Scottish Journal of Residential Child Care

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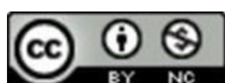

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Editorial

Graham Connelly
Editor

Welcome to the autumn 2023 issue of the Scottish Journal of Residential Care.

The autumn 2023 issue

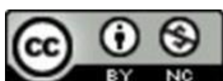
Regular readers will notice a different appearance to articles: we have adapted the template a little so that key indexing information stands out better in a sidebar on the front page of each article, and articles have been individually categorised as original research articles, short articles, book reviews etc. We continue to be mindful of our responsibilities to make articles accessible to all readers; *SJRCC* articles are not behind a paywall, thanks to our publisher, CELCIS, and the text of articles is presented in a single column using an easily readable font. We hope readers approve of these changes and of course, the editorial team welcomes feedback.

The conflicts in Ukraine and Sudan continue to seriously damage the lives of children as a result of family dislocation and interrupted schooling, and an earthquake in western Nepal has destroyed houses, schools, and health centres. Many thousands of children have been killed or maimed since October 7 in the conflict affecting Israel, Gaza, and the West Bank. The spokespersons for the various actors involved in conflicts present their cases to the world's media, and journalists risk their lives to report from the heart of war zones, with the effect that we watch on our TV screens helplessly the plight of the injured, the homeless, and the grieving. I was immensely moved by an interview conducted by journalist Matt Frei[1] with Rachel Goldberg, mother of Hersh Goldberg-Polin, who is understood to be among the hostages taken by Hamas fighters. Goldberg said: 'If you only get outraged when one side's innocent children are slaughtered, then something is broken in you'.

The aim of this journal is to provide a service to those who work directly with children and youth who have experienced trauma, in whatever context that occurs, and particularly those who become looked after in alternative care as a result of conflicts. The power of research and the exchange of ideas about practice in child and youth care represent a glimmer of hope in a generally unsettling world.

It remains important to keep an eye on what is happening in Scotland. CELCIS has published a major report on the views of the children's services workforce in Scotland on how services for children are managed, commissioned, and

[1] Channel 4 News broadcast in the UK on 1 November 2023



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delivered (McTier et al., 2023). The report, based on an online survey, focus groups and interviews, represents the fourth strand of broader research requested by the Scottish Government in the context of its proposal to include children's services within a National Care Service. The report highlights a workforce that is exhausted following the COVID-19 pandemic, a cluttered legislative, policy and funding landscape, and serious gaps in provision, particularly in relation to early intervention, specialist health services and help for children with additional support needs. There were also more positive findings, including evidence of a passionate, committed workforce focused on wanting improvements that benefit children and young people.

In the last issue, I noted the publication of Volume 1 of a report of the Scottish Child Abuse Inquiry's findings on the child migration scheme, a government-sponsored programme in the late 19th and early 20th centuries by which children in care in the UK were migrated to Canada and Australia, mostly without their or their families' consent. The second volume of this major report was published in September (2023). While the first volume presented the testimony of former migrants, Volume 2 is concerned with the history of child migration, its legal basis, and the responses of various organisations involved in migration and still operating to questions put by Lady Smith's inquiry team about these organisations' involvement in child migration. The long litany of abuse listed in the report makes shocking reading. What is more shocking is that the poor standards of care and the physical and sexual abuse of children boarded out, typically in rural farms, was reported during the life of the scheme – notably by Andrew Doyle in Canada in 1875 (see Bagnell, 2001) – but dismissed or ignored. Lady Smith notes: '…despite persistent governmental knowledge of the dangers of the practice and despite development of improved standards of childcare practice in the UK, child migration was actively pursued as a policy, and was only formally ended [in the 1970s] long after the last child migrant had left Britain's shores' (p. 8).

During the annual 'Care Experienced Week' in October 2023, advocacy charity, Who Cares? Scotland published a report calling for lifelong rights for care experienced people. The report says that a high proportion of young people leave care before they feel ready to do so and that the experience leaves them feeling unsupported. The charity says almost 40% of callers to their helpline are aged over 26 and therefore not entitled to aftercare services from their local authority. The report marks the start of a campaign by the charity and its care experienced members to gain extra protection for the right to access support to be enshrined in Scots law, and for provision of 'independent, relationship-based, lifelong advocacy for every Care Experienced person in Scotland who needs it' (p. 19).

The autumn 2023 issue

In this issue we publish three long-form original research papers. The first of these is an account of research in Malta by Kevin Borg and colleagues from the Foundation for Social Welfare Services describing the health characteristics of looked after children and young people on the Maltese Islands.

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Based on a study of 200 children aged under 18 living in 25 residential/community homes, the research found that 31% had incomplete immunisation records, 94% had a least one physical health problem, the most common being dental health issues, and 60% had at least one mental health problem. The authors conclude that early intervention in appropriate health care is important, together with including health care issues in care plans, as well as having better structures to collect health data about countries' populations of looked after children.

Next, we feature research by Matilda Steele and Sarah Elgie, psychologists with the Keys Group, providers of residential care based in England. The authors conducted a systematic review of the literature related to the use of routine outcome measures, such as questionnaires, to monitor progress of mental health interventions with looked after children and young people. They were interested in studies which explored the attitudes of children, families, and clinicians/practitioners to the use of routine outcome measures. Fourteen studies met their inclusion and exclusion criteria. The authors conclude that in general the use of routine outcome measures is regarded favourably by professionals and therefore question why more use is not made of them. They also found a paucity of research about the attitudes of children on the use of outcome measures to monitor their progress and say that more research is needed which includes young people in giving their views about the use of questionnaires and other outcome measures to review clinical interventions designed to improve their wellbeing.

Our final long-form paper in this issue by Kiran Modi and Gurneet Kaur Kalra of the Udayan care agency in India outlines Udayan's approach to aftercare support for care experienced young people. The outreach programme is characterised by 'workshop modules had been designed on career opportunities, interview skills, CV writing, placements, emotional wellbeing, legal and financial literacy, resilience, and life skills'. The authors say that a key element in the success of the programme is collaboration with different stakeholders.

Earlier in the year we put out a special call for short articles (defined as comprising 500 words or more) concerning practice or policy issues related to care experience, and the editorial team was delighted by the response. Some of the articles are still in preparation and once they complete our review process will be included in the next issue. Eight articles are published in this issue. We repeat our open call here: we are constantly on the lookout for short accounts of innovative practice or commentaries on topical issues related to care experienced children, young people and adults from around the globe.

Viviene Cree of the University of Edinburgh and Bob Mackenzie of the University of Chichester describe two years of co-research and writing about a subject in which they have both been participants: the social work agency The Guild of Service which became Birthlink, based in Edinburgh, Scotland. Viviene's connection was as an employee, a social worker, and Bob's was as a child growing up in the agency's children's home, Edzell Lodge. Reflecting on their collaboration, they say: 'we have become less concerned with artefacts of the past … and more concerned with the present, and within this, our shared

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relationship. We hope that others will take courage from our story and feel able to engage in their own exploration of their past in social work, from whatever standpoint they are coming from, and alongside whichever "critical friends" are available to support them on that journey'.

Andrew Brierley of Leeds Trinity University explores the state of young offenders' institutions (YOIs) in England. The author writes from direct experience, having spent 18 months in Brinsford YOI when aged 17-18. He reflects on that experience in the light of a subsequent report into Brinsford by HM Chief Inspector of Prisons which said there existed in the YOI a 'level of neglect and lack of understanding of the needs of young prisoners that was "breath-taking"'. Andrew argues that there is a 'crisis of visibility' whereby the public and politicians are ignorant of the use of prisons for children. He says there is a 'need to completely deconstruct the youth estate and rebuild smaller, purpose-built homes for children that can allow them to *be* and *feel* like *children*'.

David Stakes, a team leader in children and family social work with a Scottish local authority, explains the requirements for successfully bringing care experienced children and their families back to live together again. Good communication among carers, child, parents, and social worker is vital, including 'maintaining links between the young person and carer which 'might be as simple as a card on birthdays and festive occasions'.

Jade Purtell of Monash University and Christine Hawkes of the University of South Australia discuss record-keeping and children and young people's rights in residential care. They conclude that records should 'not only meet administrative demands but also honour and respect the stories they encapsulate and the wishes of young people'.

Sarah Deeley of CELCIS and Kyle Fleming of the Crossreach care agency explain how Reflection and Action Learning Sets developed by members of the Scottish Physical Restraint Action Group (SPRAG) helped staff in a special education setting to reflect on their practice in the context of implementing improvements.

Mary Morris of the Care Inspectorate in Scotland reports on her agency's analysis of key factors of key performing services based on inspection visits. These are positive caring relationships, knowledge and understanding of trauma, careful matching of children to the resources that are right for them, and effective leadership. Mary's assessment is that 'The passion, energy, and commitment in our high performing services in Scotland is a very important reason to be cheerful and gives the sector hope and energy to move forward'.

Sarah Folman Hadjidemetriou is a psychologist at the St Mary's Kenmure secure care facility in Bishopbriggs, near Glasgow, Scotland. In her article, she makes a case for formal cognitive testing as part of the assessment process. One of the reasons Sarah advances in support of a detailed cognitive assessment is that staff are thereby better informed and equipped to support young people.

Our final short article in this section is contributed by Nicola Glasgow, a Scottish police officer. She describes her work as a police liaison officer based at a large

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residential education and care centre, outlining four main aspects of her role: child protection; preventive education about online safety, substance abuse and other harms; following up concerns raised about criminal activity by and towards young people; and being the first point of contact for missing children and young people. She also explains the philosophy behind the role and lessons learned.

In the book review section, we publish three reviews. Challenging the conventional wisdom about residential care for children and youth: A good place to grow by Bruce Henderson (Routledge, 2024) is reviewed by Jim Anglin of the University of Victoria, BC, Canada. Residential child and youth care in the developing world edited by Tuhinal Islam and Leon Fulcher (CYC Press, 2016-21) is reviewed by Jennifer Brooker of Melbourne Polytechnic. Dilemmas and decision making in residential care by Abbi Jackson (Critical Publishing, 2023) is reviewed by Dan Johnson of Kibble Education and Care Centre.

Amy Robinson of PJL Healthcare has contributed a detailed report about the Lovin' Care Gathering held in Manchester, England in May 2023. Jean Marshall submitted a delightful poem based on her experience as a foster carer. The poem is written in her own dialect, Doric, which is spoken in the north-east of Scotland, notably in Aberdeenshire. Jean has also provided a short commentary about her poetry and its place in her life. Finally, we end this issue by publishing Delyth Edward's (the University of Leeds) beautiful obituary of the courageous Care Experienced campaigner, social worker, and care inspector., Ian Dickson. It seems appropriate to end this editorial by quoting Ian's own words: care experience is 'a medal not a wound'.

We return in spring 2024 with another full issue.

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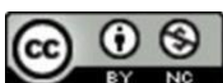

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Original Research Article

Health characteristics of looked after children and young people in the Maltese islands

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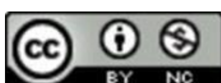
Abstract:

Looked after children and young people are a vulnerable group of minors exposed to adverse childhood experiences (ACEs), who have greater health needs. This study explored the health characteristics of the population of Looked after children and young people residing in residential care in the Maltese Islands run by the newly established looked after children and young people healthcare service, which also coincided with the relaxing of Covid-19 restrictions. The quantitative data were gathered in the form of a prospective audit. The population of looked after children and young people (N=200) showed that 90 per cent (n=180) were victims of child maltreatment. Ninety-four per cent (n=188) had at least one physical health issue, 60 per cent (n=119) at least one mental health problem, and 59 per cent (n=20) of minors under six had at least one developmental issue identified. Thirty-seven per cent (n=63) of looked after children and young people in school were statemented, indicating significant learning difficulties. Forty-four per cent (n=72) were found to be overweight/obese. This study highlights the importance of specialised healthcare services for looked after children and young people that can detect health needs specific to this group and influence pathways and policies to help improve their health outcomes. Findings further emphasise the importance of therapeutic care settings, with trauma-informed staff, who can promote resilience in looked after children and young people.



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Introduction

Looked after children and young people are a group of vulnerable minors who, for one reason or another, have been removed from their family and placed into alternative care. Most of these vulnerable minors have been exposed to social turmoil, including child maltreatment and/or other traumatic events considered to be major adverse childhood experiences (ACEs). These are known to increase the risk of negative effects on the physical and mental health of looked after children and young people both in the short-term and in the future (Alik et al., 2022; NICE, 2021). This also has an economic impact at a macro level, whereby 'in countries such as the UK the combined attributable costs for ACEs have been estimated to be around 78.6 billion USD, around 2.8% of GDP' (Hughes et al., 2021). Minors in care are at a greater risk of having unmet medical needs such as missed vaccinations that protect against communicable diseases (Walton & Bedford, 2017), as well as increased physical and developmental problems when compared to aged matched peers who are not living in alternative care (Hadfield & Preece, 2008; Martin et al., 2014; Meltzer et al., 2003; Rodrigues, 2004; Sempik et al., 2008; Steele & Buchi, 2008). Similarly, increased psychological, mental health and learning difficulties have been found in this vulnerable group, partly due to the fact they have been exposed to chronic toxic stress, which occurs when the body's fight or flight response has been activated too often or for too long (Alik et al., 2022; Burge, 2007; Erol et al., 2010; Ford et al., 2007; Garcia & Courtney, 2011; Milburn et al., 2008; Oswald et al., 2010; Sawyer et al., 2007; Ståhlberg et al., 2010). When compared to the general population, increased health related risk-taking behaviours have also been documented in looked after children and young people, including increased rates of tobacco and illicit substance misuse, and increased rates of sexual risk-taking behaviours (Ahrens et al., 2010; Carpenter et al., 2001; Meltzer et al., 2003; Williams et al., 2001). The wide variation in prevalence rates in the available studies may reflect the heterogeneity present in these studies. Methodological weaknesses in the evidence available further limits the use of observed prevalence rates, although certain health issues have been consistently observed amongst various studies.

The need for specialised medical care for looked after children and young people has been widely recognised. Evidence from other countries, such as the UK, has shown that prior to the development of specialist services (including named and designated professionals for looked after children and young people), several challenges were identified including inconsistent, delayed, or repeated health assessments of variable quality and lack of consistent healthcare (Department of Health & Department of Education, 2015; NICE, 2021). In Malta, the Minor Protection (Alternative Care) Act was established in 2019 with the aim of safeguarding, protecting, and prioritising the minor's best interests and providing permanency of care for those living in alternative care (Minor Protection [Alternative Care] [Malta] Act, 2019, c. 602). The Directorate for

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Alternative Care (Children and Youth) was established during the same year in Malta, in keeping with provisions in the legislation. The same directorate, working within the Foundation of Social Welfare Services (FSWS) in Malta, identified the need for specific healthcare services for all children in alternative care. The Looked After Children Healthcare Service (LACHS) was established in January 2021, consisting of one consultant paediatrician and two nurses. Prior to the LACHS, the medical child protection team was assessing children in out of home care needing medical attention, however, the service could not be offered to all children in out of home care due to limited resources and the volume of safeguarding work. The aim of the LACHS was to have a specialised service offering a holistic approach in assessing the health needs of looked after children and young people, through working with the minor, their carers, the minor's family, and other professionals involved in their care. The service also aims at ensuring that the healthcare needs of every looked after minor are being met and that they are safeguarded through co-ordinated services that are child-centred and in line with the Maltese Social Care Standards Authority (SCSA) guidelines for children in alternative care (Social Care Standards Authority, 2020) and the United Nations Convention on the Rights of the Child (UNCRC).

Up to the date of the study, there were just over 400 minors living in out of home care in Malta and Gozo, half of whom resided in foster care and half in residential care, indicating that both type of placements still played a very important role in the provision of out of home care in Malta, similar to a number of other countries. This is partly explained by the fact that available foster placements are limited, but also that certain minors, particularly more challenging vulnerable youth, may be more suited to a therapeutic residential setting when available. Most residential care settings in Malta have shifted towards a family-based therapeutic model, with smaller numbers of children and youth in each care unit and where children under five are prioritised for foster care placements. This paper sought to delve into the health characteristics and medical needs of the population of looked after children and young people residing in residential care in the Maltese Islands in order to better understand their health needs and to recommend improvements to services, with the aim of improving health outcomes in this vulnerable group. This study also coincided with the easing of Covid-19 pandemic restrictions during which minors in residential care were not regularly assessed due to many homes going into lockdown/semi-lockdown and where health resources were diverted to dealing with the pandemic.

Method

Ethics approval for the study was obtained from the Malta University Research Ethics Committee, application ID: SWB-2022-00249.

All looked after children and young people below the age of 18 years residing in residential/community homes were assessed by the LACHS during 2021

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(N=200). The lead key worker referred each minor in residential care to the LACHS for an assessment, using a standardised form that provided a detailed background on the minor, including the social history and reasons for entering care. Prior to each consultation, a health profile was prepared for each minor to help build a complete health history. The minor's formal immunisation records were reviewed from the official primary healthcare portal that stores immunisation records for all minors residing in Malta. Furthermore, telephone interviews took place with the minor's parents in order to obtain any relevant past medical history, as well as any relevant family history. Health information obtained from online health records was reviewed, including any previous medical history, as well as past and upcoming health appointments. LACHS also reviewed medical records kept by other health professionals who had already been involved in the healthcare of these minors.

Prior to each consultation, the respective residential home was provided with an information sheet outlining the aims and objective of the service and what the health assessment would entail, including the fact that findings may have an impact on the minor's care plan and that data may be used to improve service provision. The home was encouraged to share a child-friendly version with the minors in their care. The health assessments were not mandatory, and the child or young person could refuse such an appointment. Health assessments took place in the minor's respective care home in the presence of the main caregivers (unless they preferred to be seen alone), which could have further contributed to the high response rate. A thorough health history was taken from the main caregiver, and from the minor where appropriate, covering the physical, developmental, and emotional/behavioural well-being of the minor (a specific proforma was used). This also included information regarding education, as well as resilience promoting factors including extra-curricular activities. Every minor was given the opportunity to speak to the team alone and also to voice any concerns or feedback relating to their care they wanted to pass on.

A physical examination of each minor was carried out. Growth parameters were taken by the same consultant paediatrician for every minor using the same standardised tools, namely a portable Marsden Leicester stadiometer and medical weighing scale. The apparatus was regularly checked and recalibrated as needed. Body mass index (BMI) and corresponding centiles were calculated for school-age children using the online World Health Organization (WHO) AnthroPlus software that is commonly used to monitor the growth of school-age children and adolescents. BMI results and centiles were also calculated and plotted manually to ensure validity of results. The WHO's BMI cut-offs were used. Key values used for minors assessed were overweight (between 85th and 95th percentiles), obese (>95th percentile), the sum of the two (overweight and obese), and underweight (less than the 5th percentile).

In children under six, a screening developmental assessment was carried out using a checklist, and this was combined with clinical observations. The main

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areas of development were assessed; namely, gross motor skills, fine motor and eye-hand co-ordination, communication, and hearing, as well as social skills. The Strength and Difficulty Questionnaire (SDQ) was filled in by caregivers of all minors aged four and over to screen for behavioural and emotional difficulties of the looked after children and young people (Goodman, 1997). This tool aided in corroborating the clinical assessment in cases of known or newly identified emotional, behavioural, and mental health difficulties.

Relevant data were collected by the LACHS as part of a prospective audit, including health information that was known through the measures detailed above and newly identified information as per clinical assessment. A standardised proforma was used to code data obtained, including demographic information, care information (including risk factors exposed to), and medical information (including health conditions which were known and those which were newly identified after the assessment). The coded data were inputted onto a Microsoft Excel sheet and analysed using SPSS software. For every assessment the coded data were discussed amongst the three members of the team to minimise errors and ensure standardisation. Tight data validation techniques were used to decrease errors in data input, but the possibility of errors in data entry could not be excluded. During data collation, data were checked for errors and corrected where possible, or excluded and marked as absent if this proved difficult to correct.

Medical reports on each minor reviewed were prepared by the LACHS and shared with the professionals involved in the minor's care, including caregivers and looked after children and young people key workers, who included the identified health recommendations in the minor's care plan. The LACHS ensured that health issues identified were followed up on by caregivers and key workers.

Results

The total population of minors living in residential care, as reviewed by the LACHS, amounted to two hundred minors. These minors resided in twenty-five residential/community homes around the island which are run by various entities including non-governmental organisations as well as the FSWS. Fifty-three per cent (n=107) were male whilst 47 per cent (n=93) were female, with age groups depicted in Figure 1. Seventy-five per cent (n=151) were under a protection order, whilst 25 per cent (n=49) were voluntarily in care. All minors were exposed to one or more risk factors in the family before entering care: 74 per cent (n=148) to poor parenting, around 40 per cent to domestic violence, parental mental health issues and/or parental substance misuse (Figure 2). Ninety per cent (n=180) of minors had been exposed to specific forms of child maltreatment, with 49 per cent (n=89) being exposed to one type of abuse and 51% per cent (n=91) to more than one type of maltreatment (19 per cent [n=34] to two types, 20 per cent [n=36] to three types and 12 per cent [n=21] to four types or more). The majority were exposed to neglect, at 75 per cent

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(n=150), followed by domestic violence at 35 per cent (n=70), physical abuse (29%, n=58), emotional abuse (27%, n=54) and sexual abuse (13% n=25) (Figure 3).

Physical health and health-related behaviours of looked after children and young people

Thirty-one per cent (n=61) of looked after children and young people in residential care were found to have incomplete immunisation records for state provided vaccines. The commonest outstanding vaccines were those against human papilloma virus (HPV) and measles, mumps and rubella (MMR) at 12 per cent (n=23). For females over 12 years, this amounted to 24 per cent (n=23) being unvaccinated against HPV. A further 96 per cent (n=190) were not immunised against meningococcal disease (meningococcal types B and/or ACWY), which was only available privately for those minors born prior to 2020. Eighty-seven per cent (n=172) were not immunised against Varicella which was not part of the national schedule and only available privately.

Ninety-four per cent (n=188) of all children were found to have at least one physical health problem (excluding weight related issues which were assessed separately): 67 per cent (n=134) had a diagnosis that was previously already known and 76 per cent (n=151) had a newly identified health issue after the initial health assessment. Minors may have had more than one physical health problem.

The commonest identified physical health problem was related to dental care, at 60 per cent (n=120). Thirty-six per cent (n=72) were found to have visible dental caries that required an ongoing referral and 24 per cent (n=48) had other dental problems, including needing braces. Sixty per cent (n=118) of minors had not been screened by a dentist over the previous year, of whom 73 per cent (n=51) were found to require an ongoing dental referral by the LACHS.

Ophthalmic related issues amounted to 54 per cent (n=107) of physical health issues, with 45 per cent (n=90) relating to visual acuity problems, seven per cent (n=13) to squints, and the remaining two per cent (n=4) to other eye related problems like nystagmus. Twenty-seven per cent (n=18) of minors with known visual acuity problems had not been followed up with a visual acuity screen over the previous year.

Forty-two per cent (n=83) of minors had dermatological findings which mainly included very dry skin needing emollients and/or active eczema. Twenty-seven per cent (n=53) of minors had ENT related issues ranging from glue ear to enlarged adenoids that required nasal steroids. Seventeen per cent (n=33) had gastrointestinal related issues, mainly constipation at eight per cent (n=16). Sixteen per cent (n=32) had musculoskeletal related problems including flat feet. Table 1 indicates the physical health problems identified in looked after children and young people.

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Body mass index was analysed separately to the other physical health problems, whereby 44 per cent (n=72) of minors over five years of age had a BMI within the overweight/obese range.

Health related behaviours

With regard to health-related behaviours, 20 per cent (n=20) of youths aged 12 to 18 admitted to smoking tobacco. A higher prevalence, at 36 per cent (n=17), was found for the female teen population in residential care when compared to the male teen population, which stood at six per cent (n=3). Nine per cent of these youths experimented with alcohol whilst five per cent were making use of illicit substances.

Development

With regards to child development, 59 per cent (n=20) of children under six were found to have at least one developmental problem, the majority relating to communication (50% [n=17]). The rest of the developmental problems are outlined in Table 2. Minors may have had more than one developmental health problem.

Mental health

Sixty per cent (n=119) of children residing in residential care had a least one mental health problem (some may have had more than one): 45 per cent (n=89) with a diagnosis that was previously already known and 35 per cent (n=69) who had a newly identified mental health issue after the initial health assessment. Around one fifth exhibited symptoms relating to emotional dysregulation (21%, n=42), attention deficit hyperactivity disorder (ADHD) (20%, n=40), attachment difficulties (19%, n=37), and other behavioural problems including conduct disorders (18%, n=36). Thirteen per cent (n=26) experienced sleep disturbances, 12 per cent (n=24) experienced anxiety, 10 per cent (n=20) had an intellectual/learning disability, seven per cent (n=13) were on the autistic spectrum, four per cent (n=8) had an identifiable mood disorder, three per cent (n=6) had clinical depression, whilst six per cent (n=12) had another identifiable mental health issue such as post-traumatic stress disorder. Twenty-six per cent (n=52) of minors had regular follow ups at the local children and young people service for mental health (CYPS). Table 3 refers to the mental health problems identified in looked after children and young people. Minors may have had more than one mental health problem.

Forty-five per cent (n=73) of minors had high/very high total SDQ scores, as reported by the main caregiver. Sixty-three per cent (n=64) of those with an identifiable mental health issue had a high/very high total score compared to 13 per cent (n=8) who had none identified.

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Education

Thirty-seven per cent (n=63) of minors attending school were formally statemented, meaning that an in-depth educational psychological assessment was carried out, identifying special educational needs and the need for assistance from a learning support educator in class. Forty-six per cent (n=88) had diagnosed learning difficulties that included difficulties such as dyslexia that did not qualify for a formal statementing of needs.

Discussion

The majority of minors residing in residential care in Malta were exposed to a number of risk factors prior to entering care, including child maltreatment, which amount to major ACEs. Neglect was the commonest reason for looked after children and young people to become looked after, at 75 per cent, corroborating international evidence (NICE, 2021; Steele & Buchi, 2008). The exposure to toxic stress hormones resulting from ACEs is known to negatively affect the developing brain, particularly areas within the limbic system involved in memory formation/retrieval and emotional regulation, as well as the pre-frontal cortex, which is important in executive functioning, including complex problem solving, attention and behaviour. The findings of this study need to be interpreted in the light of this, as well as the fact that the study coincided with the easing of Covid-19 related restrictions.

Physical health

This study supports previous data that reported the increased risk of physical health problems in looked after children. Dental related problems, obesity and vision problems were the commonest physical health problems observed in this population study, which is consistent with other studies (Hadfield & Preece, 2008; Martin et al., 2014; Meltzer et al., 2003; Rodrigues, 2004; Sempik et al., 2008; Steele & Buchi, 2008). There was a higher prevalence of dermatological conditions (42%; n=83) when compared to other studies, which reported a lower range of between three and eight per cent. This finding challenges the 'hygiene hypothesis' which postulates that more frequent exposure to infections in young children likely reduces the rate of atopy (Meltzer et al., 2003; Rodrigues, 2004; Steele & Buchi, 2008).

Dental care

The high incidence of dental issues in this study are partly a result of background neglect, but also the lack of free national dental screening available in Malta, resulting in caregivers asking for dental appointments only when minors are symptomatic. Evidence from other countries such as the UK has also shown that minors in care have relatively higher rates of dental problems including oral health neglect (Waddell, 2007; Williams et al., 2014). A population data linkage study in Scotland further confirmed how looked after minors had

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low levels of access to preventive dental services, reporting high levels of significant dental decay extraction, even when accounting for sociodemographic reasons (McMahon et al., 2017). The high incidence of dental issues and lack of regular screening found in this study reiterates the importance of having more easily accessible pathways for this vulnerable group. During this study, a memorandum of understanding was signed by the local FSWS and the Faculty of Dental Surgery within the University of Malta, where all children in out of home care are now screened and offered free dental interventions.

Weight related issues

Malta already has one of the highest rates of overweight and obese children worldwide at 40 per cent (Grech et al., 2017). The results of this population study report higher levels of overweight and obese children residing in residential care in Malta (44%), which is the highest prevalence rate documented for this population group in the available published literature. Systematic reviews of population-based studies evidence possible mechanisms that link ACEs to adult obesity, including responses related to social disruption, changes in health behaviours, and chronic stress that triggers immunometabolic and neuroendocrine pathways (Felitti et al., 1998; Wiss & Brewerton, 2020). Furthermore, minors experiencing certain mental health problems such as depression may be inclined towards comfort eating as a form of reward, and lack of exercise due to anhedonia. Minors taking certain psychiatric medication, such as risperidone, may also experience increased appetite, which further contributes to this problem.

Tackling obesity requires a robust multidisciplinary approach targeting risk factors present at various levels. In residential care, implementing healthy eating policies and promoting daily exercise is essential, yet challenging. In fact, the majority of minors assessed had been residing in alternative care for a significant period of time, suggesting that this environment was not protecting them against weight related issues. Residential home managers must understand the health risks relating to obesity and promote change by engaging caregivers and children alike. This includes budgeting for healthier fresh food items that may be more expensive than processed food. In Malta, many homes receive food donations from third parties and home managers need to ensure that these types of food are healthy before accepting them. The biological family who meet their children during supervised access visits also need to be informed and educated, with unhealthy food items prohibited during such visits. As an initiative to help tackle this issue, the LACHS has collaborated with the Department for Health Regulation within the Health Promotion and Disease Prevention Directorate to work with individual homes, assessing their menus and trying to offer healthier affordable options. Workshops were also organised with minors in residential care to engage them in lifestyle changes.

