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Does Group Size of Provision Matter for Children Who Experience Residential Group Care in Scotland?

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Abstract: It is widely recognised that trauma-informed care is fundamental to meeting the needs of children who experience residential care. Service design is central to this, and the aim of this article is to illustrate the experiences of 13 young people who have lived within group care settings, to highlight how a service's capacity can impact on children's needs being met. Using findings from a PhD thesis engaging 18–29-year-olds in Scotland, the research used a mixed methodological approach of questionnaires and semi-structured interviews to elicit young people's retrospective care experiences. The findings show that the number of children within a setting can adversely affect the feeling of being emotionally and practically supported, resulting in some children feeling that their needs were not fully met. This will offer insight to practitioners, managers and decision makers who are engaged in the delivery and development of children's services. Background: The United Nations Convention on the Rights of the Child (UNCRC) articles 3, 9 and 20 and Scotland's Independent Care Review state what children should expect from authorities and services responsible for providing alternative care. The ambition for Scotland's children is that they "grow up loved, safe, and respected so that (they) realise their full potential". For those who spend a period of their childhood growing up in residential care, they should experience a relational, trauma-informed and caring approach from staff.

Keywords: residential care; relational practice; unmet need; group size; lived experience; practitioner research



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1. The Needs of Children and Implications for Trauma-Informed Care

On 31 July 2022, 12,596 children were "looked after" in Scotland, a reduction of 5% on the previous year. Looked-after children are defined within the Children (Scotland) Act 1995 [1], as children under the care of their local authority. While the number of children affected is the lowest it has been since 2005, and the majority of these children will be cared for within a community setting (90%), 10% are looked after within residential accommodation [2]. Children may become looked after on meeting the criteria set out in the Children's Hearing Scotland Act [3], under Section 67. Grounds for a child to be referred to the Children's Reporter, looked after and the subject of a supervision order include the presentation of needs and risks that seriously impact on the child's safety, health, or development.

The number of children who are referred to the Children's Reporter has also decreased by 67%, reducing from 31,371 to 10,494 from 2012–2022 [3]. Within this data a distinction is made between referrals on offence grounds (23%), where a child has been referred to the children's reporter or the courts as a result of committing a crime, and non-offence grounds (77%), where a child is referred due to care and protection concerns. However, this distinction is not clear, and it has been argued that differentiating between welfare- and offence-related needs is unhelpful as they are one and the same child [4,5].

Children may become looked after because they experience some form of abuse or neglect, require specialist care because they have additional needs, are illegally trafficked

or are unaccompanied minors, or as a result of being involved in the criminal justice system [2]. While there is no national study of Adverse Childhood Experiences in Scotland, in a study of children within secure care, Gibson [6,7] found that 68% of children looked after within this form of residential care came from families who experienced relative poverty and the children's exposure to adverse childhood experiences was reflected in heightened levels of ACEs scores. On moving to residential care, the adversity and trauma previously experienced may be further exacerbated as children may experience placement instability, breakdown, and loss. Additionally, Steckley [8] (p. 1651) states that not living with one's family can result in feelings of "fear, rage, shame and grief" for children, which may result in intense feelings and emotions that can be expressed, misplaced, and repressed. While not specific to residential care, Gobbels-Koch [9] highlights a link between childhood maltreatment and the increased incidence of suicidal ideation and behaviour among children, young people, and adults internationally who experience care. The Scottish Government's [10] (p. 90) "Keeping the Promise" implementation plan highlights that "being 'trauma-informed' means being able to recognise when someone may be affected by adversity and trauma, and collaboratively adjusting ways of working to respond in ways that supports recovery, does no harm and recognises and supports people's resilience". Trauma-informed services that cater for children therefore need to be "structured, organised and delivered in ways that promote safety and trust and aim to prevent retraumatisation" [10] (p. 90).

2. Residential Care for Children?

Residential care for children is an integrated part of children's services in Scotland [11]. Care can be provided by the third, statutory, and private sectors and the form of care may be children's residential houses, residential schools, or secure accommodation [12]. Whittaker, Holmes, del Valle and James [13] (p. 6) state that these are therapeutic specialist houses where children are cared for; however, while they share some characteristics, they "vary greatly in treatment philosophies and practices including their purposes and the intensity and duration of interventions" they provide. Despite this, Johnson and Steckley [14] highlight a consistency in Scotland's residential childcare in that a relational model is the approach used. Welch, Fowler, Ross, Withington and McGhee [15] (p. 8) indicate that "availability, seeing the young person as positive and trustworthy, offering 'parental gestures', continued transitional support, support above and beyond paid duties, feeling valued, and being there for the long-term" are features of practice that is relational.

