SJRCC 20th ANNIVERSARY

Scottish Journal of Residential Child Care

An international Journal of group and family care experience

Scottish Journal of Residential Child Care

WWW.CELCIS.ORG/SJRCC VOLUME 21.1

Table of contents

Editorial	2
The provision of residential care to children under age of 12; how is it used and is it effective	8
'Nobody does the job cause it's easy'. The factors which empower and inhibit the role of the child and youth care worker'	54
What future for voluntary children's residential providers in Ireland	74
'I'm not a children and families social worker'- Three mothers' experiences of their children being accommodated under s.25 of the Children (Scotland) Act 1995	92
Listening to Care Leavers: A case study involving 435 care leavers and 100 functionaries in 5 states in India	119
Assessing social and emotional difficulties of children in residential care settings: A systemic review of strength based measures	141
The origins of residential child care services in Scotland	166
Research with residential childcare practitioners: Early reflections of managing harm in qualitative diary study	182
Emerging adulthood: exploring the implications for care experienced young people and those who care for them	195
The 19th Kilbrandon Lecture (University of Strathclyde, 27 January 2022): A rights-respecting approach for children who offend: Building on Kilbrandon's vision	213
Book reviews	249

Editorial

Graham Connelly

g.connelly@strath.ac.uk

@DocCTweets

Welcome to the spring 2022 issue of the *Scottish Journal of Residential Child Care* (SJRCC). This year marks the journal's 20th anniversary. The journal was first published, in hard copy, in autumn 2002 under the leadership of editor emeritus, Professor Andy Kendrick, who has contributed an article to the current issue. We have exciting plans to mark this important milestone in and around the autumn issue.

COVID-19 continues its grip on our daily lives in varying ways. The WHO[1] reports more than six million people worldwide have died and that number is likely to be an underestimate. UNICEF estimates that 0.4% of these deaths have been children and adolescents, but children are affected in other serious ways, particularly in low and middle-income countries, with UNICEF noting: 'concern that the indirect effects of the pandemic on mortality in these age groups stemming from strained health systems, household income loss, and disruptions to care-seeking and preventative interventions like vaccination may be more substantial'.[2]

Children's rights under the UNCRC face substantial challenge, because of armed conflict, family displacement, and denial of access to education – as is currently the reality for young women in Afghanistan. The terrifying nature of modern warfare, and potentially crimes against humanity, genocide, and aggression, play out on our television screens and social media in reports from Ukraine. One month after the start of the war, around 4.3 million children, about half of Ukraine's child population, had been displaced, within the country, or across international borders. UNICEF's executive director, Catherine Russell, said: 'The

[1] https://covid19.who.int

[2] https://data.unicef.org/topic/child-survival/covid-19/

war has caused one of the fastest largescale displacements of children since World War II'.[3] CELCIS has a commitment to support those working with migrant and displaced children, and in response to the present crisis has published a new resource, 'Supporting Child Refugees and their Families'.[4]

Recent months have been a particularly active time for child and youth policy in Scotland. For the benefit of readers outside Scotland, I make brief reference to some significant development and discussion taking place here. The Scottish Government's 'Programme for Government 2021-22' is committed to bringing forward legislation on a National Care Service, with a draft Bill expected by June 2022. Originating in the response to the review of adult social care carried out by Derek Feeley which reported in February 2021, it was a surprise to many that the proposals included incorporating services for children and young people, community justice, alcohol and drug services, and social work. As an aid to parliamentarians and other interested parties considering the implications of reorganisation, Lynne Currie of the Scottish Parliament's Information Centre (SPiCE) has prepared a very comprehensive introduction to the care system for children and young people in Scotland.[5] Concerns raised in the consultation on the proposals include the potential loss of voice of people accessing services, and their carers, and the loss of local accountability in a centralised national service.

On 30 March, the Scottish Government published a 'Care and Justice Bill consultation'[6] which covers potential legislative reforms with a 'particular focus on children coming into contact with care and justice services or who come into conflict with the law'. One of the consultation questions relates to the use of restraint of children in care settings, and questions whether guidance and the

[3] https://www.unicef.org.uk/press-releases/more-than-half-of-ukraines-children-displaced-after-one-month-of-war-unicef/

[4] https://celcis.org/knowledge-bank/protecting-children/supporting-child-refugees-and-their-familes

[5] https://digitalpublications.parliament.scot/ResearchBriefings/Report/2022/1/20/d4917102-57bd-4f9a-af79-c8165e8e75ca-1#d7911d6e-92d4-496c-a419-ccf24e307a0a.dita

[6] https://www.gov.scot/publications/childrens-care-justice-bill-consultation-policy-proposals/

law should be made clearer around this matter. The Scottish Government is also reviewing the use of restraint and restrictive practice within education settings, with guidance expected to be released for consultation later in 2022. Ending the use of restraint is a pillar of 'The Promise,' the prospectus for change arising from the review of children's care in Scotland, with its authors saying that 'Scotland must become a country that does not restrain its children'.

Also on 30 March, the Scottish Government published a 'Keeping the Promise Implementation Plan', which includes a commitment to end the placement of 16 and 17-year-olds in Young Offenders Institutions (i.e., youth prisons) 'without delay'. Ministers said: 'We will fund care based alternatives to custody and consult on new legislation in Spring 2022. This will provide the support children need in very difficult circumstances, shifting the approach from one of punishment to one of love and support'. Concern about the use of inappropriate prison accommodation for children involved in the justice system was the theme of the 2022 Kilbrandon Lecture given by Dr Claire Lightowler, the transcript of which we publish in this issue.

Spring 2022 Issue

The first of five full-length, peer-reviewed articles in this issue, is an account of original research by Catherine Nixon and Gillian Henderson which examined how being cared for in residential care before the age of 12 affects children's health and emotional wellbeing. Using administrative data held by the Scottish Children's Reporter Administration, the research was based on the case files of 135 children subject to compulsory measures of supervision. The authors conclude that: 'being cared for in residential care was associated with a reduction in the number of behavioural difficulties displayed by children, and an improvement in their mental wellbeing'.

Amanda Ferguson's paper reports on interviews with six child and youth care workers with the aim of understanding better the demands and challenges of their role. She found, for example, that workers place value on the relationships they develop with young people and recognise that their own personal strengths help them to maintain relationships with young people.

Martin Power and David Power's paper aims to explain the drivers and challenges voluntary residential providers in Ireland face. The authors consider whether there is a future for voluntary residential children's providers in Ireland. They conclude that residential providers 'face the greatest threat to their long existence as a cornerstone of children's residential provision in a context of the expansion of private providers and marketisation of services', noting 'the irony that market mechanisms are often valued for notions of providing choice seems hard to reconcile with reducing the diversity of provider types in children's residential care'.

Dawn Simpson's research used semi-structured interviews to ask three mothers about their experience of having their children go into care in Scotland under a provision of the Children (Scotland) Act 1995 known colloquially as 'Section 25', a term taken from the section of the statute which outlines the legal terms for 'voluntary' admission to care. Dawn found 'a disparity between the language of the legislation, guidance, practice, and parents' experiences'. All three parents 'expressed a wish to have a partnership approach with social workers', but only one had 'professional support to advocate for her and inform her of her rights' and had 'a clear narrative about what happened and reported the best working relationship with her social workers'.

Kiran Modi and Gurneet Kaira's research paper considers aftercare provision in India. The paper is based on a mixed methods study conducted in 2018 of 435 young people aged over 18 who had left care institutions in five states in India and 100 child protection key informants. Identifying unmet needs for support, particularly in respect of emotional wellbeing and mental health care, the authors propose the introduction of an Individual Aftercare Plan, 'in order to ascertain their unique needs and thereby determine the nature of aftercare services that shall be required keeping in mind the voices of the care leavers'.

Danielle Day, Sara Elgie and Christopher Robinson examined 12 assessment tools often used in conducting assessments of children in care, finding that most are deficit based and only four are strength-based. They say that: 'It is important that the tools used to assess looked after children are sensitive to the adversity and trauma they have experienced prior to moving into care' and

concluded that: 'Of the measures highlighted, the ACA [Assessment Checklist for Adolescents] is the only measure that originates from the looked after children population'.

We include three short-form articles in this issue. Andrew Kendrick has contributed a paper on the historical origins of residential care services for children and young people in Scotland, from the establishment of Heriot's Hospital in Edinburgh in 1659 to the orphanages and industrial schools of the 19th and early 20th centuries. Reflecting on the relevance for today's services, he says: 'The intrinsic tension between care and control continues to confound residential work with children and young people, and create barriers to their empowerment and their voice being heard'.

Bethany Jay writes about a diary study used to explore residential child care practitioners' emotion management that was part of her PhD research. 'Diary methods', she says, 'can reveal rich data on sensitive and important matters like practitioners' emotions in residential children's homes'. They 'also raise ethical challenges for the researcher to manage'.

Kenny McGhee and Sarah Deeley explore concepts of emerging adulthood and what these might mean for people who care for young people. Acknowledging the informed and creative thinking surrounding the review of children's services resulting in The Promise, they argue that: 'if Scotland wants to be truly transformational in its practice and approach, consideration must also be given to an applied understanding of emerging adulthood as both a psychological and sociological concept'.

This issue also includes the transcript of the 19th Kilbrandon Child Care Lecture, hosted by the University of Strathclyde, and provided by webinar. The lecture, 'A Rights-respecting Approach for Children who Offend', was given by Dr Claire Lightowler, former director of the Children and Young People's Centre for Justice (CYCJ, and the text published here includes responses by Professor Ursula Kelly of University College Cork and Ruth Kerracher of the Scottish Throughcare and Aftercare Forum (STAF), and a vote of thanks given by the Minister for Children

and Young People, Claire Haughey MSP. A recording of the lecture can be found on the 'Kilbrandon Lectures' archive.[7]

We end a very full issue by including two book reviews. Dan Johnson reviews 'The Criminalisation and Exploitation of Children in Care: Multi-agency Perspectives' by Julie Shaw and Sarah Greenhow, and Emma Young reviews 'The Children of Looked After Children: Outcomes, Experiences and Ensuring Meaningful Support to Young Parents in and Leaving Care' by Louise Roberts.

