; this provided researchers with an opportunity to chat with young men and staff informally.

Ongoing concern about the use of physical restraint in residential child care led to the second study (Steckley and Kendrick, 2005; Steckley and Kendrick, forthcoming). This research [*physical restraint research*] focused on gaining the perspectives of both children and young people, and residential staff, about their experiences of the use of physical restraint. Semi-structured interviews were carried out in twenty residential establishments across Scotland, and involved 37 children and young people and 41 residential staff members. The interview schedule covered a broad range of topics, some of which included: views about the acceptability of restraint; experiences of physical restraint; and the impact of being restrained on relationships between children and staff members. The interviews also included a series of four vignettes which were constructed around some common types of situations involving potential harm, with three levels of escalation. The four situations were: threats leading to the throwing of food and property destruction; threats by young people to abscond leading to an attempt to abscond; perceived unfairness leading to verbal abuse, spitting and a physical attack on a staff member; and a conflict between young people leading to a serious physical altercation.

The third study explored the issue of interior design in residential child care [*design research*], focusing on one local authority which had employed an interior design consultancy in the redevelopment of its residential units (Docherty et al, 2006). A survey of design professionals and social work professionals was carried out, but the core of research centred on four residential care homes. Forty-five residential staff members were involved in one-to-one or group interviews. Twenty-two out of 29 children and young people in the four care homes took part in facilitated participatory workshops.

The workshops were activity-focused, highly visual and relatively informal to ensure that, as far as possible, age or ability would not be barriers to participation. A series of three participatory workshops were held in each house over the course of one month:

- Workshop 1: Introduction: drawing, cutting and pasting of preferred designs for an ideal house.
- Workshop 2: Focus on design features in the house: taking digital images of spaces and objects liked and disliked.
- Workshop 3: Describing what you like and what you don't: detailed written descriptions of preferred and disliked items in the main rooms in the house using the digital images generated from Workshop 2 as a prompt.

The duration of the workshops was around one hour each session. This seemed to work well. Twelve of the children and young people also took part in an individual interview to explore further issues of design.

### **Researching Children in their own Living Space**

We have seen how important it is for children and young people to have a voice, particularly vulnerable and marginalised groups such as those in public care, and the three studies have given priority to gaining the perspectives of children and young people. We are also conscious, however, that there is the danger that because children and young people are in residential care that they can be viewed as a 'captive audience', a ready made group of young people to be studied, interviewed, and focus-grouped.

In industrialised societies, children have most often been studied in schools for precisely the same reasons, and the setting itself is likely to shape the design and findings (James et al., 1998). We run a similar risk in only studying the lives of children in residential child care from the sole context of residential establishments, as their experiences of friendship, bullying, play, or work might look different if explored from another context of their lives (ibid). This obviously has practical implications in terms of access, which will be explored more fully further on. Additionally, because many of the children in residential care struggle with issues related to family breakdown, trauma, loss and resultant labile emotions, extreme care must be taken in engaging with them, particularly if the research is addressing sensitive issues.

Residential units are sometimes referred to as a goldfish bowl, reflecting the difficult nature of meeting the needs of children's personal lives in a professional capacity. Parkin identifies this tension in her discussion of residential child care's anomalous location within a private/public divide.

The establishments are frequently called 'homes' with the connotation of the private realm, but they are located firmly within large welfare bureaucratic organisations (Parkin, 1989, p.120).

This has been termed an ‘intermediate zone’ where the public world of work and the private domain of the family overlap (Stacy and Davis, 1983, cited in Barter et al., 2004).

Hood, Kelley and Mayall (1996) outline some of the ethical and methodological issues involved in carrying out research with children in their own homes, identifying in particular control issues in relation to access and the interview process. These issues can be exacerbated in research in residential care because of its ambiguous location in private/public space.

While it is important to increase our understanding of how we can better provide compensatory and healing caring environments, and this understanding can only come about by listening to the voices of those living in those environments, we must be ever cognizant of the fact that we are entering the private spaces of children and young people. This requires a degree of sensitivity and a tuning in to subtleties: the rhythms and routines of each unit, children’s indications of discomfort, or our own intuitive feelings that we might be intruding.