A recognition of the centrality of relationships is rooted in Scotland's national trauma training programme for staff [16]. Being trauma informed in residential care means recognising the commonality of trauma and adversity and how this can impact on individuals. The approach supports recovery and provides opportunities to avoid re-traumatisation by promoting safety and agency. Johnson [17] speaks about the importance of "predictability, structure and routine" to the healing process within group care settings. However, he also highlights that there are a number of events and interactions, such as aggression or self-harm, which may trigger children within residential care [17].

Care planning is a core component of effective trauma-responsive practice [17]. The Looked After Children (Scotland) Regulations [18] set out the responsibility of local authorities to ensure that a child's plan is prepared after an assessment has been undertaken. Local authorities have corporate parenting responsibilities which are set out in law, and there is an expectation that corporate parents have the same aspirations for looked-after children that they would have for their own children [19]. This statutory duty for agencies to work in partnership and coordinate activities may be delegated to services responsible for the day-to-day provision of care for children [19].

The National Practice Model framework, Getting It Right For Every Child (GIRFEC), was introduced in 2006 and underpins Scotland's assessment and care planning process [10], and the child's plan, in addition to reflecting the assessment, must identify outcomes that ensure the child is able to achieve the GIRFEC wellbeing indicators of Safe, Healthy, Achiev-

ing, Nurtured, Active, Respected, Responsible and Included. Under legislation, for children who have been looked after on their 16th birthday, corporate parenting responsibilities continue until the child or young person's 26th birthday.

More than 75 years ago, the Clyde Report (1946) stated that residential care homes should house less than eight children [20]. The Care Inspectorate [21] (p. 18), the body that regulates and inspects residential care establishments, recently produced a report that states their "scrutiny evidence and data suggests that people living in smaller care homes often experience better care", with children reporting a desire to live in settings with no more than four beds, which is consistent with other findings [15]. This paper will consider this further by exploring whether group size mattered for the 13 young people who engaged in this study.

3. Research Design

The research began with a literature review into successful transitions, initially exploring adolescence to adulthood, for children who experienced residential care. Smith [22] highlights that transitions are emotional, experiential, and structural, which led me to widen the focus of the research to transitions in their widest sense. As evidence reflects that children and young people with residential-care experience have poorer outcomes in relation to employment, training, education, health, homelessness, early death, criminal involvement, and early pregnancy than most of their peers who are both looked after and in the wider population [23–26], my aim was to consider the care experience in totality. To view this holistically, the study needed to consider the entire care experience, exploring before, during and after journeys for children who lived in residential care to try to understand contributory factors more fully.

There is very little research into residential care in Scotland; research can be limited to government-funded reviews to improve practice [24–26], researcher-led studies exploring outcomes [23,27], research which includes those with lived experience [28,29], research related to relationships [30,31], restraint and containment [8], and trauma [17,32]. Practice-led research is largely limited to CYC-net and CELCIS and rarely takes the form of a PhD thesis. This PhD thesis aimed to add to this body of knowledge by engaging with young people with lived experience of residential care in the belief that their knowledge and expertise would add to our understanding of the entire residential care journey. Although we know poorer outcomes continue, despite legislation and social policy to redress imbalance [33], we do not have a good understanding of what supports effective transitions. The data were gathered for this purpose but provided qualitative information on the residential care experience which informs this paper.

Knowledge and understanding differs depending on the theoretical approach adopted by the researcher. Social constructionist theory indicates that meaning can change over time, space, and context [34]. Grant and Osanloo [35] highlight that with qualitative studies—i.e., the approach I was required to employ to ascertain narrative accounts—commonly, the theoretical framework emerges within the data-analysis stage of research. The study used for this paper used grounded theory which involved identifying and integrating "*categories of meaning*" [36]. This method was used to code and categorise the data into initial themes of "family and gender", "chaotic lives and negative assumptions" and "emerging adulthood and identity". Chaotic lives and negative assumptions was a theme for young people before, during, and sometimes after their experience of group care.