The *SJRCC* will return in November with another very full issue to mark our 20th year; in the meantime, enjoy the current issue and watch out for our occasional 'From the Archive' series of previously published articles selected to coincide with events, special days, and contemporary issues.

About the author

Dr Graham Connelly CPsychol is the editor of the *Scottish Journal of Residential Child Care* and an honorary senior research fellow with CELCIS and the School of Social Work and Social Policy in the University of Strathclyde. Graham's research interests have ranged over alternative care internationally and more particularly the education of care experienced children and adults. He is a non-executive director of Kibble Education and Care Centre and a trustee of the MCR Pathways school-based mentoring programme.

7 https://www.strath.ac.uk/humanities/schoolofsocialworksocialpolicy/thekilbrandonlectures/

How is the provision of residential care to children under the age of 12 associated with changes in children's behaviour and mental wellbeing?

Catherine Nixon and Gillian Henderson

Abstract

Around 10% of children looked after in residential care in Scotland are aged 5-11. While there is a large body of evidence about the experiences of older children in residential care, little is known about the experiences of younger children in these settings. In this study we used routinely collected administrative data held by the Scottish Children's Reporter Administration to: 1) identify common features in the familial, child protection and care histories of children under the age of 12 in residential care; 2) explore how being cared for in residential care prior to age 12 is associated with children's health and socioemotional wellbeing. Case file data from 135 children subject to compulsory measures of supervisions were examined. Our analysis indicated that younger children in residential care often have complex trauma histories, long histories of service involvement, and have often experienced repeat placement breakdowns that are attributed to the socioemotional and behavioural difficulties the children exhibit in placement. Being cared for in residential care provided a period of stability for younger children, with improvements seen in their socioemotional wellbeing and mental health in the 24 months following entry into residential care. Future research should focus on understanding the mechanisms underlying these changes.

Keywords

Group care, residential care, child health, children under 12, socioemotional wellbeing, mental health, Scotland

How is the provision of residential care to children under the age of 12 associated with changes in children's behaviour and mental wellbeing?

Corresponding author:

Catherine Nixon [Research Officer], Scottish Children's Reporter Administration, Ochil House, Stirling, Catherine.nixon@scra.gov.uk

Introduction

The term residential care is used to describe non-family-based group living environments where children are cared for by paid staff who work on a shift basis. In Scotland, the residential care settings used to provide care to children include children's homes, residential schools, and other forms of residential care such as crisis units, assessment centres and secure care (Scottish Government, n.d.). The legal routes through which a child can become looked after in residential care include: being assessed as requiring a Compulsory Supervision Order (CSO) with a condition of residence in residential care by the Children's Hearing System; being subject to a legal order or warrant that allows emergency removal to a place of safety; being accommodated under Section 25 of the Children (Scotland) Act 1995; or being placed by a local authority which has made a permanence order under Section 80 of the Adoption and Children Act 2007 (Scottish Government, n.d.). A child may also become looked after in residential care through the granting of an interim CSO or through an interim variation of an existing order. These latter measures are usually used when a Children's Hearing is unable to reach an agreement about the interventions required to best support a child requiring urgent care and protection (Children's Hearings Scotland, 2020).

Residential care can be used to: provide periods of 'respite' care in order to support children to continue living with their parents or caregivers in the longer-term (Luksik, 2018); offer a place of safety while longer-term, family-based care is identified (Chege, 2018); help prepare children for a move into family-based care (Jedwab et al., 2019; Vacaru et al., 2018); and/or to support older children preparing to move to independent living (Gander et al., 2019). It can also be used: when suitable family-based care cannot be identified, is not available, has not been sustained, or has not been able to fulfil the needs of the child (Gayapersad et al., 2019; Grey et al., 2018; Wright et al., 2019); to provide intensive support for social, emotional, and behavioural difficulties (Boel-Studt et al., 2018; Eenshuistra et al., 2019; Hurley et al., 2017; Jedwab et al., 2019; Luksík, 2018; Schuurmans et al., 2018; Vejmelka & Sabolic, 2015); when a period of recovery and rehabilitation is needed for children who have

experienced childhood maltreatment or sexual exploitation, or who have been trafficked (Brown et al., 2018; Hickle & Roe-Sepowitz, 2018; Rafferty, 2018); and/or when children require additional care due to complex long-term physical and developmental disabilities (Llosada-Gistau et al., 2017). In Scotland, residential care is most frequently used for the purposes of recovery, rehabilitation, and the treatment of social, emotional, and behavioural issues in children and young people (Porter et al., 2020).

Each year, around 10% (cc. 1,400) of all children looked after by local authorities are cared for in residential settings (Scottish Government, 2021). Despite being a significant part of the care continuum, residential care is often considered 'a placement of last resort' (Berridge et al., 2012; Calheiros et al., 2015; Smith, 2009; Shaw, 2014; Woods, 2020). This belief has largely been driven by concerns about the safety and effectiveness of residential care, caused by: 1) historic child abuse allegations (Australian Government, 2013; Department of Children and Youth Affairs, 2009; Langeland et al., 2015; Marshall, 2014; Northern Ireland Executive, 2017; Sen et al., 2008); 2) outcome-driven research consistently demonstrating that residential care placement is associated with low educational attainment, high unemployment rates, poor physical and mental health, early pregnancy and parenthood, homelessness, criminality, and social isolation (Cahill et al., 2016; Dixon, 2008; Forrester et al., 2009; Rainer, 2007; Schofield et al., 2017; Stein & Munro, 2008).

Concerns about the safety and effectiveness of residential care led to policies prioritising the use of family-based placements for children (Bogdanova, 2017; Connelly & Milligan, 2012; Nary, 2016; Porter et al., 2020; Shaw, 2014). This preference for family-based placements was most notable for younger children, with the Skinner Report (1992) stating that residential care should 'only exceptionally' be used for children under the age of 12. In response to this recommendation some local authorities prohibited the use of residential care for children under 12 (Milligan et al., 2006).

The use of residential care as 'a placement of last resort' has been challenged on the grounds that judging residential care on outcome evidence alone may

'significantly underestimate the contribution that they can make, the stability that they can deliver, and the high-quality care they can extend to children who have had terribly fractured lives' (Narey, 2016, p. 5). This is because much of the outcome evidence generated is based upon the experiences of adolescents and young adults who have left residential care at the end of complex journeys through the care system, and is thus likely to be confounded by the effects of: 1) the complex trauma histories that young people in these settings tend to have; and 2) the impact that multiple placement moves and types may have had upon young people's access to education and health services.

In 2009, a review commissioned by the Scottish Government concluded that the needs of children, not their age, should underscore decisions about when to use residential care. The review also concluded that residential care should be considered earlier in the care trajectories of some children, namely those who had substantial histories of neglect, serious attachment problems, complex physical and mental health needs, and increasingly challenging behaviours that were difficult to manage within family-type placements (Hill, 2009). The importance of utilising needs-driven decision making has recently been reinforced by the Independent Care Review, in which it is stated that 'residential homes and schools can be the right place for children or young people, specifically those who would find the intensity of family settings overwhelming' (Independent Care Review, 2020 p. 79). The recommendation that residential care be used earlier within the care trajectory has also led to calls for evidence to be gathered about the benefits, or detriments, of using residential care for specific groups of children, including those under the age of 12 (Hill, 2009). It was also highlighted that there was a need to measure the effect of residential care upon the educational and health outcomes of younger children (Scottish Government, 2009).

Despite these recommendations, very little has been published about the use of residential care for children under the age of 12. Those studies which have been conducted have focussed specifically upon the characteristics of younger children in residential care, concluding that children who enter residential care prior to age 12 tend to be boys who have had multiple changes of foster carers, are exhibiting significant behavioural difficulties, and require crisis care (HIQA,

2017; Milligan et al., 2006). None of the studies we identified explored the impact of residential care on health, wellbeing, or education. As the information gathered by Milligan et al. on the use of residential care for children under 12 in Scotland is now 15 years old, the aim of this paper is to use routinely collected administrative data to address the following research questions:

- RQ1) What common features characterise the familial, child protection and care histories of children under the age of 12 in residential care?
- RQ2) How is being cared for in residential care prior to age 12 associated with children's health and socioemotional wellbeing?

Methods

Study details

The case file analysis presented is drawn from a mixed methods study being conducted by the Scottish Children's Reporter Administration (SCRA). The aims of the study are to: 1) explore temporal trends in the use of residential care for children under the age of 12; 2) explore the familial, child protection, and care histories of children who have entered residential care prior to age 12; and 3) identify the benefits and detriments of using residential care for younger children's socioemotional wellbeing, mental health, and educational engagement.

Extraction and analysis of case file data

Data were extracted from SCRA's Case Management System for 135 children who were subject to their first compulsory supervision order with residential care conditions between 01/04/2015 and 31/03/2017. SCRA's Case Management System contains all casefiles relating to children involved with the Children's Hearing System. The data held includes referrals and reports from social work, police, school, health professionals, safeguarders, etc., as well as records of all decisions made by the Children's Hearing System and any statutory measures enacted. As such we can construct a rich overview of children's lives.