### **Access, information, consent and choice**

Gaining research access to children and young people in residential care is a complex process which involves different stages of discussion and negotiation. In the first instance, the agency running a residential establishment will have to give permission for access. At this stage, detailed discussions need to take place about various aspects of the research, especially about ethical issues of consent, confidentiality, and procedures in the event of suspicions of harm or poor practice raised by the research and interviews with the young people. Obviously, this process will be affected by the relationship of the agency to the research. In the case of the *evaluation study* and the *design research*, the agencies had commissioned the studies and were therefore fully supportive in enabling access to the residential units. In the case of the *physical restraint research*, however, which was a national study funded by Save the Children, gaining access proved much more problematic and time-consuming. Access can be less of an event than a continuing process involving negotiations with a number of gatekeepers who may support or hinder the research (Hayes, 2005; Heptinstall, 2000; Masson, 2002; McGee, 1999). Hood, Kelley and Mayall (1996) refer to this as ‘a hierarchy of gatekeeping’ running from the organizational level to the parents and finally to the child (Hood et al, 1996, p. 120). Heptinstall (2000) demonstrates how gatekeepers’ ability to block children’s participation can constrain children and young people from making decisions themselves about involvement in research, effectively silencing them.

Sometimes young people need to see and hear from the researcher before they become interested in or willing to take part in the study. A couple of local authorities who agreed to participate in the research on *physical restraint* came back and stated that none of their young people were interested in the study. Rather than abandoning the sites before even getting a foot in the door, the researcher went out to speak to staff, hoping the young people might become interested and change their minds. Through a chat and shared cup



of tea, some (though not all) young people did end up deciding they wanted to be involved. This brings up an interesting ethical tension between, on the one hand, demonstrating a respect and sensitivity for a young person's living space as previously discussed, and on the other, ensuring young people have a full opportunity to be heard.

Once access to the residential establishments has been granted at agency level, discussions and negotiations need to take place with residential managers and staff members. In addition to the issues outlined above, consideration needs to be given to the more practical aspects of the research, for example: timing of visits, identifying where interviews or workshops might take place; who will be available to support children and young people. Establishing good relationships with the residential managers and staff is crucial in this process, and, in the case of the *physical restraint* study, the researcher's experience as a residential child care practitioner and manager was important in establishing the credentials of the research (see Thomas and O'Kane, 1998). Access also has to be granted by the social work department which has supervisory responsibility for the child, and this may involve discussions with a number of individuals: research staff, children's services managers, and the child's social worker. The issue of gaining consent from parents of children and young people is also complex and is dealt with in more detail below.

### *Information*

Morrow (1996) identifies 'informed consent' as one of the two key preoccupations in discussions about research ethics. Informing and allowing young people choice and the ability to give consent is an important part of the research process. It is obviously important to present information about the research to be undertaken in as clear a form as possible (Morrow, 1996). Information sheets for children and young people basically set out the *who*, *what*, *when* and *how* of the research. The *who* section tells young people about the researchers, where they are based and their experience in carrying out research; the *what* section sets out the main questions that the research will focus on (for example, why a project was set up, how well it is working, what children and young people think and feel about being involved); the *when* simply states when the research will start and finish; and the *how* section describes how information will be collected and who will be involved (for example, interviews with children, accessing case files, questionnaires to residential workers, etc). Other sections in the information sheet cover: agreeing to be involved in the research, which sets out the process; who will speak to them about the research; and what they need to do (such as signing a consent form). This section also stresses that 'It is up to you to decide if you want to be involved in the research' and that 'no-one will try to persuade you to be involved if you don't want to be.' There is a section on confidentiality, setting out the nature of the confidentiality for the particular piece of research (see below). We also include a section called 'Telling the researchers to go away.' This covers information about interviews, for example, telling children that they can stop the interview at any time, that they don't need to answer particular questions if they do not want to, or that they can have a break whenever they want. Depending on the nature of the research, this section of the information sheet might also

state that young people or staff can ask the researchers to leave the residential unit at any time (Berridge and Brodie, 1998).

Young people must understand that the information they provide will not be used to their detriment or harm in any way. They must also understand the limitations of the research (O’Kane, 2000). Nieuwenhuys (1997) points out that this is particularly important in relation to children and young people, as they are usually dependent on adults to meet their needs. They should not have unrealised expectations in terms of additional services or items that they expect to receive and should not feel obliged to provide information on the proviso that they will receive additional services or items.