4. Methods

The approach taken within the PhD thesis was a mixed methodology which combined a short one-page questionnaire with semi-structured interviews. The methods were selected to elicit demographic information and narrative retrospective accounts from 13 18–29-year-olds with experience of residential care in Scotland. The approach relied on recall as some of the participants had left residential care many years before the interviews took place. The questionnaire asked participants for their age, gender, and ethnicity, before requesting

information on entry, exit, number of placements, relationships, and the participant's understanding of the explanation for why they were received into care.

The interview schedule consisted of the following questions:

1. Did you feel ready to leave care?
2. How did you know you were ready?
3. Did your experience of residential care help to prepare you for the transition to adulthood? In what way?
4. What does being an adult mean to you? If necessary, prompt re role transitions, responsibility taking, decision making.
5. At what age did you feel like an adult?
6. Did you feel that you were supported if things didn't go to plan?
7. How and who provided you with support?
8. What role did your family play in your care experience?
9. Did you feel there was a stigma of being in residential care? Why do you think that is?
10. Did you leave care with qualifications? What were they?
11. Have you revisited formal education since leaving care, if so at what age?
12. Do you feel that you've achieved successful outcomes? What does successful outcomes mean to you.
13. What successful outcomes have been important to you?
14. Is there anything you feel you missed out on?
15. What could people have done to make your experience better?
16. Is there anything else you'd like to say?

These were designed to answer the research questions:

1. 'What are the early childhood experiences of young people who are placed in residential care in Scotland?
2. To what extent are young people supported to understand these experiences?
3. To what extent do young people get what they need from residential care?
4. To what extent are young people prepared for leaving residential care and what supports a successful transition.
5. Does the theoretical framework of emerging adulthood add to our understanding of their transition to adulthood?' [37].

5. Data Collection

The data were gathered between May 2017 and September 2018, pre-dating the COVID-19 pandemic. Recruitment was through a gatekeeper within an advocacy organisation who played a considerable role in supporting me to gain access to young people. It is recognised that recruitment of young people with experience of this setting is particularly challenging [38,39]. I aimed to recruit between 20 and 40 young people, a representative sample of around 4% of the children who are accommodated within children's houses over a one-year period [40]. Recruitment challenges resulted in 13 young people being interviewed.

Participants provided informed consent for all elements of the research, and they received both verbal and written information which included contact details for support services. Interviewees completed the questionnaire, which also served as an icebreaker, before the interviews commenced. Interviews ranged from 12–52 min; the average interview was 25.43 min. Interviews were recorded on a Dictaphone from the outset as discussions began when participants had begun to complete the questionnaire. Interviews took place at a time and location convenient to participants; the researcher travelled to offices, quiet coffee shops, and third sector services to undertake interviews. Ethical approval for the PhD was gained through the university research ethics committee and participants were given a £10 Amazon voucher for taking part in the study.

As I am a practitioner–researcher with 25 years' working experience of residential care for children, Reid, Brown and Smith [41] suggest that I shared an identity with participants. My practitioner experience as a residential child and youth care worker and residential

house manager combined with my social work training, meant that I did share an insider language that made it easy for conversations to flow, and my “emic” perspective appeared to enhance relationships with participants. My 20 years as a residential manager made me consider my positional authority. While all of the participants in the PhD study were born in Scotland and described themselves as white Scottish or British, I identify as a Black Afro-Caribbean Scot, I am female and middle aged. My insider relationship was invaluable in enabling me to engage effectively with my gatekeeper [42]. The data have to be considered in this context as I believe these connections and relationships afforded me a unique opportunity in what is an under-researched area of practice outside academia. “You know what I mean” was frequently said within interviews, suggesting a shared knowledge and understanding from the perspective of participants.

6. Demographics

Data collected show the demographics of participants (Table 1). The group consisted of six girls and seven boys and the age range selected was informed by legislation in Scotland that supports care leavers up to the age of 26, and emerging adulthood transition to adulthood research, which reflects 18–29 year olds [43,44]. This range was determined by one of the purposes of the PhD thesis, which was to explore transitions from adolescence to adulthood. This range also allowed me to consider how experiences and perceptions of adulthood changed over time.