Data extraction involved both authors reading and manually coding information relating to demographics, family characteristics, child trauma histories, child

protection histories, risk-taking and offence-type behaviours, indicators of mental wellbeing, and other behaviours that we had identified through piloting work as being commonly referenced in the files of children (i.e., controlling, violent and physically aggressive behaviours). Appendix 1 provides an overview of the variables extracted, including exemplars of the language that was used within statutory documents to record these variables. It should be noted that the language used within these reports does not always sit comfortably with the belief 'that all behaviour is communication' (*The Promise*, 2020, p. 85). This tension is an issue that we will address in more detail when discussing our findings.

Data were extracted between April 2020 and June 2021 and collated in a Microsoft Excel datasheet that had built-in data validation checks to reduce the potential for data entry errors. All variables were coded based upon whether there was evidence that the event had been experienced, not experienced, or was not recorded within children's case files. All outcome data were measured at three time points: 12 months preceding first entering residential care (T1); 12 months after first residential care placement (T2); and 24 months after first residential care placement (T3). Descriptive statistics and Cochran's Q test for repeated dichotomous measures were used to assess change within groups over time. Data are reported as being significantly different where $p<0.05$[8]. All tests were conducted in Microsoft Excel 2016.

Ethical approval

Approval to use data from SCRA's Data Warehouse and CMS was granted by SCRA's research ethics committee. SCRA data access policies required that both authors had criminal background checks conducted through the Protecting Vulnerable Groups Scheme run by Disclosure Scotland.

[8] The p-value is used to identify whether to accept or reject a null hypothesis, for instance that there will be no difference in the number of children displaying offence-type behaviour over time. Where $p>0.05$ we accept the null hypothesis of no difference. Where $p<0.05$ we reject the null hypothesis, and use the data available to determine if that behaviour has improved or declined.

Results

RQ1: What common features characterise the familial, child protection and care histories of children under the age of 12 who have been looked after in residential care?

Our analyses indicate that children who become subject to compulsory supervision orders with residential care conditions prior to their twelfth birthday tend to come from families that have additional health and social care needs. They also have complex trauma histories and have often experienced multiple placement moves.

Family backgrounds

Table 1 indicates that most of the children who became subject to compulsory supervision orders with residential care conditions before age 12 were male (80%) and of white ethnicity (96%). Just over half (54%) had parents who were known to have experienced financial difficulties. Around one in three (30%) of the children had parents who had separated from each other. Half (50%) of the sample were recorded by SCRA as having a known disability; however close reading of case files indicated that three quarters (70%) of the children had either a known or suspected disability. Learning and communication difficulties were the most frequently recorded disability type.

Figure 1 shows that the family backgrounds of children who are subject to compulsory supervision orders with residential care conditions before age 12 were often characterised by complex health and social care needs. For instance, many of the children in our sample had one or more parent who had: mental health difficulties (72%); misused drugs and/or alcohol (74%); a history of housing instability (53%), engaged in offending behaviour (60%); or had been imprisoned (28%). The misuse of drugs and/or alcohol, mental health difficulties and housing insecurity were more commonly seen for the mothers of younger children in residential care. Offending behaviours and imprisonment were more commonly seen for fathers.

Maltreatment and trauma histories

Figure 2 shows that the children who became subject to compulsory supervision orders with residential care conditions before age 12 had complex trauma histories, with high proportions of our sample having been sexually abused (62%), physically abused (68%), physically neglected (76%), and exposed to violence within the home or community (83%). In addition to the high levels of maltreatment observed, a third (32%) of the children had experienced the death of a parent, a sibling, or significant relative/caregiver. One in six (16%) were considered to have been disowned by at least one parent.

Looking specifically at adverse childhood events (ACEs, see Felitti et al., 1998 for further details), Figure 3 shows that the median number of ACEs experienced by children in our sample was five (range: 1-9).

Child protection histories

Figure 4 indicates that children who became subject to compulsory supervision orders with residential care conditions before age 12 often had extensive child protection histories. Overall, three quarters (75%) of the children in our sample had been known to services prior to 2.56 (median: 0.50, range: -0.30 to 9.16) years of age. A third (32%) of the children had been known to services prior to birth (data not shown). Overall, 90% of the children in our sample had been identified as requiring support from services by their fifth birthday i.e., while they were still under the care of health visiting services (data not shown; see Scottish Government, 2015 for information on the health visiting programme).

Our analysis indicates that three quarters (75%) of the sample had been referred to the Children's Hearings System by 5.11 (median: 2.73; range: 0.00 to 11.08, Figure 4) years of age. Nearly all of these referrals (93%, data not shown) were on care and protection grounds. Although most children were referred prior to their fifth birthday, our analysis indicates that the median age for becoming a looked after child was 5.49 (range: 0.00-11.38) years of age, while the median ages for being placed onto a compulsory supervision order (CSO) or a child protection order (CPO) were 6.07 (range: 0.02-13.41) and 6.49 (range: 0.00-11.08) years of respectively. Overall, three quarters (75%) of the

children had been subject to one or more of these legal measures by the time they were 8.77 years of age.

Finally, Figure 4 indicates that on average the children in our sample were 7.37 (range: 1.00-11.85) years old when they were first accommodated by the local authority. Overall, three quarters (75%) had been accommodated by 9.72 years of age. The median age for entry into residential care was 9.85 (range: 5.60-11.87) years old, with CSOs with residential care conditions enacted when children were 10.63 (range: 6.28-11.97) years old on average. One quarter (25%) of the children first entered residential care between 5.60 and 8.24 years of age.

Placement breakdowns

Figure 5 indicates that 83% of the children in our sample had experienced one or more placement moves prior to entering residential care. The median number of placement moves was three (range 0-12; data not shown). Looking at the type of placements that children had experienced, our data indicates that two-fifths (42%) of the sample had experienced one or more episodes of being looked after at home by their parents with support from social work services, while just under a third (29%) had experienced one or more episodes of being looked after in kinship care. Foster care was the most common placement type, with two thirds (69%) having experienced one or more fostering placements. The median number of foster care placements experienced was two (range 0-9; data not shown).

Our analysis indicates that the main reasons for placement breakdowns included: concerns about parents' and/or caregivers' ability to keep the child safe (69%); concerns about the safety of others (i.e., other children in placement and caregivers' own biological children and grandchildren) due to physically aggressive and violent behaviours from the child (47%); the needs of the child not being met by the placement (47%); and the high levels of care some children required due to: soiling; sexualised behaviour; and being overly controlling of their environments and people, dysregulated sleep etc. (40%). It was common for placement moves to be unplanned, stemming from the child being perceived as being 'in crisis'. While our data indicated that children and

their birth parents received significant levels of intervention from health and social care agencies prior to a child becoming formally looked after, foster carers received very little direct support from services, beyond routine supervision and the offer of respite care. Despite respite care being the main support offered to foster carers, only 50% of the children who had been in foster care had received respite care. Please note that the data on placement breakdowns and support are not shown in the tables.

Entry into residential care and subsequent placement moves

Table 2 indicates that half (47%) of the children in our sample entered residential care because they were placed onto a compulsory supervision order (CSO) with residential care conditions. Just under a third (31%) entered residential care because they were subject to interim or emergency measures such as an Interim CSO (ICSO), an Interim Variation of a CSO (IVCSO), or a place of safety warrant. Around one in six (16%) were accommodated under Section 25 of the Children's (Scotland) Act 1995. Half (53%) of the children were first looked after in a children's unit, while a third (31%) were first cared for in residential schools.

Table 2 shows that half (47%) of the children in our sample experienced no placement moves in the two years following their entry into residential care, while 27% experienced a single placement move, and 26% experienced 2-9 moves. Our results indicate that there were limited attempts made at returning children to family placements, with just 18% of the sample being returned to family-based care. Two in five (40%, n=25) of the children who returned to family-based care required multiple stays in residential care to facilitate successful return to family living. Looking specifically at the 109 children who remained in residential care, our results indicate that two years after becoming looked after in residential care, 38% were living in children's homes, while 47% were cared for in residential schools. The remaining 15% were cared for in other residential care establishments such as crisis care, short-term assessment centres, specialised therapeutic placements for traumatised children, small-group (2-4 children) living environments, and singleton residential placements with a team around the child.

RQ2: How is being cared for in residential care prior to age 12 associated with children's health and socioemotional wellbeing?

Our analysis indicates that placement into residential care for children under the age of 12 was associated with significant improvements in children's socio-emotional wellbeing and mental health over time, with most of the improvements occurring within the first year of being in residential care.

Risk taking and offence-type behaviours

Figure 6 highlights that very few of the children in our sample were engaged in risk-taking behaviours such as smoking tobacco (4-7%), consuming alcohol (1-5%), using drugs (1-4%), or engaging in non-concerning and age-appropriate sexual exploration such as consensual touching or kissing a child of a similar age (4-6%) at any time point. A fifth of the children (19%) were considered to have demonstrated offence-type behaviour in the 12 months preceding entry into residential care (T1). There was no significant change in the number of children demonstrating offence-type behaviours within 12-24 months of entering residential care (T2=23%, T3=21%; $p>0.05$). Looking specifically at those with offence-type behaviours, the most reported behaviours were assaults (79%), vandalism and destruction of property (54%), culpable and reckless behaviour (49%), threatening and abusive behaviour (22%), and breach of the peace[9] (17%); please note this data is not shown in the tables.

At T1 the majority (84%) of children in our sample were perceived by their caregivers as placing themselves at risk within the community. This figure had reduced to 57% within 12 months of entering residential care (T2) and 50% within 24 months of entering residential care (T3). Most of the change in perceived levels of risk occurred between T1 and T2 ($p<0.001$), with no further significant change ($p>0.05$) occurring between T2 and T3. There were no changes in children's own awareness of risk, with less than 2% of the children in

[9] In Scots law the common public order offence 'Breach of the Peace' refers to 'conduct severe enough to cause alarm to ordinary people and threaten serious disturbance to the community'. The offence may also be prosecuted as 'threatening or abusive behaviour' under Section 38 of The Criminal Justice and Licensing (Scotland) Act 2010: https://www.legislation.gov.uk/asp/2010/13/contents

our sample considered to be aware that they were at risk of harm at all time points.