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Vaccinations and lifestyle issues

With regards to immunisation records, the number of minors who had outstanding immunisations (31%, n=61) was concerningly high, especially considering that the national rate of vaccine uptake in children in Malta is between 90 and 98 per cent (WHO, 2021). This is concerning, especially when most of these minors had already been residing in residential care prior to the date of this study. Furthermore, the implication of this finding is that looked after children and young people were at an increased risk of preventable diseases as well as an increased risk for larger outbreaks within such settings. The high prevalence of outstanding vaccines can be partly explained by the fact that certain residential homes had gone into lockdown over the preceding months due to the Covid-19 pandemic. Other reasons described by youths included them finding it difficult to approach general primary healthcare services. In other instances, the care home management were unaware of outstanding vaccines, which is concerning as most of these minors were under a protective care order, implying that their health needs should be safeguarded by the care home.

Up to the date of the study, minors in residential homes in Malta were not entitled to free meningococcal and varicella vaccines from the national health service. The cost effectiveness of such vaccines in preventing communicable diseases and possibly outbreaks with more serious repercussions should be a good enough reason to have these vulnerable group of minors vaccinated. Since the completion of this study, some residential homes in Malta found private funding for meningococcal vaccines which the LACHS helped in administrating.

In this study, collaborating with the local Primary Child and Youth Health and Immunisation Unit within the primary healthcare division allowed the LACHS to administer immunisations to minors at their care home. This approach helped to better engage these minors, through understanding why they found it difficult to attend health clinics. In fact, female youths who had outstanding HPV vaccines were all updated by the end of this study. This intervention will likely help in improving future health outcomes, by decreasing the risk of HPV infection, especially since this cohort are known to have a greater chance of engaging in sexual risk-taking behaviour (Ahrens et al., 2010; Carpenter et al., 2001). Furthermore, since the completion of this study LACHS has collaborated with the obstetrics and gynaecology department as well as the genito-urinary clinic who facilitated easily accessible screening for sexually transmitted infections as well as free contraception.

The rates of smoking, alcohol and illicit substance misuse in young people residing in residential care in Malta were less than those documented elsewhere in the literature (Meltzer et al., 2003; Williams et al., 2001), however, these might have been underreported.

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Mental health

The high rate of mental health disorders found in this study (60%), corroborates international data of increased rates of mental health problems in looked after children and young people. A wide variation in such rates is reported in the literature (25-72%), likely due to the heterogeneity of the studies available. Most studies seem to focus on foster care, however Ford et el. (2007) carried out a robust study analysing data from a large random sample of looked after children and young people in the UK. In minors aged five to 15 years living in residential care they found a rate of 71 per cent having at least one mental health issue, which was much higher than their national rate of ten per cent in aged-matched peers. The high rate of abnormal SDQ scores found in this study provided further evidence that these minors are at higher risk of mental illness. The abnormal SDQ scores in looked after children and young people, at 45 per cent, were higher than those found in the literature, where Marquis & Flynn, for example, found that 32 per cent of a sample of looked after children and young people had abnormal SDQ scores when compared to ten per cent of the general population. This supports the use of the SDQ as a standardised screening tool for looked after children and young people in helping to detect possible mental health concerns at an earlier stage (Marquis & Flynn, 2009). The high rates of mental health problems further reiterate the importance of having easily accessible mental health services for children and young people.

Data from this study shows that a significant number of children below five years were still residing in residential care in Malta. Since the completion of the study, the prevalence rate has decreased drastically, especially for those below three, who may be temporarily placed in a small residential setting awaiting a foster placement. Evidence shows that even in good high quality residential care, young children may still be at risk of a negative impact on their attachment and socio-behavioural development. Hence countries require stronger changes at policy level and better recruitment incentives for foster carers to ensure that children under the age of five are not placed in residential settings, in keeping with international recommendations (United Nations General Assembly, 2007).

Education

Looked after children and young people in Malta are nearly five times as likely to be statemented when compared to age matched peers, given that the national rate of minors in school who are formally statemented is eight per cent. This reflects a much higher prevalence rate of learning difficulties in this minority group, similar to other countries, such as the UK, where around 56 per cent of looked after children and young people had a special educational need when compared to 15 per cent of age matched peers (NICE, 2021). This reiterates the importance of ensuring that schools have behavioural management policies that reflect trauma-informed practices in order to improve educational outcomes. This includes practices that have been established in other countries, such as the

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designated teacher role for looked after children and young people who can advocate for minors' educational progress (NICE, 2021).

Trauma-informed practices

In view of the exposure to ACEs and the significant health findings reported in this study, particularly the high prevalence of emotional dysregulation, attachment difficulties and behavioural and learning problems, looked after children and young people need to be placed in therapeutic settings that provide safe, stable, stimulating, and nurturing environments. These environments provide settings that promote positive childhood experiences that counteract ACEs; environments where new skills, practices and positive relationships are made, and where caregivers recognise and understand the effects of trauma and work to avoid re-traumatisation. This requires services and professionals working with such minors to be trained in trauma-informed care, moving away from focussing on what is wrong with the minor who may appear to have an unwanted type of behaviour and instead empathically questioning what happened to the minor that is leading towards such behaviour (Sweeney et al., 2018). It is through understanding how these minors have been affected by their experience of trauma that professionals can adapt their practices in ways that better engage looked after children and young people, helping them feel understood, validated, and worthy, aiming towards boosting resilience, making more secure attachments and overcoming future adverse outcomes (Holden & Sellers, 2019).

Strengths

The strengths of this study include data drawn from the total population of minors in residential care in Malta with a one hundred per cent response rate. Furthermore, no measures were needed to address the effects of missing data, as data was complete. All data was collected by the same team which minimised bias.

Limitations and future studies

The information relating to the minors' social background, including risk factors and type of abuse they were exposed to, was dependent on what the lead key worker included in the standardised referral form. Although the total population of looked after children and young people residing in residential care was assessed, the numbers were still relatively small. It is difficult to ascertain whether the effects of Covid-19 directly contributed to certain health issues described in this study or whether they were mainly related to exposure to ACEs. Future studies could usefully consider the views of looked after children and young people themselves when it comes to their healthcare and the type of health service provision they would like to have.

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Conclusion

This population study of looked after children and young people in residential care provides further evidence as to the negative impact ACEs have on the physical, developmental, and mental health of such minors. This valuable information emphasises the need for policy changes and strong governmental commitments that ensure funding for therapeutic care settings, including training in trauma-informed care for all professionals and caregivers working with vulnerable minors, focussing on promoting resilience. The health needs identified also highlight the importance of investing in preventative work, including earlier intervention and better support for high-risk families, especially where ACEs have been identified. This may limit the health needs of these minors prior to entering alternative care and also be more cost effective in the long-term. This study highlights the fact that investing in specialised healthcare services for looked after children and young people is one way of improving health outcomes through earlier detection of health-related conditions that may otherwise be overlooked by universal services who cannot offer regular holistic assessments. Furthermore, having such services helps in creating pathways and collaborations with other entities involved in the minor's care. Incorporating health issues in the minor's care plan also ensures that outstanding health concerns are documented and more easily followed through. This study also reiterates the importance of countries adopting better structures to collate standardised health information about their population of looked after children and young people, in order to have stronger evidence to improve their local practice and policies relating to looked after children and young people. This study also sheds light on the impact of the Covid-19 pandemic in the health of minors residing in residential care.

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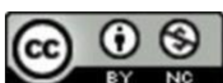

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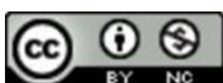

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Declarations

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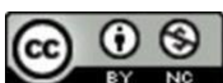

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Appendices

Table 1: Physical health problems identified in looked after children and young people

Medical Problems	Already Known		Newly Identified		Combined point prevalence	
Physical Health Related Problems	**Number of Children (Total Count)**	**Percentage (%)**	**Number of Children (Total Count)**	**Percentage (%)**	**Number of Children (Total Count)**	**Percentage (%)**
Dental Caries	8	4	64	32	72	36
Dental other	39	19,5	9	4,5	48	24
Ophthalmic: Visual acuity	70	35	20	10	90	45
Ophthalmic: Squint	8	4	5	2,5	13	6,5
Ophthalmic: others	4	2	0	0	4	2
Dermatological	17	8,5	66	33	83	41,5
ENT	14	7	39	19.5	53	26.5
Gastrointestinal: Constipation	7	3,5	9	4,5	16	8
Gastrointestinal: other	14	7	3	1.5	17	8.5
Musculoskeletal	20	10	12	6	32	16
Allergies	13	6,5	4	2	17	8.5
Infectious disease/ Need for infectious screen	1	0,5	16	8	17	8,5
Neurological	12	6	3	1,5	15	7,5
Urogenital/Renal	12	6	3	1.5	15	7.5
Respiratory	13	6,5	0	0	13	6,5
Genetic conditions/syndromes	8	4	2	1	10	5
Endocrine related (including Diabetes)	5	2,5	2	1	7	3,5
Cardiac	5	2,5	1	0,5	6	3
Gynaecological	2	1	2	1	4	2
Oncological	2	1	0	0	2	1
Other	5	2.5	11	5.5	16	8

Table 2: Developmental problems identified in looked after children aged under six years of age

Medical Problems	Already Known		Newly Identified		Combined point prevalence	
Developmental Problems (O – 5 years old)	**Number of Children (Total Count)**	**Percentage (%)**	**Number of Children (Total Count)**	**Percentage (%)**	**Number of Children (Total Count)**	**Percentage (%)**
Communication problem: Articulation difficulty	2	5.9	8	23.5	10	29.4
Communication problem: Speech delay	5	14.7	2	5.9	7	20.6
Fine motor delay including dyspraxia	1	2.9	1	2.9	2	5.9
Global development delay	2	5.9	0	0	2	5.9
Development other	0	0	1	2.9	1	2.9
Gross motor delay	0	0	0	0	0	0

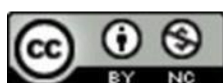

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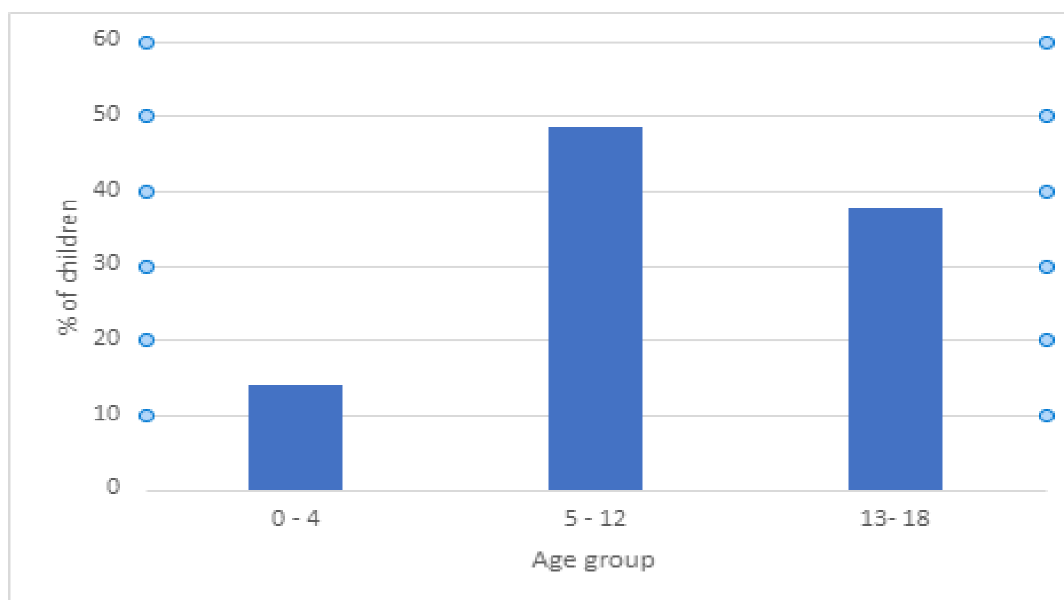
Table 3: Mental health problems identified in looked after children and young people

Medical Problems	Already Known		Newly Identified		Combined point prevalence	
Mental Health Problems	**Number of Children (Total Count)**	**Percentage (%)**	**Number of Children (Total Count)**	**Percentage (%)**	**Number of Children (Total Count)**	**Percentage (%)**
Emotional dysregulation	31	15,5	11	5,5	42	21
ADHD	33	16.5	7	3.5	40	20
Attachment disorder	8	4	29	14,5	37	18,5
Behavioral problems	31	15.5	5	2.5	36	18
Sleep disturbances	15	7,5	11	5,5	26	13
Anxiety	9	4,5	15	7.5	24	12
Learning Disability	20	10	0	0	20	10
ASD	9	4,5	4	2	13	6,5
Mood disorder	8	4	0	0	8	4
Depression	5	2,5	1	0,5	6	3
Mental Health Other	10	5	2	1	12	6

Figure 1: Looked after children and young people residing in residential care according to age group



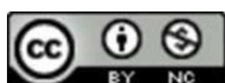


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Figure 2: Risk factors that Looked after children and young people in residential care were exposed to before entering alternative care

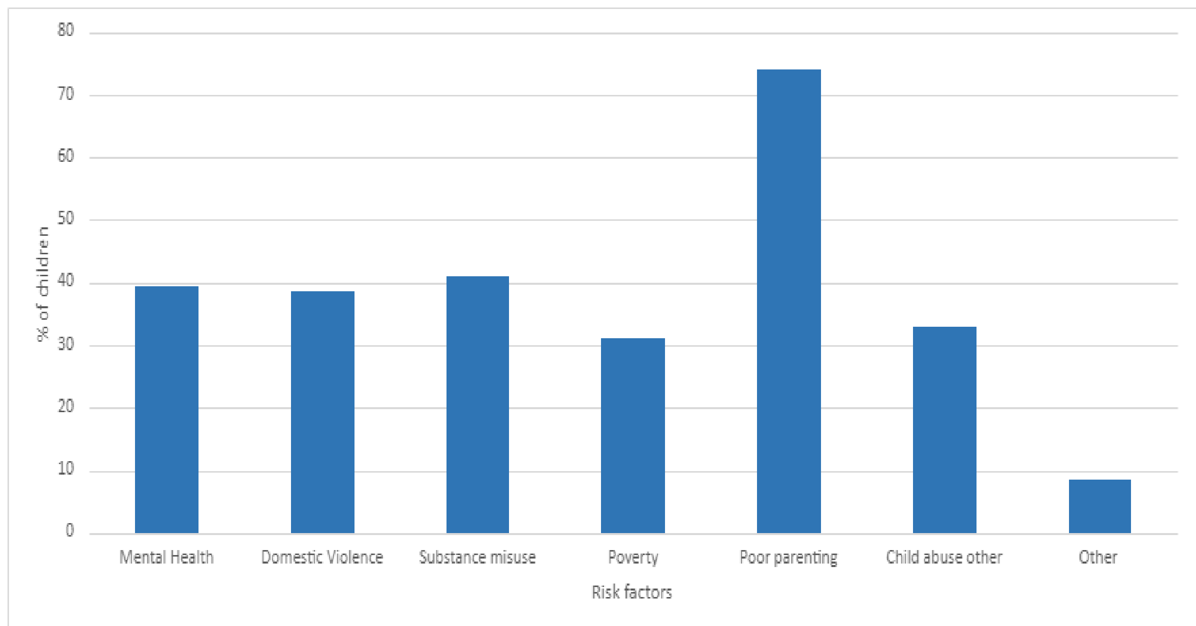
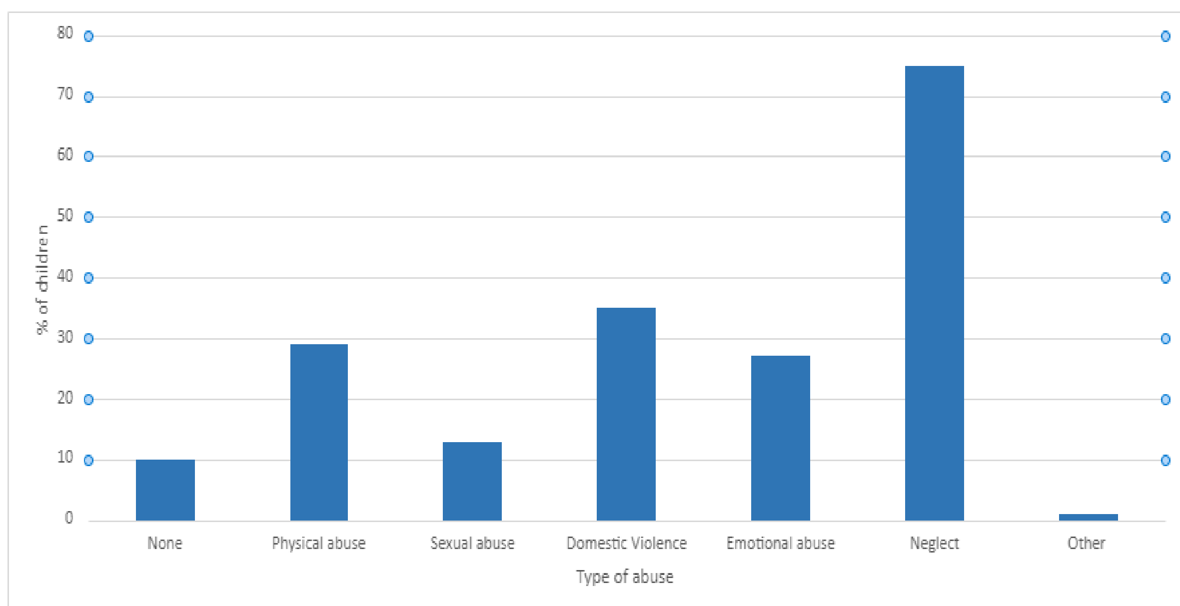


Figure 3: Type of child maltreatment that looked after children and young people in residential care were exposed to before entering alternative care



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Original Research Article

Attitudes to using outcome measures in children's services: A systematic review

Matilda Steele and Sarah Elgie
Keys Group

Abstract:

One in eight children in the UK experience a mental disorder, which increases when we look at looked after children's prevalence alone. Due to these climbing rates, the Improving Access to Psychological Therapies program was introduced, which involves the mandatory inclusion of routine outcome measures (ROMS) in England. However, this increased implementation of ROMs has often been met with uncertainty by professionals. Whilst research into attitudes regarding ROMs has already been conducted in children's services, no systematic review exists looking at this population's views regarding this form of monitoring. The current research sought to systematically review attitudes to using ROMs in children's services, and to specifically consider these findings in relation to looked after children, including those in residential care. Results showed that overall positive views were held regarding the use of ROMs by clinicians, families, and young people alike. However only three studies included children/adolescents as participants, with no studies considering looked after children, making it hard to decipher the true opinions of young people with regard to ROMS. Future directions include putting the child's beliefs more at the heart of ROMs research, engaging looked after children in research by actively asking for their thoughts on the use of ROMs, and making ROMs more accessible for all children.

Introduction

Childhood mental health problems are the main cause of disability in adolescents, severely limiting their development, educational success, and future quality of life (McEwan, Waddell & Barker, 2007), with this figure climbing substantially when we consider looked after children (McCann et al., 1996).

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Therefore, successful treatment and intervention is vital to ensure our young people are supported through the turbulence of childhood. Yet, therapy dropout amongst this age range is commonplace (Baruch, Gerber & Fearon, 1998; Luk et al., 2001; Warnick et al., 2012), and in some cases, therapeutic intervention can result in negative outcomes (Reese et al., 2014; Warren et al., 2010). Clinicians with clients who are subject to this deterioration often cannot see it themselves (Hannan et al., 2005; Hatfield et al., 2010), and in general often tend to be overly optimistic about the therapy's effectiveness (Walfish et al., 2012). Systematic and objective information surrounding a client's progress could therefore be of assistance to clinicians (Hamilton & Bickman, 2008).

One way to achieve this is via outcome monitoring. Monitoring outcomes is essential in order to objectively evaluate the effectiveness of clinical interventions and services, and it is fundamental to the UK government's NHS Outcomes Framework Policy (NHS, 2015). Routine Outcome Measures (ROMs), defined as the regular comprehensive evaluation of a client's functioning which is regarded as clinically important (Johnston & Gowers, 2005), are a crucial way this can be carried out regularly. An example of a ROM is the Revised Child Anxiety and Depression Scale (RCADS). This questionnaire includes six problem specific scales which are related on a 0-3 Likert Scale (Wolpert, Cheng & Deighton). The six scales correspond with DSM-IV dimensions of anxiety (Chorpita et al., 2000). The RCADS' aids diagnoses, monitors clinical change and distinguishes between anxiety and depression disorders, demonstrating its robust use in both clinical and research settings (e.g. Chorpita et al., 2000, 2005).

The benefit ROMs offer is three-fold: 1) they allow change to be monitored over a period of time and the drawing of conclusions between different sources of information i.e. the child, their parent, the clinician (Ford et al., 2006; Garralda, Yates & Higginson, 2000); 2) they allow for the service user to see fluctuation in their results over time, and provide them with an opportunity to voice their opinion of the care received (Batty et al., 2013); and 3) at a service level, outcome data can signpost areas in need of development and set out clear targets, as well as indicating where funding should be allocated (Garalda et al., 2000). The information ROMs provide can therefore greatly improve clinical work, advise service development, and inform users and other stakeholders (Outcomes Subgroup CAMHS EWG-NSF, 2003).

Despite sustained appeals by professionals over time (Marks, 1998; O'Leary, 1995), during a CAMHS service lead survey in 2005, ROMs were only reported to have been implemented in less than 30% of the 186 responding CAMHS providers (Johnston & Gowers, 2005). This highlighted a crucial gap in the service which helped to influence the creation of the Improving Access to Psychological Therapies (IAPT) programme, which was nationally introduced in 2008 (Faija et al., 2022). This UK systems-level approach aims to deliver psychological therapies underpinned by an evidence-based approach for those

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struggling with mental health difficulties. At its core, this involves the mandatory inclusion of ROMs (Law & Wolpert, 2014).

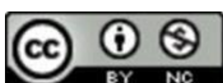
However, this increased implementation of ROMs has often been met with sustained uncertainty by professionals (Meehan et al., 2006; Unsworth, 2011). Clinicians' key concerns involve the practicalities of using ROMs (time issues and the added costs) and philosophical boundaries that prevent them from supporting the introduction of ROMs (privacy and mistrust of such measures) (Boswell et al., 2015). This professional resistance offers a key barrier to ROM implementation in the context of child and adolescent mental health (Johnston & Gowers, 2005). Indeed, Waldron, Loades and Rogers (2018) demonstrated that these implementation barriers fell under six main themes amongst CAMHS clinicians: (1) Poor support surrounding ROM data input and sharing; (2) ROMs not being sensitive enough to measure the therapeutic process, systemic changes, or the ability to 'reflect/mentalise/regulate'; (3) Taking up time when session time is already limited; (4) Use of ROMs is not always appropriate (e.g. during crisis); (5) Concerns regarding misuse of data; (6) Perceived to be a 'top-down directive'.

Whilst research into attitudes regarding ROMs, both in terms of barriers and facilitators, has already been conducted in children's services (Hall et al., 2013; Johnston & Gowers, 2005), to date, no systematic review exists looking at professionals' working in children services, young people accessing children services or their families' views regarding this form of monitoring. This is imperative due to ROMs now often being conducted as part of routine clinical practice. This systematic review aims to compile the current literature that exists regarding attitudes towards ROMs in children's services, to consider the implications of these findings, and then to focus on what existing research tells about ROMS use within the looked after children population.

Method

Search strategy

Prior to conducting the systematic literature review, Google Scholar was used to screen existing research. This initial search aimed to (1) source any existing reviews of the current literature, and (2) ascertain appropriate search terms for the goals of this study. From the initial search, various existing reviews were found in the field of ROMs, with one study in particular concentrating on compiling service users' views on ROMs (Solstad, Castonguay & Moltu, 2019). However, as this study only looked at service users views (and not that of clinicians), and included both adult service users and adolescent/child service users, this created a noticeable difference from our review. From reading the existing reviews, the search terms depicted in Table 1 were identified. To allow



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for variation in the terminology used, the search terms were truncated and then combined with Boolean operators 'AND' and 'OR'.

Table 1: Search terms used in systematic review

	Routine outcome measure* or outcome monitoring or ROMS or PROMS
	attitudes or perceptions or opinions or thoughts or feelings or beliefs
AND	"children" [MeSH Terms] or child* or kids
AND	"young people" [MeSH Terms] or adolescents or teenagers

The literature search was then conducted using EBSCOhost (selecting the following databases: Medline, Child Development and Adolescent studies, and Psychology and Behavioural Sciences collection) and Web of Science, which allowed for a simultaneous search through numerous databases. A total of 310 articles were found, with a further five being sourced through Google Scholar and reference list searching. From the 310 articles sourced, 283 records did not meet the inclusion/exclusion criteria detailed in Table 2 and were therefore excluded.

A total of 27 outputs remained, of which the full text was screened and further assessed against the eligibility criteria. From this, a further 13 outputs were excluded for not meeting the inclusion criteria. As such, a total of 14 outputs detailing the views of ROMs met the inclusion criteria and were subsequently used in this review. Details of these 14 outputs can be found in Figure 1.

Table 2: Search terms used in systematic review

Inclusion Criteria	**Exclusion Criteria**
Written in English	Looks at attitudes to adult completed ROMs
Looks at ROMS in children's services	No consideration of attitudes or beliefs
Looks at attitudes to ROMS	Looks at ROMS in physical health settings
Looks at ROMS for mental health outcomes	Literature reviews/commentaries on ROMs
Outpatient services	Parental outcome monitoring

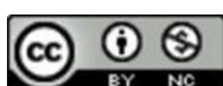

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Figure 1: Prisma diagram depicting the selection process of this study

Identification of studies via databases and registers

Identification

Records identified through database searching

EBSCOhost (n=160)
Web of Science (n=150)

Records identified through other sources

Reference list searching (n= 5)

Screening

Abstracts screened (n=315)

Eligibility

Reports sought for retrieval (n=27)

Records excluded, including duplicates (n= 283)

Reports assessed for eligibility (n=27)

Reports excluded (n= 13)

Included

Studies included in review (n= 14)

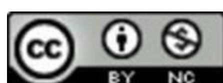

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Table 3: Characteristics of studies included in this review

Paper	Participants	Research question, methodology	Summary of findings
Batty et al. (2013). UK	127 CAMHS practitioners	Aimed to assess the existing use of ROMs using 3 data collection methods: (1) audit of service user records, (2) web-based survey and (3) stakeholder workshops.	94% cent of participants regarded the use of ROMS as 'important' or 'very important'. Participants noted the usefulness of ROMS in recording service users' progress. However, they cited limitations including low return rates, limited clinical utility, lack of training and administration support, and ROMS were frequently regarded as a 'paper exercise' which took time away from direct work.
Norman et al. (2014). UK	50 CAHMS practitioners	Aimed to explore practitioners' initial views of ROMs using semi-structured interviews.	Participants identified a large number of issues regarding using ROMs, including finding them depersonalising and under-representative, and highlighted ethical concerns and implementations issues. However, overall practitioners saw more ROMS as having more advantages than disadvantages, citing ROMS as being validating and helping to predict goals.
Bear et al. (2022). UK	184 CAMHS practitioners	Gained practitioners' attitudes and practices to ROMs using a 42-item online survey.	Participants who frequently used ROMS reported more positive attitudes towards them, citing them as helpful in planning support, encouraging shared decision making, and higher return rates. However, just under half of participants who frequently used ROMS felt they were too time consuming, in contrast to three quarters of non-frequent users.
Stasiak, et al. (2013). New Zealand	21 family members and 34 young people who had accessed mental health services	Gathered attitudes of service users through semi-structured focus groups.	Participants reported ROMS as helping to identify the presenting difficulty and as effective in tracking progress but noted limitations, in that they failed to consider daily changes in mental health, had restrictive questions and caution was needed to ensure they did not seek to label the child. Young people also highlighted that they wanted more collaboration over which measures to use and how feedback was given and raised concerns over privacy and confidentiality. Young people also shared the need to feel able to trust the clinician.

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Waldron, Loades & Rogers (2018). UK	20 CAMHS clinicians at time 1, and 19 clinicians re-participated at time 2	Aimed to gather clinician experiences of using ROM pre- and post- a ROM implementation initiative.	No significant change in participants' attitudes towards ROMs at time 1 vs time 2. Participants consistently reported ROMS were helpful if used meaningfully and encouraged discussion between clinician and young person. However, concerns were raised regarding additional workload demands and how ROMS fit with complex cases.
Edbrooke-Childs et al. (2017). UK	109 CAMHS practitioners	Aimed to look at the association between use of ROMS and clinician demographics, attitudes, and efficacy, using an online survey and a structured questionnaire.	No significant change in ROM attitudes between clinicians who received training vs those who did not. However, PROM use and PROM *self-efficacy* were higher for clinicians who had training.
Wolpert, Curtis-Tyler & Edbrooke-Childs (2016). UK	Four CAMHS clinicians and six adolescents accessing CAMHS	Aimed to explore the attitudes of adolescents, parents, and clinicians from a specialist CAMHS for young people with diabetes using semi-structured interviews.	Participants reported ROMS enabled them to tailor care more closely to individual need, empowered service users and promoted 'better, quicker outcomes'. However, clinicians and service users alike reported ROMs had the potential to negatively impact the patient-clinician relationship, and young people raised concerns regarding how their answers would reflect on their clinician's practice.
James et al. (2015). UK	Study 1: 12 CAMHS practitioners Study 2: 59 CAMHS professionals	Aimed to explore clinicians' views and use of ROMs. Study 1: Focus groups.	Study 1: Positives: systematic and accurate view of service users' experience, provides focus, collaborative process, client autonomy, demonstrates progress, tool for engagement, useful (if quick and easy).