Table 1. Pseudonym, age, number of placements and Local Authority.

Pseudonym	Age on Admission to Care	Residential Care Admission	Age on Leaving Care	Age when Interviewed	Number of Placements	Local Authority Area
Luna	13	13	18	19	4	LA1
Lisa	12	16	16.5	22	6	LA2
Carol	6	12	18	24	4	LA3
Tania	0	13	17.5	20	18	LA3
Kevin	10	10	18 *	22	2	LA1
Bruce	Unknown	12	18	18	5	LA4
Mark	15	15	17	19	2	LA5
John	12	13	20	20	2	LA3
Hamish	9	14	19.5	29	51	LA1
Liam	11	11	21 *	27	15	LA1
Tina	3.5	7	19.5	20	14	LA3
Amy	15	15	16	24	5	LA6
Bob	6	12	18	27	2	LA7

* denotes moving on from a supported carer and not group care.

The Chart indicates that the young people who took part in the study came from seven of Scotland’s 32 local authority areas. The time young people spent within residential care varied considerably, from 6 months–12.5 years. The mean duration of residential care placements was 5.3 years, while the median duration was slightly higher at 6 years; this differs slightly from the statistics in the table as nine young people moved on to supported accommodation or supported care placements. Three children entered residential care before the age of 12 years old, while most of the group entered as teenagers. Four young people experienced 14 or more placements. This data is consistent with the findings of [45].

7. Results Section

7.1. The Journey to Residential Care and Placement Stability

The Care Review [26] highlighted that multiple transitions may be “accompanied by feelings of loss, sadness, anxiety and a lack of security” [26] (p. 56). Within this study,

young people were more likely to experience multiple placement breakdowns when they were placed within family-type placements, contradicting the continued view that family environments are the best place for children to grow up) [26]. Although less frequent transitions largely offered greater stability for young people in the study, Kevin spoke about how the transient nature of relationships impacted on his mental health (Kevin, Interview five).

Consistent with other studies reflecting the prevalence of ACEs for children within residential care [6,7,17], the young men experienced up to five adversities while the young women experienced between three and four. Devaney, Frederick and Spratt [46] highlight that children may find it difficult to cope with a high number of adversities over time. The number, however, does not reflect the impact or nature or the resilience of the child who experienced the adversity [47]. Most participants shared experiences of adversity that included poor parental mental health, familial criminal justice activity or imprisonment, substance use amongst parents, domestic violence, and issues of abuse and neglect within the family.

Amy spoke about her physical journey to the residential placement, during which nobody spoke to her or explained where she was going or why (Amy, Interview twelve). She feared that she was going to be beaten with coat hangers due to urban myths about residential care, and her way of trying to gain control over her life resulted in her refusing to eat (Amy, Interview twelve). She expressed a lack of insight shown by professionals and felt that it would have been helpful if staff had put themselves in her shoes. The Secure Care Pathway and Standards [48] Standard 13 states “I know the details of where I will stay, and I have access to information which explains daily life there. Every effort is made to visit before going to stay”. These co-produced standards resulted from children sharing experiences similar to Amy’s where they were deceived or kept in the dark about their intended destination.

7.2. Perceptions of Residential Care for Children

There is a lack of understanding about residential care—this is consistent within secure care [49]—and a need to disperse historical urban myths and reconstruct the narrative which has centred around residential care as a choice of last resort [50]. In part the stigma may inadvertently result from research illustrating poorer outcomes [26,28,38]. Information reflecting the fact that children placed in residential care have more complex needs without critically evaluating and analysing can exacerbate this view [51]. Within the study, only two participants went to a residential house as their first care placement and both of these young people experienced good outcomes overall (Kevin, Interview five; Mark, Interview seven). Most within the study could be described as high achievers when using educational outcomes as a measure [52], although Kevin stated that because he was doing well at school his emotional needs went unchecked. This finding is consistent with Duncalf [45] in her study of care leavers aged 17–78, suggesting that educational attainment develops over time. Nine out of thirteen participants went to college and three university. Matheson and Connelly [53] highlight that poor educational outcomes are not inevitable, and with supportive, stable placements trajectories can improve over time [54].