Behaviours that caregivers found challenging to manage

Figure 7 provides an overview of behaviours that were frequently cited within statutory documents as being challenging to manage by caregivers, and as contributing to the breakdown of placements prior to entry into residential care. Looking first at toileting behaviours, our results indicate that there were significant reductions in reported rates of both night and day wetting in the 24 months after entry into residential care (night wetting: T1=17% vs. T3=10%, $p<0.05$; day wetting: T1=8% vs. T3=3%, $p<0.05$). The reduction in night wetting was mainly driven by a reduction in these behaviours between T2 and T3. Significant reductions in other toileting concerns such as soiling and smearing were also observed over time (T1=31% vs. T3=13%, $p<0.05$).

Moving on to look at how children interacted with others, we found that entry into residential care was associated with a reduction in the number of children who were described by their caregivers as trying to exert control over situations or the people around them (controlling situations: T1=42% vs. T3=32%, $p<0.001$; controlling people: T1=59% vs. T3=46%, $p<0.001$). There was no significant change in the proportion of children considered to be controlling of food or hygiene over time (food: T1=24% vs. T3=18%, $p>0.05$; hygiene: T1=13% vs. T3=13%, $p>0.05$). There was a significant decrease in the number of children who had demonstrated sexualised behaviours that carers considered to be age and developmentally inappropriate between T1 and T3 (T1=44% vs. T3=20%, $p<0.01$). These behaviours included young people: exposing their genitals; simulating sexual acts; using sexualised language; inserting objects into their genitals; excessive touching of, or causing harm to, their genitals; viewing pornography; inappropriately touching children and adults; lacking awareness of privacy and boundaries; and showing disinhibited behaviour towards adults.

Indicators of conduct disorder

Figure 8 specifically looks at those behaviours that are listed within the diagnostic criteria for conduct disorder (American Psychiatric Association, 2013). Our analysis indicates that 70% of the children in our sample had three or more indicators of conduct disorder recorded within statutory documentation at T1. By T3 this figure had significantly reduced to 36% ($p<0.001$). Most of this reduction occurred within the first 12 months of being in residential care ($p<0.001$). Looking specifically at the individual behaviours listed within the diagnostic criteria for conduct disorder, our analysis indicates that there was a significant reduction in the number of children who were recorded as having absconded from placement on two or more occasions (T1=47% vs. T3=27%, $p<0.01$) and having displayed offence-type behaviours such as the destruction of property, through arson (T1=13% vs. T3=4%, $p<0.001$) or other means (T1=55% vs. T3=35%, $p<0.001$).

Moving on to look at children's interactions with others, our results indicate that residential care was associated with significant reductions in the proportion of children whose behaviour was described as cruel, physically aggressive, and violent. For instance, mentions of cruelty towards people and animals both significantly fell over time (animals: T1=12%, T3=3%, $p<0.001$; people: T1=53%, T3=26%, $p<0.001$). Descriptions of children being physically aggressive and violent towards animals and people also significantly fell (animals: T1=21%, T3=4%, $p<0.001$; people: T1=88%, T3=70%, $p<0.001$). Finally, our results indicate that reports of children using weapons, including knives, to threaten or harm others significantly reduced after entry into residential care (T1=41% vs. T3=21%, $p<0.001$), with the largest reduction seen in the first 12 months.

Indicators of mental wellbeing

Figure 9 provides an overview of the mental wellbeing of children in our sample over time. Entry into residential care was associated with a significant reduction in the number of children who were self-harming (T1=34% vs. T3=16%, $p<0.001$) and frequently expressing that they wanted to die (T1=20% vs. T3=10%, $p<0.01$). Placement into residential care was also associated with a

reduction in the proportion of children who were considered to have anger management issues (T1=79% vs. T3=64%), low self-esteem (T1=45% vs. T3=39%), and who were described as frequently experiencing low mood or feeling sad (T1=36% vs. T3=15%, $p<0.001$) within statutory documents. In all cases the reductions observed were greatest in the first 12 months of being in residential care, i.e. between T1 and T2. A significant reduction was also observed for the proportion of children considered to be unusually anxious or experiencing social anxiety (T1=71% vs. T3=57%, $p<0.001$); however, this change took longer to occur, with the falls in anxiety largely occurring between 12 and 24 months in placement.

Finally our results show that there were significant reductions in the proportion of children who were described as being fatigued (T1=14% vs. T3=4%, $p<0.001$), having poor concentration (T1=23% vs. T3=10%, $p<0.01$), having experienced changes in appetite or weight (T1=10% vs. T3=6%, $p<0.01$), and experiencing sleep difficulties (T1=39% vs. T3=17%, $p<0.001$).

Discussion

Our results indicate that children who become subject to compulsory supervision orders with residential care conditions prior to their twelfth birthday have complex trauma histories, have experienced inconsistent and unsafe care due to the demands that parents' additional health and social care needs place upon their ability to parent, and have often experienced repeat episodes of loss due to bereavement, family breakdown and multiple changes of caregiver. Although these findings provide insight into the characteristics of younger children in residential care, they are not novel, with numerous studies demonstrating that entry into residential care during adolescence is preceded by: childhood maltreatment (Cox et al., 2017; Garcia-Quiroga et al., 2017; Hickle & Roe-Sepowitz, 2018; Wendt et al., 2019); factors such as mental ill-health, drug and alcohol dependency, incarceration and interpersonal violence adversely affecting parenting skills (Jaramillo et al., 2016; Jozefiak et al., 2017), and family-based placements repeatedly being unable to meet the emotional needs of the child (Grey et al., 2018; Milligan et al., 2006; Wright et al., 2019).

Many of the children in our sample had complex emotional and behavioural needs that could not be fully supported or contained within foster care. These needs included: demonstrating age-inappropriate sexualised behaviour; having dysregulated sleep; demonstrating risk- and offence-type behaviours within the community; being overly controlling of situations and other people; and requiring additional levels of care and support due to disability, delays in toileting, attachment difficulties, and histories of self-harm and suicidal thoughts. These findings build upon existing knowledge about the increased levels of behavioural difficulties that are present within the care histories of younger children, particularly boys, in residential care (HIQA, 2017; Milligan et al., 2006), as well as existing knowledge demonstrating that adolescents in the care system are more likely than their peers to experience mental health difficulties (Ford et al., 2007), display harmful and age-inappropriate sexual behaviours (McKibben, 2017), demonstrate offence-type behaviours, have insecure and disorganised attachment styles (Bifulco et al., 2017), and show dysregulated and maladaptive behaviours, such as smearing, hoarding, and being overly controlling of situations and people (Dejong, 2014).

Emotional and behavioural difficulties adversely affect the quality of the interpersonal relationships that children in residential care form (Gwynn et al., 1988). Children in residential care frequently demonstrate social skills deficits, overaggressive and antisocial behaviours, fears of groups, distortions in reality-assessment, hyperactivity, impulsiveness, and episodes of peer-to-peer violence (Barter, 2003, 2008; Cicchetti and Toth, 2005; Greger et al., 2016; Monks et al., 2009; Tricket et al., 2011). This was something that we observed within our data, with many of the children in our sample demonstrating behaviours considered to be aggressive, controlling, bullying or manipulative towards people, most often female caregivers or other children in placement, and animals. From a psychological point of view, it is important to note that these behaviours are likely to be secondary manifestations of the maltreatment and lack of consistent care and protection that they had received (Porter et al., 2020). They may also represent maladaptive attempts by children to seek proximity to, and acceptance from, others using the only forms of affection (i.e. abuse and neglect) they have known (Crittenden, 1992; Schore, 2001).

The Independent Care Review[10] (2020, p. 85) emphasises that there is a need for caregivers to be curious about the reasons behind challenging behaviour, as 'all behaviour is communication'. Foster carers, who do not benefit in the same way as residential care staff do from being able to build a team around the child, may find it difficult to be curious about behavioural underpinnings when faced with a child in crisis and escalating levels of distress. This may be particularly true if the dysregulated behaviour being displayed includes sexualised behaviour, and/or aggression and violence towards the caregiver or other children in placement. Identifying how best to support caregivers to identify and address behaviours that they find challenging, while also acknowledging and addressing any compassion fatigue and secondary trauma that caregivers experience as a result (Browning, 2020), may be an important step towards promoting placement stability for one of the most vulnerable groups of children in the care system. Promising examples of work in this area include the evaluation of the Reflective Fostering Programme, a trauma-informed group-based psycho-educational programme that is designed to help foster carers reflect upon how they experience, respond to, and manage challenging behaviour (Midgley et al., 2021a; Midgley et al., 2021b). Helping caregivers, and the professionals who support them, to better understand how children use behaviour to communicate their unhappiness or distress would also address some of the more pathologising language that we found when examining case files.