The level of detail and the use of language has to be appropriate to the age and understanding of the children and young people involved in any particular research study (Fine and Sandstrom, 1988). In the *design research*, for example, we produced two information sheets, one for young children and one for older children. As Emond points out, ensuring that children have a full understanding of the research process ‘requires time and flexibility on the part of the researcher’ (Emond, 2005a, p. 127). Language does not necessarily have to be made simpler, as research with children who have medical disorders has shown, but researchers must be aware of and adapt to children’s level of understanding and communication (Alderson, 2000).

### *Confidentiality, Anonymity and Protection*

The issue of the confidentiality is of major concern in undertaking research with children and young people, particularly in relation to those in residential child care because of issues of vulnerability and/or dangerousness. There is a general consensus that there should be a limit to confidentiality, although this is by no means straightforward and issues arise in relation to the seriousness of harm which might then be disclosed (Alderson and Morrow, 2004; Hill, 2005). The approach taken in our studies was to limit confidentiality. In the *design research*, for example, the information sheet included the statement: ‘Anything you tell us will be confidential. Except if you say that someone has been harmed or will be harmed. Then we might have to tell a member of staff about it.

But we will discuss the best way to do this with you’. We stress, then, that we will discuss how to pass on such information with the young person before doing so. Emond (2005a) also emphasises discussion in relation to limits on confidentiality. On the other hand, Thomas and O’Kane (1998) argue that it is ‘important for us to be able to give children an assurance that we would not repeat what they told us to other people, and for the children to know that they could trust us’ and that procedures for dealing with disclosures ‘would be an inappropriate intrusion into the relationship between research and subject’ (Thomas and O’Kane, 1998, p. 340). They also say, however, that if there was information of harm to a child then it would be the researchers’ responsibility to support the child in telling someone, with the child’s consent. And they could envisage circumstances where the researchers would have to tell someone notwithstanding the commitment to confidentiality, ‘but because this was so exceptional it did not mean that we needed to qualify the principle in advance (Thomas & O’Kane, 1998, p. 340). In

doing research with children and young people in residential care, we felt that, on balance, it was more appropriate to be explicit about the limits of confidentiality (see also Barter et al, 2004; Berridge and Brodie, 1998).

The issue of anonymity is also an interesting one in relation to research with children and young people. It is almost taken as axiomatic that participants in research will be guaranteed anonymity (Hill, 2005; Masson, 2002). It is not unusual, however, for children and young people involved in our studies to want to be named in reports or presentations. Emond (2005a) also found that many of the children wanted their names to be included. We have always used pseudonyms for children and young people to ensure their anonymity and, in certain circumstances, have changed details to ensure that children cannot be identified. As in other research studies, in relation to anonymity 'the adult view of the children's best interests prevailed over the expressed wishes of some of the children' (Hill, 2005, p. 75)

Linked to issues of confidentiality are the mechanisms which are put in place to support children and young people, if necessary, especially when researching sensitive subjects, such as physical restraint or work on sexual aggression. It is important that procedures for debriefing or additional support for children and young people are put in place. In most cases, this support might be provided by the young person's residential key worker, or another professional linked to the residential establishment, such as an educational psychologist (Galloway, 2006). In another project dealing with mental health issues of young people in residential care, one young woman was visibly nervous and shaking during the interview. While she insisted she was fine, both during the interview and afterwards (when she did have a member of staff present), the researcher could not help but feel that perhaps something more could have been done to support the young woman. We must recognise that children and young people, in consenting to research, are making strong commitments to address sometimes painful issues.

### *Parental Consent*

The issue of gaining parental consent creates both ethical and practical complications when undertaking research on children and young people in residential care. There is uncertainty about the necessity of parental consent in relation to research with children (Alderson and Morrow, 2004; Hill, 2005). The *Gillick* case, a judicial decision upholding the confidential relationship between a young person and her G.P. without the requirement of parental consent or even knowledge, may have parallels to research with young people. '[T]he ruling about respecting the consent of competent children could surely apply, but this standard has not been clearly or formally agreed' (Alderson and Morrow, 2004, p. 100). For some, it is accepted as good practice that parental consent should be sought when doing research with children. The Economic and Social Data Service guidance on '*Legal and Ethical Issues in Interviewing Children*', for example, concludes, "Caution on the part of the researcher is important and in most cases it is advisable to seek the consent of the responsible adult in addition to that of the child"

(Economic and Social Data Service, 2006). We have seen, however, that others have argued that this may restrict the participation of children and young people in research.