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		Study 2: Themes observed in study 1 were used to develop a questionnaire regarding professionals' experience and views of ROMs.	Negatives: concerns surrounding how information used, influences focus of therapeutic sessions, extra work, time-consuming, negatively impacts therapeutic relationship. Positives: collaboration is empowering for young people, visual progression, motivation, focus therapeutic work. Negatives/speculation: 'paper exercise', demoralising, eats into time spent talking about young person's difficulties. Study 2: Regardless of whether clinicians used session-by-session monitoring or not, they were more in agreement with positive than negative beliefs regarding ROMs. Participants who used session-by-session monitoring were in stronger agreement with both positive and negative beliefs regarding ROMs.
Moran et al. (2012). UK	22 parents/carers of CAMHS users[2]	Aimed to gather service users' attitudes towards ROMs[3] using focus groups.	Participants were in support of the use of ROMS. However, they raised six general issues: (1) difficulties identifying what a good outcome is, (2) identifying the cause of change, (3) needing several measures, (4) alternatives for assessing outcomes (something to supplement the 'tick-box' approach), (5) ROMS reliability and validity, and (6) needing help to complete ROMs.
Sharples et al. (2017). UK	Nine CAMHS practitioners	Aimed to explore clinician attitudes to ROMS and, in particular, the facilitators and barriers to implementing outcome measures.	Participants reported that ROMS encourage evidence-based practice, can validate service users' difficulties, and provide useful information to commissioners, but concerns were raised regarding their potential to impact the therapeutic relationship and whether a 'one-size-fits-all approach' was helpful. Participants also noted implications in discussing lack of change/deterioration and time taken to complete ROMS within sessions. Participants also shared that successful implementation of

[2] Originally tried to include adolescents and gather their views, but responses were so limited they had to exclude this data
[3] Focuses on specific measures. This systematic review is only looking at overall outcome measures therefore not including specific feedback from each outcome measure instead key themes that were noted by participants

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		Used semi-structured interviews.	ROMS relies on training for clinicians and adequate data systems/administration support.
Hall et al. (2014). UK	Ten clinicians, eight administrative staff and 15 families from CAMHS clinics	Aimed to explore participants' perceptions of feasibility and acceptability of ROMs using semi-structured interviews.	Participants reported ROMS assisted clinical judgement, service users seeing a visual change helped highlight improvements, helped engage the service user in the sessions and useful to track progress. Clinicians and service-users identified that ROMs were best completed outside of the session and noted ROMs cannot encapsulate all the information about a young person and were not suitable for all, for example, young children.
Sundet (2014). Norway	15 parents and 11 children from intensive family therapy unit	Aimed to explore families' views on ROMs, using semi-structured interviews.	Participants reported lots of positives including ROMS helping service users express their views, helps prioritise goals and facilitate progress tracking. Participants also highlighted they preferred verbal feedback over scales.
Fullerton et al. (2018). UK	41 child mental health clinicians who were UPROMISES[4] training attendees	Aimed to assess the impact of training on using PROMs in clinical practice. Mixed-methods, observational design.	After UPROMISES training, supervisors' positive attitudes and self-efficacy related to using PROMs increased.

[4] Using PROMs to Improve Service Effectiveness for Supervisors

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Edbrooke-Childs, Wolper & Deighton (2016). UK	Child mental health clinicians who were UPROMISES attendees Sample 1: 28 clinicians Sample 2: 12 clinicians	Aimed to assess the impact of training on positive attitudes and self-efficacy in regards PROMs using a structured questionnaire.	Participants held more positive attitudes and higher levels of self-efficacy regarding administering PROMs and using feedback from PROMs after training. Clinicians who attended the three-day training vs those who attended the one-day training had greater increases in PROM self-efficacy.

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Results

Descriptive summary of studies

Table 3 outlines the characteristics of the papers included in this review. One paper included data from both a mental health service and a diabetes service, but in line with the purpose and inclusion criteria only the data from the metal health service was included.

The literature search yielded 14 studies from three countries: 12 from the UK, one from Norway and one from New Zealand. The studies were published from 2012 to 2022 by Bear et al. (2022) and Moran et al. (2012) respectively. Overall, most studies focused on professional perspectives/parent views, but four out of the 14 papers included the views of young people and children (Hall et al., 2014; Stasiak et al., 2013; Sundet, 2014; Wolpert et al., 2016). It should be noted however, that Moran et al. (2012) originally tried to include adolescents' views of ROMs but responses were so limited they had to exclude this data. Additionally, three of the 14 studies also investigated the impact of pre- and post-ROMs training on clinicians' attitudes to using ROMs (Edbrooke-Childs et al., 2016; Fullerton et al., 2018; Waldron et al., 2018)

Evaluation of quality

To evaluate the quality of the papers included in this review, the quality criteria was adapted from Solstad, Castonguay and Moltu (2019). In this way, the criteria were based on how well the studies were able to describe the children/adolescents', families' or professionals' experiences of ROM. Like Solstad et al. (2019), we recognise that this may not have been the studies' objective, and stress that these evaluations are not evaluations of the papers beyond the purpose of our aims. The criteria were as follows: transparency and rigour (are all parts of the research process described and presented in a clear and precise manner?), appropriateness of methods (specifically for our study purposes, are service users'/clinicians' attitudes/views outlined?) , validity checks, reflexivity (context, analysis of results, generalisability, limitations, and implications), and usefulness (provide detailed information of service users'/clinicians' views of ROMs, results provide contribution to clinical practice). Results of the papers' quality evaluations are presented in Table 4.

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Table 4: Quality evaluation of studies

Paper	Transparency and rigour	Appropriateness of methods	Validity checks	Reflexivity	Usefulness
Batty et al. (2013)	High	High	Notes collected/summarised by independent researcher. Themes from both data sets were compared to make sure consistency was achieved across the whole data set. This also ensured initial findings from the online survey could be confirmed.	High	High
Norman et al. (2014)	High	High	Transcribed interviews. ROM questions were coded using an open coding system. Coding scheme then independently coded and assessed by a second researcher.	High	High
Bear et al. (2022)	High	Some	Developed items using the COM-B Model. Took data from five child and adolescent mental health sites. Used the full information maximum likelihood procedure (FIML) to account for the presence of missing data. The sample size to variable ratio was 1–8, which exceeds sample size recommendations.	Acceptable	Some
Stasia et al. (2013)	High	High	Independent analyses, group discussion, participant feedback.	Some	High
Waldron et al. (2018)	High	High	Used James et al.'s (2015) 12 item survey which they reported to have a Cronbach's alpha of .89 for the negative subscale and .91 for the positive subscale, suggesting good internal consistency.	High	High
Edbrooke-Childs et al. (2017)	High	Low	None	Some	Some

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Wolpert et al. (2016)	High	High	Interviews audio-recorded and transcribed verbatim.	High	High
James et al. (2015)	High	??	Study 1: groups were audio-recorded and transcribed. Transcribed data was individually reviewed by four researchers. Study 2: questionnaire items developed from themes identified from study 1 were reviewed by all clinicians separately. The 24 items, had a high internal consistency (Cronbach's α = 0.938).	High	High
Moran et al. (2012)	High	Acceptable	Independent coding of one transcript.	Some	Some
Sharples et al. (2017)	High	High	At Phase 4 a section of the data was checked by the interviewer to ensure consistency in coding.	High	High
Hall et al. (2014)	High	High	Independent coding.	Some	High
Sundet (2014)	High	High	Participant feedback.	High	High
Fullerton et al. (2018)	High	Some	Video-recorded supervision sessions after training. This was used for accreditation of/ triangulating the questionnaire and interview data. Used the 23-item Routine Outcome Assessment which has been demonstrated to have reliability.	High	Some
Edbrooke-Childs et al. (2016)	High	Some	Used the 23-item Routine Outcome Assessment which has been demonstrated to have reliability.	Some	Some

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Discussion

This systematic review aimed to gather professionals', families' and child service users' views and attitudes of ROMs. A total of 14 studies met the specified inclusion and exclusion criteria for the review, and they all highlighted ways in which psychological therapies can be helped and hindered through the use of ROMs in specialist children's mental health services. In general, the papers included highlighted that the attitudes of participants were mainly positive. However, a reoccurring theme was suspicion as to the usefulness of ROMs and the ability of this method to encapsulate the complex lives and needs of service users in order for them to access the correct care. Concerns regarding a 'one-size fits all' approach, and ROMs simply being used as a 'paper exercise', are not new and have been well documented across all mental health services in regard to service users (Beresford & Branfield, 2006; Crawford et al., 2011; Gordon et al., 2004; Graham et al., 2001) and clinicians (Stedman et al., 2000; Unsworth, 2011).

Three of the studies investigated the impact of pre- and post-ROMs training on clinicians' attitudes, which provides an insight into whether the negative attitudes regarding ROMs can be explained via lack of understanding/education and be modified and become increasingly positive through focused training. The studies reported an increase in positive attitudes and self-efficacy following training when compared to pre-training (Edbrooke-Childs et al., 2016; Fullerton et al., 2018). This is encouraging and illustrates that clinicians and health care staff in general should have the opportunity to access targeted ROMS training, to get the most out of ROMs and to ensure they engage with the process. However, one paper noted no changes in attitudes, but despite this, clinicians found ROMS were helpful if used meaningfully, and noted that they encouraged discussion between the clinician and young person (Waldron et al., 2018). It would appear reasonable to assume that this finding should help inform how ROMs are introduced within looked after children's services and should serve as a reminder that when residential care settings use measures to assess and track children's progress, all staff who are involved in the monitoring need robust training on how to use the measures. This is especially pertinent as whilst many practitioners working within CAMHS settings are likely to have exposure to using measures within their professional training, we should not assume healthcare workers within residential children's homes will have any prior knowledge around measures and their application, even though they will often be involved in completing and administrating measures.

The strengths highlighted by Waldron et al. (2018) were mirrored by the majority of the other papers included in this review, with a common advantage in these papers citing that ROMs allow for: (1) the ability to monitor change, and (2) to tailor care and encourage collaborative care.

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The research also highlighted a concern that collecting ROMs is time consuming for the clinician, and adequate administrative support is needed to allow for their successful implementation and use. Low return rates were also cited as a noticeable issue in services, although interestingly, the return rates were noted to be higher the more the practitioner used ROMS. It is not clear if this indicated that greater enthusiasm, belief and commitment to using ROMs is associated with a better return rate, and further research could be helpful to consider why return rates improve with increased practitioner use.

The systematic literature review also highlights that services need to allocate adequate administrative support to enable practitioners to effectively use and embed ROMs in their practice, and if ROMs are going to be used meaningfully within a service, adequate resources are needed. Future research could further explore what administrative support clinicians find most useful, and whether there is a need to develop IT infrastructure around all ROMs to allow for quick data input and analysis. The administration demand is relevant to all children's services, but research has specifically highlighted that a high administrative workload within residential children's homes can be a barrier to carers successfully managing challenging behaviour (Abraham et al., 2021)

What is disappointing from the literature review is that no studies involved looked after children's services specifically, and only four sought the views of children accessing mental health services. The majority of the studies focus on the beliefs and attitudes of clinicians and parents rather than of the young people themselves. This suggests that future research should seek to address this and put the child's beliefs more at the heart of ROMs research, and that research is needed to specifically address the looked after children population, including those living in residential care.

Strikingly, the studies which included the views of adolescents and children saw that the potential to collaborate in their care was considered empowering (Wolpert et al., 2016) and young people wanted more autonomy in the choice of measures and how feedback was given (Stasiak et al., 2013). This highlights a key strength in the use of ROMs, especially in children's services, which is their ability to give children a voice. This is in line with Article 12 of the Convention on the Rights of the Child (1989), which stipulates that children have the right to have their opinions accounted for when adults are making decisions affecting them.

Accordingly, ROMs should be applied in a flexible, transparent, and non-hierarchical manner (Boswell et al., 2015). Service users in children's services should be consulted during the construction and modification of ROMs, and work collaboratively with clinicians in a 'shared decision-making context' (Wolpert et al., 2016). Indeed, consulting with children and adolescents, and gaining their opinions in contexts in which they are affected, promotes belonging (Baumeister and Leary, 1995) and increases wellbeing (Riley, 2019). This review clearly highlights that, when measures are used to give children a voice, ROMs foster

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collaboration and allow for a concentration of person-centred care. ROMs enable service users in children's services to be involved in defining their own outcomes, and also promotes engagement in the treatment planning process. This view is supported by studies investigating ROMs in general mental health settings, as long as it was used within the context of a trusting clinical relationship (Black et al.,2009; Callaly & Hallebone, 2001; Happell, 2008; Perry et al., 2013). Trusting clinicians was a key theme in the implementation and completion of ROMS, as highlighted by Stasiak et al.'s (2013) adolescent participants. It seems clear that the implementation of ROM should be based on, and optimally foster, a positive therapeutic relationship.

This issue of trust being a potential barrier for children engaging with ROMS is particularly relevant to the looked after children population, as children in care significantly struggle with issues of mistrust (Furnivall, 2011; Hepp et al., 2021). However, we know that looked after children have a greater likelihood of having experienced adverse circumstances (Meltzer et al., 2003; Simkiss, 2019), and as a result have increased vulnerability to poorer life outcomes such as unemployment and links to the criminal justice system (Jones et al., 2011). There is substantive evidence that the use of ROMs, particularly within this population, allows for early detection of socio-emotional difficulties (Jee et al., 2011), diagnosis of hyperkinetic disorder (Foreman and Ford, 2008), and identification of risk and protective factors for mental health issues (Aguilar-Vafaie et al., 2011; Richards et al., 2006). Therefore, it is paramount that this group receives regular monitoring via ROMS, as delays in identifying and meeting their emotional wellbeing and mental health needs impacts all aspects of their lives, and decreases their future potential (McAuley & Davis, 2009). Additionally, the use of ROMs during intervention programmes has enabled the potential for better care practice. Golding and Picken (2004) studied the use of receiving support and psychoeducation for foster carers over 18 months. Their results indicated a reduction in total difficulties on the Strengths and Difficulties Questionnaire, carer-rated peer difficulties and hyperactivity, supporting the use of foster carer group interventions to promote better care for looked after children.

Furthermore, gaining looked after children's views in terms of their wellbeing and the care they are receiving is vital in order to empower them. Adults need to provide looked after children with more opportunities to have their say and their voices heard (Dixon, Ward & Blower, 2019) as they are the 'experts' on their own experiences (Alderson et al., 2019). It is important that future research seeks to engage looked after children in research, actively asks for their thoughts on the use of ROMs, and addresses the barrier of mistrust in terms of successful engagement of service users. Looked after children are most likely to be able to help us understand how to increase trust in the ROMs process, and this could include absolute transparency over how the 'data' collected will be used, with information being presented as to why the child's voice is being sought, and why this matters.

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A key limitation of the studies included in this review is that they do not describe enough demographic details of participants. With the exception of Staisiak et al. (2013), who selected four locations in New Zealand to include urban and rural locations and ensured input from Māori people. The remaining reviews do not appear to make efforts to strive for a diverse participant pool. Additionally, participants in all studies were categorised as male and female participants, representing a lack of inclusivity for non-binary people. This finding made us look closer into the measures routinely used for monitoring outcomes. Many measures, including the Strengths and Difficulties Questionnaire (Goodman, 2001) and the Assessment Checklist for Children (Tarren-Sweeney, 2007) and Adolescents (Tarren-Sweeney, 2013) are not inclusive of gender identity. How do parents or carers completing measures that ask questions about 'males' or 'females' respond when the child is non-binary, and what unconscious biases does this create? Furthermore, if we use measures that do not allow for non-binary children, how does this invalidate this population?

An interesting finding of the research reviewed is that young people prefer ROMs to be visually engaging. Future research needs to explore further how to increase accessibility for all children accessing mental health services but, given the vulnerability of the looked after children population, it is essential that ROMs are particularly accessible to this client group, and ways to present and feedback ROMs needs consideration. The Outcome Star (**Triangle Consulting Social Enterprise, 2013**) and Well-being Web (Angus Council, 2012) are two measures that are designed to capture the voices of looked after children and seek to be visually engaging, but research needs to seek feedback from children and young people as to whether these measures are perceived to be user-friendly and meaningful. Could future research ask children within looked after children's services to design and develop their own measures, based on what is important to them, or helps them evaluate existing tools? This is consistent with the comments from Porter, Mitchell and Giraldi (2020, p.5) who stated,

> There remain significant gaps in the research literature around outcomes […] the clearest of these is the lack of research looking specifically at the experiences of children and young people within, or with experience of, residential facilities. In particular, studies which allow the young people themselves to highlight the outcomes that they feel residential care has provided for them, and the components of care which they felt facilitated, or inhibited, positive outcomes.

Where efforts have been made to seek the views of children accessing looked after children's services, their perspectives have been insightful. For example, when vulnerable children, including looked after children, were listened to about their healthcare, they identified the importance of improved planning and resources, as well as age-appropriate facilities and good communication (Curtis et al., 2004). Likewise, in a review of mental health and looked after children, children provided meaningful comments about treatment and service

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provision (Davies and Wright, 2008). Similarly, looked after children have reflected on their experiences of social care. In early work in the West, adolescents in care articulated they want to be involved in decisions but felt this was rarely an option (Cashmore, 2002); yet they emphasised their desire to exercise choice and control when seeking support (Stanley, 2007). Failure to listen can leave them feeling helpless and impact on their confidence as they realise the lack of decision-making opportunities available (Leeson, 2007). Future research should ask children about their experience of ROMs, including what it looks and feels like to have ROMs collected about you. Special consideration should be paid to what types they have been subject to, how often they are required to engage in ROMs, awareness of why ROMs are being collected regarding them, and how these outcomes are fed back.

In conclusion, it is apparent from this literature review that despite concerns regarding their inappropriate use, in general attitudes to using ROMs in children’s services are favourable. It is therefore surprising they are not more widely used by settings or services, particularly in residential childcare. However, this review does more in terms of highlighting that children and adolescents are not being involved in research that directly affects them. Future research needs to address this, with particular emphasis on including marginalised groups such as the looked after children population. It is important to note that there could be additional papers investigating the attitudes of children and adolescents regarding the use of ROMS outside of this review, that did not fit within the inclusion/exclusion criteria employed. Despite this, it is clear from the current review that there still needs to be a shift in research in terms of including this age group when investigating something that directly affects them.

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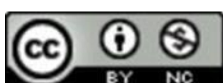

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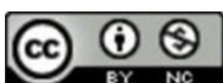

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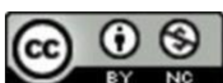

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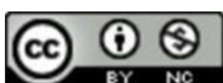

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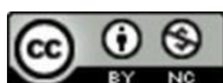

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About the authors

Matilda Steele, assistant psychologist, and Dr Sarah Elgie, clinical psychologist, work for a large provider of children’s residential care. They are passionate about improving the outcomes for children in residential homes and in particular ensure looked after children get a voice.

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Original Research Article

Overcoming the odds: Demonstrating an aftercare model of providing targeted support to care experienced youth

Kiran Modi and Gurneet Kaur Kalra
Udayan Care

Abstract:

Aftercare is a vital continuum of care process, crucial for care experienced youths to fully realise their true potential and thereby become resilient members of society. In India, according to the Juvenile Justice (Care and Protection of Children) Act, 2015, institutional care should be seen as a 'last resort'; yet there are large numbers of children living in childcare institutions (CCIs) due to the absence of robust family-based care models (Beyond 18, 2019). This paper highlights targeted interventions with CLs at various levels, through Aftercare Outreach Programmes (AOP), based on their needs assessment through a tool developed and implemented by Udayan Care. It presents the interventions applied in providing transition and rehabilitation support to Care Leavers (CLs) under several domains of the Sphere of Aftercare (Beyond 18). This support is provided holistically through skills: training and development – workshops, mentoring; education/vocational training: information, access, financial support; experience – internships, apprenticeships, placements; and bringing them together on a common platform, such as the care leavers network. As this programme, AOP, aims to mentor and guide these CLs through a smooth and supportive transition period, similar interventions during and post transition can be designed and applied to other CLs across the globe in different settings.

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Introduction

Researchers globally have characterised the transition of care experienced youths to independent living as challenging and complex. The overall goal of becoming independent young adults (Bond & van Breda, 2018) can lead to youth facing trouble, including difficulties securing employment and stable housing, homelessness, poor outcomes with regards to education, higher vulnerability to suffering mental wellbeing issues, and substance use (Sulimani-Aidan & Melkman, 2018; van Breda & Dickens, 2017). However, while nations are legally required to support and provide alternative care, thereby addressing the needs of children until they are 18 years old, this support is usually not applicable during their transition to adulthood and when they exit the care system (Stein & Ward, 2021).

Experiences that enhance resilience and positive self-concept lead to successful trajectories and outcomes for care experienced youths transitioning to adulthood, as reported by several researchers highlighting these pathways (Bengtson et al., 2020; Lou et al., 2018; van Breda & Dickens, 2017). Hence, support during transition is one of the most vital and challenging aspects to be considered and provided with respect to ensuring the successful transition of care experienced youth into independent living (Harder et al., 2020).

Adequate preparation is essential for these youths prior to leaving care, providing early opportunities for them to gradually develop independent living skills (Armstrong-Heimsoth et al., 2020; Mendes et al., 2011). Without any goal setting and readiness, they fail to meet their goals and aspirations, and even struggle to earn a livelihood. Low confidence, traumatic past experiences, lack of adequate education, lack of skills, psychological issues, and lack of exposure to the outside world are factors that make them vulnerable, and as an integral part of this society their rights and opportunities should not be overlooked. This transition from living in a protective care facility to independent living often brings a myriad of difficulties, due to marginal community integration, the absence of a pivotal family-like ecosystem, and limited ownership of essential resources within the care setting. Ensuring adequate support for care experienced youths to support them to become independent and resilient and to not fall back onto previous vulnerabilities, is crucial and may be achieved through aftercare. Aftercare is an integral part of the child care provided to children who do not have their biological families to take care of them. The vulnerabilities of youth transitioning from alternative care persist even after they enter this new phase of life, in the absence of support from their birth families. Multiple placements, ruptured education, a lack of secure attachments, lack of training in independent living skills, and poor access to mental health services, all make independent living more challenging for them. The last few years have seen increased interest in developing transitional support services for young people in care to improve their life skills (Woodgate et al., 2017). There is evidence that participating in independent living programmes has some positive

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effects on post-transition outcomes for care experienced youths (Heerde et al., 2018).

India is confronted with the concerning reality of more than 23.6 million children who lack parental care (MOSPI, 2018). The country is home to over 370,000 children residing in approximately 9,598 child care institutions (CCIs), with 8,744 of these care homes being operated by non-governmental organisations (NGOs) (MOSPI, 2018). To address the challenges associated with children who lack parental care, laws have been enacted to establish various alternative care options. These alternatives encompass community-based or family-based care, as well as residential or institutional care. Institutional care, ideally considered as the last resort for children when all other alternatives have been exhausted, has emerged as the primary mode of formal care provided by the state in many developing countries in Asia (Modi et al., 2016; SAIEVAC, 2011).

In India, according to Section 2.5 of the Juvenile Justice (Care and Protection of Children) Act 2015, aftercare support is provided to people in the age group of 18 to 21 years, extending up to 2 more years, who 'have left any institutional care to join the mainstream of the society'. There is also a provision for community group housing on a temporary basis for groups of six to eight persons, scholarships and stipends for vocational training or higher education, support until a youth finds employment, placement in commercial establishments through coordination with central or state government programmes and corporations, arrangements for skills training, etc., the provision of a counsellor to stay in regular contact with such persons to discuss their rehabilitation plans, the arrangement of loans and subsidies for persons in aftercare who aspire to set up entrepreneurial activities, and encouragement to sustain themselves without state or institutional support, and the provision of creative outlets to channel their energy and to tide them over during crisis periods in their lives (JJ Act, 2015). Youth from CCIs are mandated to receive aftercare support (both financial and non-financial), but largely these youth are left on their own. Unfortunately, the number of youth annually leaving child care institutions in India is not even estimated nor adequately budgeted, despite aftercare planning being a global issue. There is a certain amount budgeted for each district in India, depending on its size, as per the law.

Following the recommendations of the 'Beyond 18' study, there has been a remarkable development in terms of provisions for schemes, policies, and on the ground practices required for aftercare support of CLs. The term 'alternative care' was used for the first time in a policy document by the government of India, in Mission Vatsalya (2022), which also mentions transition planning and preparation in the course of transition planning for children from 16 years of age within care homes - on housing, employable skills, education, loan support, and industry apprenticeship. Subsequently, in 2022, Mission Vatsalya introduced the concept of Individualised Aftercare Plans (IAP) for the first time, marking a significant milestone. This was accompanied by an increased allocation of

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financial support in various Indian states through the integration of existing welfare schemes. Furthermore, the introduction of state-level guidelines and the establishment of Care Leavers' Networks (CLN) in multiple states have played a pivotal role. Currently, there exist nine 'Care Leavers' Network' groups across India, collectively giving rise to the formation of the 'National Care Leavers' Network' (Kalra & Prasad, 2022). The realm of aftercare has undergone substantial progress, as evidenced in the inception and enforcement of new provisions. This evolution prompted the necessity of assessing the evolving trends in different aftercare domains, particularly through the lens of the Beyond 18 study.

Need for intervention

In order to address care experienced youths' concerns interventions are required at various levels, recognising the crises and trauma they experience. The experiences and voices of these care experienced youths must be at the heart of recovery planning (Gofen et al., 2021). Care experienced youths lack social support networks; therefore, preparation for care leaving and transitioning into adulthood should make them more self-confident, and resilient enough to face challenges in the outside world. Interventions are required both at the immediate level to address short-term challenges, and at the long-term level to ensure they are independent and self-reliant, along with addressing their mental health challenges. The poor employment outcomes for care experienced youths compound the socio-economic inequalities that most care experienced youths are likely to have experienced prior to their care history, as well as reflecting the impact of both placement and education instabilities (Berridge, 2016; Children's Commissioner, 2019; Coy, 2009; Driscoll, 2013).

Both policies and on the ground practices in India are unable to address the needs and challenges of children in care. They lack the systemic and systematic processes required to support care experienced youths through their transition into independent living. Data on youth aftercare is lacking with no tracking mechanisms to track their progress. Lack of systematic research on aftercare services and their efficacy leads to a lack of monitoring and evaluation of these youth. The reduced capacities of families to care for their children during their transition from child care institutions is a result of increased poverty and the loss of livelihoods, due to which they face loss of education, accommodation and unemployment.

Udayan Care's Aftercare Outreach Programme (AOP)

Udayan Care, a Delhi-based NGO, has been supporting youth exiting from its residential care homes for children in need of care and protection, through its aftercare programme for several years. Here, youth are provided with financial and non-financial support in multiple domains – such as healthcare, accommodation, and education — through specific individual care plans. In the year 2020, when the world was dealing with the pandemic crisis, discovering a

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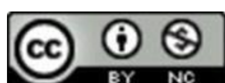
gap in services provided to youth exiting care from many institutions, Udayan Care designed and started an Aftercare Outreach Program (AOP) to support the care experienced youths who were exiting various child care institutions, and missing out on aftercare support. The 'Sphere of Aftercare', a theoretical framework (Figure 1) developed from a research study on aftercare called 'Beyond 18' (2019), became the basis for AOP. This framework outlines the eight domains of support required by care experienced youths during and after transition: housing; education and vocational skills; physical health; emotional wellbeing; independent living skills; social support and interpersonal skills; financial independence and careers; and identity and legal awareness (Beyond 18, 2019).

Figure 1: Sphere of Aftercare

This project has been conceived to provide transitional and rehabilitative support to care experienced youths who are ageing out of various governmental and non-governmental CCIs. It includes educational/vocational training; internships and placements; monetary and mentoring support; and bringing them together on a common platform, such as the Care Leavers' Network. AOP aims to enable these youth to be self-reliant, confident, and job-ready, while providing non-institutional support. Even after migrating from the programme, it allows these care experienced youths to come back for any further support and guidance.

Program Objectives: AOP aims to contribute to the overall well-being of care experienced youths by nurturing them, providing them with hope, confidence, and access to varied opportunities for their holistic development such that they evolve as independent and responsible citizens. It ensures their skills development and readiness for employability and motivates them to pursue a pathway of career progression, as well as aiming to inculcate positive values in



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care experienced youths, with a focus on giving back to society. The main aim of AOP is to emerge as a demonstrable model of aftercare and to advocate for the rights and entitlements of care experienced youths, thereby improving the aftercare ecosystem in India. It also ensures their social reintegration and mainstreaming towards independent living by preparing these youth to be financially independent through imparting education, employability skills and vocational skills, aiding in obtaining accommodation, providing counselling and/or mentoring, and assisting in getting internships and placements. Such supports reduce the risks of youth facing deprivation, homelessness, vulnerability, unemployment, and other mental health issues.

Figure 2 shows the phases of the intervention, including a nurturing approach towards the youth which cuts across all the phases.

Figure 2

In September 2020, this programme was rolled out in the National Capital Territory of Delhi and in Vadodara, in Gujarat state, where a total of 42 youth from different CCIs in Delhi and 12 youth from CCIs and those receiving alumni of sponsorship support (Palak Mata Pita scheme) in Gujarat were included through a needs assessment and aptitude check. Based on care experienced youths' individual needs and capacities, AOP developed and implemented an Individual Aftercare Plan (IAP) based on the eight domains of the 'Sphere of Aftercare'. Its primary focus was on education, life skills and vocational training. Extensive workshop modules had been designed on career opportunities, interview skills, CV writing, placements, emotional wellbeing, legal and financial literacy, resilience, and life skills. The second cohort of this program started in August 2021, with more care experienced youths from both states, alongside broadening the scope to other Indian states, including Madhya Pradesh and Hyderabad. Over the two years, AOP supported a total of 166 youth who had turned 18, in six cities of India in partnership with multiple donors. In the year 2022–23, the project continued with all the previous cities, and more youth have been on board in the current year (2023-24). A total of 315 care experienced youths are being supported in the year 2023-24.