Foster care placement instability, including the experience of multiple placement moves and episodic care, are known to significantly increase the probability of children requiring mental health service intervention (Meltzer et al., 2003; Rubin et al., 2004). In contrast, our results indicate that being cared for in residential care was associated with a reduction in the number of behavioural difficulties displayed by children, and an improvement in their mental wellbeing. One

[10] In October 2016 The First Minister of Scotland made a commitment to identifying 'how Scotland could love its most vulnerable children and give them the childhood they deserve'. To facilitate this the Independent Care Review, which was chaired by Fiona Duncan, compiled the views of 5,500 individuals with experience of living and working in and around the 'care system' to properly understand what needs to change in order to achieve this. The findings of the Independent Care Review and its implications for both care- and hearings-experienced children and families can be found here: https://thepromise.scot/independent-care-review. At the heart of these recommendations sits 'The Promise' which narrates a vision for how Scotland's statutory agencies, local authorities and third sector organisations will work together to effect change for children and families.

possible explanation for these improvements is that three-quarters of the children in our sample had experienced either no placement moves, or just a single placement move, within the two-year follow up period. As limiting the number of moves children in care experience is considered to offer one of the best means of improving outcomes for this group (Independent Care Review, 2020, p. 68), being able to assess whether the number of placements moves children experience after entering residential care is associated with differential outcomes is a logical next step of this research. Unfortunately, this may not be possible with our existing sample due to the small numbers of children who have experienced multiple placement moves.

In addition to understanding the impact of placement stability upon the socioemotional and mental wellbeing of the children in our sample, there is a need to understand the wider mechanisms that may underscore these changes. This research should explore: whether there are specific characteristics or groups of children whose needs are likely to be better met by being cared for in residential care settings; how differences in the types of residential care available to children and variations in practices and resources across settings are associated with variations in outcome; and the extent to which the matching of children's needs against what residential settings were able to provide affected both the outcomes observed for children and the stability they experienced within placement.

Finally, given that our results show that residential care can be a stabilising environment for children who are demonstrating dysregulated and trauma-driven behaviours, we believe that there is a need to explore in more depth what role residential care should play in providing care to younger children and when it could best be utilised. One question that we would like to see explored is whether residential care provision could be better utilised to provide children and caregivers with a period of respite where assessments of need could be conducted for both children and their caregivers, and intervention pathways developed to practically address those needs in a setting where the child could remain in placement on a longer-term basis if required. Addressing this question is particularly important given that our findings reaffirm that, beyond regular supervision and the offer of respite services, foster carers were provided with no

practical support or intervention when there were indications that placements were beginning to break down (Murray et al., 2011; Triseliotis et al., 1998). Conducting this research is particularly important given the emphasis that *The Promise* (Independent Care Review, 2020, p. 51) placed upon ensuring that children within care receive intensive support to maintain their place within their home in whatever family setting they are living in.

Strengths and limitations

The use of administrative data both limits and strengthens the findings of this study. The main limitations of the study focus mainly upon reporting bias. The data held by SCRA were not collected for research purposes and therefore are not standardised. Lack of standardised data increases the risk of information not being captured if it was not considered to be salient to the decision-making process by the individual completing the documentation. It is therefore possible that our study may underestimate both the level of risk and adversity experienced by children in our sample and the effect that residential care provision has upon behaviour and mental health outcomes over time. This risk has previously been identified in work exploring the reporting and recording of information about disability in case file data (Nixon et al., 2021).

Our findings are also limited by the exclusion of children who are in residential care but have never been subject to compulsory measures of supervision. This group, which is likely to include children with long-term physical and complex disabilities, may not share the familial and trauma histories of the children in our sample. It is also possible that the impact of residential care upon their health and wellbeing is consequently different, as well as the impact this may have upon practice. The sample size of this study also limits our ability to explore differential impacts of residential care (i.e., by gender or setting) upon the health and socioemotional wellbeing of children. Addressing these gaps through larger scale administrative linkages or via the use of qualitative methods is an obvious extension of this work as it is likely that differences in the support and education packages that can be provided to children, particularly if these include access to bespoke therapeutic services or the ability to build a team around the child, will affect the outcomes achieved.

While there are limitations to using administrative data the strengths are as follows. Our data covers every child who was subject to compulsory measures during the specified time-period, thereby reducing the risk of bias usually associated with sampling and non-participation. The risk of attrition bias, which is frequently seen in surveys and is disproportionately experienced by socially excluded groups, is also reduced due to the need for ongoing case reviews for as long as a child is considered to require statutory measures. Finally, the use of statutory documents reduces the risk of recall and reporting bias that can be observed in self-reported data, particularly when the data that participants are asked to provide focuses upon sensitive or distressing issues that individuals may be reluctant to disclose (Connelly et al., 2016).

Conclusion

Residential care can provide a period of stability for younger children who have experienced complex trauma, inconsistent and unsafe parenting, and repeat episodes of loss due to family breakdown, bereavement, and placement instability. There is a need for future research to understand the mechanisms that underscore the improvements in socioemotional wellbeing and mental health that were observed for our sample after 12-24 months in residential care. This research should be supplemented by work to understand: 1) how to better support foster carers to understand and manage the dysregulated behaviours that they are encountering when caring for children; 2) how residential care settings might be better used to help sustain foster care placements at risk of breaking down.

Table 1: Characteristics of younger children subject to CSOs with residential care conditions

		%	n
Sex	Male	80.00	(108/135)
	Female	19.26	(26/135)
	Unknown	0.74	(1/135)
Ethnicity	White	95.56	(129/135)
	Mixed	1.48	(2/135)
	Unknown	2.96	(4/135)
Parents known to be experiencing financial difficulties	Yes	54.07	(73/135)
	No/Unknown	45.93	(62/135)
Parents have separated	Yes	29.63	(40/135)
	No/Unknown	70.37	(95/135)
Disability recorded in casefiles	Yes	49.63	(67/135)
	No	28.89	(39/135)
	Not stated	21.48	(29/135)
Has known or suspected disability	Yes	70.37	(95/135)
	No/unknown	29.63	(40/135)
Identified or suspected disability	Learning and communication difficulties	67.99	(73/95)
	Social, emotional & behavioural difficulties	16.76	(18/95)
	Neurodiversity	24.22	(26/95)
	Physical or motor impairment	9.31	(10/95)
	Audiovisual impairment	6.52	(7/95)
	Chronic physical health problems	46.57	(50/95)
No. of identified or suspected disabilities	0	29.63	(40/135)
	1	28.15	(38/135)
	2	27.41	(37/135)
	3	11.11	(15/135)
	4	3.70	(5/135)
	5	0.00	(0/135)

*Conditions included under this category include autistic spectrum disorders, sensory processing disorders and ADHD.

Figure 1: Familial characteristics of children under 12 subject to CSOs with residential care conditions

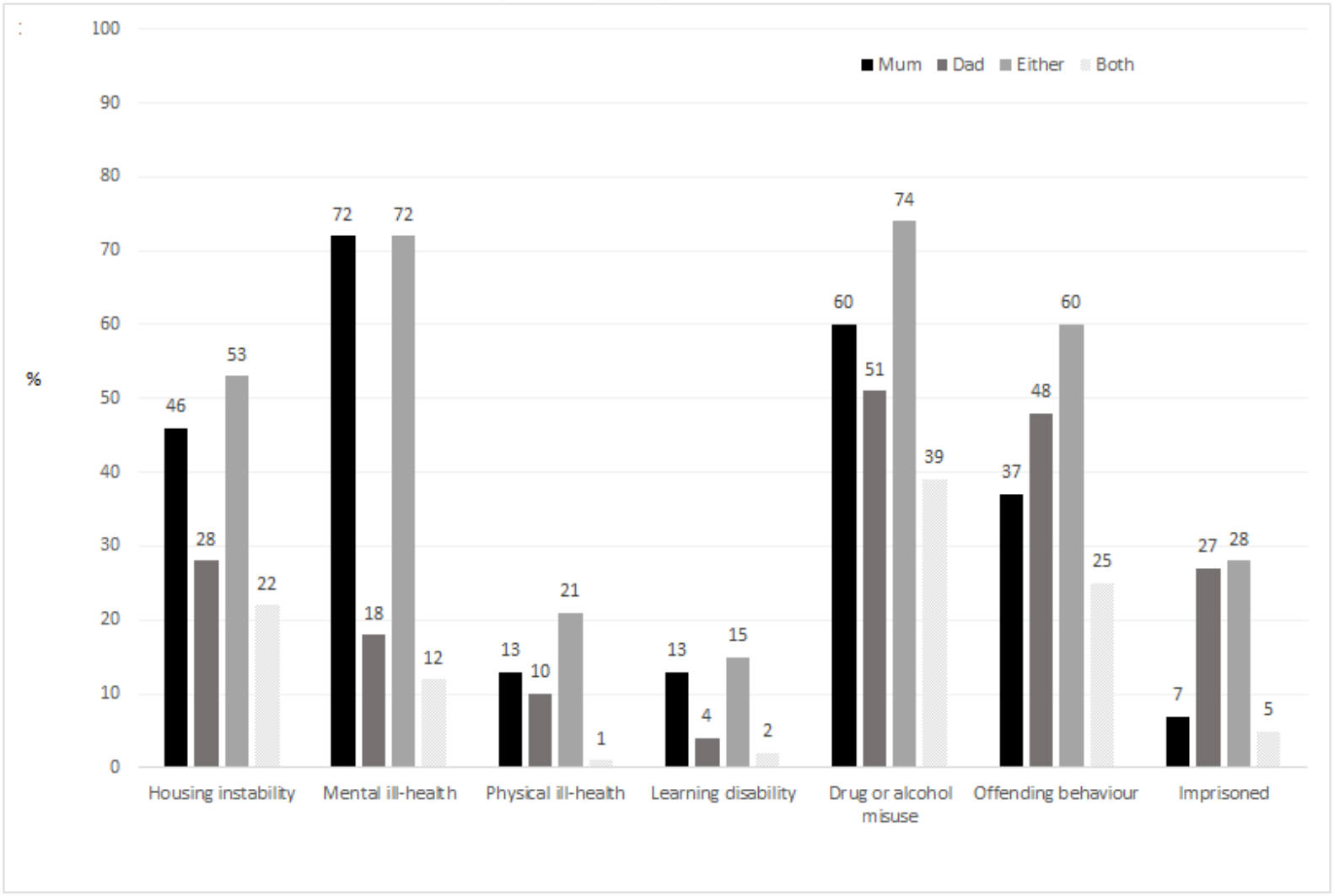


Figure 2: Trauma histories of children under 12 subject to CSOs with residential care conditions