7.3. Placement Stability

Participants experienced between one and 50 placement moves. Although these figures are not unusual [26,45], there is an assumption that the placement instability is experienced within the group care setting. Amy describes a very swift transition during her initial period within residential care. Arriving at the children’s house late at night she was taken to a dark room where she slept on a sofa bed before being moved in the morning. A smaller setting may have afforded staff the opportunity to familiarise Amy with her surroundings and explain the process [15], but Amy was moved to a house where she lived with five other children without any preparation. Placement instability is described as being in-built to a service viewed as a last resort [50].

Placement instability, reflected in moves in living arrangements, was also evident in many children transitioning to new schools. Seven of the participants spoke about changing educational provision; six of the group spent a period of time within specialist education provision while the remaining seven were sustained within mainstream secondary education. Dixon and Stein [55] note the instability of movement from family and community and the subsequent impact on unfulfilled educational, developmental, and health needs. Within the study, it appears that almost half of the participants had additional support for learning needs that may have been exacerbated by a lack of secure educational provision. The young people also spoke of difficulties being supported after school with homework or access to a computer (Kevin, Interview five).

While movement in education provision was not always viewed positively and may impact on educational attainment [27,54], Hamish said that he moved to a better area and school when he moved into residential care (Hamish, Interview nine). He felt that he missed out on the opportunities afforded his peers, such as school trips, saying “they would get to go snowboarding and France and quite fancy things so I used to think that I was missing out because you can’t do that when you have eight other kids to consider” (Hamish, Interview nine).

7.4. The Number of Children within the Residential Placement

The number of children within the residential house was mentioned by a further nine participants in the study. They expressed feeling that the ability of staff to meet their emotional and practical needs was affected by the number of children in the placement and this view is reflective of contemporary experiences of children shared in research and as part of a Care Inspectorate review [15,21]. The Care Inspectorate [21] (p. 19) found that smaller houses were viewed as supportive of the ability of “people to form positive, worthwhile relationships with staff and other young people”. Smaller houses were seen as more homely and settled and more conducive to time to oneself. This reflects what the Care Inspectorate describes as a “domestic model” [21].

Within the study, the young people shared their experiences of the group living situation, which was viewed more negatively, both by the young people themselves and their wider social network, than familial-style care settings. The young people associated living within residential care with failure. Tania stated that she lived within a residential house when she “was too much for the foster carers” (Tania, Interview four). Placement breakdown was associated with self-blame rather than an inability of adults or the system to meet children’s care needs. Perceptions of children as either dangerous or in danger is pervasive in welfare provision for children [56]. Lisa talked about assumptions made by people that she had possibly committed murder to be placed within a group care setting (Lisa, Interview two). Negative stereotypes were expressed by 11 out of the 13 participants, resulting in many blaming themselves for being in care.

7.5. Comparisons with Peers

Children made comparisons between themselves and multiple peer groups, comparing themselves to brothers and sisters, friends at school, and those within their household group (Luna, Lisa, Kevin and Hamish, Interviews one, two, five and nine). Normative sibling rivalry can be exacerbated when children have the complexity of being members of multiple comparison groups. Klass [57] highlights that parents can differentiate their children, for instance as the pretty or clever child. Isaacs [58] states that sibling rivalry can be viewed as universal and a valuable developmental opportunity where children can learn to problem solve and manage conflict. Within a residential setting, where children are unlikely to be related to each other, organisational processes and bureaucratic constraints may limit children’s opportunities to learn from each other.

7.6. *Living with Children Who May Have Experienced Trauma*

When living in a group setting with unrelated individuals, even as a result of entering care for your own safety, which was the case for five young women in the study, the residential care setting can be experienced as hostile and unpredictable. Children may have limited control or respite from other children or adults and re-traumatisation may occur when behaviour is a reminder of past experiences or events. Kevin noticed “people’s behaviour being so radical because they were seeking care and attention by doing ridiculous things that was getting them into trouble” (Kevin, Interview five). Pain-based behaviours are a way for children to express their pain [59]. Kevin stated that because he did not make demands on staff or act out, his emotional needs were not met as staff attended to self-harming behaviours. Johnson, et. al. [32] highlight the prevalence of self-harming behaviour within residential care, and the distress that it causes to both the individual and others within the setting. Self-harming and acting-out behaviour impacts on the availability of staff to the wider care group [32,60].