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Table 1

State	Care experienced youths
Delhi	144
Telangana	100
Gujarat	33
Madhya Pradesh	38
Total	315

Phases of aftercare outreach programme

Preparation phase:

The programme began by engaging children over 17 years of age who were still living in CCIs, to prepare them better for their transition from residential care to independent living. Over a period of three months, rapport building was done using an engagement module, along with understanding their aspirations, gauging their commitment level, preparing them, and assessing their motivation, interest and talents, along with maturity and commitment, as qualification mandates for AOP support. The selection basis included:

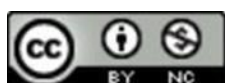

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Table 2

Qualifying Criteria	**Selection criteria**	**Needs Assessment Tool (NAT)**	**Final Scoring on various criteria**
• Age - 17+ years • Education: minimum middle primary passed • Not receiving support already • No special needs/ disability/criminal records/substance abuse	• Aspirational wants to earn asap • Learning ability • Communication skills • Commitment	• Personal details • History and reason for institutionalisation • Status of education and vocational skills, skills independent living • Experience in CCI • Health • Identity • Weakness/strengths • Purpose for joining AOP	• Social • Gender • Financial • Other vulnerability

Since 2023, a five-day bootcamp (residential) has been started at the beginning of every batch after the selection of the youth. This ensures a comprehensive induction into AOP and Udayan Care, their career pathway plan, required practical and life skills (leadership, decision making, creative thinking, gratitude), self-care, peer mentoring, and so on. The main aim is to prepare the selected youth in self-reliance through employability along with the offerings of the programme, stating clear expectations and deliverables, enabling them to develop practical skills, and exposing them to a wider range of opportunities.

Learn and earn phase:

The selected care experienced youths were offered three different pathways to choose from. Based on the learnings from the first two years of the project, care experienced youths were not offered career ideas based on blue-sky thinking. This was due to evidence that they are under extreme peer pressure and have no real understanding of their strengths and choices, which could lead to them dropping out in the middle of the project, despite all the checks, thereby leading to loss in terms of financial investments in them. After stream finalisation, they took part in skills development, enrolments in short-term vocational courses, industry connections, and opportunities for internships, traineeships and apprenticeships in government and corporate work environments. To cater

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to the individual needs of the youth, mentoring, counselling, and follow-ups continued to ensure that youth would continue to pursue their career growth plans and move forward in life. The life skills enhancement continued through the delivery of work-life readiness modules which have been specially designed to capacitate and empower them for work readiness, day-to-day management and mainstreaming in the external world. This involved various topics such as mainstreaming and facing the external world, preventive health, the importance of education and its alternatives forms, career goals, building resilience, needs and aspirations, sexual and reproductive rights, team building, stepping into the world of work, communication skills, identity and related documents, strengths and weaknesses, and finance management skills. The care experienced youths were enabled to acquire a range of practical life skills so that they can lead their life independently with confidence and dignity and learn self-reliance. They also received learnings to ensure safe and affordable housing, build and maintain healthy relationships, develop positive mental health along with providing them with services to address their psycho-social needs.

Grow phase:

Youth are continuously motivated to retain their first job for at least a year and will be followed up for two more years. This phase included coaching and direct support for educational opportunities that took them to the next level of education, enhancing their opportunities for employment. AOP ensures every CL gets an opportunity to continue their education, with the team processing their admissions and provided handholding support. Based on their performance, learning and experience, these youth were supported and guided to jump to their next level of job (increased salary/role) as part of their career progression. This phase included their willingness and capacity to give back to society in various ways, such as contributing actively to their city care leaver networks or peer mentoring younger youth. Quarterly check-ins occurred to monitor their growth through guided career progression plans and followed them throughout, up to two years post completion of financial intervention support.

Programme support designed for youth and the progress so far

The ‘Sphere of Aftercare’ comprises 8 interdependent domains (see figure 3 below). AOP interventions ensure youth under the programme are provided with needs-based support relating to the following domains:

- Housing and food support (paying guests, rented facility, group living etc.)
- Next level education support (distance learning)
- Vocational training
- Interpersonal and independent living skills
- Emotional wellbeing (psychological support)
- Physical health

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- Identity and legal awareness
- Financial independence (financial support – pocket money, mobile phone, mobile recharge, travel allowance, stationery items, formal dress etc.)

Figure 3

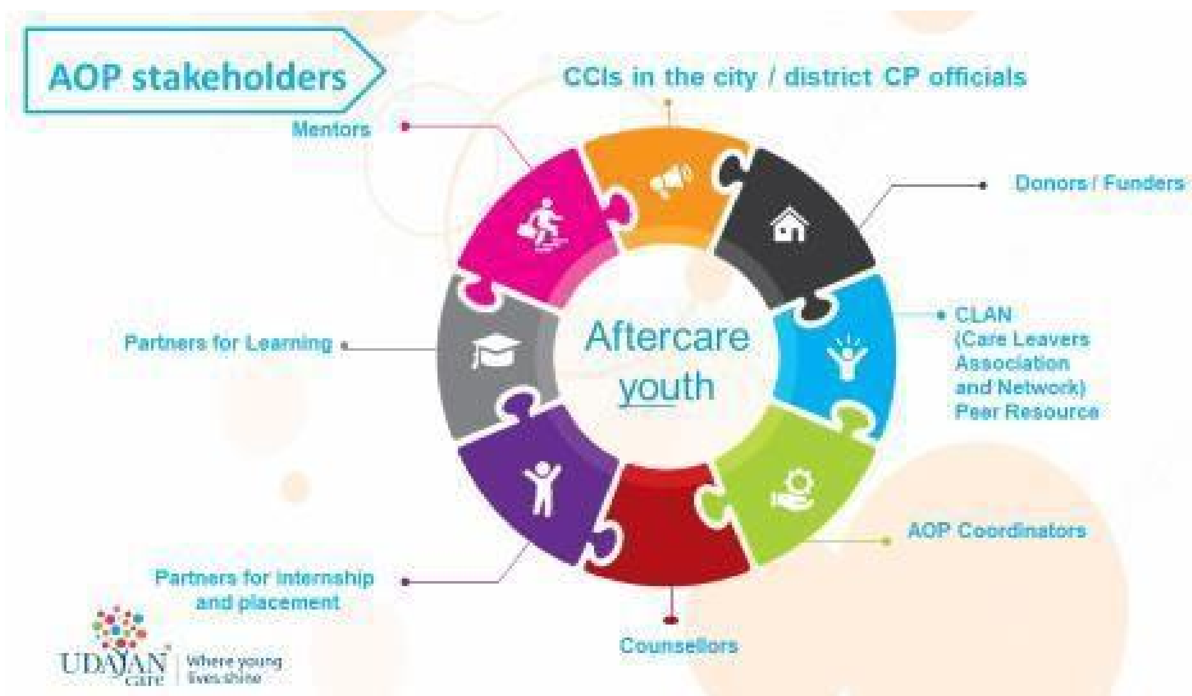
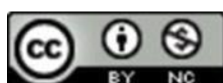


Table 3

Domains	
Food and resident support	64 youth
Mentors and counsellors	42 mentors
Financially supported next level education	72 youth
Vocational training	307 youth
Care leavers in jobs	131



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Vocational training

Vocational training is of key importance in this programme as its choice plays a vital role in deciding a career path or job sector. Across AOP chapters there are more than 30 skilling courses being offered to youth that ready them for entry level jobs. It is not an easy task and requires lots of time and sessions with youth, and in many cases the team has to arrange a career counsellor so that youth can best be guided towards skills development courses relevant to their needs, interests, potential, and academic ability, and also to something which aligns with their long-term goal. Computer education, graphic design, training for the hospitality sector, medical jobs, pharmacist, patient care assistant, hotel management, beautician, teacher training, finance management, electronics repairing, digital marketing, sales and marketing, and travel and tourism are some of the areas in which these care experienced youths are provided training. During the reporting period, by August 2023 a total of 307 youth have been enrolled on various skilling courses.

Independent living skills

'Designed work life readiness modules' are identified as major activities that play a central role in developing interpersonal skills, boosting confidence levels, providing an opportunity to interact with multiple people, developing relationships, developing soft skills, and preparedness for work life.

Offline sessions are very interactive and fruitful, and the team has observed drastic changes in the youth through these workshops and training sessions. It is mandatory for every chapter to ensure delivery of 32 prime booster sessions to each cohort, plus training and awareness sessions on various other topics being provided as necessary. The sessions are as follows: 'getting to know each other', 'education and its alternatives', 'my identity and related documents' 'effective communication', 'strengths and weaknesses', 'needs and aspirations', 'my rights as a citizen working in teams', 'preventive healthcare', 'my career goal', 'keeping myself safe in the virtual world', 'managing emotions and building resilience', 'sexual and reproductive health rights', and 'stepping into the world of work'. So far 92 work life readiness sessions have been organised through virtual and offline modes.

Mentioned below are some of the case studies of care experienced youths depicting the challenges they faced, the interventions provided by Aftercare Outreach Program and the impact of the support so far. (Names of the care experienced youth have been changed to protect the identity of individuals)

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Case studies

Case study I

Vikas is a 22-year-old care experienced youth who is supported under AOP, Vadodara.

Impact: Udayan Care supported him to build his confidence for digital marketing as a career option. He was also briefed about improving his English through Eklavya coaching. His friend helped him to learn graphics at Udayan Care's office. He completed his certificate course in digital marketing and worked part-time at a cafe. Now he is a confident and self-disciplined youth. After completing a six-month paid internship at 'OpsHub' he has joined them as an employee with a monthly salary of Rs. 33,000/-. He recently moved out from the aftercare facility and lives in a rented place. For Vikas this opportunity had been a stepping stone to march ahead in his field.

Case study II

At the tender age of five, Srihari's father abandoned him and his mother. In 2016, when he was in grade 8, he joined the Friend's Foundation, where he received his education. Srihari proved to be an excellent student who is a graduate in the field of commerce.

Impact: He finished his diploma in information technology and with the support of AOP. He was hired by 'Credright', a finance company located in 'Durgam Cheruvu' as and operational officer and is earning Rs.16,000/- per month. Srihari has expressed his immense gratitude to AOP for providing him with needed skill sets which helped him secure a good job.

Case study III

Four youth, huddled together in a small room, all unemployed, are constantly worried about food and accommodation, alongside the overarching fear of being infected with Covid-19. They have no space to quarantine and can see no future for themselves. They do not have the legal documents needed to aid their access to rations or any other support.

Impact: Sporadic support from the state government was provided for dry rations etc., and lack of identity documents prevented many of them from accessing these benefits as they lacked financial security.

Case study IV

Payal, a 20-year-old female care experienced youth, was in a full-time job and well on her way to independent living. However, after a few weeks of lockdown she lost her job and received a warning from her landlord to pay her rent in a week's time, failing which she would become homeless. She doesn't know who to approach for help.

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Impact: Many care experienced youths lost their accommodation and/or faced difficulty paying their rent during Covid-19, leading them to search for emergency support. Living all by themselves often led to isolation from their peers, and lack of devices and internet connectivity restricted their opportunities to stay connected remotely, exacerbating their anxiety and stress levels.

Case study V

Rakesh, a boy from Ludhiana, lived with his uncle and aunt after he lost his parents when he was just five, but because of the maltreatment he received there he ran away. He lived on the streets at a railway station and ended up at a shelter home, but he ran away from there too.

Impact: Despite all the hardships he has been through he kept his spirits high and ended up playing cricket at state level, but unfortunately was disqualified and had to stop playing for the regional cricket team. After multiple counselling sessions and continuous handholding today he is a 20-year-old entrepreneur who owns his own CLAN (Care Leavers' Association and Network) team stall in Vadodara.

Support received through AOP intervention

A random self-assessment survey conducted with 54 care experienced youths highlighted that AOP intervention played an important role in transitioning them to independence. Ninety-two per cent of them stated that they received support across several areas of their lives through AOP intervention, and amongst these, 30% of them were totally reliant on this programme, while others were partially dependent. AOP intervention occurred largely in the domains of education (98%), capacity building and life skills education (98%), mentoring support (89%), technology (80%), and social awareness (87%). This intervention also provided care experienced youths with several training courses, amongst which 78% of the total participants were enrolled under AOP in vocational trainings, such as graphic design, multimedia, e-accounting, data entry operation, computer applications and programming, food production, beauty and hair design, lab technician, digital marketing, graphic and print design, computer hardware assembly and maintenance, web development, fitness training, hotel management, puppetry, beauty therapy, digital marketing, technician, auto-cad, and community technology skills. Some of the care experienced youths were also provided with support to complete their basic school education, and some their undergraduate programmes. Apart from vocational training and education opportunities, this intervention also provided these youths with some financial support, accommodation and food, travel support in terms of allowance, training and development in life skills, mentoring support where each youth was assigned one mentor who guided him/her on various aspects of life, and internships, apprenticeships and placements at the end of the programme. Some of the care experienced youths, based on their individual requirements, were also provided

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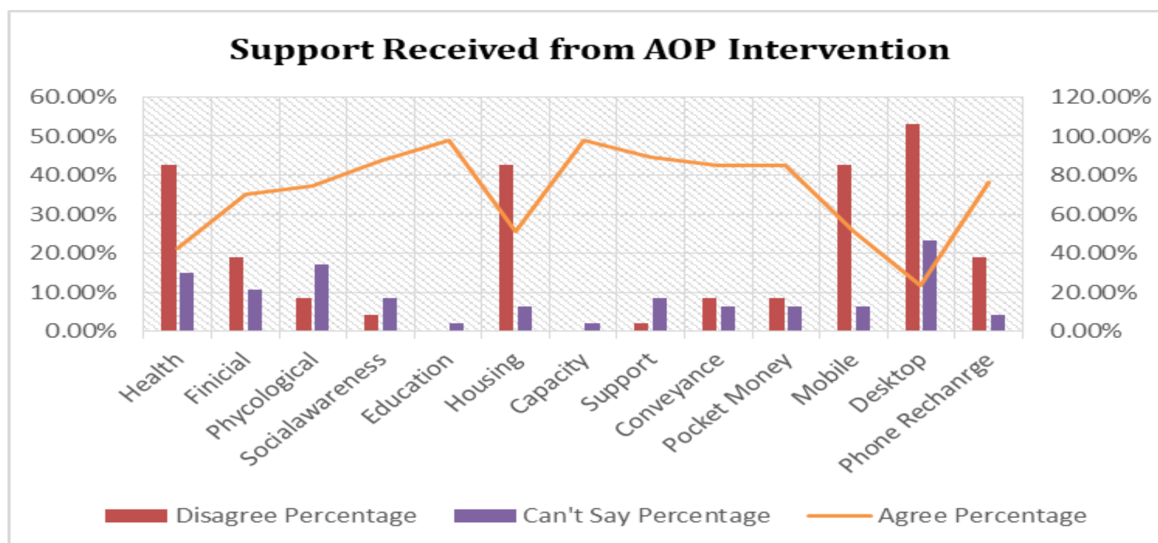
with electronic gadgets. As Udayan Care believes in the collectivisation of care experienced youths, AOP intervention encourages these youths to join the Care Leavers' Association and Network (CLAN), which is a group run by care experienced youths for care experienced youths, where they support and guide each other.

Figure 4

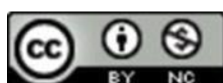


Voices of care experienced youth

The AOP intervention guided and supported care experienced youth to become independent and self-reliant. Most of them (90%) believed that this programme provided them with support in several domains of aftercare and helped them transition from their previous child care institution. At least 90% of the care experienced youths stated that they received support in several aspects of their lives through the AOP intervention; amongst these, 30% of the care experienced youths were totally reliant on this programme, while others were partially dependent. Mentioned below are a few excerpts of the voices of care experienced youths who received AOP intervention.

> Once I transitioned out of my CCI, my grandmother got me married as she was not able to bear my expenses due to which I had to quit my studies. I was shattered as I had my career goals and wanted to continue with my studies. Udayan Care's Aftercare Outreach Program provided me with counselling services, work- shops on career development along with aiding me with completing my studies. I am also grateful to my AOP mentor who played a vital role in guiding me and making me self-reliant. (A youth from Vadodara)

> I used to feel very lonely, had no social support, and didn't know whom to turn to for support, and with whom to share my problems. I didn't have any friends and used to spend most of the time alone. Many times, I used to sit



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> alone thinking how my life would be if I had a family. AOP helped me connect with the CLAN group, where I felt a sense of belongingness and felt like a family. It helped me develop my social skills and one of the members connected me to an employer and I finally got my job. (A youth from Delhi)

Conclusion

The Aftercare Outreach Programme serves as a good practice model which provides quarterly follow-ups even after the care experienced youths' support period is over. It gives them the opportunity to further embrace any additional guidance required through this programme. AOP provides assistance through mentoring, career mapping, career progression, needs-based counselling services, and guidance and preparation for peer mentorship for the next cohort. Collaboration with different stakeholders has been a key element in the success of this intervention project, where networking and partnerships with funders have helped us to make this theoretical framework for the betterment of care experienced youths an on the ground reality. Several CCIs have provided us with data of children transitioning out of their care homes, helping us to connect with youths in need of this support. Many institutions have been a great support in providing technical courses at subsidised rates to our youths; and lastly, collaborations with various employers to place these youths at relevant jobs also helped in fulfilling the objectives of AOP.

Globally, many researchers and practitioners have advocated for increased investment in areas such as career opportunities, housing facilities, higher education, and mental health services to improve care experienced youths' experiences of transitioning out of care. There is an urgent need to prioritise care for care experienced youths' mental health along with increasing opportunities for other services to further build their resilience. It is crucial to understand and take into consideration how care experienced youths view the care leaving process themselves, to analyse this, to name improvements and what can be done further, and to make recommendations to improve the quality of life of these youth, so that they grow into wholesome individuals and be a resource to themselves, to the cause, and to larger society.

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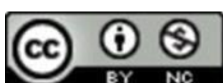

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Short Article

Collaborative storytelling in residential social work: Revisiting our shared past.

Viviene E. Cree [a] & Bob MacKenzie [b]
[a] University of Edinburgh [b] University of Chichester

Abstract:

In the hope that it may be of use to others, this short article introduces a journey of reflection and discovery that we are currently engaged in, from two very different perspectives. Both of us have first-hand experience of the Edinburgh voluntary organisation, The Guild of Service for Women (later Family Care and now Birthlink), one of us as a former social worker and the other as someone who grew up in residential care. We first met online almost two years ago and, since that time, we have been working together on our shared past in a process of co-inquiry, learning much about social work and childcare from the 1940s onwards. We have also been learning about ourselves and about some of the other people involved in our stories. Our main 'take-home' message is that the history of social work and childcare belongs to all of us. Furthermore, there is much to be gained from stepping outside the boxes (real and imagined) that constrain us and beginning to truly listen to each other's stories.

Introduction

Our story begins with an email sent during the first Covid-19 'lockdown', when Bob wrote to Viv to say that he had read her PhD thesis online and that it had changed how he thought about his childhood growing up in residential care. His email marked the beginning of a journey of discovery which goes back more than 30 years since the PhD was completed, and more than 70 years since Bob first arrived at Edzell Lodge children's home as a two-year-old in 1946. We will now relate the story of our work together since then – we call this a co-inquiry – before drawing some conclusions for social work history research and storytelling practice in the future. But first, we will introduce Edzell Lodge and ourselves.

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Edzell Lodge

Edzell Lodge children’s home was opened in 1946 in a large house in the leafy Inverleith district of Edinburgh, Scotland, opposite the Royal Botanic Gardens and next to Inverleith Park with its playing fields, allotments, and skating pond. That the home was opened at this time was due to a generous donation by two upper middle-class Edinburgh sisters; the Guild of Service for Women (hereafter, the Guild of Service) had been on the lookout for a suitable venue for a children’s home since the early 1940s, and Edzell Lodge was, for the committee and its organising secretary, Miss Kay Stewart, quite literally a gift from heaven. The Guild of Service (formerly the National Vigilance Association [NVA], Eastern Division) was a social work agency with its roots in the social purity movement, saving women and girls from ‘the terrible wickedness and cruelty of the white slave trade’ (Cree, 1995 p13). In the early years of the twentieth century, the NVA’s activities in Edinburgh included working at railway stations and the docks, where unaccompanied young women travellers were befriended by NVA workers and volunteers and taken to what were considered safe lodgings and employment.

During the Second World War, the Guild of Service and other moral welfare organisations turned their attention to the increasing number of unplanned pregnancies and the social problem of ‘unmarried mothers’ – women who had no family support that would allow them to bring up their ‘illegitimate’ babies. The 1941 formation of the Scottish Committee (later, Council) for the Unmarried Mother and her Child (SCUMC) demonstrates this concern, as a range of agencies sought to provide support for these women, though not, at this time, through adoption. On the contrary, it was widely believed that helping a mother to keep her child would encourage her sense of responsibility and, at the same time, reduce the likelihood of her having any more unplanned pregnancies (Ashley, 1995). And so, the Guild of Service’s aspiration was to open a children’s home in which children of unmarried mothers would live until their birth mothers were able to offer them a home; if necessary, this would be throughout their childhoods. Mothers (and occasionally, fathers) were expected to pay towards their children’s care and to visit them regularly.

This account is a very different one to the current dominant narrative around unmarried mothers and what is today described as ‘forced adoption’. The Guild of Service (under Miss Stewart’s leadership) was one of the organisations that argued *against* adoption for many years; although adoption was legalised in Scotland in 1930, the agency did not become an adoption society in its own right until 1954, at which point Miss Stewart left and a new ‘professional’ social work discourse gained prominence. In examining the agency’s history, it is very clear that this shift in direction brought with it gains and losses along the way (see Cree, 1993, 1995).

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Viv and Bob

Viv was a social worker at Family Care (now Birthlink) from the early 1980s until the early 1990s, working mainly with what were then described as 'single parents'. When she learned about the agency's history in the NVA and Guild of Service, she was hooked, and began a PhD in which this agency's story became a case-study for exploring the history of social work in Scotland more broadly. By the time the PhD thesis was completed in late 1992, she had begun work as a lecturer in social work at the University of Edinburgh, and since then, she has enjoyed working with students and writing and researching, often with history at the core of her work. As Professor Emerita, she remains an active researcher and writer.

Bob lived in Edzell Lodge and later Margaret Cottage (both Guild of Service children's homes) from 1946 until he left to go to Edinburgh University in 1962, graduating with 'honours' in History in 1966. He became part of the latter-day Scottish diaspora, taking up an overseas development post in East Africa. His career since then has spanned UK and international settings within the public, private, voluntary, and higher education sectors; he also undertook a DPhil on facilitating learning through writing and conversation (MacKenzie, 2005). Bob retained contact with his mother throughout his life, albeit intermittently. She died in 1985, aged 69.

What is most striking about Viv and Bob's stories is our shared love of learning and writing. Although working in very different disciplinary fields, and coming from very different starting points, we have more in common than that which divides us, and we see it as a great privilege to work together on our shared past.

Our approach to working together

It seems contrary to everything we believe to introduce our approach as 'methodology' (or even 'Methodology'), as if we had selected a specific approach from a range of alternatives in some objective way, and as if the approach we chose was somehow separate from what we actually did. In reality, lots of different theories and concepts contributed to the approach we took to our work together; additionally, all were (and are) intimately connected to how we see and experience each other and the world of which we are a part. Reflexivity reminds us that we are all implicated in the research and writing we undertake; there is no such thing as 'insider' or 'outsider' research (see Breen, 2007; Etherington, 2004). Of course, mainstream academic research and writing often claim otherwise. As early as 1960, Sir Peter Medawar posed the question, 'Is the scientific paper a fraud?' He pointed out that through the conventions of article-writing, mistakes are concealed, and discrepancies smoothed over, creating the illusion that science is somehow less messy, unpredictable, and contradictory

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than is the case in practice. So it is with some humility that we now attempt to outline the big ideas that have impacted our approach to working together.

At its simplest, we have been involved in a reflexive programme of excavating the past and then recording it, in the sure belief that all types of knowledge claims (including memories) are social processes; they are socially constructed, and because of this, the process by which they are co-created, and the context within which they are located, matter. Foucault's (1972) idea of historical research as a kind of archaeology helps us further. Foucault prompts us to examine 'discourses' (understood as ideas and practices) as things in themselves, not seeking to resolve any contradictions, but instead, understanding that continuity and change can, and do, exist side by side. More specifically, we have drawn on theories of learning, storytelling/narrative, action research and curating as ways of understanding and explaining our roles and identities as we work together.

Learning theory

Writing and learning are both exercises in imagining. Learning theory assumes that humans are social creatures who, unless constrained by circumstances, are constantly involved in a process of learning: we learn from past experiences and from current challenges, from others and through self-reflection, from reading, writing, music, dance, and from everything around and within us. Learning is an active process in which 'learners strive for understanding and competence on the basis of their general experience' (Cust, 1995, p. 280). Motivation is intrinsic to learning, as we seek to make sense of the world (Piaget, 1972; Rogers, 1969). This is why memory is so unreliable and uncertain; we change the stories that we tell ourselves based on new understandings; 'old knowledge is always revised, reorganised and even reinterpreted in order to reconcile it with new input (Cust, 1995, p. 281). Adults who have grown up in residential care often reach a point in their lives when they seek to make sense of their childhood experiences, and as Malcolm Knowles (1984) argues, adults learn best experientially and through problem solving, when they are ready to do so. This is exactly the moment we have found ourselves in.

Action research

Action research starts from the premise that research should be carried out 'with' rather than 'on' people. It sees learning as a cyclical process, beginning with a stage of reflection, followed by an action stage in which ideas are tested out in practice. In a third stage (itself a second action phase), experiences of stages one and two can lead to new fields of inquiry. By the fourth stage, co-researchers reflect on what they have learned in stages two and three (Reason, 1995). From this perspective, Bob's decision to send the first email was prompted by a period of reflection which many of us experienced when normal

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life stopped during the Covid-19 pandemic. Our first communication (through email and then on Zoom) might be seen as stage two, while our first writing together became stage three. Stage four takes us back to reflection, and the cycle begins all over again, as we learn about our past through co-inquiry (Heron, 1996). Of course, the real world is less tidy than this – there is a great deal of going round in circles and messiness along the way – the learning cycle is rarely as straightforward as implied herein.

Curating

In our writing together, we have made use of the notion of 'curation' as a way of conceptualising what we are doing together (Cree & MacKenzie, in press). Drawn from a museum and art gallery context, it 'places multiple artifacts in dialogue with each other, instantiates them around a complex set of themes, elicits multiple meanings from related artifacts and narratives, and promotes questions as often as answers' (Persohn, 2021, p. 21). This seems to us a helpful way of explaining Viv's role, as she has had the main responsibility for gathering together the various bits of our project and facilitating the stories that the former children's home residents (Bob, Rose and Doug) have wished to share.

Methods

Our co-inquiry began with an email invitation and a response. We will now outline what happened next, as we have built our shared understandings through reading, researching, meeting online and in person, and, of course, writing.

Reading

Viv's PhD, now digitised by the University of Edinburgh, was the trigger to our work together. In it, Viv introduced Bob to subjects that he was not familiar with, including the professionalisation of social work and the influence of 'psy' discourse on social work practice in the 1950s and 1960s. She also introduced him to authors whose work he knew, but had not studied in any depth, including Michel Foucault (1972, 1977). It was Foucault's ideas that helped Bob to see differently what he had experienced as competing discourses in his childhood and upbringing in the children's home. For his part, Bob then shared his own redacted case record with Viv, as well as the transcript of an interview that had been conducted with him some years previously by another researcher. He also shared a letter which he had earlier received from his mother about her early memories and experiences, written at his request. And Bob introduced Viv to his own subject – management learning – and specifically his DPhil on the topic of 'explication', that is, the process of analysing and developing an idea or principle in detail through writing about it (much as we are doing now).

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Over the last two years, Viv and Bob have literally bombarded each other with anything they had found interesting. This included writing we have done ourselves, and also writing from a very wide range of academic and non-academic backgrounds. Through this, we have built an extensive library of resources and references to which we can now turn for support for our ideas and discussions.

Researching

We began by applying for and gaining ethical approval for our collaborative research from the University of Edinburgh's School of Social Science Research Ethics team. As part of this, a former colleague at the University of Edinburgh, who also had experience of working (as a volunteer) at Birthlink, agreed to be contactable should any of the former residents wish to do so. So far, this has not proved necessary, but he has remained interested in, and committed to, our enquiry.

Our project has involved different research methods over our time together. Viv has carried out archival documentary research (examining Guild of Service minute books, records and annual reports) and genealogical research, exploring the family histories of Bob and, with their permission, two other former Edzell Lodge residents, Rose and Doug. She has also conducted interviews online and in person with Bob, Doug and Rose. In all of this activity, her role has been that of researcher and former social worker; meanwhile Bob's role has been more complicated, because he has been researcher and research participant/respondent at the same time. This dual role has necessitated exploration and care on our parts: care in our relationship with each other and in our relationship with others, including Rose and Doug. We have also met with current social workers and the acting CEO of Birthlink and presented our emerging findings at two conferences.

Meeting and dialogue

Since our first email contact in 2021, we have met online on approximately a monthly basis. We began by recording our Zoom meetings, in the expectation that these recordings might form an integral part of our ongoing work. In fact, that has not proved to be the case. Instead, Viv has relied on a scrappy notebook, recording Bob's words verbatim during our meetings together, and writing up observations and flashes of inspiration (sometimes in the middle of the night) ever since. She is now on her third blue A4 notebook. These notes, and Bob's annotations on draft papers, seem to do the job just as well as a fully transcribed recording of our meetings. We also met once in a coffee shop in Edinburgh six months into our journey, later in Southampton (where Bob lives), and more recently in Milan and Stirling. We enjoy talking with each other and

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sharing stories of our lives, but mostly, the focus in our meetings has been the sense-making we have been doing through our writing.

Writing

As will be clear by now, it is in co-writing that all of our co-enquiry (and indeed all of our learning) has come together. The process of writing and storytelling has been episodic and has stretched over time. Surfacing a publishable story inevitably involves several acts of partnership; it rarely happens in one fell swoop, and this extended time span needs to be factored in. Nevertheless, the process, laboured as it has been at times, has allowed for further negotiation and reflection along the way.

We began, at Bob's suggestion, by writing our autobiographies for each other to read. Since then, we have written two journal articles and delivered two conference presentations together. Up to now, Viv has taken the lead in writing first drafts of articles and conference outputs, with social work academics and practitioners as our intended audience; for his own part, Bob has been kept busy responding to Viv's drafts and bringing his own insights and experience to the writing. Our next article will be led by Bob, this time for a 'learning' journal.