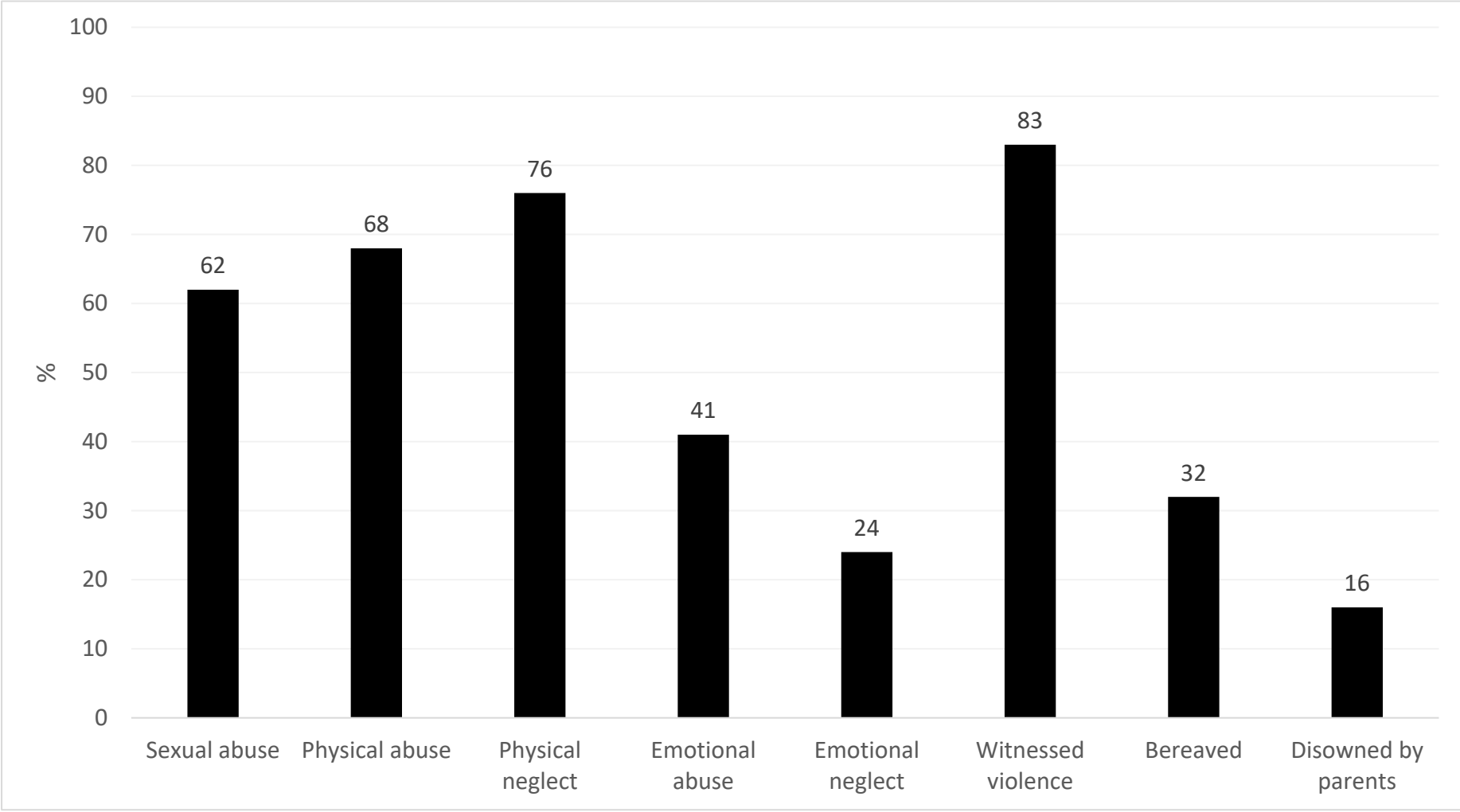
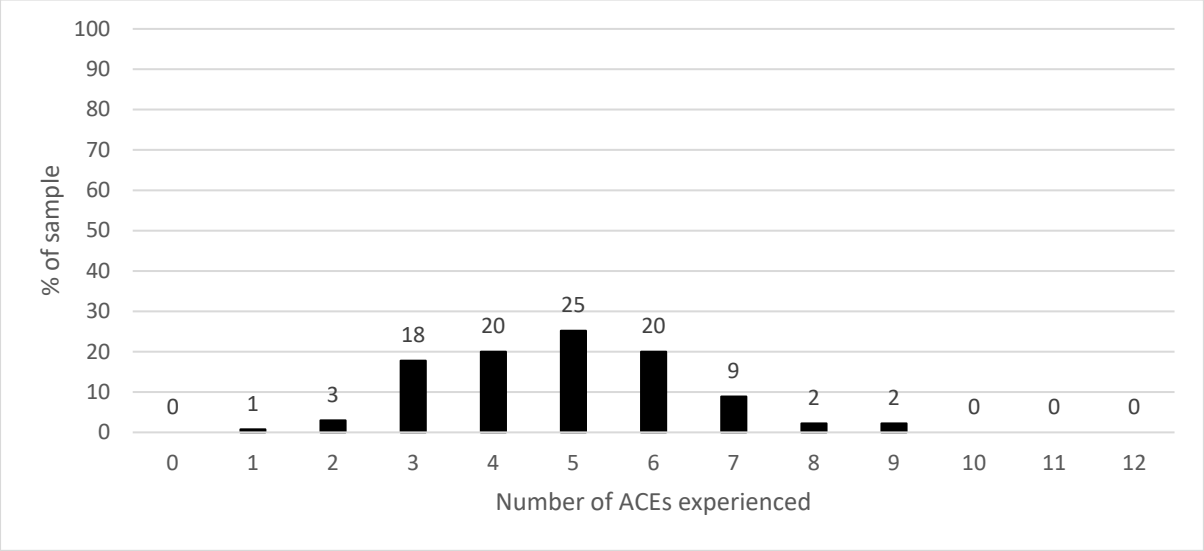
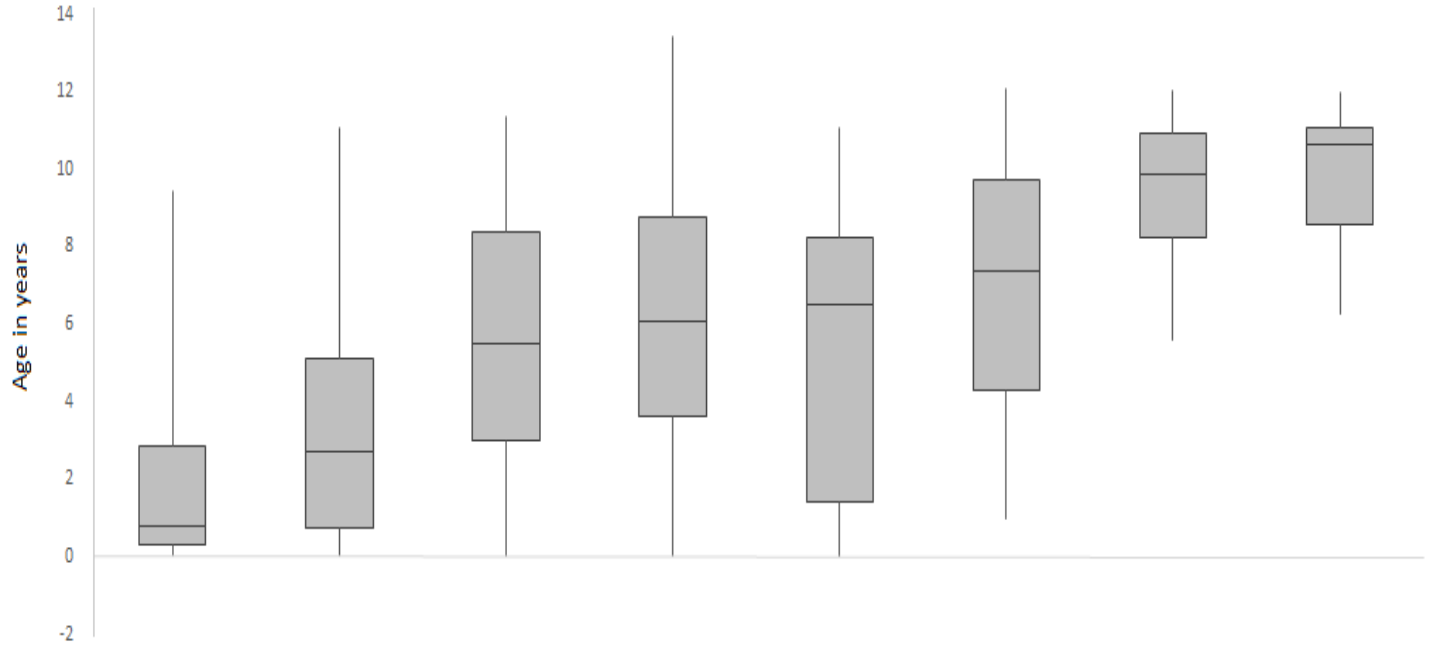


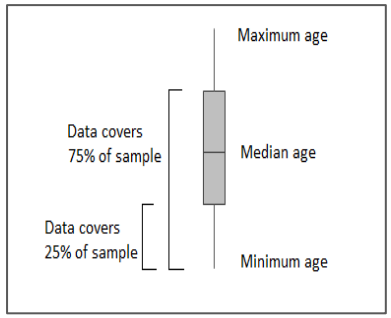
Figure 3: Distribution of adverse childhood events (ACEs)[1] experienced by children under 12 that have CSOs with residential care conditions



[1] Total ACEs were calculated by summing the number of indicators present from the following list: parental mental ill-health, parental substance misuse, parents separated, parental imprisonment, child experienced significant bereavement, child maltreatment types (sexual abuse, physical abuse, physical neglect, emotional abuse, emotional neglect), child witnessed violence in the home or community, child has been bullied, child has been removed from parental care.