Hamish said that his behaviour mirrored people’s expectations of children who live in children’s houses. He said: “I kept lashing out at people as well, so it was a self-fulfilling prophecy” (Hamish, Interview nine). Goffman [61] distinguishes between social identities, which are shared, and social alliances. All of the young people who took part in the study defined themselves as care-experienced. Goffman states, “the stigmatized individual may exhibit identity ambivalence when he obtains a close sight of his own kind behaving in a stereotyped way” [61] (p. 131). Unlike Hamish, two of the other participants spoke about trying to distance themselves from the stigma associated with residential care by avoiding their immediate peer group and associating with children and young people outside the care system (John, Interview eight; Kevin, Interview five).

Luna found it difficult to live away from home in a residential setting and found the house “a really hard place to live” (Luna, Interview one). While she recognised that there were worse places, her emotional needs remained hidden. Luna spoke about struggling to form relationships with other children due to the fear that they would move on. This view was shared by many participants and Kevin spoke about a lack of felt security despite remaining in the same placement for eight years, due to the transitions experienced by other children and staff (Kevin, Interview five). Young people seemed to be so accustomed to others coming and going that despite placement stability there was a fear that they could be moved at any time.

A lack of a consistent staff team was reflected within the Care Review [26]. Three participants spoke about shift working and its impact on the group living experience. While children may need to navigate differences in parenting styles within a family, within a group care setting the presence of multiple adults may result in the need to adapt to what may be changing rules, expectations, and demands. The size of the staff team will invariably affect the impact of this. Kevin and Hamish viewed the impact of three shift changes daily as disruptive (Kevin, Interview five; Hamish, Interview nine). A lack of consultation and discussion around staff movement also caused anxiety and exacerbated a sense of insecurity (Kevin, Interview five). Only three young people in the study formed friendships with peers that continued after they left care (Luna, Interview one; Bruce, Interview six; Mark, Interview seven). There was a fear of forming friendships when relationships could be fleeting.

Bob struggled with how staff prioritised their duties (Bob, Interview thirteen). He stated that when he wanted to speak with his keyworker they would ask him to wait and would prioritise administrative tasks; emotional availability is likely to be affected by the demands of the shift [60]. This left him feeling unsupported and disempowered when preparing for meetings or time with his family. Staff members have to prioritise needs and, while relational models of practice are crucial to meaningful engagement, not all children may receive this prioritisation well [32].

7.7. Relational Practice

Every young person in the study experienced positive child–adult relationships before and during their time in residential care and beyond. Liam spoke about the ongoing support he continued to receive from his former keyworker, who was like a father to him; they had had a constant relationship for 11 years (Liam, Interview ten). Tina’s experience was similar in that her residential worker was viewed as a mother and the relationship had continued and was enduring for 12 years (Tina, Interview eleven). Characteristics of beloved staff included active listening, and being present, caring, reliable, and stable. These traits are consistent with findings elsewhere [15]. Unsurprisingly, children didn’t get on with all staff, but John reflected that this could be down to a number of things including personality (John, Interview eight). However, for Hamish and Tina, screening should identify staff that should not work within residential childcare. Hamish reflected on a time when he had briefly moved on from a placement. He said “there was one staff member who took a grudge. I don’t know if she felt I’d betrayed her or abandoned her or whatever, but she was horrible after that. . . another lassie about a year later had a similar situation. . . and she got the same treatment” (Hamish, Interview nine). Kilpatrick, Berridge, Sinclair, Larkin, Lucas, Kelly and Geraghty [62] indicate that staff’s own life experiences and the stresses of the job may impact on their receptiveness to those within their care. Relationships within this setting are complex and “blocked care” can be evident when stress can affect a staff member’s capacity to be empathetic and the propensity to sustain loving feelings [63].

The young people’s relationships with non-residential staff lacked consistency, as highlighted by Lisa and John’s accounts. John said, “I went through eight social workers in five years which isn’t ideal. It’s having to get to know someone else, someone else who knows everything about you and someone else making decisions and you probably don’t want them making those decisions” (John, Interview eight). Lisa said, I “had thirteen social workers in four and a half to five years or so. . . I never had that one person I could talk to” (Lisa, Interview two). Hamish reflected an understanding of social work and the social work system. He said, “you understand a bit more [as you get older] . . . I found out that my last social worker had 28 cases. . . no wonder she had such a shit time” (Hamish, Interview nine). A high caseload impacted on his ability to receive the support that he needed.