Conclusion

We began by suggesting that we have been engaged in a shared journey of discovery, about social work, about childcare and about ourselves. That journey continues, as we look to our future writing and to drawing Doug and Rose further into our process of co-inquiry. Over time, we have become less concerned with artefacts of the past (Viv's PhD and Bob's casefile) and more concerned with the present, and within this, our shared relationship. We hope that others will take courage from our story and feel able to engage in their own exploration of their past in social work, from whatever standpoint they are coming from, and alongside whichever 'critical friends' (MacKenzie, 2015) are available to support them on that journey.

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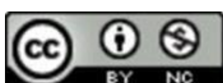

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All contributors to the article have agreed to share their real names.

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Short Article

Clear approach: Peer-led approaches in Youth Offender Institutions

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Abstract:

This article undertakes an analysis of His Majesty's Inspectorate of Prisons' (HMIP) inspection reports of Young Offender Institutions (YOIs) in England over a 20-year period. The analysis is synthesised with the author's lived experience of being both an incarcerated child in YOI and a professional working with children in custody. The analysis was instigated by a letter written by the Independent Monitoring Board (IMB) to the Rt Hon Damian Hinds, Minister of State for Justice, indicating that the current state of affairs in England's YOIs is 'positively inhumane.' The current article argues that YOIs have never been 'positively humane', having always fallen short of 'improving outcomes for children', through the lens of recidivism. The author argues that YOIs also overlook peer-led programmes to promote children desisting from offending, through illuminating a growing body of evidence which suggests this approach can provide 'hooks for change' for children to desist from crime, and that it presents a model of good practice that could be used as a child first approach.

Introduction

This article will first explore the current state of Young Offenders Institutions (YOIs) in England, before arguing that the use of 'experiential peers' and 'peer mentors' in the youth estate is overlooked as a means to reduce violence and rates of suicide and self-harm. The article firstly examines His Majesty's Inspectorate of Prisons' (HMIP) report from the year 2000, when I was incarcerated myself in Brinsford YOI. Extrapolating from the historical state of affairs and comparing this with a recent letter written by the Independent Monitoring Board (IMB) to the Rt Hon Damian Hinds, Minister of State for Justice, to call on him to undertake an analysis of effectiveness. The IMB states that YOIs, although dealing with far fewer children than in 2000, require 'urgent action' towards a renewed focus on 'improving outcomes for children' (IMB, 2023). Exploring the data of reoffending rates over this 23-year period,

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alongside the author's 'lived experience' of childhood incarceration, this paper argues that there is little evidence that YOIs have ever 'improved outcomes' for children entering them. Furthermore, although the pandemic has amplified these issues, many of the challenges highlighted by the IMB are 'business as usual' for the youth estate. The article also draws on literature and my current practice in a YOI to illustrate how the use of 'mentors' and 'peers' is a resource that could positively impact on the experience of child incarceration 'in its current form.'

Historical context

I had just turned 17 years old when incarcerated in Brinsford YOI as a juvenile in January of 1999 for 18 months - along with my 15-year-old brother who was serving a 15-month sentence. Upon arrival at Brinsford YOI at that time, the number of children in custody in England and Wales was approximately 2,700 (Youth Justice Statistics, published 2023 according to site). Several months after I had been released on Home Detention Curfew (HDC) for good behaviour due to being assessed as having a reduced level of *risk*, HM Inspectorates conducted their inspection of Brinsford. In the preface to their report, Sir David Ramsbotham, the HM Chief Inspector of Prisons at the time, stated that 'our inspection, of which this is my report, was one of the most disturbing my team and I have carried out, disclosing a level of neglect and lack of understanding of the needs of young prisoners that was "breath-taking"' (HMIP, 2000, p. 3). In their book *The Penal System 6th Edition* Cavadino et al. (2020) outline that Brinsford was not the only YOI at the time to be called into question. Indeed, in 1999 the conditions at Feltham YOI were described by HMIP as 'unacceptable in a civilised country.' Meanwhile, in the same year, being just as scathing about Portland YOI, describing conditions there to be a 'moral outrage' (Cavadino et al., 2020, p. 289).

As someone who was in Brinsford at the time, these inspection reports came as absolutely no surprise to me at all. It is worth pointing out that I certainly was not reading inspection reports shortly after being released from prison as a child, but I did see reports of a failing YOI on the news which caught my attention, and I found it was my previous place of residence, Brinsford. The reports claimed that conditions in Brinsford were a 'disgrace' and that these conditions were a 'stain' on the prison service (BBC, 2001). Sir David Ramsbotham also stated that it was 'inexcusable' as similar reports had been filed with respect to other YOIs, as highlighted above, and in Brinsford 'last year three inmates took their lives, and there was one death there earlier this year' (BBC, 2001). My memory of Brinsford at the time – although Brinsford no longer holds under 18s – was that violence, self-harm and intimidation were a way of life and 'doing jail well' meant actively participating in the culture of dysregulated children acting up to the role of prisoners, because they were indeed in 'prison.' I would argue that officers at that time had little to no knowledge of youth development or the impact of childhood trauma. I am currently training prison officers in the Unlocked Graduates scheme and these concepts, alongside trauma-informed practice and

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child first principles, are central to the prison officers' MSc, especially for those working in the youth estate.

Independent Monitoring Board

The Independent Monitoring Board (IMB), a statutory but independent organisation which monitors prisons' day-to-day practice, recently wrote a letter to Rt Hon Damian Hinds, Minister of State for Justice, outlining that the current state of YOIs is 'positively inhumane' (IMB, 2023, p. 2). They highlight that there are staff shortages, cycles of violence, lack of purposeful activity, and limited educational opportunities across the four YOIs currently operating in England, even though the number of children in custody in May 2023 is 453, which is a reduction of 83% (HMPPS & YCS, 2023). However, I remember being on the enhanced wing (a unit for prisoners with privileges) with a job in the kitchens in Brinsford while my brother, being less fortunate, was on basic (a unit with very few privileges) as he struggled to adapt to the rules and environment of prison. Staff were frequently cancelling our association (time on the wing for phone calls and showers) due to a lack of staffing. I recall frequent suicide attempts, as outlined in the HMIP report, and the level of violence was always high, leading to feelings of anxiety and fear. This does lead me to wonder whether there is a 'crisis' in the youth estate, or whether we are now opening our minds to what we have been doing to children by placing them in establishments run by the prison service.

Another similarity is that there were two main gangs at the time from Birmingham: Burger Bar Crew and Johnson's Crew. Upon arrival, children were asked by staff which gang they affiliated with so they could place children on separate wings along with their affiliated gang members. This is interesting as the IMB report states that YOIs are using 'keep-aparts' (IMB, 2023, p. 4), which is separation. Again, if we look at the evidence from HMIP reports, as well as my own embodied experience, it seems that the crisis we are witnessing here is what has already been conceptualised in literature as the 'crisis of visibility' (see Fitzgerald & Sim, 1982). It has been argued that if the secrecy lingering behind prison walls becomes known to the public, this opening up of the prison's internal functions and harms is 'likely to decrease the legitimacy of the system' and that 'if knowledge is power then there is a danger that the system will lose much of its power if it loses control of information about itself' (Cavadino et al., 2020, p. 21). Therefore, we must question whether the crisis unfolding in 2023 is due to the secrets being exposed, rather than reflecting a significant change in how children are treated. Although I accept that the pandemic has amplified current challenges and staff shortages have become even more of an issue, I think this is more 'business as usual' in responding to the pandemic than a 'crisis' in comparison to common practice. Not that I am playing down the challenges of the youth estate, just to ask what it is we want the youth estate to be effective at, because if it is to improve outcomes for children maybe we should consider what we have been doing to children throughout recent history.

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A child first alternative

I spent nine months over the first Covid-19 lockdown working in a Secure Children's Home (SCH) which held only 28 children. The children frequently stated that it 'wasn't a prison' in their view, which in my experience and observations allowed them to act more like children than *prisoners*. Yet, SCHs only house 10% of the children held in custody, with YOIs holding 73% (MoJ, 2022). This indicates that if we purposely built smaller SCHs – managed by the local authority not the prison service - around the country to house the remaining 450 children, this would align closely with a 'child first' approach to youth justice (Ministry of Justice & Youth Justice Board, 2019). The child first evidence base was adopted as the guiding principle for the Youth Justice Board's strategic plan 2021–2024 (Youth Justice Board [YJB], 2021). The four tenets that underpin the child first approach to working *with* children in the youth justice system are seeing children as children, developing a pro-social identity for positive outcomes, collaboration with children and promoting diversion from the justice system to reduce stigma (Brierley, 2023; see also Case and Browning, 2021). If we placed children who commit serious offences in SCHs until 18 years old, that would allow us to *divert* children away from the prison system and to respect their age and maturity as *children* in the process.

Inevitably, my experience could be argued to be anecdotal, and so this paper will now explore the raw data relating to the ability of the current youth estate to 'improve outcomes for children.' According to the Ministry of Justice (MoJ), in 2023, 64% of children in custody (not including SCHs) reoffended within 12 months of release (MoJ, 2022). This means of every child released from YOIs in recent times, almost seven in ten would reoffend. If we return to 2012, MoJ data indicates that 66.5% of children released from custody reoffended within a year (MoJ, 2015). If we travel as far back as 2000, when I was an incarcerated child, there was a far greater proportion of children in custody, and the reoffending rate within the year was 76.8% (MoJ, 2013) – almost *eight* in ten. This inevitably means more children were negatively affected by the 'pains of imprisonment' (Crewe, 2011, p. 510) and far higher numbers of children were reoffending post-custody, which calls into question any evidence of 'improved outcomes' for children.

Although the Covid-19 pandemic seems to have had a certain negative impact on prisons across the country, as stated by adult prisoners themselves (User Voice, 2022), consideration must be given as to whether there is an expectation that the youth estate is to deliver something that it is simply incapable of achieving if the standard is to 'improve outcomes for children' through a child first approach. Reflection over time demonstrates that YOIs have never achieved improved outcomes, but they have certainly introduced me, and so many other children, to what Sykes described as the pains of imprisonment (see Sykes, 1958). I reiterate, when I arrived at Brinsford YOI, although I had a challenging childhood that included heroin addiction, school exclusion and the care

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experience resulting from abuse and neglect, I was still ill prepared for these prison pains. I did manage to develop skills to navigate the prison space eventually. However, upon release I was not provided with guidance to understand how to reshape those skills, or supported to know how those skills I developed to navigate the prison context were transferable into the workplace, which did happen as I matured into an adult.

Peer-led approaches

As I am not one to simply highlight problems, I do have *a* solution to the challenges facing the youth estate in its 'current form.' I am currently working with care leavers in Wetherby YOI, delivering the Clear Approach Programme (see Fitzpatrick & Williams, 2014). This is a participative *peer*-led programme that allows children in custody who have experienced being in care the opportunity to work with someone who has also 'been there' (Fitzpatrick & Williams, 2014, p. 22) and will 'listen, care, and encourage small steps' (Buck, 2021, p. 7). These features are person-centred tenets and core conditions of peer-led initiatives in criminal justice practice (Buck, 2021). There is indeed a growing body of literature highlighting that peer mentors can become 'hooks for change' (Nixon, 2020, p. 54; see also Giordano et al., 2002) and support people involved in offending to desist through the mechanisms of Experiential Peers, Wounded Healers, and Peer Mentors in both adult and young offending populations (Brierley, 2023; Buck 2018; Creaney, 2020; Kirkwood, 2023; Lebel et al., 2015; Lenkens et al., 2021; Maruna, 2001). In contrast, I was originally denied access because of my historical offending in youth, requiring the governor of Wetherby YOI to be creative, override this decision, and allow me to deliver the programme as a peer. This is despite me being an author and researcher, working directly with vulnerable children in the youth justice system for 15 years, and now being employed in a leadership role in a university. Surely, people wanting to 'make good' (Maruna, 2001), 'give back' and be role models to children would be helpful to the youth estate in obtaining *legitimacy*. There is an embodied understanding of navigating through persistent offending in childhood into a crime-free life known as desistance (see Maruna & Farrall, 2004). This embodied knowledge can produce a shared understanding, develop a generative desistance culture, and aid a prison system that is *forever* in crisis - so to reduce the barriers, follow Wetherby YOI's lead.

Conclusion

This paper has explored a personal journey from youth incarceration to youth justice practitioner. The paper draws on HMIP inspection reports to illuminate that the evidence suggests there is not, and never has been, a crisis, other than a 'crisis of visibility.' The argument is that if we want the prison service and young offender institutions to improve outcomes, we, the British public, and politicians alike need to completely deconstruct the youth estate and rebuild smaller, purpose-built homes for children which allow them to *be* and *feel* like

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children. Given that this may seem like a drastic and expensive change, this paper argues that there are innovative approaches to obtaining *legitimacy* for the youth estate's current form. This would be to allow adult peers the opportunity to lead by example and share their experiences and knowledge of travelling through the desistance process whilst acting as mediators between children and officers. Simply reduce the barriers we as mentors face to returning and offer advice and guidance post-custody. After all, 'we can't be it, if we can't see it.'

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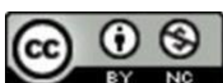

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This paper is dedicated to the late Darren Coyne. He was a man of huge compassion and authenticity who developed the Clear Approach programme, while working for the Care Leavers' Association and fighting for the rights of the care experienced in the criminal justice system. Darren set a high standard for us to follow, and his work and fight live on through those of us that have been influenced by his work. I would also like to thank Sam Davey from the Care Leavers' Association as well as staff at Wetherby YOI for being creative and forward thinking, especially Harriott and Joanne from the social work team. Last, but not least, the care leavers that left their comfort zone to speak publicly and share their insight for service development.

About the author

Andrew Brierley has 15 years' experience in youth justice practice and two years of teaching prison officers on a MSc. Alongside this Andrew is currently a PhD student studying lived experience in criminal justice practice. Prior to his professional career, Andrew lived through the care experience, school exclusion, drug addiction, and prison, which fuels his perspective on social justice.

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Short Article

Successful family reunification: The role of foster families, kinship carers, and children's houses

David Stakes
Children and families social work

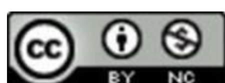
Abstract:

The successfully reunification of families with care experienced children (children who are looked after away from home) involves the carer's support of the family in the context of relationship-based practice and constructing a shared assessment and narrative around the child. Practice is informed by an understanding of the impact of trauma on children and adults. It is based on hearing the informed views of children and young people when successfully planning family reunification. This work requires collaborative work with the family's social worker.

Introduction

Every time children are removed from their family there is a tragedy of adult failing. The failing is rarely one of an individual's actions. More often than not, it involves the complex interplay of a range of factors. Austerity and adversity, parental trauma, gender-based violence, sexism, racism, and agency failings often feature in this (Curtis, 2022; Featherstone et al., 2018). However, sometimes there needs to be a 'circuit break' in an abusive and harmful situation. Children need carers in foster families, kinship, or a children's house (hereafter referred to as carers). Where there is successful family reunification, carers have a key role in effecting that change, and the positive carer relationship with the child aids in the healing process. At the same time building trusting collaborative relationships with the parents is a key foundation to rebuilding the child/parent relationship and securing reunification.

I am a Scottish statutory social work team leader who, for a number of years, has had responsibility for the care planning for care experiencing children and young people. During the period, my local authority has made great progress in



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supporting families in their communities, using more family support workers, Family Group Decision Making (Scottish Government, 2016), and women's projects, for instance. At the same time, there have been major policy and legislation shifts in Scotland, including legislation with respect to care experienced children's rights to relationships with their brothers and sisters (Children (Scotland) Act 2020) and a public policy commitment to improve lifelong outcomes for care experienced people (Independent Care Review, 2020). Legal, policy and resource shifts have improved the opportunities for care experienced children to go home. Going forward carers need to be seen not only as an alternative to the birth family but also as having a vital role in helping children return home. Accordingly, this reflection aims to highlight the importance of, and key areas of work for, carers in aiding family reunification. It is important that this is enshrined in policy and practice by services.

Building relationships

Relationship-based practice is an essential part of the carer's role (Ingram et al., 2018). From the outset it is imperative that, despite often harrowing circumstances, the carers have a positive regard for the parents. To enable this, the social worker needs to clearly communicate an honest balanced assessment of the family which helps make sense of both parental responsibilities and the difficult and traumatic experiences the family has been through (Calder et al., 2012). This enables the carer to both support the child and help with the healing in the family.

Whilst a primary task of the carer is to build a trusting and caring role with the child/ren, it is also important that they build a working relationship with the parent/s (Independent Care Review, 2020, p. 23). Parents will experience loss and separation, feelings of failure, incompetence, and shame. There can be a natural resentment or distrust of carers because 'you've got my child. I do not know you. All I know is, lots of children have been abused in care.' Carers need to be aware of such feelings and look for every opportunity to build a working relationship with parents.

Carers need to provide honesty and sensitivity. There needs to be a willingness to listen to a parent's point of view and help with their motivation to change (c.f. Ward et al., 2014, p. 143). They need to be aware of disadvantage and austerity. The carers, for example, will usually have greater resources than the birth family; finances, housing, education, and transport (Independent Care Review, 2020, p. 17).

Things that help in the carer/parent relationship include:

- Carers who value family reunification.
- Carers who share with families a little about themselves and their home. Parents need to know who is looking after their children.

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- Conversations are important – meetings and taking children to and from visits to family (contact) is an opportunity to build relationships. An informal discussion over a coffee is even better.
- Attending appointments such as medicals together.
- It is important that children see parents and carers working together. This not only helps build the parent's confidence but also the child's confidence in their parent.
- Practical help from carers: taking children to family time, providing pictures and written updates help.
- These actions build trust which leads to collaborative working and enhanced parental confidence. The parent is then best able to effect positive change. Compare this to social behaviour and network therapy where a support network is involved in successful planned changes (Ward et al., 2014, p. 93).

Trauma-informed practice with children

The child or young person away from home has experienced separation and loss, and usually trauma (Lyons et al., 2020, p. 3). Children's conversation and behaviour, at times very distressed, communicates something about that experience, and carers need to build relationships in this context (Independent Care Review, 2020, p. 19), providing children with confident nurturing care (Holmes et al., 2012). This vital relationship between the carer(s) and child needs to be explored, assessed, and supported by practitioners.

A key area of work here is when carers are asked to advise on how the child was before or after family time (contact). Identifying, describing, and recording these responses is a very challenging but vital task. The carer needs a good relationship with the child to sensitively monitor any changes in behaviour and to respond appropriately in conversations. The social worker in turn needs to carefully explore the feedback with the carer. By way of illustration, initial feedback from carers can often be very activity focused: 'Frankie said he enjoyed the café and loved the trainers.' Workers and carers can assume this is a sign of disconnection between traumatised child and parent. Without attuned engagement this becomes a narrative of a child not interested in his parents, but only in the material things given. It can be interpreted that the child focused on the activity and gifts because they could not manage their feelings of hurt. However, children, like adults, find talking about concrete things easier than expressing their feelings. More detailed discussion might identify moments of warmth and attuned caregiving: 'Yeah, when I put the trainers on, mum had a huge smile on her face. She said I looked brilliant.' Also note that a child's distress can often be seen as relating solely to their harmful experiences, when in fact the behaviours can also relate to the experiences of separation and loss with respect to the parent (Wali, 2022).

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Trauma-informed practice with adults

Trauma-informed practice needs to extend to the parents, who themselves have often experienced trauma, and are certainly experiencing loss and separation (Lyons et al., 2020, p. 21). They will be anxious for themselves and their children. Parents can respond in a defensive, hostile manner; distrust, anxiety and, at times, anger, are often observed. The team around the child, including the carers, need to help the parents move forward:

> The process of behaviour change is well-established, incorporating a number of common elements including resistance, ambivalence, motivation, engagement and action. Lapse or relapse is also viewed as an integral part of the change process (Ward et al., 2014, p. 12).

Parental presentation, combined with a difficult case history can touch on the carers' own fears and anxieties. Indeed, in more difficult situations this can trigger fears and anxieties related to the carer's own past trauma, potentially leading to a destructive cycle of distrust between carer and parent. The parent's behaviour triggers negative feelings in the carer which in turn the parent notices. This requires careful management by all involved. Formal meetings and legal hearings are particularly difficult for most parents, and carers in this context need a good understanding of the stressful impact of trauma. Again, the role of the carers is important because 'relationships heal relationship trauma' (Treisman, as cited by Lyons et al., 2020, p. 22).

Carers also need supervision, support, and opportunity to prepare for and reflect on these situations. Likewise, the team around the family need to be aware of these possible dynamics. In moving forward, careful narrative work benefits the understanding of all involved. It not only draws on risks but also highlights the strengths in the family.

Building a shared narrative

The team around the child need to complete comprehensive assessments which brings understanding to the situation (Calder et al., 2012). From this, a shared narrative is established. Critical to this is to involve the family themselves. The family are the people who have been first hand witnesses to all that has happened. It is important that wherever possible the narrative is drawn with them (Featherstone et al., 2018, p. 67).

A shared understanding of what has happened and is happening is a sound foundation for; talking to children, understanding, life story work (Rose et al., 2005), and reparative work with the parent. Major problems occur if practitioners are not mindful that they each bring their own values and background with them when constructing a narrative. Participants need to be aware that their views are affected by the values of the organisation, individual attitudes, and ethics. Indeed, this includes attitudes to parental responsibility and the very value of children's houses, foster care, and adoption. Likewise,

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views on drug use, domestic violence, feminism, and racism can all influence the narrative they try to establish (see Holland, 2000; Ward, Brown & Westlake, 2012, as cited by Lyons et al., 2020). If the team around the child do not establish a shared narrative there can be confusion, distrust, and conflict between team members. Given their respective levels of contact, a particular challenge in family reunification work is that carers and supervising workers can have a different perspective to the social worker, as drawn from their respective relationship positions. The carers, in being with the child, often have more direct experience of the impact of trauma on the child, whereas the social worker, in doing parent assessment work, has more experience of the trauma the parent has been through, such as, for example, in cases of gender-based violence. This means they can have different perspectives, and in these situations, resolution comes when the respective narratives are openly discussed and reviewed, and a consensus is sought.

As well as our perceptions, narrative work often involves understanding the feelings and perceptions of carers (Independent Care Review, 2020, p. 32). Anxiety can influence how the carer shares their understanding and narrative. It is vital that communication here is clear and unambiguous. Carers often talk about keeping children safe but are cautious to speak in more detail regarding difficult topics. A narrative might be that 'mum loves you, but social workers need to keep you safe.' This narrative might be regularly repeated over time. In doing so, the words 'mother's love' are conflated with a lack of safety, or 'harm'. This can leave a child fearful and undermine the parent/child relationship. There needs to be a much clearer narrative in such situations. Key information and words need to be contextualised to help the child's understanding:

> You know in the past your mother was living with Mr B. He was a violent man who hurt her badly and this was very frightening for you and her.
>
> I know your mother loves you because she has left that man. She always comes to see you. She is always asking after you and I see her lovely smiles as soon as she sees you.

Hearing the child's views

Children must be listened to and involved in their care plan (Independent Care Review, 2020, p. 13). The narrative work in this context is vital because children, just like adults, make better, more confident decisions when well informed. In a case where the mother was previously abusing alcohol (a source of vivid and distressing memories for the child), for example, the child can only give an informed choice when she is told how well her mother's recovery is going. Tangible information helps us all in such situations. Going to see that the parent's house is clean and tidy helps a social worker. By the same measure, a visit home by the child will also help.

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Carers have a role in building parental confidence. A well supported father, shown by the carer how she feeds the baby, can learn, and grow in confidence with respect to feeds. Feeding becomes a positive experience for the baby and the baby responds more confidently to the father. A mother who is trusted by the carer is herself more confident in responding to her child. This can result in the child having a well-founded, more trusting, positive view of their parent. Accordingly, children's views need to be carefully responded to: 'I want to go home because I am worried for my mum.' Do we focus on the 'worried' or the 'want' or both? Why is the child worried? Is this a sign of continuing fear of the father? Does the child simply want assurance about her mother? Does the statement mean she wants to be home because she is worried her father will harm her mother and she can protect her? Does she talk about being worried for her mum because she does not want the carer to feel rejected, but in fact simply wants to go home? How the carer responds in these conversations is of critical importance. Likewise, just as they need to sensitively engage with the child, they need to sensitively reflect with the social worker to enable both to best understand what is happening.

Where there is a good foundation to report parental progress, the carers need to keep the child aware of that progress, balancing reasonable confidence with an awareness of risk. This needs to be communicated with due sensitivity to the child's age and stage of development, and in a trauma-informed way. It is only in this context that the informed view of the child can be given. Ultimately successful reunification depends on an honest narrative that supports the child's identity and solidarity with their family (c.f. Featherstone et al., 2018, p. 152).

Carer support of the child's journey home

As the case progresses and actions are taken to move to reunification, close communication between parents and carers is very important, particularly as the child is likely to be spending increased amounts of time with their parents. Again, with support, close interaction will instil confidence in the parent and child alike. Consistency of routines in the 'two homes' matters. The closer collaboration of the homes means that ultimately the transition evolves with due sensitivity (NSPCC Learning, 2015, p. 14). This is all facilitated by effective care review and planning (NSPCC Learning, 2015, p. 5).

Carers are asked to bring their 'whole selves to work so their interaction with children is natural and relational' (Independent Care Review, 2020, p. 23). In this context it is important that the carer is aware of their own emotions and feelings. Their own feelings of worry, loss, and separation when a child has been in their care need to be recognised and supported by the team around the child. In one case children's house staff had to respond to progress in a case where there had been a very difficult drug related family history. This led to understandable worries for the carers. Conversations with the parents, young person and social worker helped the carers process a very difficult family history. This helped everyone 're-write' the shared narrative about events and helped the

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carers identify that the situational stressors at the time the child was removed from their parents' care no longer existed. Things had changed and there were now opportunities for family reunification. Knowing this, the carers were then able to confidently support the changes taking place.

After the return to the family

Children and young people need continuity in their lives. Wherever possible thoughtful attention needs to be given to maintaining links between the young person and carer. This might be as simple as a card on birthdays and festive occasions. Planning later life links with family group decision making can help support this (Scottish Government, 2016). In one successful case of family reunification, the single father was a socially isolated asylum seeker from North Africa. Prior to reunification he regularly visited the foster home for meals and on festive occasions. These visits continued successfully for both father and son once reunited. The carers became a very positive social support to the family.

Conclusion

Supporting reunification can be one of the most challenging tasks for carers. They need the support of established good practice, good communication, supervision, and training (National Foster care Review, 2013 p. 23). Supports must come from both the carer's supervisor and the team around the child (Independent Care Review, 2020, p. 19). The relationship between social worker and carer is vital in this. Carers have a key role at a pivotal time in children's and young people's lives. They give something of themselves in this process as carer, including emotionally, in terms of their empathy and making a human connection with the whole family.

When carers can model a confident, trusting relationship between themselves and parent(s), the attachment/security between parent(s) and child is supported and fostered. In doing so, they emotionally give the child 'permission' to move. At each stage of this process the adult's narrative needs to change alongside their role. The carer moves from being the 'safe base' for the child to helping enable the restoration of the parent/child relationship. Accordingly, the team around the child need to consciously take the role of the carer into account when planning change. In doing so, families are best helped to achieve reunification.

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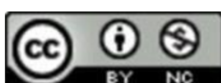

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A note about confidentiality

Please note that specific details of the writer's case experience have been altered to protect client confidentiality.

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Short Article

Privacy and dignity in recordkeeping for out-of-home care: A discussion

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Abstract:

This paper provides a preliminary exploration of recordkeeping contexts for young people in residential care experiencing criminalisation and at risk of exploitation. Within the Australian context, the paper explores the potential ramifications of certain recordkeeping processes – notably those of a deficit-based, accusatory or pejorative nature – on a young person's rights to privacy and dignity. An emergent hypothesis questions whether negative sentiments within these records might indirectly precipitate or amplify challenging behaviours that subsequently face criminalisation. While empirical research in this area remains limited, this discussion piece serves as a foundation to instigate conversations and further investigations into the interplay between recordkeeping, identity perception, and behavioural outcomes. As a foray into a relatively uncharted domain, this article aspires to be both a contribution and a call to action for the research community, underscoring the profound significance of records beyond mere administrative utility and their potential role in shaping the lives of children in the care system.

Child protection systems and care recordkeeping research

The records created and kept by professionals in the child protection continuum not only demonstrate adherence to legislative and professional mandates but are pivotal for transparent, consistent, and responsible child social care (Brown et al., 2020; Gursansky et al., 2012; Hoyle et al., 2019; Prince, 1996).

In Australia, reviews, inquiries, and royal commissions, together with recent research in this area, have underscored the deficiencies of recordkeeping systems in child protection systems, especially in the aftermath of child fatalities or serious injuries. Critiques range from data discrepancies and subjective and pejorative narrative styles, to an absence of children's voices and views

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(Commonwealth of Australia, 1997, 2001; Evans et al., 2020; Evans, McKemmish & Rolan 2019; Golding et al., 2022; Humphreys & Kertesz, 2015; Nyland, 2016; Ogle, Vincent & Hawkes, 2022; Reed et al., 2018; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017; Senate Community Affairs Reference Committee, 2004; Shepherd et al., 2020).

Such limitations have been identified as impeding early detection of child maltreatment and compromising transparent, accountable care systems that uphold children's rights. They also hamper the upholding of a child’s future identity needs and potentially result in profound distress for those mentioned in the reports, especially children who have experienced trauma or those with care experiences.

This paper discusses recordkeeping issues within the context of children and young people’s rights as prescribed by Article 16 of the United Nations Convention on the Rights of the Child (1989) (UNCRC). Article 16 states that ‘No child shall be subjected to arbitrary or unlawful interference with his or her privacy (…) nor to unlawful attacks on his or her honour and reputation’. When we consider recordkeeping processes in children’s social care, what might be considered ‘arbitrary’ or ‘unlawful’ interference with privacy? What could be an unlawful attack on the honour and reputation of a child or young person in care? If recordkeeping processes are dictated by social care policies and procedures, we can be confident they are lawful. However, recordkeeping research on care records suggests that many records created are felt and/or perceived by subjects of the records as attacks on their honour and reputation (Senior, 2023; Wilson & Golding, 2016).