Figure 4: Child protection histories of children under 12 subject to CSOs with residential care conditions[1]





	First known to services	First SCRA referral	First looked after	First CSO	First CPO	First accommodated	First enters residential	First residential CSO
Minimum	-0.30	0.00	0.00	0.02	0.00	1.00	5.60	6.28
25th percentile	0.00	0.73	3.02	3.64	1.43	4.29	8.24	8.57
Median	0.50	2.73	5.49	6.07	6.49	7.37	9.85	10.63
75th percentile	2.56	5.11	8.40	8.77	8.22	9.72	10.93	11.07
Maximum	9.16	11.08	11.38	13.41	11.08	11.85	11.87	11.97

SOs alone and the
of safety warrants.

ditions

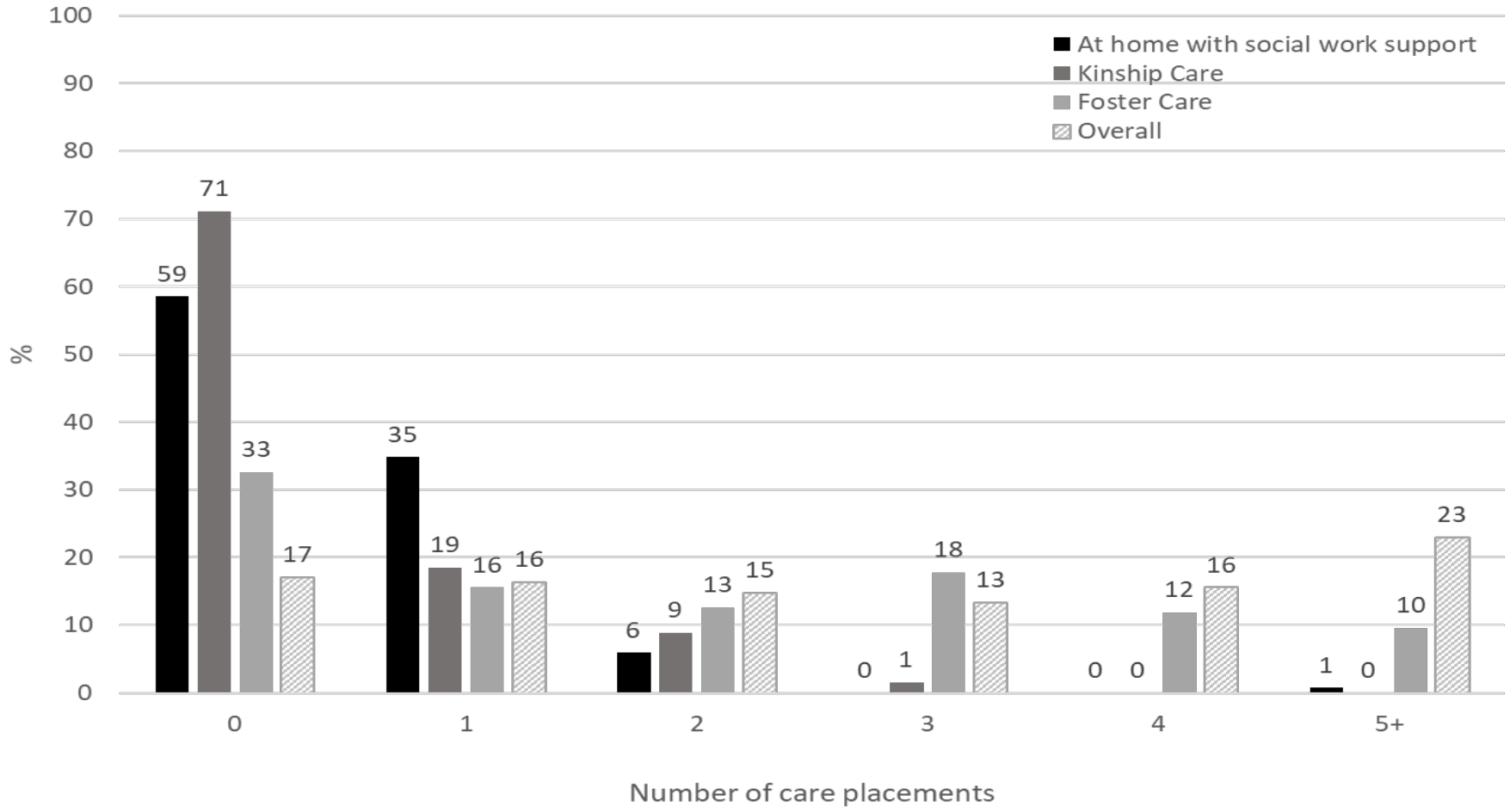
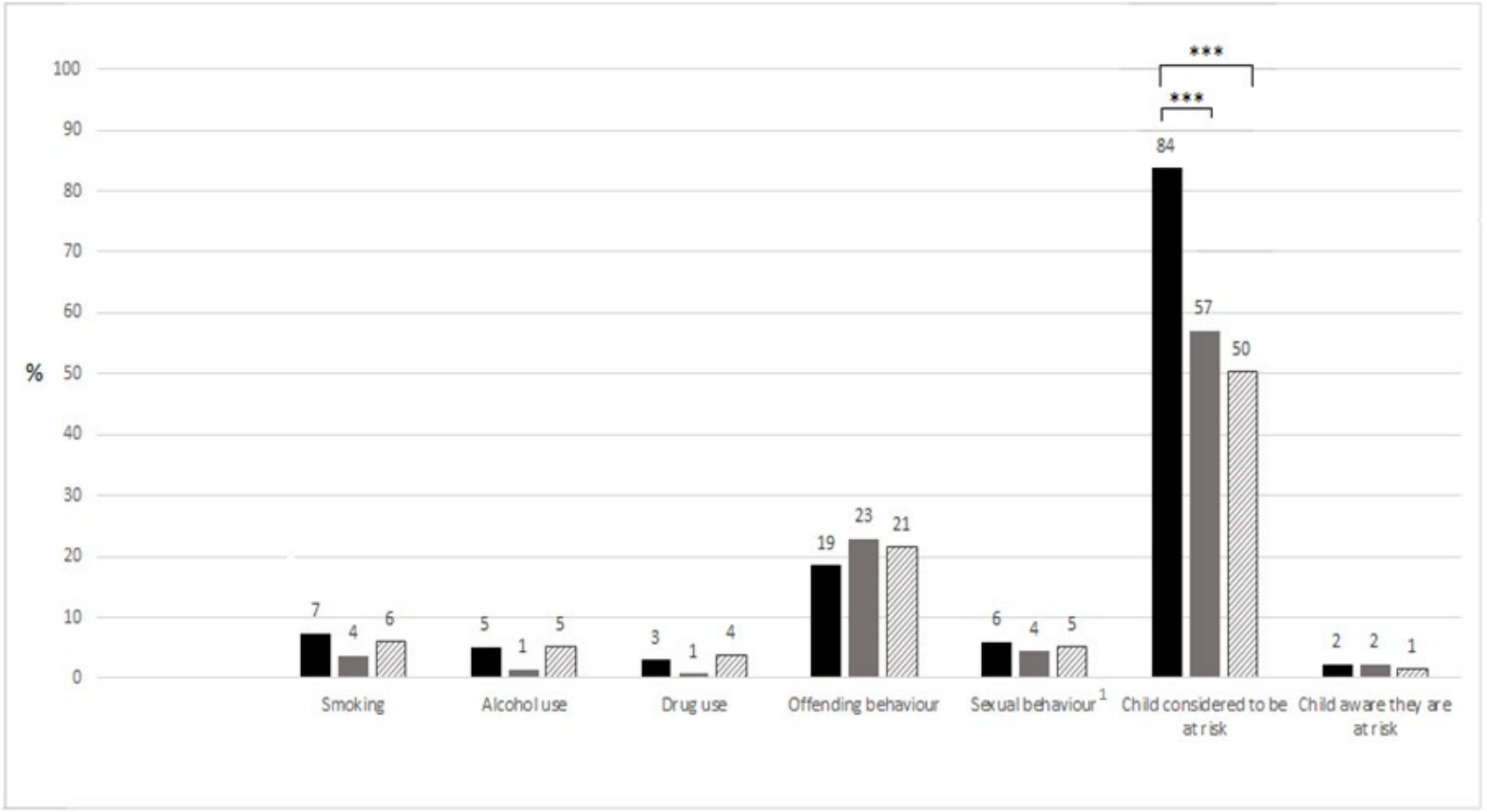

100
90
80
70
60
50
40
30
20
10
0
%
At home with social work support
Kinship Care
Foster Care
Overall
59
71
33
17
35
19
16
16
6
9
13
15
0
1
18
13
0
0
12
16
1
0
10
23
0
1
2
3
4
5+
Number of care placements