Developing trust, for children who may have experienced trauma or adversity, can be challenging, so consistent, reliable relationships are crucial. Tania said, “I didn’t trust people because I was always getting told lies. . . so I didn’t really. . . build relationships with all the staff” (Tania, Interview four). For Kevin, an inability to trust resulted in him feeling alone “even now being surrounded by friends and stuff” (Kevin, Interview five). In a study by Gabriel, Keller and Bombach [64], adults displayed emotional and social scepticism towards both others and themselves, and this continued for years on leaving care. Lisa felt she missed out on having the emotional support from that one person, the stable parental figure you could confide in. Someone “that would cuddle me when I was crying or understand when I was upset” (Lisa, Interview two).

7.8. Familial Relationships

Family relationships with brothers and sisters were important to all of the young people within the study, except Amy (Interview twelve) who was an only child. As children, they experienced a sense of loss on going into care. Hamish spent a short period of time placed with his brothers in foster care, but only Kevin experienced a period of time in residential care with his brother (Hamish, Interview ten, and Kevin, Interview five). This broke down when the brothers’ sibling rivalry was seen as problematic, resulting in the brother being moved on (Kevin, Interview five). Membership of a sibling group gives children a unique identity, so separation can have a significant impact. Luna’s experience, in which her brother continued to have regular contact but the relationship with her sister was confrontational, would indicate the complexity of relationships (Luna, Interview one). Almost half of those involved in the study had brothers and sisters who had no experience

of care, but it is difficult to ascertain if this is consistent with other findings as data is not collected nationally.

Ibsen and Klobus [65] describe fictive kin as nonrelative relationships that are kin-like in nature. Two of the youngest participants in the study spoke about ongoing mental health concerns despite the development of a consistent fictive relationship with an adult while they lived in residential care (Kevin, Interview five; Tina, Interview eleven). Miller, Wakefield, and Sani [66] link positive mental health with multiple group identities including family, school, and peer. This was an area that was lacking for most of the participants, with few experiencing positive affiliations as they had moved away from their family, community peer group, and, for all but one, their local school. The strongest indicator of good mental health in 13–17-year-olds has been highlighted as a positive association with one's school [66].

7.9. Group Care Norms

Liam stated that the children's home, with five other children, provided him an opportunity to opt in or out of daily routines such as eating at the dinner table (Liam, Interview ten). While he viewed this as agency, if he had not subsequently experienced a supported foster placement, this may not have been part of his life experience or accepted familial norms. For Kevin, bureaucracy within his residential placement had an impact on his ability to integrate within the local community. He said, "my friends [weren't] allowed to stay over at my house. . .when they [came] in my house, they [had] to sit in a reception room, [as] they weren't allowed to come through and sit in my bedroom" (Kevin, Interview five). It is difficult to envisage how individualised care planning approaches can be consistent within a setting housing five or seven other children, such as the setting where Kevin lived. Kevin spoke about how this affected his experience of childhood as he felt different to his peers. He also reflected on practices that were risk-focussed, such as visits to the beach which needed to be supervised or have a trained lifeguard on hand (Kevin, Interview five). A blanket approach resulted in staff being unwilling to give him train fares for fear that the money would be misappropriated or spent on alcohol (Kevin, Interview five); a smaller milieu with supportive opportunities may have resulted in different childhood experiences. Tina also spoke about institutionalised practice that became internalised as norms such as having a sanitary bin in your ensuite, or toiletries and razors stored centrally within a locked cabinet (Tina, Interview eleven).

7.10. Positive Experiences

While outcomes studies illustrate that residential care-experienced young people are more likely to experience homeless and unemployment, have higher early mortality rates, poor mental health, increased risk of contact with the criminal justice system, an increased risk of early pregnancy, and low educational attainment [24,39,67], this is not the experience of the young people within this study. Duncalf [45] also illustrates that residential care-experienced care leavers were more likely to describe their experiences as "mainly positive" than those who experienced foster care and less likely to share this experience as "mainly negative". Research illustrates that multiple caregivers are able to provide the nurture and support that children and young people need [68–71], and all of the young people in this study benefited from the love and care they received from staff whose job it was to look after them. More positive experiences may partially be explained by the participant recruitment process, as all but one of the participants had ongoing contact with an advocacy agency which engendered positive wellbeing support.