Trauma, care systems, and care experiences

Research often focuses on the material outcomes of care leavers rather than on the subjective experiences, meaning-making and identity formation of individual children and young people. Life story work goes some way towards expressing the importance of life narrative in personal development and healing from trauma, loss and grief. Much work in this field is instructive on how to support positive identity formation (Kontomichalos-Eyre et al., 2023).

The focus on trauma in alternative care contexts is often presented as being outside of the care system, relating to events that precipitate removal from family or in exploitation experienced outside of care placements (Commission for Children and Young People, 2021; Lloyd et al., 2023). However, we are becoming increasingly aware of aspects of care systems that create their own trauma as we hear from care-experienced people and care sector stakeholders through major inquiries and reviews (Yoorrook Justice Commission, 2023).

The South Australian Office of the Guardian for Children and Young People’s final report concerning young people involved with child protection and youth justice observes 'systems abuses' in routine practices of care authorities:

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> Harmful or inappropriate decisions are made at different levels of the decision-making hierarchy that have associated problems and possible lifelong implications. It is difficult to avoid the conclusion that ongoing child protection system practices such as poor placement matching, problematic staff training or competency expectations, and a propensity to call police to manage behaviour in residential care constitutes systems abuse. These practices foreseeably cause harm to children and young people and help propel them deeper into the youth justice system (Office of the Guardian for Children and Young People, 2022, p. 83).

Reports into the criminalisation of young people in residential care typically highlight staff reactions to challenging behaviours as leading to police involvement (Baidawi et al., 2022). Are there events and experiences preceding challenging behaviours that are so far being missed in our analysis of these complex problems?

Stability and care

Similarly, instability in care (typically measured by the number of placements, though this is not necessarily a true measure) is often attributed to young people exhibiting challenging behaviours (Bollinger et al., 2021). Young people are said to become too difficult to place in family-based care and end up in residential care placements. These explanations obscure or omit young people's explanations as to why they may not become settled in a given placement or in any.

Which care practices may be experienced by children and young people as aggravating, disempowering, angering or triggering? Could aspects of care recordkeeping be experienced by children and young people as invasions of their privacy? Could the routine notetaking and recordkeeping practices of institutional care contribute to a felt loss of dignity?

Recordkeeping practices

The individual impacts of the creation, 'sharing' and/or distribution of care files on individual children and young people, the *subjects* of these records remain largely unexplored. Do any of these lawful and routine practices contribute to young people's trauma and become expressed through challenging behaviours that may become pathologised or criminalised? If this was a concern for young people, how might that negatively influence feelings and contribute to negative identity development? This excerpt from a Centre for Excellence for Children's Care and Protection (CELCIS) blog suggests these are significant concerns for care-experienced people. In a section titled 'Reports and letters are almost what define you', a hearings-experienced young person called Helene argues:

> Language is so important, especially when you're in care. It's a period of your life when so much is happening, and the only way to keep track of what's going on is through paperwork. So, if the language in hearings and paperwork is constantly negative about you and your family it's

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> going to make you feel worse, especially as a child. You think, 'if everyone else is thinking that then maybe I should be thinking that too.' It's really strange that adults are allowed to speak to children in this way and call them 'badly behaved' and 'challenging' and 'a nuisance', when the reality is, that child's going through a hard time (Miskimmin-Logan, 2023).

Care records primarily detail young people's affect and behaviours, critical incidents, goals and planning. Care leaver academics have highlighted how their records make assumptions and judgements that paint them in a bad light (Senior, 2023; Wilson & Golding, 2016). Professionals and carers reading these files prior to meeting young people are likely to be making judgements based on this information alone as they have access to little else.

Such records could contribute to the criminalisation of care-experienced people and surveillance bias in relation to care-experienced parents (Purtell et al., 2021). When a child or young person is brought before the courts, who is reading their files and what information is represented? What rights do care-experienced people have to challenge their 'records', which are taken as evidence relevant to a court's decisions?

Regressive or progressive policy innovation?

Moral panic about deepening youth crime crises has recently led to policies seeking the suspension of the Queensland Human Rights Act by the Queensland Government in Australia to allow children in police custody to be kept in adult prison watchhouses (Williams, 2023). A crisis in foster care recruitment and retention (Arney et al., 2022) and growing numbers of children placed in out-of-home care (The Productivity Commission, 2023) will likely exacerbate existing placement shortages, resulting in placement instability and challenging behaviours from young people who are unsettled (Miles & Lee, 2023). What do we know about how to ensure that children and young people placed in care are safer than they were previously?

Policy and practice realities

In the context of foster and kinship care in South Australia (SA), the SA Charter of Rights for Children and Young People in Care (Guardian for Children and Young People, 2021) and Section 80 of the Children and Young People (Safety) Act 2017 SA, alongside Article 16 of the UNCRC, stress the importance of children and young people being adequately informed about their carers while safeguarding their personal information from undue sharing. This is fortified by the information privacy principles and Manual of Practice of the SA Department for Child Protection (the government department responsible for statutory child protection in SA), which underscore the protection of privacy and judicious information sharing, with paramount consideration being given to the safety of the child.

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Despite the foundational principles established, submissions to SA's 2022 Independent Inquiry into Foster and Kinship Care revealed a stark disconnect between policy and practice (Arney et al., 2022). Submissions to the inquiry highlight instances where confidential details about foster and kinship carers, the child's birth family, or other children were wrongly disseminated, leading to compromised privacy, safety concerns, and negative perceptions within the foster care system, through 'the recording, retention and sharing of defamatory, misleading, insulting, prejudicial or otherwise inaccurate information by the Department and other persons and bodies involved in foster care or kinship care' (Arney et al., 2022, p. 93). Many foster and kinship carers also reported delays in obtaining critical information, often post-placement, potentially endangering the safety of the child and others in the household. This communication gap meant carers were inadequately equipped to care for the child, leading to unstable placements or the neglect of certain health, behavioural or cultural requirements. Such lapses arguably jeopardise the privacy and safety of carers, children, and birth families. Such a practice environment also likely contributes to placement instability.

In navigating the intricacies of child social care, the lens of recordkeeping emerges as a pivotal tool, yet remains a double-edged sword. While recordkeeping is vital for transparency, understanding the nuances of the rights to participation in decision-making provided by Article 12 and the rights provided by Article 16 of the UNCRC brings forth the ethical considerations of privacy and dignity. The discrepancies between policy and actual practices demonstrate the ongoing struggle of balancing bureaucratic processes with human experiences.

To better understand the human experiences we need to employ diverse methodological approaches in research. We need a range of evidence to support our learning about young people's identity development, their feelings about their care, and their impressions of the records that are kept about them to form their 'care files', which for some are their main source of family and personal history. It is beholden on care stakeholders to ensure that our research produces reliable evidence that informs effective safeguarding policies, which are implemented in practice.

Records are more than just archival data; they hold significant emotional and legal weight, impacting rights to privacy and dignity as well as a young person's perceptions and identity. As we work to refine these processes, we must foreground the lived experiences of those in care, ensuring records not only meet administrative demands but also honour and respect the stories they encapsulate and the wishes of young people.

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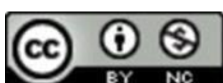

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Short Article

A promising change

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Abstract:

In this paper we aim to explore how, together, an education workforce introduced a change in the way they approached and participated in reflective practice through a Reflection and Action Learning Sessions model. Using quality improvement theory and methodology to aid implementation, they explored individual and collective motivation for change, what it meant for them, and what it meant for the children and young people they were caring for and educating.

Introduction

In Scotland, we are committed to providing all our children and young people with opportunities to learn in an environment that best meets their individual needs (Scottish Government, 2009).

Some children or young people who face a barrier or barriers to learning, may be offered the opportunity to learn in an alternative environment to mainstream education, where they are supported to achieve their full potential through a highly personalised curriculum, based on their strengths, skills and interests. The requirement for additional support can arise from a number of distinct and often unseen needs, including but not exclusive to; being looked after by a local authority, not attending school regularly, having emotional or social difficulties, or living with parents who have mental health difficulties or are abusing substances (Scottish Government, 2010). It is crucial to note that this is not an exhaustive list, nor is it pre-destined or assumed that a child or young person who falls into one of the example categories will be deemed as requiring additional support, or that it will be necessary.

Children learn and grow best in relationally rich environments where they feel safe and cared for by stable, predictable, loving adults (Biermeier, 2015; Bomber, 2020). They need adults to be relationally and emotionally attuned, and able to manage their own reactions and responses to a variety of behaviours, including ones that are potentially or actually harmful, in the event of a child or young person becoming distressed (Furnivall & Grant, 2014).

For the adults working alongside, caring for and educating children and young people in the complex environment of a specialist education setting, their day is

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busy, fast paced and often unpredictable. Providing the right support at the right time for children and young people can be particularly complex and challenging when working to support children with additional support needs, due to the additional vulnerabilities that they may have experienced, or continue to experience, in their lives (NES, 2017). To offer the most effective, high-quality support to children and young people, it is crucial that adults working in this space are themselves offered support to understand the behaviours and systems which are most effective in helping and responding (Scottish Government, 2023).

Acknowledging the aspirations of the Promise to hold the hands of those holding the hands of the child (Independent Care Review, 2021), safe spaces to reflect and learn are necessary for individuals to effectively challenge themselves, their practice, and their organisations, thereby improving outcomes for children and young people. Unfortunately, providing space and opportunity for reflection can be challenging, often becoming sidelined by other more immediate tasks or demands (Hepburn, 2023). Yet it is an individual's capacity to reflect that is one of the key components of good practice (Oelofsen, 2012). High quality reflection can support practice improvement, improve reflective and reflexive problem solving, and contribute towards improving outcomes for the children and young people we are working to help and support.

Both research and feedback from those in direct practice tell us that when practitioners are given the opportunity to engage in regular quality reflective practice with a skilled facilitator, their reflective and reflexive capabilities increase outwith these sessions, resulting in better responses and experiences for the children and young people they are caring for (Mann et al., 2009).

This paper explores how one organisation, as part of their journey towards embedding a culture of reflective practice within their specialist education setting, embarked on a change project to introduce a different approach to reflection for the workforce through implementing Reflection and Action Learning Sessions Their theory of change was that by creating conditions that enable a shift in reflective capacity within individuals, reflexive capacity in practice would be increased, resulting in a better educational experience for their children and young people.

What are Reflection and Action Learning Sessions?

Reflection and Action Learning Sessions were first developed by members of the Scottish Physical Restraint Action Group (SPRAG)[5] as one part of its overall work to positively influence practice related to physical restraint in residential child care. Combining and balancing the complimentary purposes of Action Learning Sets and reflective practice, this model provides a reflective space, a space for

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[5] For more information about SPRAG, please see A Final Note in Appendix 1.

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learning through the sharing of good practice examples, and the opportunity to think together about specific challenges. They offer a structured, facilitated space that uses reflective processes to challenge and creatively expand members' perspectives and problem-solving capabilities, enabling them to choose to respond differently to future scenarios. Group members are not given advice during these confidential sessions, but rather the opportunity and capability to develop new ways of thinking.

Action Learning is a structured, reflective group process offering the opportunity for members to share a scenario or problem, and to reflect upon and review actions and learning points. This process guides future decision making, reactions and responses (Action Learning Associates, 2023). This part of the session is adapted from the structure set out by Theadon (2018), promoting the ethos and value that there is no expert member within the group, and rather that through recognition of the power of collective knowledge and shared understanding, opportunities and outcomes will be improved for both young people and the adults around them.

In contrast to the Action Learning Sets the reflective practice space provides an opportunity for all members of the group to reflect together on the impact of their work on them. This is an unstructured space where people have the opportunity to process and digest some of the emotional experiences, resonances and distress evoked by their work. This type of group experience can be difficult and may include uncomfortable silences, but it can also be very powerful in transforming experiences and emotions, that can feel, at their extreme, almost intolerable, into something much more bearable (Taylor, 2011).

The role of the facilitator is to hold the boundaries of the group and provide emotional safety and containment. Participants should avoid inadvertently blaming, shaming or rescuing each other. It is a place where people can be honest and own difficult or uncomfortable feelings without being judged. Confidentiality is essential and the detail of what is talked about in the group should not be discussed outside, even between group members.

How the team explored their change idea

Opportunities for reflection already existed within this setting through, for example, supervision, training and debriefs, yet feedback from the workforce showed that they would value additional or different opportunities to reflect. The leadership team recruited a cross-section of representatives from different areas and roles within the education system, who became known as the implementation team, to consider introducing Reflection and Action Learning Sessions.

Implementing change across a full team is difficult (Ewenstein et al. 2015; Fixsen et al., 2019) with many change programs failing (Percy, 2019) as a result

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of the poor implementation of change ideas. To aid this process the group utilised the Quality Improvement Model for Improvement. This framework offered key questions to ask about the change the team wanted to make, a framework to follow, and tools to aid the planning and testing of change ideas (Langley et al., 2009). The team found tools such as the driver diagram and forcefield analysis exercises helpful in considering specific issues.

Completing a driver diagram aided consideration of the potential for introducing Reflection and Action Learning Sessions to the current system structure. The driver diagram is used to help plan improvement project activities and to ensure team engagement (Langley et al., 2009). It visually presented the team's theory of how their improvement goal of increased reflective capacity could be achieved. It articulated what parts of the system needed to change, and in what way, and included ideas to make that happen.

A forcefield analysis is a decision-making aid that helped the team consider all those forces that were both driving and resisting the change (Langley et al., 2009). The aim of this exercise was to identify ways to amplify enabling factors that would strengthen or remove restraining factors that might be acting as barriers to progressing with the implementation of Reflection and Action Learning Sessions.

Change ideas are based on existing theory, knowledge and evidence. One of the key pillars of quality improvement is the understanding that individual practitioners are the ones who know their part of the system best and it's therefore crucial to have a range of individuals from across the system leading input to the change process (Kotter, 2012). Full team engagement sessions encouraged and empowered every member of the education team to contribute and offer input and feedback on the change idea. The team worked together to agree an operational definition of reflection, thereby ensuring shared understanding of the improvement goal and the language used to describe it.

While the education team had a collective improvement goal, there was recognition that individual team members' motivations for implementation might differ. A reflective exercise offered the opportunity for self-reflection and connection with personal values and workplace motivations (Lipmanowicz & McCandless, 2013), after which the team created a word cloud with their answers to the question, 'what would it feel like as a learner if their [education] adults had more access to reflective space?'. Responses included descriptions such as 'safe', 'valued', 'accepted', and 'cared for'. Offering space for each member of the team to individually connect with and attribute personal value to the project aided buy-in and support (Cooperrider et al., 2008).

How did the team know change would lead to improvement?

The leadership team had committed to changing how they offered space for structured, facilitated reflection. They were also open to finding the right model and wanted to ensure that their Reflection and Action Learning Sessions model

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was actually an improvement and not just a change to the current system. During the initial phase of the project the implementation team participated in ten Reflection and Action Learning Sessions. Qualitative and quantitative data was collected throughout to inform adaptations and to determine if the change idea could be considered successful enough to be implemented into daily practice. The results of both data forms are outlined below.

Qualitative data

Plan Do Study Act (PDSA) cycles offered a model which could be used to test if the change idea was actually an improvement. These small-scale iterative testing cycles are fundamental to quality improvement (Langley et al., 2009), and to support this approach the team initially piloted the project within a small cohort. Each session offered an opportunity to complete a PDSA cycle and test changes and enabled ongoing learning. This approach provided a foundation for growing internal capacity, and offered opportunities for practice, role modelling and coaching, as well as allowing the implementation team to adapt and hone their change idea before scaling and spreading this across the wider team.

Feedback is a key aspect of any change project (Syed, 2020) and at the end of every session the team were invited to anonymously contribute. This qualitative data was reviewed and thematically analysed. The highest scoring category related to positive experiences was group dynamics (31%):

> Very open reflection, emotional for all involved. It showed how trusting the group are of each other.

The highest scoring categories of what might be improved were related to practice of the model (40%) and participation (34%):

> Only one person wanted to share today, it does work best when there are more people sharing.

Quantitative data

Prior to participation in the first, and then at the end of each subsequent, session each member of the implementation team completed the Reflective Capacity Scale (RCS), a 16-point reflective capacity sub-scale of the Reflective Practice Questionnaire (RPQ) (Gustaffson, 2021). This was selected based on Priddis and Rogers' (2018) analysis identifying the RCS as a useful means of research, evaluation and learning across a number of settings, and Rogers et al.'s (2019) assertion that it was a reliable measure of reflective capacity in medical students. The aim of this particular data measure was to identify any changes to members' self-perception of their reflective capacity. Individual measures were collated, averaged, and then input into a run chart, which enabled us to study collective shifts in reflective capacity over time (Provost & Murray, 2011). This run chart data showed a positive increase of 10% in the average reflective capacity of the implementation team over the 10 pilot

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sessions, also it further suggested that the team's collective reflective capacity was influenced by the time of year and connected to points of transition and change.

In response to concerns that this project would be excessively time consuming, a balancing measure was introduced that offered the opportunity to measure participants' perceptions of the impact on their daily workload, and thereby to provide an indication of how accessible and sustainable the project was. Balancing measures help to ensure that the changes made to one part of the system don't negatively impact another part of the system or practice (Provost & Murray 2011). Over the 10 pilot sessions 95% of responses indicated that taking part in the project did not negatively impact ability to complete overall work tasks. One occasion where an impact was recorded was following a participant's first time participating in a session. Participants were not required to provide any identifiable details for this portion of data collection, such that further analysis or clarification was untenable with regards to whether there was, for example, a potential shift in value attributed, or if there was preparation required for attendance at the first, that was not required in subsequent, sessions.

Conclusion

Scotland has been at the forefront of many innovative and forward-thinking approaches to care and education (Scottish Government, 2020), with national political support through frameworks including Getting It Right For Every Child (GIRFEC) (Scottish Government, 2022) and The Promise (Independent Care Review, 2021). We are also undergoing a period of reform within both the education and care landscapes with proposed changes to the SQA and Education Scotland, as well as the possible introduction of the National Care Service.

We would contend that for Scotland's ambitions to be truly transformational, as we collectively strive to implement new ways of working to ensure we are doing all we can to keep The Promise, our systems must also adapt to support the needs of our workforce. This should be done via evidence-based tools, improvement methodology, and interventions to aid change and ensure that any change is the right fit for each unique system and setting. Systems must be understood from the perspective of those working in them, and the complex reality of specialist settings that offer care, education and support to children and young people must be incorporated into any change programme.

Our systems must provide our workforce with the space required for reflective thinking and create and protect relational spaces where we can reflect critically and at depth with our colleagues. Spaces that allow us to develop skills that benefit the children and young people we are educating and caring for and aid us to respond or react differently are important. How adults respond to children and young people influences relationships; the strength of a relationship between an

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adult and a child influences the child's learning experience, influences how they feel, how they learn, and how they react and respond to the adults around them.

This project has the potential to be truly transformational across the education team, building new ways of thinking and reflecting in adults, and building additional relational skills with respect to teaching and caring for children and young people. With individual and collective aspirations, this team stepped into an uncertain space and made a commitment to each other to try something different. A recorded 10% increase in reflective capacity across the implementation team evidences a positive shift, however the benefits to the team of collective action and collaboration for change, while unmeasured, will have their own separate powerful impact and aid the successful scale and implementation of the next phase of the project.

The more fully we support Scotland's adults through Reflection and Action Learning and effective implementation of change, the greater are the wide-reaching positive impacts and outcomes for Scotland's children and young people.

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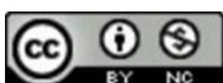

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Kyle Fleming is a head of education leading Erskine Waterfront Campus, part of Crossreach, Children and Families. Kyle and his team run the school provision at Erskine: an all-through school for complex additional support needs. All the pupils have impacted learning journeys and struggle with pain-based behaviours. Many are looked after. Kyle has 26 years' experience in the small school sector and 15 years as a headteacher.

Appendix 1

The Scottish Physical Restraint Action Group (SPRAG) is a member-led group of over 70 organisations and individuals working towards the common vision of:

> *bringing about more effective, empathic, loving ways of holding children, young people and the adults who care for them in residential child care – in*

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relationally rich environments, populated by adults who are properly equipped with requisite skills, knowledge and ways of being with children in the way that children need.

[SPRAG] will work towards making coercive forms of holding less or even unnecessary and, when children are restrained, ensuring that it is carried out relationally and with care. (SPRAG's Vision Statement)

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Short Article

Reasons to be cheerful: Factors making a positive difference to children in residential care in Scotland

Mary Morris
Care Inspectorate

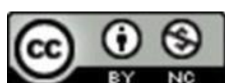
Abstract:

The Care Inspectorate, the regulator for care homes for children in Scotland, has analysed some of the key factors that contribute to our evaluations of high performing services. These services are making a positive difference to the children and young people living in them. Many residential childcare services in Scotland are helping children experience a good, loving childhood, with their needs met and their rights upheld. This article will outline these factors and hopefully convey a sense of optimism regarding residential childcare in Scotland. These key messages were shared in an online session in April 2023.

Introduction

There are some serious challenges facing the residential sector in Scotland in 2023. Staff recruitment and retention is complex and difficult. While Scotland has welcomed the arrival of unaccompanied asylum-seeking young people, this work has created additional pressure on the sector. The levels of trauma experienced by many children and young people are high. Residential care operates within the wider public sector resource and cost of living crisis. Despite these very real difficulties, this article outlines that there are reasons to be cheerful and that many residential services are responding to children and young people with compassion and love. The Promise Oversight Board (2023) acknowledges that change is happening, and that progress is being made, with a commitment to keep the Promise embedded in many organisations. The report also highlights the importance of hope and encouragement. This article aims to support that message.

The Promise (2020a) highlighted that if children are not able to live with their families, then the focus of their care must be on building childhoods that are underpinned by loving relationships, fun, play, education, and opportunity. The Care Inspectorate has tried to capture these messages in their current inspection



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methodology with key quality indicators 7.1 and 7.2 (2022b) focusing on the extent to which children and young people are safe, feel loved and get the most out of life, and on leaders and staff having the capacity and resources to meet and champion children and young people's needs and rights. When we look at services that are doing well in meeting these aspirations, some key messages emerge, some of which this article summarises. The Care Inspectorate believe that these messages celebrate the positive work that is going on in the sector and are hopeful and optimistic. These messages were outlined in a Care Inspectorate webinar (2023).

Relationships

In high performing residential services that support children to have a good childhood, stable loving relationships thrive. Staff working with children have time to let loving relationships develop and to be sustained, they are supported to do so, and understand trauma-informed approaches. Children feel safe and trust the adults caring for them. Affection, warmth, fun, empathy, nurturing, and a gentle response to distress are integral to the culture of these services. Children experience relationships as authentic and meaningful. The Pinky Promise (2020b, p. 9) stated: 'What is important to children is that children are loved and feel loved. Children said they want relationships that are important to them to be protected and allowed to grow.' Positive caring relationships between the adults and children in residential services are not new. The increased awareness of the importance of these relationships and approaches to support them in many services is welcomed. Loving relationships with attuned adults help provide necessary support and scaffolding for children and young people. This can help them feel connected and valued. In high performing services we are observing warm, stable relationships underpinning all aspects of the care children and young people receive.

The shift in the language used so that children, young people, staff, and the regulator now routinely use the word love in this context is also something to celebrate (Love InC, 2022).

Knowledge and understanding of trauma

A recurring feature in the residential services the Care Inspectorate are evaluating as very good or excellent is an understanding of the impact of trauma on the children and young people cared for. This understanding permeates all aspects of these services. We find that there are huge benefits when there is an investment in training which gives staff an understanding of the impact of trauma on how affected children and young people experience their world. This understanding and knowledge is then translated into how the children and young people are cared for and responded to. Staff can make the link between behaviour and trauma. We see staff who can tune into how children are feeling, who are able to enable co-regulation. Staff have an understanding of the need to be present and emotionally available. We see care plans that are trauma-

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informed and compassionate. Instead of responding to behaviour in a reactive or punitive way there is an enhanced understanding of the feelings behind the behaviour, such that responses are attuned and individualised. The National Trauma Training Programme (2021) principles of safety, choice, collaboration, trustworthiness, and empowerment are embedded in these cultures. There is also a culture of learning and reflection. Investment in training and continuing discussion and learning about trauma is making a positive difference in many services. Again, this development and sector wide commitment is something to be cheerful about and to build on. High quality residential childcare settings in Scotland are investing in this approach, which is making a huge difference to outcomes and experiences for children in these services.

Considered and careful matching of children to residential services

Our evaluations of services that are delivering compassionate and loving care to children in Scotland indicate that very carefully considered matching of children to the right resource for them is essential. Having the time and space to understand what a child or young person needs and what their story is makes a positive difference to that child's outcomes and experiences. Considered thinking about what the individual child needs and whether the staff team have the right skills to meet these needs underpins effective matching decisions. Are there enough staff to provide individualised care to that child or young person?

Are there appropriate resources that have availability nearby to support the young person? Is the location and environment going to work well for that child or young person? Will the location support connection with the people who are important to that child or young person? Does the staff team feel confident that they can care for an individual child or young person with compassion and love? Is the potential placement going to fit in with a children's rights approach? Purposeful contemplation of important questions allows services to effectively support children, ensure they are in the right place, and minimise the chances of further moves, which may be experienced as rejection.

Analysis of risks and how these can be reduced and managed need to be factored in. Deliberation about how well a child or young person will fit in with other children and young people needs to be part of the process. Can the service safely meet the needs of all children and young people? Are there enough staff with appropriate qualifications and experience to meet all the needs of the children and young people? Having a rigorous well considered matching process, as outlined in the Care Inspectorate guidance (2022c), is an essential component of delivering high quality care. Within this context sometimes it will be the right decision for the service to assess that at a particular point in time they are not well placed to respond to an individual child or young person's needs. Being part of a wider environment that respects and listens to that assessment is a key part of ensuring residential care is of a high standard. Recognising this and building wider capacity to ensure that all of Scotland's children can have their needs met is part of Scotland's wider commitment to

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keep The Promise. The Care Inspectorate recognises there are complexities and challenges for many services within the current Scottish context, but our analysis of what works at an individual service level is that this is a key component. It is important to recognise and build on this understanding so that all children, as far as possible, are matched to a service that is right for them.

Leadership

Effective leadership, both within the residential service and providing external support, is critical to delivering high quality residential care for children and young people in services in Scotland. Leadership is pivotal in terms of establishing a culture that responds sensitively to the often-complex needs of children and young people. Establishing a culture that understands trauma and responds in a way that is healing needs leaders that have that informed understanding themselves. They can model this and ensure staff get impactful training. Leaders can ensure there is a culture that is reflective and loving, with safe spaces created for staff to reflect. They set the tone that makes the residential house a home that children and young people may heal and thrive in. Leaders who are aspirational and embrace research and feedback from children and young people can drive up standards. Effective and responsive quality assurance that supports improvement has an impact on what happens for children and young people and the staff who support them. Leadership which is ambitious for children and young people usually underpins high quality day-to-day life in residential services. In Scotland we are seeing leaders who are striving to do better, through buying into the aspirational agenda of The Promise. We see leaders who are committed to reducing restraint for children and young people in residential care, who are supporting the rights of children and young people, and who speak out on their behalf. They are taking on board messages from The Promise about language that is child focused and non-stigmatising. They ensure that as far as possible children have what they need to support connection, adjusting staffing and resources as needed. They work hard to ensure matching is right at individual service level. They contribute to wider strategic discussions about ensuring there are resources that meet children's needs and have in-depth knowledge of trauma. This powerful and authentic leadership within the residential houses in our high performing services is making a valuable difference to how those services are supporting the children and young people living in them. External leaders who provide appropriate support and challenge and are committed to the best possible outcomes also contribute hugely to the effectiveness of well performing services. They champion the rights and needs of the children in their care. It is important to recognise and celebrate the leadership and commitment within residential care in Scotland. Very good care does not just happen, and the passion, energy, and commitment in our high performing services in Scotland is a very important reason to be cheerful, giving the sector the hope and energy to move forward.

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Conclusion

This article has set out some of the common denominators in high performing residential services that are caring for children. Each service is of course unique, and there is no magic formula or tick box approach for the complex task of ensuring traumatised children feel loved and get the most out of life. Nevertheless, the key factors briefly outlined feature in services that are getting it right. The sector can continue to evolve and develop and build on these vital strengths going forward. There is much to be cheerful about.

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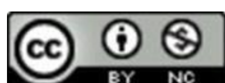

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Short Article

Cognitive profiles of children and young people in secure care

Sara Folman Hadjidemetriou
St. Mary's Kenmure

Abstract:

Children and young people in secure care often have significant vulnerabilities and can experience multiple adversities. Whether these are biological, psychological, or social in nature, the impact can be significant and traverse many domains of functioning, including cognitive skills. The ability to think, reason, learn, problem solve, pay attention, concentrate, remember, and communicate are essential life skills. Despite previous research documenting a link between trauma and cognitive impairment in looked after children and in young offender populations, there is a dearth of research specifically exploring the cognitive profiles of children in secure care. Furthermore, experience working in a secure care setting has exposed a tendency for professionals and care staff to attribute a higher level of skill and competency to young people who have not undergone any formal testing. Given the vulnerabilities of this group, it is critical that we understand and properly respond to their needs. One way to ensure that their cognitive profile is considered when designing their care plan, is to include formal cognitive testing as part of the assessment process. Having an accurate profile of areas of strength and weaknesses can ensure that care plans are properly tailored to maximise young people's outcomes.