In our studies with children in residential care, there is the possibility that they have been placed there because of abuse by their parents, or because there has been a breakdown in relationships in the family. In such situations, it may not be appropriate and in the best interests of the child to approach their parent(s) for consent for the child to be involved in research. This issue was raised when the University Ethics Committee stated that parental consent was required for children under the age of 16. We argued that some children and young people under the age of 16 may object to researchers approaching their parents for consent. Having to obtain parental consent could mean that this group of children and young people would, effectively, be excluded from participating in research. Following consideration of this issue, the Ethics Committee concluded that parental consent was not required when it was not in the best interests of the child or young person, and, in these situations, the child or young person themselves would give consent. They also concluded that a distinction should be made between 'consent' and 'permission' and that, apart from the child, 'only the parents, guardians or legally appointed representatives could give consent on behalf of the child'. Social workers, residential managers or keyworkers could give permission that the research be undertaken, but could not give consent on behalf of the child.

In those situations where parental consent is being sought, it must also be acknowledged that the parents of children and young people in residential care will often be undergoing stressful situations themselves. They may feel a sense of conflict with social work services which may predispose them to refuse consent, or they may be experiencing distress or chaotic circumstances that interfere with them prioritising the signing of forms. The simple practicalities of getting informed consent statements signed and returned from parents can be difficult and time consuming.

### *The consent of children*

In all the studies, we have adopted the principle that children and young people should positively consent to take part in the research. This has involved producing information sheets, discussing the research with children and young people, and asking them to sign a consent form. This is the case for younger children as well, and it is important not to make assumptions about competency and understanding simply on the basis of age (Hill, 2005).

We also stress that involvement in the research is voluntary and that children and young people can withdraw at any time. There is, then, a renewal of consent throughout the research process (Barter et al, 2004). It must be noted, however, that on more than one occasion, young people in the *physical restraint research* seemed disinterested and impatient with the process of offering information and gaining their consent. Many seemed keen to 'just get on with the interview'. This highlights a tension between what is sometimes an adult value of informed consent, and the necessity to respect the young

person's level of interest and the amount of time they wish to spend hearing about the study and/or interview.

It is important to be aware of the status and power issues in the process of gaining the consent to ensure that consent is truly voluntary. Cree et al (2002) discuss the relationship of the researcher to adult gate-keepers:

... children are more likely to agree if both their social worker/child care worker and parents seem supportive of the research. In this way, trust in one individual or agency is passed onto the researcher. This 'sponsorship' makes it impossible to be certain that all children and young people have made their own 'freely given' decision to participate. (Cree et al., 2002, p.51)

Such influence might be more explicit. In the *evaluation study*, for example, the researcher discovered that one young person had been 'persuaded' to take part in a research interview by the promise of a game of pool with his key-worker. The issue of payment or gifts is also debated and:

Some view this negatively as inducement or bribery. Alternatively it can be seen as fair recompense. (Hill, 2005, p. 71)

In the *design research*, we did give the children and young people a store token to thank them for their participation, and also took them on a trip to an Architecture and Design Centre. These were given after the research had concluded so as not to influence whether children and young people took part.

No matter how careful researchers are in producing information, discussing the research and carefully going through the consent process, there is no guarantee that children and young people will rush forward to take part. In the *physical restraint* research, in particular, it took much longer than intended to identify the sample of young people, and many of those approached did not wish to take part (see also Cree, Kay and Tisdall, 2002).

### **Spending time with young people**

Children need time to develop a sense of rapport or relationship with the researcher, as they can often be unused to discussing their opinions or experiences with unknown adults (Morrow & Richards, 1996, Punch, 2002). Galloway (2006) describes spending time within the residential environment in order to develop a positive relationship with the young people who were to be involved in the interviews. She also cautions, however, about issues in maintaining 'proper boundaries within the researcher-participant relationship' and discusses instances where 'a small number of the female participants found these difficult to understand and observe' (Galloway, 2006, p. 105; see also Berridge and Brodie, 1998).