Tina spoke about what could be considered a well thought-out preparation and planning experience for moving on from her residential house (Tina, Interview eleven). Preparation begun at the age of 15 years old, when a plan was formulated and tasks were gradually introduced to promote selfcare skills such as tidying her bedroom, laundry, setting an alarm and budgeting, shopping, and cooking (Tina, Interview eleven). Appropriate support was provided through a whole-team approach, including the house cook.

Mendes, Standfield, Saunders, McCurdy, Walsh, Turnbull, and Armstrong [72] state good transition planning should begin between the ages of 12 and 15 years old, with a holistic approach required. The young people within the study spoke about barriers to preparation including the number of children to staff ratio, and most of the residential houses ranged in resident group size from 6–16, making it difficult to prioritise individual needs. Young people found it difficult to experience the quality time required to make this preparation meaningful (Liam, Interview ten; Bob, Interview thirteen; Luna, Interview one). In contrast, the study group spoke about beginning preparation for leaving care within supported carer or accommodation placements; however, these were not experienced until young people were 16 (Lisa, Interview two; Bruce, Interview six; Mark, Interview seven; Amy, Interview twelve) or 18 (John, Interview eight; Liam, Interview ten; Hamish, Interview nine). These experiences are despite local authorities having a statutory duty to prepare children and young people for leaving care.

8. Limitations of the Study

This study offers insight into the lives of thirteen young people with experience of residential care. A single agency was used to recruit participants, with one exception where recruitment resulted from word of mouth. Recruitment of young people who have left care is challenging as they are likely to be disengaged [39]. A single recruitment source may have limited the experiences of participants as they were all actively involved in the children's services sector in an advocacy capacity and had support networks in place. This also restricted eligibility, as most children and young people who accessed the agency did not have experience of residential care. Attempts to recruit young people outside this agency proved unsuccessful, resulting in a low response rate.

The small sample size may not be representative of the wider residential care-experienced population, making it difficult to draw conclusions from the study. Additionally, retrospective accounts rely on recall and, as children may have experienced traumatic experiences and shared their stories repeatedly over time, the accuracy of recall can be high but complex [73].

9. Future Research

The primary function for data collection was to gain a better understanding of the journey before, during and after residential care. The purpose of the PhD thesis was therefore not to ascertain children and young people's experiences of the limitations or benefits of group size. However, this was an area that was discussed by 11 of the 13 participants and provides a starting point for this discussion. Future research should focus on this experience of residential care with particular attention given to provision for smaller group sizes. This would provide us with a clearer picture of the impacts of group size and placement capacity.

10. Conclusions

This paper shares the experiences of thirteen young people who spent a period of their time in care within residential care. Many experienced a number of transitions before entering residential care, reflecting rejections from family-style settings. Urban myths and a lack of understanding about residential care can result in children and young people feeling anxious when entering this type of placement and stigma can be associated with this form of care. There is a lack of understanding more widely about Scotland's relational approach in group care.

Placement instability was experienced by most young people in the form of their own moves, moves of peers, or staffing moves or shift changes. This affected children's ability to form relationships for fear that they would be transient, but all of the young people in the study were able to form a meaningful relationship with a significant adult. Children, young people, and staff may move from one setting to another, affecting people's ability to trust and form meaningful relationships for fear that they will be transient. One young person, who had experienced a stable eight-year placement, lived in fear that his placement

would come to an end as a result of the instability of others. Despite this, the young people within the study all had a significant adult who had played a positive role in their life.

The group size was mentioned by almost all within the study. Consistency and felt security within a larger group setting were seen as being difficult to achieve as staff responded to the needs of children who required their immediate attention. Childhood experiences were impacted by residential care bureaucracy and young people felt that their developmental, practical and emotional needs went unmet. The group achieved good outcomes educationally, but this success was also viewed as masking unmet emotional needs. Only one young person within the study was prepared for a time when they were no longer going to be in care and others saw a lack of preparation resulting from staff to child ratios, administrative priorities, and the needs of the residential group. Most young people experienced additional support if they moved on to supported accommodation.

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