Introduction

International research has shown that children exposed to adverse childhood experiences (ACEs), who are looked after away from home, who are in secure care, and/or who perpetrate offences are, as a group, more likely to experience cognitive vulnerabilities (Hawkins et al., 2021; Kamath et al., 2017; McMillan et al., 2023; Van IJzendoorn et al., 2008). However, as of August 2023, it has been impossible to locate any publications specifically investigating the cognitive functioning of young people in secure care facilities in Scotland. Also, experience

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of working across such settings has revealed a tendency for practitioners to often attribute high levels of skills to the children they were looking after. Statements such as 'extremely intelligent', 'academically able', and 'capable' have featured in many reports and professional discussions where there seemed to be little or no objective evidence to substantiate such claims. Indeed, it seemed more likely that the opposite was true, thereby raising the possibility that children with vulnerabilities had unrecognised, unmet, and misunderstood needs.

Since secure childcare is designed to meet the needs of some of the most vulnerable and marginalised children in the country, it is perplexing that this data does not exist. If we are to ensure that every effort is made to understand and support children who, by virtue of their risks, needs and vulnerabilities, are required to lose their liberty for varying periods of time during their formative years, it is vital that we do not miss any opportunity to gain a better understanding of how to help and to ensure that interventions are properly matched to their capacities and capabilities.

In summary and given what we know about other looked after populations, this article aims to explore the complex interplay of vulnerabilities that young people in secure care are likely to be subject to and how these vulnerabilities have been empirically linked to certain cognitive weaknesses. In response to this, the article introduces the notion of formal cognitive testing as an effective way to overcome cognitive barriers, given it has been helpful in reliably identifying and supporting the needs of other vulnerable populations. Finally, the article discusses certain practice observations made by the writer within a secure care setting, which could have negative implications on the progress of young people and which can also be resolved or at least mitigated through a better understanding of the young person's cognitive profile.

Secure care

Every year, approximately 100,000 young people are being looked after by the state (NCCSP, 2021). The latest yearly average calculated in 2022 indicated that 74 young people were housed in secure care facilities across Scotland (there are four secure care facilities in Scotland with a capacity to accommodate around 84 children (Scottish Government, n.d.)).

Secure accommodation has been described by the Scottish government as a 'form of residential care that restricts the freedom of children under the age of 18. It is for the small number of children who may be a significant risk to themselves, or others in the community' (Scottish Government, n.d.). Children and young people are typically placed in secure care via the Children's Hearing System (when there is a welfare concern) or by the courts (when there are offending behaviour concerns). The government outlines the five main legislative routes that can lead to a secure care placement. Firstly, a secure care authorisation might be included in an order such as a compulsory supervision

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order (CSO), or a warrant issued by the children's hearing system or the sheriff's court. Secondly, children who are looked after by the state or are subject to a permanence order could be placed in secure care in the context of an 'emergency placement' authorised by the Chief Social Work Officer (CSWO). In some limited circumstances, when a child is under the age of 16, or is between 16 and 17 years of age and has a CSO, the police can approve a temporary secure placement until the young person is due in court. In addition, young people who are under the age of 16 and are on remand by the court, are placed back in local authority care, which might decide to house them in secure care. Finally, a young person might also be transferred to secure when they are found guilty of an offence (as covered by section 44 of the criminal procedure act 1995 (Scottish Government, 2022)). Restricting the freedom of a young person is a very difficult decision, and one that should not be taken lightly. Thus, their time within secure care should be a period of intensive interventions that are instrumental in changing the course of their life.

Children who have experienced disrupted family, school and living arrangements have typically endured adversity and are at risk of experiencing difficulties in their development. Compared to other forms of residential care, the number of young people housed in secure care is small and not all countries have such facilities. Thus, research dedicated to these young people is somewhat limited. However, findings can be extrapolated from other looked after populations to inform understanding. It has been recognised for decades that multiple variables can impact outcomes for children, including factors inherent within them and their environments, as well as interactions between the two (Bronfenbrenner, 1979). Thus, their current presentation is likely the result of a multifaceted interplay of biological, psychological, and environmental factors. As a result, many, if not most, of the young people housed in secure care have a complex combination of biopsychosocial vulnerabilities. Young people who are looked after have a higher prevalence of mental health problems in comparison to their same-age peers (Dubois-Comtois et al., 2021), with around half of them meeting the criteria for a diagnoseable condition (Carmichael et al., 2016). They also experience a high level of comorbidity when it comes to mental disorders (Jozefiak et al., 2016) and are more likely to be prescribed psychotropic medications (Raghavan et al., 2005). Studies have found that children cared for by the state have lower educational attainment (Sebba et al., 2015), are more likely to experience academic disruption (Mannay et al., 2017), have been exposed to adversity or trauma prior to entering care (CYCJ, 2021), and are likely to have been reared in low socioeconomic backgrounds, which in turn further compounded adversity (Bennett et al., 2022). Looked after young people have also been found to be more likely to be in conflict with the law (Biehal et al., 2010), show higher rates of risk-taking behaviours (Stevens et al., 2011), and are more susceptible to poor physical health outcomes (Selwyn et al., 2017). Finally, looked after young people have been repeatedly associated with comparatively poorer outcomes, like for instance unemployment, poverty,

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offending, mental health difficulties, and becoming young parents (Naccarato et al., 2010; Svoboda et al., 2012). In summary, looked after young people are amongst the most vulnerable members of our society, partly due to the experiences that preceded their removal from home and partly to the multiple placements they are likely to face until they reach adulthood, which increases the risk of their needs remaining unrecognised and unmet. Combining the above allows for a taste of the complex, multifaceted interaction of factors contributing to the vulnerability of the looked after population that includes those housed in secure care.

Cognitive capacities

The significance of these varied risk factors to cognitive development is borne out in the literature. For example, a recent longitudinal study by Hawkins and colleagues (Hawkins et al., 2021) reported that ACEs (i.e., stressful or traumatic life events such as abuse, neglect, exposure to domestic violence, parental separation, divorce, or living with a parent with substance abuse issues) directly contributed to poorer cognitive abilities, but importantly the different types of ACEs had varying impacts. For instance, deprivation type ACEs, which represent any form of neglect, have been found to specifically hinder memory and executive functioning in the long-term, thereby impeding language development amongst other cognitive functions (Hawkins et al., 2021). Moreover, the study concluded that ACEs that are of a threatening nature have been found to result in neurocognitive harm due to the continuous production of toxic stress which impacts internal biological systems (Hawkins et al., 2021). Surveys conducted amongst the secure care population in Scotland have suggested that on average young people have experienced at least four ACEs prior to entering secure care (CYCJ, 2021). Thus, considering young people's different types of ACEs is invaluable when designing care plans and implementing intervention approaches that consider cognitive profiles. Another important finding, particularly for young people sent to secure care via the courts, is the high prevalence of traumatic brain injury. A recent study by McMillan et al. (2023) found that 80% of young people assessed in His Majesty's Young Offenders Institution in Scotland had a history of significant brain injury and, as a group, these young people struggled more with controlling their behaviour and self-regulating. They also engaged in high-risk behaviour as well as demonstrating problematic substance use (McMillan et al., 2023).

Some further factors discussed in the literature - which have been found to be correlated with cognitive vulnerabilities - include comorbid mental health disorders (which looked after young people are more at risk of having), brain injury (which McMillan et al. [2023] noted is a common phenomenon in incarcerated youth), insecure attachment styles (which would be likely given secured young people's chaotic lifestyle (Ding et al., 2014)), and more.

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Studies such as the above underscore the need to consider cognitive profiles and could explain why looked after young people have a higher prevalence of undetected communication, cognitive and language disorders (McCool & Stevens, 2011).

Creating opportunities for understanding

Cognitive assessments are standardised, formal assessments that have been designed to measure a person's abilities compared to other people of the same age. Cognitive assessments are founded on longstanding empirical theories of cognitive development and typically evaluate a broad range of skills, such as verbal comprehension, verbal reasoning, abstract reasoning, attention, memory, executive function, problem solving, and visuospatial skills (McGrew, 2009). They are the result of extensive and repeated reliability and validity investigations. These assessments can be used for a variety of reasons and in various contexts, such as assessing whether a child is developing in an age and stage appropriate way, or the effects of any illnesses or injuries. These tests can provide detailed profiles of a young person's abilities across all the aforementioned areas (Kelso & Tadi, 2022). Thus, by administering these assessments professionals can gain insight into a person's overall functioning as well as their domain specific abilities, which often show a variable pattern of skills (e.g., if someone had a brain injury their domain specific performance might contribute to better understanding the location and extent of the damage).

A common theme in the literature seems to be that an effective way to support vulnerable young people is by completing a comprehensive and up to date assessment of their strengths and weaknesses (this can be reliably achieved via the completion of a cognitive assessment amongst other important tools such as observations, background information and more (Dawson & Guare, 2018; Kaul et al., 2021)). In addition, due to the biopsychosocial vulnerabilities that young people in secure are likely to present with, as discussed above, completing a comprehensive biopsychosocial assessment could be beneficial. Such assessments usually include an exploration of the young person's current functioning, which, again, can be understood using cognitive screening tools. Researchers suggest that such assessments contribute greatly to the appropriate design and tailoring of educational and rehabilitation programs for the young person (Chokron, 2021). The findings from such assessments could also assist in educating the people involved in the child's care regarding their specific needs (Chokron, 2021). As noted above, upon assessment young people who were looked after by the state, as well as those housed in secure care facilities in other countries (e.g., Australia; see Vidanka, 2009), have demonstrated certain cognitive difficulties (Fry et al., 2016). As such the inclusion of these assessments in secure care facilities could be helpful in identifying and combating these weaknesses.

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In summary, due to the varied and complex histories of children and young people in secure care, understanding their domain specific abilities is invaluable in contributing to a clearer understanding of their strengths and weaknesses. This information can then be used within the multidisciplinary secure setting to ensure that the team around the child comprehends their cognitive profile (their unique set of strengths and weaknesses) and how these cognitive skills impact or drive their behaviour. For example, if a child has weaknesses in their working memory domain, staff should not assume they can retain and/or recall information previously communicated to them.

Creating opportunities for intervention

When young people are in secure care, they are under constant supervision, they are kept safe, and they are exposed to positive stimuli (e.g., education or sports). These advantages mean that in a secure placement there is increased scope for reliable formal cognitive testing and interventions. The following recommendations pertain to the looked after populations housed in secure care facilities across Scotland.

Using the findings to effect change at the individual and systemic level

By better understanding young people's cognitive profiles and their subsequent strengths and weaknesses we can adapt care to ensure that these factors are accounted for. This is because, with the right support, cognitive abilities can be optimised. For example, research has shown that working memory, which is an important determinant of a variety of cognitive functions, can be enhanced with mental exercises (Morrison & Chein, 2011). Even minor changes in the daily lives of young people can help enhance their cognitive abilities, such as engaging in physical activity, which has been empirically associated with improvements in educational attainment and cognitive functioning (Rasberry et al., 2011).

A sizeable literature exists which attests to the usefulness of making adaptations in the social, relational, and physical environment for young people who have cognitive difficulties. Various strategies have been recommended. For example, when young people identify an area of interest for them, staff can help expand their critical thinking and comprehension by questioning them about this topic. In addition, when a young person is expressing something, staff can encourage them to elaborate on their thoughts, thereby improving their language or verbal reasoning skills. Staff can also ensure young people have routines and predictability, encourage them to accumulate sufficient sleep, make sure they are paying attention prior to delivering instructions, and ask them to reiterate what has been discussed. If a young person is struggling to comprehend a topic, alternative aids can be used, like pictures or flow charts. Even modelling pro-social problem solving to young people can be helpful. When communicating

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with young people, speaking slowly and clearly is of utmost importance as even if weaknesses have not been identified in this area, cross cultural accents or vocabulary might influence understanding. Recognising their strengths is also critical to their progress. Positively reinforcing good behaviour using a reward chart or providing casual compliments can encourage this behaviour to continue and increase whilst ensuring it does not cease.

Supporting staff

In addition to direct interventions, having access to accurate cognitive profiles will ensure that staff are better informed and equipped to support young people. As indicated above, the tendency to misattribute skills to children and young people has been observed, and whilst this is merely anecdotal it is a potentially problematic phenomenon which could lead to unrealistic expectations being placed upon young people. This could, in turn, cause anxiety or frustration and contribute to behaviour problems or to the breakdown of relationships between young people and staff, as well as hindering young people's progress within secure care. Where cognitive assessments have been completed, staff may be debriefed to ensure their understanding of the young person's unique set of strengths and weaknesses. Training can also be offered which will inform staff of alternative techniques that can be used to help communicate information in a manner that compliments young people's abilities. Staff might also benefit from receiving input to better understand how particular cognitive strengths and weaknesses manifest. For example, a young person might become dysregulated after receiving a complex myriad of instructions due to not understanding what has been said. Staff might perceive this dysregulation as challenging behaviour, instead of a cognitive impairment. Conversely, the opposite can also happen, where young people who exhibit desired behaviours might be at risk of having their cognitive abilities overestimated. This could be a result of staff becoming acclimatised to many young people presenting with externalising conduct type behaviours and thereby perceiving those who don't as more able. Studies have found that residential care workers are more likely to recognise a problem if it co-occurs with problematic behaviours (Winsor & McLean, 2016).

Conclusion

In conclusion, young people housed in secure care are a complex and vulnerable segment of the population who could benefit from robust and comprehensive assessments, tailored to their specific needs. Recent data from similar populations has reminded us of the importance of considering cognitive profiles when assessing young people's strengths and weaknesses. Thus, thinking about implementing intervention approaches that would include cognitive assessments as a vital part of formulation could be beneficial, as insight would be gained into the young person's unique cognitive profile, which would subsequently inform their individualised care plans. This could also allow for an in-depth

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multidisciplinary and cross campus understanding of the pragmatic needs of these vulnerable young people. The literature concedes that detailed assessments depicting strengths and weaknesses in vulnerable populations is an effective intervention strategy as it allows for tailored care and education plans. These assessments can also be used for educational purposes, to better inform the team around the child. Thus, understanding every aspect of young people's development, including their cognition, could result in young people and secure care facilities becoming better equipped to implement meaningful change.

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Sara Folman Hadjidemetriou is an assistant psychologist at a secure care facility called St Mary's Kenmure.

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Short Article

Police and residential care

Nicola Glasgow
Police Scotland

Abstract:

This article describes the role of a police liaison officer working at a large Scottish residential education and care centre. Four main aspects of the role are outlined: child protection; preventive education about online safety, substance abuse and other harms; following up concerns raised about criminal activity by and towards young people; and being the first point of contact for missing children and young people. The article explains the philosophy behind the role and the author's perceptions of lessons learned.

Introduction

I have been a Police Officer for the past 12 years and for the last two years have been a Police Liaison Officer at a large Scottish residential education and care centre. The service supports at risk children and young people. Many of these young people have experienced significant trauma in their lives and have concerning behaviours that can increase their risk to themselves and others.

My Role

My role originated when Police Scotland and the residential provider agreed that having an officer who could work more closely with young people would be helpful both for young people and for the services supporting them.

My role covers a wide remit but can be broken down into four main areas:

1. Child protection: being the first police point of contact for young people and / or residential staff who want to raise concerns about child protection.
2. Educating young people, and sometimes staff, with a preventive focus, such as online safety, drug/alcohol misuse, knife crime, hate crime, anti-social behaviour, road policing safety, and criminal and sexual exploitation.
3. Dealing with complaints from young people in relation to them being a victim of crime or from staff members who are concerned about a young person's criminal activity.
4. Missing people: being a first police point of contact for staff who are concerned about a missing young person.

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Police Scotland have a dedicated department within the Partnership, Prevention and Community Wellbeing Division known as The Children and Young People (CYP) Team. This team take the lead in delivery of Police Scotland's priorities and commitments to over one million young people within Scotland. At the heart of what the team does are the principles of Getting it Right for Every Child[i], children's rights, and Police Scotland's responsibilities as a Corporate Parent[ii]. I work closely with the CYP Team on a regular basis. They provide me with relevant materials they feel would benefit children and young people and offer various inputs from external agencies that I am able to link in with should I feel they would benefit any of the children and young people at the residential service. Creating links with external agencies allows children and young people at the service to access various opportunities. For example, I have recently referred two young people to take part in a Cash Back Programme that two local football clubs offer. This is financed by funds recovered through the Proceeds of Crime Act 2002 and invests into community programmes largely aimed at diverting 'at risk' young people away from criminal or anti-social behaviour. This has allowed both young people to participate in a programme which helps them move towards a more positive future, including working, volunteering, or further education. The feedback has been extremely positive from both young people, and I hope that more young people from the service are able to take part in the future.

The philosophy behind my role

From the outset I believed that my role would be most effective if I could build meaningful relationships with young people. I wanted to break down barriers and hostilities they may have towards police given their previous interactions, often in a context of family neglect or following criminality. When I began in post, I invested a lot of time in being 'Nicky' rather than just a police officer. I got to know young people, was interested in them, and, most essential of all, I listened to them. I had hoped this would be useful, but it proved more so than I expected, as young people really responded to me. Being around every day and engaging with young people for reasons other than criminality meant I was more accepted, such that much of the usual stigma and hostility was broken down. Focusing on relationships has been a key aspect and without this relational approach I doubt I would have got far. Leaving the uniform at home once a week may have helped too!

Lessons learned

Working daily with care experienced young people has in turn been a huge eye opener to me. Listening to and being involved with young people has in turn shaped and developed my understanding of them. I have come to understand their backgrounds and how these have been key to their current difficulties. Usually as a police officer you are under many and varied pressures which means your time with people can be brief and focused on the immediate issue,

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rather than their wider context or background. Now I know the trauma that the young people have often, if not always, experienced. I have learned how important this is in explaining their behaviours and how they engage with the world, including the police. Their hostilities towards the police are rooted in their experiences and I wanted to provide better experiences that could balance these.

The residential provider has supported a lot of training and learning for me, including their trauma-informed training that all residential staff receive. I believe that being trauma-informed is key for anyone working with young people in residential care, and this includes the police. I have tried to embody this in my work, trying to understand young people through their experiences and current situation. I'm convinced this means I'm more effective in my role.

The outcomes

I have been in post for some time now and the feedback I have received, and my observations, suggest that there have been a number of key changes.

1. Young people feel able to speak with me, as a police officer. Being 'Nicky' has meant that young people have been able to overcome hostility and difficulties and instead put some trust in me. I believe this has meant that they have been able to report child protection and safety concerns more easily. The importance of this is hard to measure, but given it is such an important aspect of keeping young people safe and preventing future harm I'm very pleased we've achieved this.

2. Young people are more open to education and hearing about how to keep themselves safe. Police officers have a particular set of experiences and knowledge that are hard to achieve in other roles. We can provide useful education that can be very specific to young people. Young people have been more likely to engage in preventive education around many areas, which has hopefully prevented future victimisation and criminality.

3. Young people have also felt more able to raise complaints about criminal behaviour towards them. This is empowering for young people and has meant that more of them have achieved some form of response, when in the past they would have accepted some crimes without expecting anything from adults or services. In turn, the response I and the police in general have provided has challenged their biases towards the police and helped show them that the police can support them and be a help, rather than an enemy.

4. Working in partnership with the residential service regarding missing young people has enabled a more effective response from both police and the residential provider. This has meant that robust responses have been delivered when needed and helped avoid unhelpful or disproportionate responses when a more subtle approach is appropriate. Having a close and

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collaborative partnership on this has resulted in a more nuanced response that has benefitted young people, the police, and the residential service.

5. The Philomena Protocol has recently been introduced to care establishments within Scotland. This involves compiling a standardised form of useful information which can be used in the event of a young person being reported missing. I have conducted staff training in relation to the protocol to ensure they are aware of the vital information. Details of this can be found at https://www.scotland.police.uk/what-s-happening/news/2023/may/new-process-to-help-trace-missing-children-rolls-out-across-scotland/

These successes would not have been possible without a relationship-focused and trauma-informed starting point. This has enabled both my own and young people's biases to be challenged and overcome. It has helped create collaboration between young people and the police, but also with the residential service.

Recommendations

My role is funded by the child and youth care provider, while Police Scotland remains my primary employer. It is acknowledged that this will not be possible for many services, however where this is possible, it can be a unique use of resources that can directly benefit young people in both the short and longer term. If the resources are not there, then creating closer links between residential services and the police can be achieved in other ways. I would encourage anyone working in residential care to contact their local community police to establish links, build relationships, and increase understanding of each other's roles to support young people in our communities.

About the author

Nicola Glasgow is a police officer within Police Scotland currently conducting the role of police liaison officer at a large residential placement in Scotland.

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[i] Getting It Right for Every Child is the Scottish Government's policy on the rights and support entitlements of children and young people in Scotland.

[ii] Corporate parenting refers to the statutory duties of certain public bodies in Scotland in respect of children looked after by local authorities.

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Book Review

Challenging the conventional wisdom about residential care for children and youth: A good place to grow

By Bruce Henderson

Publisher: Routledge

ISBN: 9781032564739

Year of Publication: (due) 2024

Reviewed by: James P. Anglin
Emeritus Professor, School of Child and Youth Care, University of Victoria, BC, Canada, janglin@uvic.ca

I need to be clear that I do not come to this review as a dispassionate or objective reviewer. Quite the opposite. I have been an advocate for the premise of this text for a great many years, and I was engaged with the author as an informal advisor as he wrote this book. However, I believe this is an important and timely text that deserves to be widely read by all those involved in the residential child care system, at any level, and in any jurisdiction. To my mind, this book is overdue. It offers a rigorous examination of over 400 references from the international literature on the provision of residential care for young people, undertaken by an expert in research methodology with an open and curious mind about what the evidence tells us about the effectiveness of residential care for children and youth.

The conventional wisdom that Henderson identifies is the belief that residential care, ongoing 24/7 care outside a family setting, is harmful for children of any age. As such, any such placement should be a last resort and for the shortest possible time period. All children and youth should be with their own families or, failing that, in family foster care, kinship care, or adoption. Those who hold these views will likely hate this book as, in my experience, their minds are firmly made up and invested in eliminating virtually all residential care. However well-meaning the intentions of these critics of residential care, this text demonstrates that there is no significant research base for such a position. To the contrary, there is significant and growing evidence for the provision of good quality

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residential care for children and youth for whom family-based care is not appropriate or efficacious. As many readers of this journal will know, there are significant numbers of young people in every society for whom, for many different reasons, any type of family-based care is not appropriate or effective.

In Chapters One and Two Henderson sets the scene. He briefly presents his own journey to writing this book and then situates it in the context of current anti-residential care lobbying in the US. He also identifies a set of assumptions characteristic of the conventional wisdom.

Chapter Three provides a very useful overview of how to read research literature, so that readers themselves can consider the literature from an evidence-based perspective. In this way, readers are introduced to how Henderson approached his research review and can thereby follow his subsequent analyses with an informed and critical mind.

Chapter Four explores the hostility expressed towards residential care for young people, and systematically examines the various purported 'authoritative' statements condemning residential child care. Henderson demonstrates that most of the credible research used to support the conventional wisdom is based on studies done with infants in deprived environments, such as the infamous Romanian orphanages under former President Nicolae Ceaușescu. These studies are inappropriately generalised to all forms of residential care for all ages of young people by opponents of residential care.

Chapter Five then examines the growing evidence that counteracts the conventional wisdom. Some readers of this journal will be aware of some of the research cited by Henderson, but this broad overview of recent research will offer a useful basis for confidence in the importance of good quality residential care as part of child welfare and mental health systems. While we would all agree that bad residential care needs to be immediately improved or eliminated, there is solid evidence that residential care can be a positive option for some children, with certain needs, at specific times in their lives.

Chapter Six suggests that we already know a good deal about what comprises quality residential child care, and in Chapter Seven, Henderson presents two quite different models that both have a significant research base, and which have evidence-based status at the 'promising practice' level with the California Clearinghouse on Evidence-Based Practice. I am very familiar with one of these models, the Cornell CARE Program Model. Over the past 15 years or so, this approach to quality care, with its articulated values, principles and practices, has been demonstrated to be applicable not only to the provision of residential care, but also to foster care, educational settings, and community-based programs.

The final chapter, Chapter Eight, summarises the book's conclusions and sets out the findings of this impressive research review in succinct terms, and this should be required reading for anyone who manages, provides, funds, or assesses residential care for young people. In fact, I think it would be of great

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benefit if every funding application for residential child care could have a copy of this text appended to it. The major limitation to anyone actually doing so is the current cost of the hardcover edition. Regrettably, it exceeds $120 US, even with an introductory discount. The good news is that the publisher, Routledge, is committed to bringing out a soft-cover version about a year and a half after initial publication, which should lower the cost considerably and make it more widely accessible. Also, the e-book version will be available after December 1, 2023, for purchase at $47.65 and a six-month rental will be $29.13 (https://www.routledge.com/Challenging-the-Conventional-Wisdom-about-Residential-Care-for-Childre/B-Henderson/p/book/9781032564739).

An important feature of the book is a set of extensive references following each chapter, totalling over 500 in number. This is a valuable resource for anyone wanting to explore the literature on residential care and its effectiveness in more depth, such as graduate students doing related research. Another feature I enjoy about this text is the pleasantly readable writing style of the author. A book such as this could have been a rather dry and pedantic treatise appealing only to avid researchers. Fortunately, Henderson writes in a direct and somewhat personal manner while maintaining a high degree of academic rigour. For example, I particularly enjoyed such succinct and straight-forward statements as the following.

> I do not intend to be defensive. Those who support high-quality residential care have been too defensive. However, let me be clear again about what I am *not* saying. First, not all family-less children and youth should be in residential care. Residential care is not for infants or young children except in emergencies. High-quality residential care should be available for older children and adults as one option among many. It should be a matter of fit. (Chapter 1)

About the reviewer

James P. Anglin is an emeritus professor in the School of Child and Youth Care, University of Victoria, Canada, and a research affiliate of the Residential Child Care Project, Bronfenbrenner Centre for Translational Research at Cornell University. He is a member of the editorial board of FICE-International, this journal, and six other CYC journals. He regularly contributes articles and chapters to international publications, supports graduate students, and has a passion for the history, evolution and enduring value of the child and youth care profession. He is also a member of the International Work Group on Therapeutic Residential Care.

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

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Book Review

Residential child and youth care in a developing world Volumes 1-4

By Tuhinul Islam and Leon Fulcher [Editors]

Publisher: CYC-Net Press

ISBN: 978-1-928212-21-8 (2016), 978-1-928212-24-9 (2017), 978-1-928212-37-9 (2018) and 978-0-6399718-7-2 (2021)

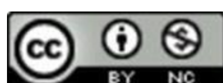
Years of Publication: 2016, 2017, 2018 and 2021

Reviewed by: Jennifer Brooker
Melbourne Polytechnic

Residential Child and Youth Care in a Developing World (2016 – 2020) is a unique insight into global residential child and youth care practice, which emphasises that the usually negative Western literature perspective that many of us read about is not the experience of the majority of those involved in care, whether as participants or workers. Rather, we are offered glimpses into residential care practices in geographies that are often unfamiliar and not often included in the surrounding discourse.

The editors, Islam and Fulcher (2021, p14) use Edmond's (2000; 2009) definition of residential child and youth care as '[a]ll … living and learning environments (that) operate with 24-hour, activity-based life-space care and education, 7 days a week for specified periods of time – whether measured by cohort, semester, term, season or year', to present us with 71 case studies in this four-volume series. Divided according to the FIFA Football Confederation regions, each volume is distinct in its focus:

> Volume 1: Global Perspectives (2016) – highlights the tensions created when western child and youth care systems, policies and practices are imposed onto non-western nations (18 case studies).
>
> Volume 2: European Perspectives (2017) – the differences historically between western (institutions) vs eastern (community-based and extended family) European practices in residential child and youth care (18 case studies).



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> Volume 3: Middle East and Asia (2018) – how the impact of warfare, political instability and natural disasters has shaped residential care for children and young people in that region (25 case studies).
>
> Volume 4: African perspectives (2020) – the important role of families and the impact of colonisation on how children and young people are cared for (19 case studies).

A unique collection of stories about resilience, triumph, and turbulence, this series allows the reader to pick and choose a country of interest or to read about a region from cover to cover. Highlighting the local and international standards, similarities, and differences in care options available to families, children and young people around the world, this series provides a fascinating overview and comparison. We are presented with a broader understanding of the concept of residential care that is often not available to those beyond a nation's borders, and, more importantly, runs contrary to the main Western literature perspective. Rather, we learn that in the developing world, community-based care is the most dominant form of residential child and youth care across the world.

Every contributor was asked to consider the following questions when writing their submission, creating a baseline that provides the reader with consistency in the information presented:

- What does child protection and youth welfare policy mean for children and young people where you live?
- What is the history of residential child and youth care practices where you are, and what values and aims operate within these places?
- Why do children and young people end up in out-of-home care where you are?
- What types of residential child and youth care are available?
- How many children and young people are in out-of-home care where you live and how many kinds of out-of-home care placements might be found there?
- What are the physical environments of residential child and youth care institutions or group homes like and what are the routines and rhythms of a typical day in the life of children or youth in care in these places?
- Think about a life story of a typical care leaver for a few moments and then ask yourself: what experiences did that child or young person go through while in care from the first hour of his or her first admission right through to a year after leaving care?
- What good child and youth care practices might others learn from what is happening in your places(s) in the world?
- Looking ahead, what are your thoughts on the future for residential child and youth care where you live – including hopes, fears, and challenges?

Presented uniformly, each volume follows the same format, of a preface, an introduction to the volume written by the editors, case studies written by a guest

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writer associated with residential child and youth care in that country, and a concluding chapter presenting a final overview of the volume, also written by the editors. Each chapter begins with an abstract, an introduction, and the author's contextual response to the eight questions posed by the editors, concluding with questions for small group discussion and reflective thinking, with the aim of furthering the dialogue and discourse prompted by each chapter. An author biography is also included.

Capturing some of the challenges and changes faced by those involved in child and youth residential care, the reader becomes aware of the history, cultural values and traditions that shape the care and education of children in each country, as well as the key issues impacting the identities of care leavers. Highlighted is the fact that care is everywhere – homes, orphanages, hostels, schools, centres, residential colleges, refugee camps, institutions - and is provided for a variety of reasons, including supporting families through the provision of education and care for a specific period of time.