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Spending time with young people can also have an undesired effect, as was the case when one of the researchers had evening tea with a young person in a secure unit. The interview (for the *physical restraint* research) was planned after the meal, and the young person seemed to be enjoying the conversation and banter while sharing the meal. Despite a warmth or friendliness that appeared to be developing between the two, toward the end of the meal the young person abruptly stated he was not going to participate in the interview. While other young people have changed their mind, this instance came as a surprise to the researcher and was initially puzzling. Upon further reflection, however, it may be that the young man experienced the researcher as seeing him in a positive light. The thought of sitting down and discussing painful, embarrassing and/or shameful experiences could have been completely unwelcome at that point; sometimes it is easier to speak about such things with a stranger.

Even when children and young people have agreed to take part in the research, there may be a number of reasons why they do not take part. Galloway describes academic commitments, bad behaviour and alternative, more entertaining pursuits (i.e. football practice) as the principal reasons why young people did not take part in her study (Galloway, 2006; see also Cree, Kay and Tisdall, 2002).

At the far end of the continuum in terms of spending time with young people is the ethnographic research of Emond (2003, 2005a, 2005b). She has discussed in detail the issues in gaining access to the views of young people and that:

...getting into the building was not the same as getting into or accepted by the group... I quickly discovered that this was not my choice to make, I had to wait to be invited. Thus, my initial few weeks were marked by both fear and loneliness but also made me acutely aware of the importance young people have in the process of admission (Emond, 2005b, p. 129)

In the final analysis, the usefulness or necessity of time spent with young people before and during data collection likely depends on the young person, the topic of the research, the ethos of the unit, and the dynamic between the young person and the researcher, but related considerations should be reflected in research design and resources.

Another issue linked to spending time with children and young people in residential care concerns the effect on the researcher. While there are certainly issues related to physical safety for researchers involved in studies of residential child care (Berridge and Brodie, 1998), we have never experienced feeling unsafe or threatened. Such issues, however, possibly have less impact on researchers than the emotional effect of listening to the distressing stories of children and young people, and revisiting these in the analysis of data.

A number of researchers have commented on the emotional upset of hearing young people's stories. Hannan, Foster and McLaughlin (2002) commented that they found it difficult to listen to problems voiced by young people in care, in part because it felt at times as though nothing was being done to help them, and that they in turn could do little,

at an individual level, to help. As well as the emotional intensity of the stories narrated, Burman, Batchelor and Brown (2001) highlight that fieldwork can stir up personal, emotional issues for the researchers. Such emotions may impact on the interview process itself (Kay, Cree, Tisdall and Wallace, 2003) or they can become an issue in analysis, when listening to tapes can re-awaken the emotions experienced during fieldwork.

Set against this are the numerous positives and rewards of researching children and young people in residential child care. These are often the little things, the sharing of aspects of children's lives: the memory of sitting around a kitchen table during a powercut with a group of young men while telling ghost stories in the candlelight; the rush experienced when a young person offers a poignant insight; the appreciation of the importance that young people can place on being involved in research as a young man very seriously tells someone who calls him on his mobile, that he is in the middle of an interview telling people about his impressions of the house and its design, and would they mind if he phoned back later.

## **Conclusion**

This paper has set out a range of ethical issues in researching children and young people in residential care. Many of these are common to research with all children and young people. Some, however, have a particular slant because of the ambiguous status of residential care in the public/private domain. Throughout the research we have undertaken, we hope to have placed children and young people at the centre, in terms of the respect they deserve and the importance of their voice.

Contemporary constructions of childhood have given prominence to the voice and participation of children and young people. This has had an important impact on traditional ethical practice associated with research 'on' (as opposed to 'with') children and young people. As we have highlighted in this paper, traditional values are being challenged and appropriate ways to include young people in research according to current constructions are being widely discussed. These issues influence much research practice including gaining consent, accessing children and young people and choice of research methods.

Ultimately, we hope to improve the lives of children and young people in residential care through changes in policy and practice. Perhaps, the greatest reward is receiving feedback that practice has been changed and improved on the basis of research. Hopefully, the studies outlined here will have such an effect on the quality of care for children and young people

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