Throughout the series we are also shown the significant value of those working with children and young people in residential care. Islam and Fulcher refer to them constantly as *influential healers and helpers in the young person's life*. Responding and intervening pro-actively and immediately to what is in front of them, residential care workers teach those in their care new ways of acting and experiencing the world around them. The inspiring stories found within the various case studies counter and remove the stigma and discrimination Western literature often imposes upon the system and those within it.

As a result of this series my own understanding of the provision of residential care for children and young people has broadened beyond my Western experiences. As a trainer to the industry in Victoria, Australia, this is very important, in providing global alternatives that workers I train rarely learn about or experience. This information will help to shape my own teaching in the sector. It has also provided a springboard for my own research into those who provide statutory care for children and young people around the world.

I urge you to read this series and be prepared to be challenged about what residential care looks like globally, and how it could be delivered from a more positive perspective in the West. I then encourage you to create a dialogue about the options presented to you in *Residential Child and Youth Care in a Developing World* (2016 – 2020) and how that information could be used to challenge the traditional western residential care system, enabling more positive outcomes for the children and young people who reside there.

About the reviewer

Based in Melbourne, Australia, and a leader in youth worker education, Dr Jennifer Brooker currently trains Victorian Out-of-Home Care (OOHC) workers in the mandated qualification required to work in the sector. A Senior Research

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Officer at the University of Southern Queensland, as well, she continues her many years of research and education with the youth sector around the world, providing training development and project management for those who work with and for the world's young people.

The publisher (CYC-Net Press) supplied copies of volumes 1-4 of this book for review.

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Book Review

Dilemmas and decision making in residential child care

By Abbi Jackson

Publisher: Critical Publishing

ISBN: 9781915080806

Year of Publication: 2023

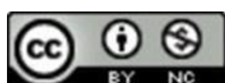
Reviewed by: Dan Johnson
Clinical Director, Kibble Education and Care Centre,
dan.johnson@kibble.org

Anyone who has worked in residential care will know that it is full of frequent, varied, and difficult decisions to make.

These can occur in intense and stressful situations where decisions can have severe implications. In such situations there can be little chance to carefully think things through. This can place both young people and those looking after them in at least difficult, and at worst dangerous, situations.

Jackson's book offers part of a solution. The book is not an academic study of the ethics or morals involved in providing residential care. Instead, it is a pragmatic and practical look at many examples of dilemmas and decisions. It provides numerous case study scenarios, exploring the decisions made and the reasons for these. It gives practitioners what is often missing in practice: a chance to think. Importantly, Jackson does not rigidly state what is right and wrong. She instead encourages reflection and critical thinking, which is so important in residential childcare. What this book has, that many others do not, is a comprehensive range of examples of practice and exploration of the thinking and reasoning of workers in these difficult situations. By exploring these examples readers can gain many ideas and possible strategies they could apply themselves.

Importantly, Jackson is able to relate theory to these scenarios, including ideas about mentalisation and trauma. She demonstrates how an understanding of theory can inform and therefore improve decision making. By highlighting and relating theory and concepts to real life scenarios she makes them more practical and encourages practitioners to apply them directly to their practice.



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This is such a positive aspect that I found myself wishing there was more of this threaded throughout the book.

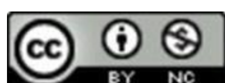
This book will be of interest to anyone who has to make decisions in residential child care. This includes both those new to the practice and those with many years' experience. It will also be a useful tool and resource to anyone supporting or developing staff, such as those in learning and development.

I had expected an academic book that discussed some of the underlying moral and ethical semantic themes behind decision making. Fortunately, this book is not that. Instead, it provides resources that have real life utility and that may help improve decision-making in residential care.

About the reviewer

Dan Johnson is the clinical director at the Kibble Education and Care Centre.

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



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Conference Review

Lovin' Care Gathering – hosted by Children's Homes Quality

19th May 2023, Manchester, England

Reviewed by: Amy Robinson
PJL Healthcare, amy.consultancy@outlook.com

A heart-warming experience at the 'Lovin' Care Gathering'

'Make care incredible – with love part of the deal' was the slogan for the event which set the tone for a thought-provoking and inspiring day - and it was just that!

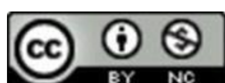
Children's Homes Quality (CHQ) is a small organisation with a big heart. They provide independent services to children's homes across the country, supporting them to provide outstanding care to the children in their homes. The organisers, Margaret Davies, Training and Development Lead, and Valerie Tulloch, Director, certainly delivered on their promise to stimulate thought and reflection and to motivate those attending to develop their love-led practice.

The gathering, which took place in May, was a heart-warming and transformative event that left delegates feeling both inspired and motivated.

We know how privileged we are to work in this sector, whilst also being acutely aware of how challenging it can often be. This day created an exciting, almost electric, atmosphere, igniting us all with a sense of energy and a passion to rush back to our homes and dive into our work of making a profound difference in the lives of our children.

From the moment delegates walked through the door, it was evident that this conference was special. Seeing many familiar faces from the previous conference, hosted by CHQ in Birmingham in 2022, there was a strong sense of community, and the room was filled with warmth, unity, and a shared commitment to making a positive impact on the lives of children in residential care – with love leading the way.

Organised by the passionate and dedicated Margaret Davies, this conference was born from a dream she had, to gather individuals in the residential childcare sector and unite them in a love–led revolution. As she welcomed everyone to the



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gathering, held in the beautiful setting of the Midland Hotel, she described how the event had evolved from what started as a simple idea. There was a sense of pride that made me feel lucky to be there, absorbing all the wisdom and knowledge the day had to offer.

During Margaret's speech, she recognised the positive steps taken in the sector to identify love as an essential part of a childhood. However, she also pointed out that a significant cultural shift is necessary within the sector. We need a culture that places secure attachments, based on loving, consistent relationships, at the foundation of every decision we make about children, and there is still much work needed to make this a reality.

To bring about this cultural change, the sector needs to change its priorities at all levels, from individual practices within homes to the policies and actions of agencies and governments.

Margaret highlighted specific issues within the system, such as the lack of resource and encouragement for young people to stay beyond their 18th birthday in children's homes. This lack of support can disrupt the lifelong connections and sense of belonging that young people in care so desperately need. Additionally, the system often does not provide a pathway for young people to return for support when they require it, further obstructing their ability to form genuine and lasting attachments.

It was encouraging that institutionalised language was referenced as a barrier to forming genuine loving attachments, underscoring the need for a cultural shift towards more compassionate and empathetic approaches in the sector.

This introduction set us up for a day of discussions and actions aimed at addressing these issues and working together towards a more loving environment for children in care.

Valerie Tulloch, Founder and Director of Children's Homes Quality, delivered a compelling call to action. She urged conference delegates to reflect and find ways to integrate the principles of 'Lovin' Care' into their roles, thereby making an impactful difference. 'Lovin' Care' seeks to dismantle barriers and challenge unhelpful narratives about the role of love in residential childcare, which is so important because the cost of these barriers is that young people grow up feeling unloved and unlovable. These principles encourage us to be bold and brave and to implement love-led practices, by shaping our leadership, workforce and environments to create the conditions where love can safely flourish between children and adults.

Valerie's powerful message deeply resonated with the audience, leaving everyone with a sense of responsibility and hope. She invited all to be part of a 'love revolution', underlining the importance of love as a driving force in providing quality care to children.

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Keynote speakers and workshop presenters

CHQ put together a remarkable line-up of speakers who were all experts in their field and deeply passionate about the power of love in the care sector. Their talks came firmly from their own unique perspectives, relevant to their work, or life, experience.

One of the standout moments of the day was a heartfelt presentation by Scott King, a care-experienced man who shared his raw personal journey through the care system. His emotional and moving account of how 'love saved his life' left a lasting impact on the room. His story served as a powerful reminder of the significance of loving attachments in the lives of children in residential care.

During Scott's talk, what stood out the most was the clear lack of transparency from those in charge of his care, regarding the genuine nature of the bond that his foster carers had formed with him when he was a child. As a young person Scott moved from one home to another, from one set of caregivers to the next, but one piece of crucial information remained undisclosed: his carers had loved him.

Scott vividly recounted the transformative impact of accessing his care records as an adult, where he learned that the foster parents he had perceived as rejecting him for many years had, in fact, wanted to adopt him as a child. He wondered what a difference this knowledge could have made, if social workers hadn't thought it was in his best interests to keep this from him.

Perhaps he wouldn't have felt so rejected and so angry. Perhaps the love his foster carers had felt for him had the power help him in ways we can only imagine. As over 100 people listened, captivated by Scott's message, I couldn't help but feel proud of how far we've come as a sector, and hopeful that we can continue to spread the word and make a real difference.

In a presentation titled 'Love on the Brain', Dr Shona Quin, another enlightening speaker, delved into the fascinating and scientific aspects of love's impact on a child's brain development. Her presentation provided delegates with valuable insights into the neurological and psychological effects of love on children in care. Dr Quin's research highlighted the importance of creating love-led environments within which children can thrive and heal from their trauma, whilst captivating us all with the scientific evidence that love has healing powers on the brain of a child.

Dr Quin delivered an outstanding presentation on 'neuroplasticity'. She eloquently illustrated this concept by projecting an image of a wheat field, featuring a well-trodden path running through it. She emphasised our capacity to forge new neural pathways in a child's mind through the consistent and loving nurture they receive. Much like the creation of a fresh trail through the field with

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each daily walk, we hold the power to shape a child's neurological development through the repeated expression of love and care.

It was great to hear from Liz Mitchell, Project Development Manager of the Love InC Project (Aberlour, Scotland's Children's Charity). It was clear to see that Scotland is leading the way in loving practice.

Following the commitment made by Scotland's First Minister in 2016, for Scotland to 'come together and love it's most vulnerable children to give them the childhood they deserve', The Love InC project have been working hard to understand the barriers to children experiencing loving bonds in the care system - and to make meaningful change. We were treated to Liz's insights into the Love InC project, which were inspiring! She provided a comprehensive overview of the project's journey with a strong focus on the important link between love-led practice and trauma responsive care. The audience were left with a clear understanding of its positive impact.

Following a panel Q&A with the keynote speakers in the morning (and a delicious lunch with the added energetic buzz of people using the time to debrief on the powerhouse morning), there were several great workshops on offer in the afternoon. My only criticism was not being able to attend them all as it was almost impossible to choose.

I attended a workshop with the incredible Mary-Anne Hodd, lived experience trainer and adviser, on the topic of interdependence and how lasting relationships with children can support successful transitions into adulthood.

Mary-Anne's reframing of the term 'care leaver', in saying 'we didn't leave care, care left us', is a powerful and poignant reminder of the challenges young people face when they turn 18, as the relationships they've come to rely upon often abruptly disappear.

Mary-Anne's thought-provoking reflection on the term 'independent', a commonly pursued goal for young people in care, highlighted the shared understanding that it often conveys a sense of self-reliance and isolation. This realisation highlights the need to shift the focus from mere independence to interdependence.

The concept of interdependence emphasises that these transitions are not solely about self-sufficiency but also about the relationships and support systems that surround and sustain young people during this critical phase of their lives. This perspective highlights the importance of the relationships and care they continue to need as they transition into adulthood.

Other workshops on offer included:

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'Lovin' the Leadership' was an insightful workshop facilitated by Valerie Tulloch, Director of Children's Homes Quality, where delegates learned about the transformative powers love-led leadership can have on the staff, as well as children.

'Safe Loving Touch' by Clair Davies MBE, consultant and trainer, was so popular that the organisers had to change her room to fit the audience in!

'Developing emotional intelligence' was facilitated by Eithne Staunton, registered manager and independent consultant, who encouraged delegates to develop their awareness of their own emotions and how they might affect the children we care for.

Matt Langley and Ben Thomas, registered managers of Lovin' Care Children's Homes, delivered a workshop specifically focusing on the issues men face with love-led practice.

And finally, a workshop was held by Liz Mitchell, Andy Finlay and Rhianne Ewen from Aberlour, Scotland's Children's Charity, who invited attendees in to learn about their love-led approach to recruitment for care experienced young people within the Love InC Project.

The children's homes community

Throughout the day, there were numerous opportunities for networking and connecting with like-minded individuals in the field. These interactions allowed delegates to exchange ideas, share experiences, and build a strong community of people committed to the cause of love-led care.

During the event, delegates were encouraged to document their thoughts and ideas, which were then displayed for everyone to see. A common key takeaway from this exercise included the importance of fostering more affection and care within the staff team, serving as role models for these relationships, and establishing a genuine love-led environment. For me, this experience emphasised that to genuinely cultivate love-led practices within the team it's imperative for leadership to embody and demonstrate a love-led approach (as the old saying goes - lead by example). This insight highlights to me the significance of leadership in setting the tone for the entire organisation, and how a love-led approach to leadership can benefit the outcomes of our children.

The 'Lovin' Care Gathering' not only provided a platform for learning and inspiration but also demonstrated the empathy, compassion, and dedication that exists in the residential childcare sector. It was clear that the organisers had poured their hearts and souls into this event, and their passion was infectious.

A great success

In conclusion, the 'Lovin' Care Gathering' was an extraordinary conference that successfully brought together individuals from the residential childcare sector to

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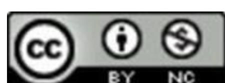
inspire and promote love-led practice. With its powerful speakers, educational workshops, moving personal stories, and informative presentations, this gathering left delegates with a renewed sense of purpose and a deep commitment to bringing love into the picture for children in care. Margaret and Valerie deserve commendation for their vision and dedication in making this event a resounding success. It is events like these that have the potential to bring about real change and improve the lives of vulnerable children.

About the reviewer

Amy Robinson has worked in residential children's homes since 2009. She has held every position from support worker to responsible individual and now enjoys using her experience in her role as an independent trainer and consultant. Observing the many changes the sector has seen in the last 15 years, Amy has fostered a deep appreciation for and interest in trauma responsive and attachment-based care – care that holds relationships to be at the heart of everything.



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Correspondence

Oor Loons

A Poem by Jean Marshall

Aa manner o loons got sent tae us.
They didn't hae a choice.
Brave loons we kent them as,
takkin their chances wi us
the unknown.

Emergency, short term, supposed tae be
and planned respite.
Regular weekend laddies
alang wi unexpected loons.

Beloved loons came in a cocoon,
self worth webbed through
the layers o their ain labelled luggage.
Cases carefully curated,
packed wi clean claes
beyond their needs and
wi familiar transitional attachments,
invisible umbilicals keepin them
fae driftin awa.

The broken an lost loons were the
laddies withoot luggage
but plenty o baggage.
Loons fa felt they never hid
a chance o being a 'beloved loon'.
Fa stood at wir door,
delivered wi a black bag,
nae case or robust container.
Black bag, black affronted.

A thin black plastic bag that rips like
the linin o yer hairt.
Far dis a black bag belong?
Metaphor, imagery, symbolism,
foo mony degrees tae decipher?
The loons a kent an felt it.

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Black bag, black affronted.

Nae mair loons withoot luggage
It wis ruled and regulated.
Ower late for the loons
fa came thru oor door
wi aa their being in a black bag .
The loons fa felt themselves
tae hae been binned.
And fa cairy the feelin still.

Black bag, black affronted,
Abolished, consigned tae the past ?
Aye, luggage came wi oor last loon.
Cut loose and adrift ,
he arrived wi his regulated case.
Tagged wi a 'lost loon' label,
the case wis empty o attachment.
Nithin personal for touch or smell.
Nae even much claes or
a spare pair o sheen.

Years later I still mine that case.
It wisnae a banned black bag
but my feelings surface the same.
Black affronted, hairt sair and still
ful o deepest shame.

Poetry: Why?

The meaning of 'care' has been discussed and debated for as long as care has been organised and overseen by the state. As a foster carer I was part of the system, and later I was part of its governance through Alternative Family and Fostering and Adoption Panels. I have had plenty of opportunities over the years to feed back my reflections on policies, and I certainly hope I did so.
Why then have I chosen now to construct a poem from my experiences?

I have discovered that poetry gives me a different voice from that used in the feedback forms, the reviews, the interviews. The language used then is the formal, the bureaucratic, the legalese and the academic.

In my poems, in contrast, I am using Aiberdonian/Doric and the language of emotion. Doric however is not the normal manner of my speech. I was brought up surrounded by family members who spoke Doric, but I was certainly firmly discouraged from its usage! I was sent to a school where only English was to be spoken and my family voiced their strong opinion that only by speaking 'proper' would I succeed in life.

For the time they were probably right, but I have felt over the years that I lost a lot of connection to my roots by having the language cut off from me. I think

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that feeling can resonate with others who have not just had language displaced but country as well. I now live outside the north-east of Scotland and I think that my use of the Doric is a response to missing hearing it spoken around me.

One of my first poems was my attempt to understand an event which probably was part of the foundation of my own decision to become a foster carer. My great grandmother, who I remember very well, was abandoned as a baby in the lodgings housing herself and her mother. Her mother went out one day and never returned. The year was 1871 and fortunately the woman whose house it was, kept her.

I found that writing a poem, Speirin 1871, focusing on the day of the abandonment and asking questions allowed me to engage with the event in a far more direct manner than a prose piece of writing. Through this process the Doric voice just came naturally to me.

This piece of commentary is partly a response to the question 'does writing poems help me to make sense of powerful emotions and help me highlight issues?' My answer is most definitely yes. I hope my poem regarding abandonment highlights the horrific choices women were often forced to make, and the consequences.

I hope my poem Oor Loons reflects my still strong emotions when I think about the poor state of arrival of some children who came into our care. I am writing here about boys who were already allegedly 'looked after'. I also hope it highlights the importance of 'good care' and what this can look like, as well as showing what obviously does not constitute even 'good enough' care.

Whilst we were fostering, I was fully immersed in family life, our fostering and my own full-time career. We had to give up fostering when my husband became terminally ill. Sometime afterwards I joined the Fostering and Adoption Panel, and a large part of my motivation was as a response to the boys who had in my view experienced inadequate care. Unfortunately, a large number of boys came from 'care' breakdowns. It was heartening for me to see at panel so many carers who demonstrated really high levels of very good care. They restored some faith for me in the system.

I have only now turned to writing myself. I think that the space in time between fostering and writing has maybe been beneficial in terms of allowing for greater reflection.

I still have my childhood poetry books, and those more up to date as well, and a love of reading. Although I did not specifically promote poetry for the boys we fostered I did very much try to encourage reading. From my own, at times, challenging childhood, I remembered how much of an escape, and positive experience, an immersing piece of poetry or prose could provide. The Night Mail by WH Auden for example was a particular favourite.

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I hoped that some of our boys could maybe find a reflection of their own emotions as well as insights into and routes to other lives, other worlds, through reading. Some of them did!

Poetry for me stems from feelings and expressing them. However, although I have ownership of the voice in the poem, I do not want to exploit the emotions of those most affected. What I write is what I felt and that came from what I saw, listened to and experienced.

Our first fostering experience was planned to last for three weeks and lasted 13 years. It cannot really be said to be finished even now. I have read the poem to my first 'loon' and I was anxious as to his response. I got a positive response in that he said that it expressed for him the shame involved and the loss of self-esteem.

I hope to continue writing as a means of quite therapeutic self-expression! I am grateful for the opportunity to share Oor Loons with journal readers. I hope it conveys not just my own feelings but opens a small route through which other folk can reflect on 'care' – particularly how important it is to get it right.

About the author

Jean Marshall worked in education and originally trained in social work. Now retired, she was a local authority foster carer for 13 years and subsequently an Adoption, Fostering, and Alternative Family Care Panel member.

Glossary

Loons/Laddies - Boys
Kent - Known
Claes – Clothes
Hid - Had
Hairt - Heart
Far - Where
Foo mony -How many
Fa - Who
Cairy- Carry
Black Affronted - Embarrassment or shame
Sheen - Shoes
Mine - Remember
Sair - Sore

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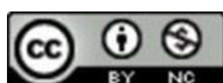
Obituary

Ian Dickson

1950 - 2022

By Delyth Edwards
University of Leeds

Sometime in 2014, I was reading an article in *The Big Issue* that was discussing an announcement made on the 14th of December in 2013 by the government, that children who were living in foster care would be allowed and supported to remain with their foster carers until they were 21 years of age. This policy became known as 'staying put' and it infuriated me. What about young people growing up in children's homes, how can they be so cruelly excluded from this, I thought to myself. I wanted to know more, and I wanted to see if anyone else was outraged by this plan and the hierarchy being created through it. With some online research I became aware of Every Child Leaving Care Matters (ECLCM), 'a



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campaign group, without funding or political affiliations with any other group, formed to stop Government discrimination against children in residential care who want support to 21, the same as those in foster care' (ECLCM). This group, made up of many care experienced people, shared my outrage and they were doing something about it, they were collecting signatures for a petition. I signed the petition, I followed the campaign on Twitter, and I also followed the founding members of this group, with Ian Dickson being one of them.

Like many friendships in the age of digital technology, I got to know Ian through Twitter. As someone who was researching care experience from both a past and present-day perspective, Ian's presence on Twitter, his voice, the clarity with which he spoke, intrigued and inspired me. Over the years, we continued to communicate about all things care experience. We both believed that the 'system' of care for children and young people could not change until older care leavers were consulted and listened to. We both shared the view that to improve the present and future of care, we need to look to the past and learn from it. This stemmed from our autobiographies, Ian as a care experienced person and me, as a researcher and daughter of a care experienced mother. As I shared snippets of my mum's care experience, Ian shared his, and parts of his experience of care were very similar to my mum's, despite experiencing the 'system' at different times. In our conversations over Twitter, we wondered whether there could be a space for this type of conversation with older care leavers and what would come from such conversations.

In 'A ladder to the stars' Article 39's director, Carolyne Willow, and Ian, 'held a series of conversations over Zoom to record his reflections on growing up in care, and how he has devoted his adult life to making sure children are loved, valued and can fulfil their dreams' (Willow, 2022 n.p). These conversations took place between January and July 2022. I am so appreciative that Carolyne was able to capture on record Ian's important story and part of his legacy in this way. This is a story that everyone, especially those who work in children's social care, should be required to read.

Born in Manchester in 1950, Ian spent 16 years in care during the 1950s and 1960s. He once explained that he 'experienced good and bad residential and foster care and spent some time as homeless' (Ian, The Care Experienced Conference 2019a). Ian was, as he said, 'discharged from care in 1968' with no educational qualifications (Ian, The Care Experienced Conference 2019a). He worked at a chemical company, where he was encouraged by his mangers to enrol in a further education college which 'rekindled his love of learning', and he eventually gained his O-levels (Ian, in conversation with Willow, 2022). He trained to become a social worker at the University of Manchester in 1973, earning his Certificate of Qualification in Social Work. During his years working in social care, he filled a variety of roles, including social worker, residential service manager, and inspector. He focused mostly on working with adolescent young people in and leaving care, and those in custody. Ian was one of the first care

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experienced social workers to openly talk about his experiences on his social work course and throughout his career. He was in a unique position of having both lived and worked within the 'care system'. He told Carolyne that he saw his care experience 'as a medal not a wound' (Ian, in conversation with Willow, 2022). Ian has inspired and continues to inspire other generations of care experienced social workers and his legacy continues with the work of the Association of Care Experienced Social Workers (ACESCW), formed in June 2021 (Dickson and Starr, 2021). Melville-Wiseman (2022, p. 1) writes of Ian's role in forming the Association:

> …we [the ACESCW] are immensely grateful for his pioneering work that has led us to where we are today. It is a national organisation made up of a diverse group of people with different outlooks, perspectives, and priorities, but all of whom have the shared experience of care as children and young people.

After his retirement in 2010, Ian did not forget or move away from trying to make things better for children and young people growing up in care. His work was far from over. I feel so lucky and privileged to have met Ian and stood alongside him on his campaign to 'challenge the injustices and improve the quality of care we offer children in state care and the support we offer to them once they leave care' (Ian, The Care Experienced Conference, 2019a). In 2017, seven months pregnant with my first child, I exited Warrington train station to meet Ian. This was the first time we were meeting in person. At his home, where I met Ian's wife Sue and their cat Honey, is where we continued our previous conversations and pondered whether there could be a gathering (we didn't have the words for it then) that could bring together care experienced people of all ages. We started to make plans. I said the event could be something small, but Ian was adamant it needed to be big. This was the first time I was at the receiving end of Ian's firm determination! We decided it could take place at Liverpool Hope University, where I worked at the time, and I knew they would be happy to support and host it. But then I went on parental leave and that is when Ian drove the idea forward, reached out and contacted people, fundraised, organised a committee and created something that was beyond what I could ever have hoped or imagined.

On April 26th, 2019, The Care Experienced Conference took place at Liverpool Hope University. It was one of the first conferences for care experienced people of all ages, as Ian said: 'in all our diversity…to share their experience and views of how the care system can be improved in the future' (The Care Experienced Conference 2019a). The conference brought together 141 care experienced people between the ages of 14 and 82 as well as professionals working in children's social care. Some of the professionals, were also care experienced. But as Ian emphasised, the professionals were invited to do nothing but *listen*. The day consisted of small group discussions, workshops, an opening lecture and

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displays of art by care experienced artists, including our late, dear friend, Yusuf Paul McCormack (a fellow member of the organising committee).

The following day Ian, as chair of the organising committee for the conference, appeared on BBC Breakfast with Carrie Wilson-Harrop (a fellow member of the organising committee), to discuss the conference, where the presenters were shocked to learn that an event like this had not taken place before. As the weeks passed the organising committee wrote a conference report (The Care Experienced Conference, 2019c and a research report (The Care Experienced Conference, 2019d), summarising the experiences and priorities delegates shared at the conference, and 'the reports were shared with central government, Ofsted, the Children's Commissioner and others involved in the care of children' (Willow, 2022). The experiences and priorities were also disseminated as a set of top 10 messages (The Care Experienced Conference, 2019b) (see figure 1 and 2).

Figure 1

TOP 10 MESSAGES

1 We need more love in the care system, including displays of positive physical affection.

2 We want to be seen as individuals worthy of respect much more than we are.

3 Relationships are critically important to us.

4 Instability and loss of continuity in our lives is made worse through no fault of ours by pressure in the care system.

5 Mental health and well-being are our biggest worries and the most important and urgent things that have to improve.

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Figure 2

TOP 10 MESSAGES

6 The impacts of the care experience do not end at 18, or 21, or even 25.

7 Our sense of who we are is important. Our family, heritage and history are uniquely ours and must be protected.

8 Having our say is essential.

9 We have legal rights and entitlements and we are not always being told what they are.

10 Nobody knows more about what it means to be in care than we do.

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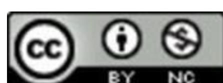

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Additionally, a 'pledge' was developed from the top 10 messages to enable its recommendations to be implemented in policy and practice (The Care Experienced Conference 2019a). In November 2019, some of the committee members attended an event in Manchester, the *Greater Manchester: Doing Things Differently for Care Leavers conference*. Ian, along with Dr Cat Hugman (a fellow organising committee member), gave a presentation. The delegates listened intently as Ian spoke about his care experience and key findings from The Care Experienced Conference. In attendance was the Mayor of Greater Manchester Andy Burnham, who signed the pledge at the event, which was eventually adopted by all ten Greater Manchester authorities and went on to inform the Greater Manchester Care Leaver Guarantee and the Local Offer (Marshall 2019). This was particularly meaningful for Ian, who was born in the city and had spent most of his life living, working and studying there. Other regions subsequently followed suit and have adopted the pledge to improve their support for children in their care, including The Liverpool City Region and North Yorkshire and Coram (O'Sullivan, 2021).

There is one thing that I particularly admired about Ian, and that was that he *never* held back in publicly voicing his concerns and disappointments and holding people in positions of power to account. He never let anyone off the hook with nonsense or self-importance. In October 2019, Ian and others from the conference organising committee presented the two conference reports to the then education minister, who, in the words of Ian on Twitter, 'did absolutely nothing at all to address their recommendations. A complete waste of space'. Ian disliked politicians paying lip service; especially those who in contrast to their public announcements and displays did absolutely nothing to address the lack of care for children and young people. Ian was very outspoken about his dissatisfaction with the Care Review. At first, I think we all, including Ian, saw the review as an opportunity for change, as a marker of hope, but soon came to see the betrayal of care experienced people during the process and particularly at its conclusion. But Ian was not alone in his hopes for improving the lives of children and young people in care. Ian has inspired and motivated others to speak out, and on the 16th of January 2023, MP for South Shields, Emma Lewell-Buck (who attended the Care Experienced Conference) made the following statement to the government in the chamber of the House of Commons:

> On New Year's Eve, the care community lost a highly respected dear friend and true advocate. Ian Dickson spent his entire life making a difference to children in care and urging Governments to listen to them. The care review does not have all the answers, so will the Minister please implement the recommendations of the pioneering care experienced conference, in which Ian played a leading role? (UK Parliament, 2023)

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As I look to the future, I hope I will have Ian's courage, transparency, and the wisdom with which he spoke, and will carry on asking the difficult questions, the questions I know Ian would ask.

As well as our shared interest in the history of care, Ian and I also shared the importance of family in our lives. We shared news about our families, and this is something we often discussed over private messages where I would send photos and updates on my two young children. Ian would share glimpses into his family life with us too, such as the lovely memories of his late wife Pam or displaying how proud he was of his daughter and grandchildren. He was so very grateful, and felt very lucky, that Sue, his wife, stood by his side and campaigned alongside him.

Like so many others, I am grateful to Ian for so much, for dedicating his life to create positive change for the care experienced community and for the legacy he has left behind. On a personal level, as an early career researcher setting out on my journey into academia, he consistently showed me support and encouragement when many others didn't. But above all, Ian was devoted to his family; his wife Sue, his daughter Karen and his four grandchildren. All of us who were privileged to know, campaign, and work with him greatly miss an inspiring and wonderful friend and a genuine advocate for the care experienced community.

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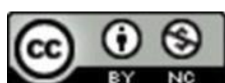
Delyth Edwards is a lecturer in Inclusion, Childhood, and Youth in the School of Education at the University of Leeds.



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