Table 2: Care trajectories in the two years after being looked after in residential care for the first time

		n	%
First residential care placement type	children's unit	52.59	(71/135)
	residential school	31.11	(42/135)
	other residential establishment[1]	16.30	(23/135)
Legal status first residential care placement	CPO	3.70	(5/135)
	CSO	46.67	(63/135)
	ICSO/IVCSO/Place of safety warrant	31.11	(42/135)
	Section 25	15.56	(21/135)
	Record not available	2.96	(4/135)
Number of placement moves within two years of entering residential care	0	46.67	(63/135)
	1	27.41	(37/135)
	2	8.89	(12/135)
	3	8.15	(11/135)
	4	2.96	(4/135)
	5-9	5.92	(8/135)
Child returned to living in a family placement within two years of entering residential care	child living in a family setting after first attempt	11.11	(15/135)
	child living in a family setting after 1+ attempts	7.41	(10/135)
	attempted but returned to residential care	10.37	(14/135)
	not attempted	71.11	(96/135)
Placement type two years after entering residential care	at home with parents	7.41	(10/135)
	in a kinship placement	3.70	(5/135)
	in foster care	7.41	(10/135)
	in a children's unit	31.11	(42/135)
	in a residential school	37.78	(51/135)
	other residential establishment	12.60	(17/135)

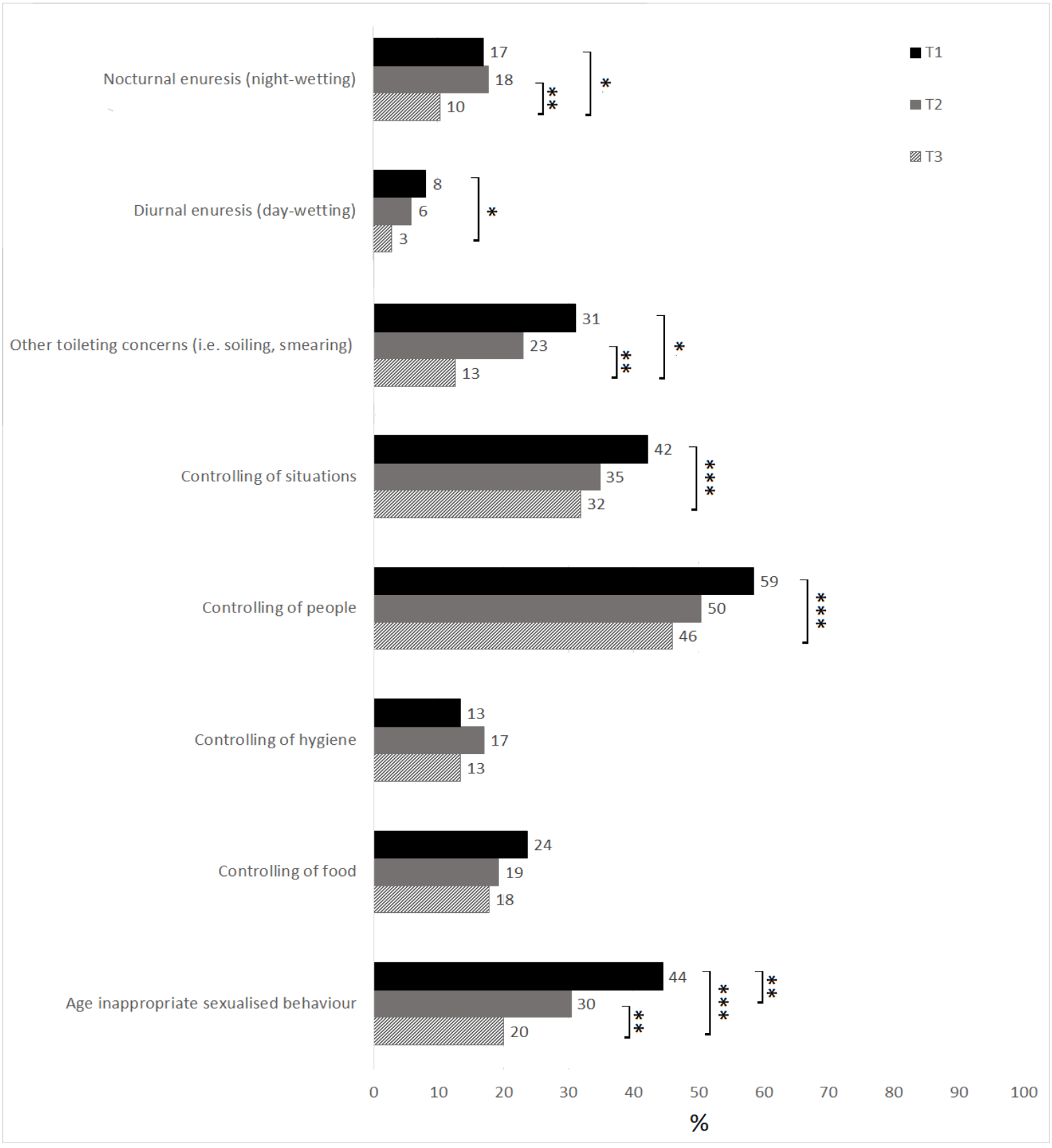
1 Other residential establishments include crisis care, short-term assessment centres, specialised therapeutic placements for traumatised children, small-group (2-4 children) living environments for children with complex health and social care needs, and singleton placements with a residential care team. Close support units and secure care are also included in this category to protect the anonymity of the small number of children requiring this level of care.

Figure 6: Risk-taking and offence-type behaviours among children under 12 subject to residential care CSOs



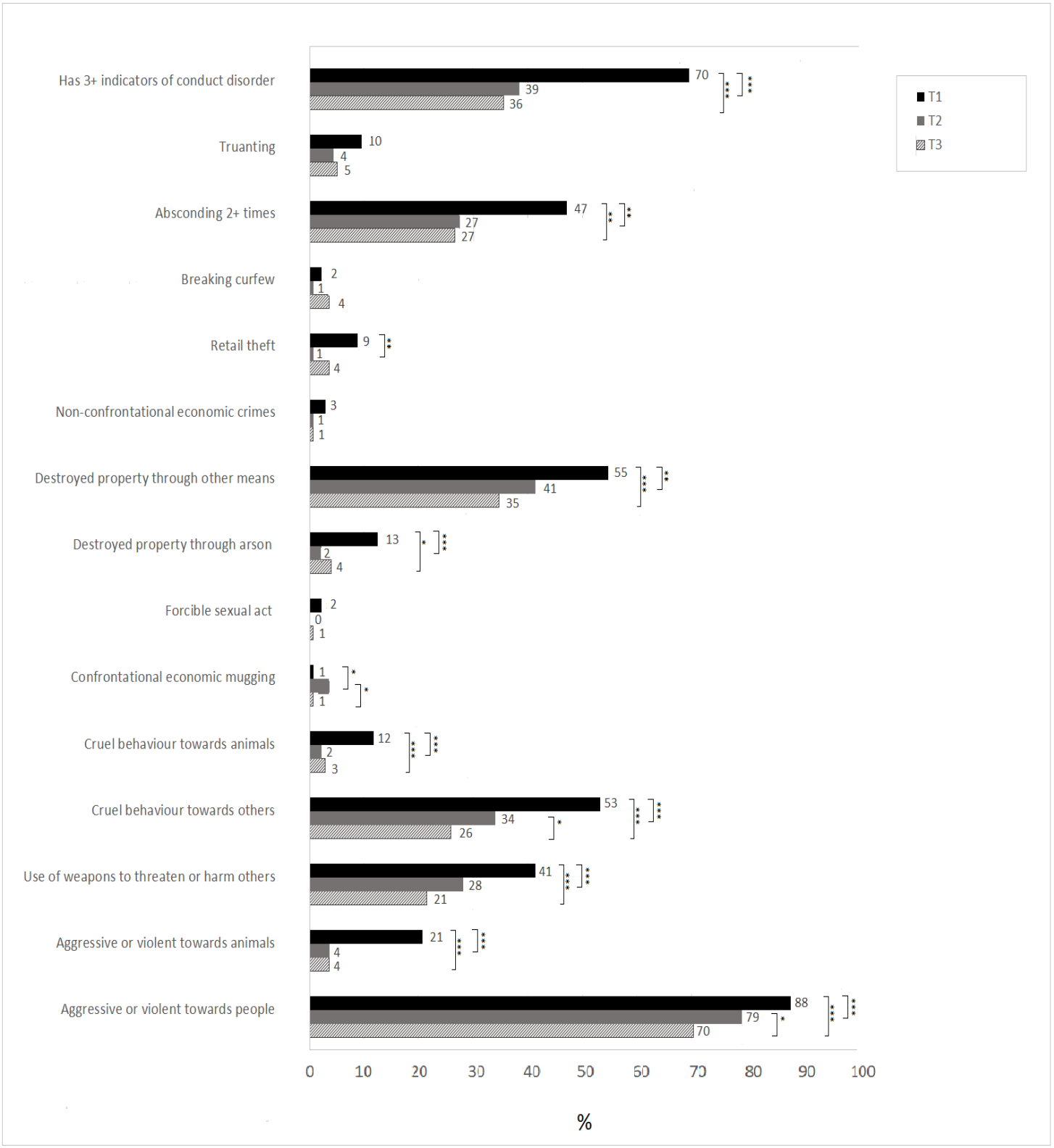
[1] Sexual behaviour recorded if case files described non-concerning, age appropriate and consensual sexual behaviour, i.e. kissing, mutual touching/exploration, bodily self-exploration. Sexual behaviour excludes all references to penetrative sex for children under the age of 13, any sexual behaviour that occurred with an age gap between participants >= 3 years, behaviours that were considered alarming, non-consensual or reminiscent of past sexual trauma (i.e. re-enactment of sexual acts) or where the child was considered to be exchanging/receiving gifts for sex or was engaged in sexual behaviour with somebody perceived to be in a position of power; Significance levels indicated by: *** p<0.001; ** p<0.01; * p<0.5

Figure 7: Prevalence of behaviours identified as challenging by foster carers among children under 12 subject to residential care CSOs



Significance levels indicated by: *** p<0.001, ** p<0.01, * p<0.05

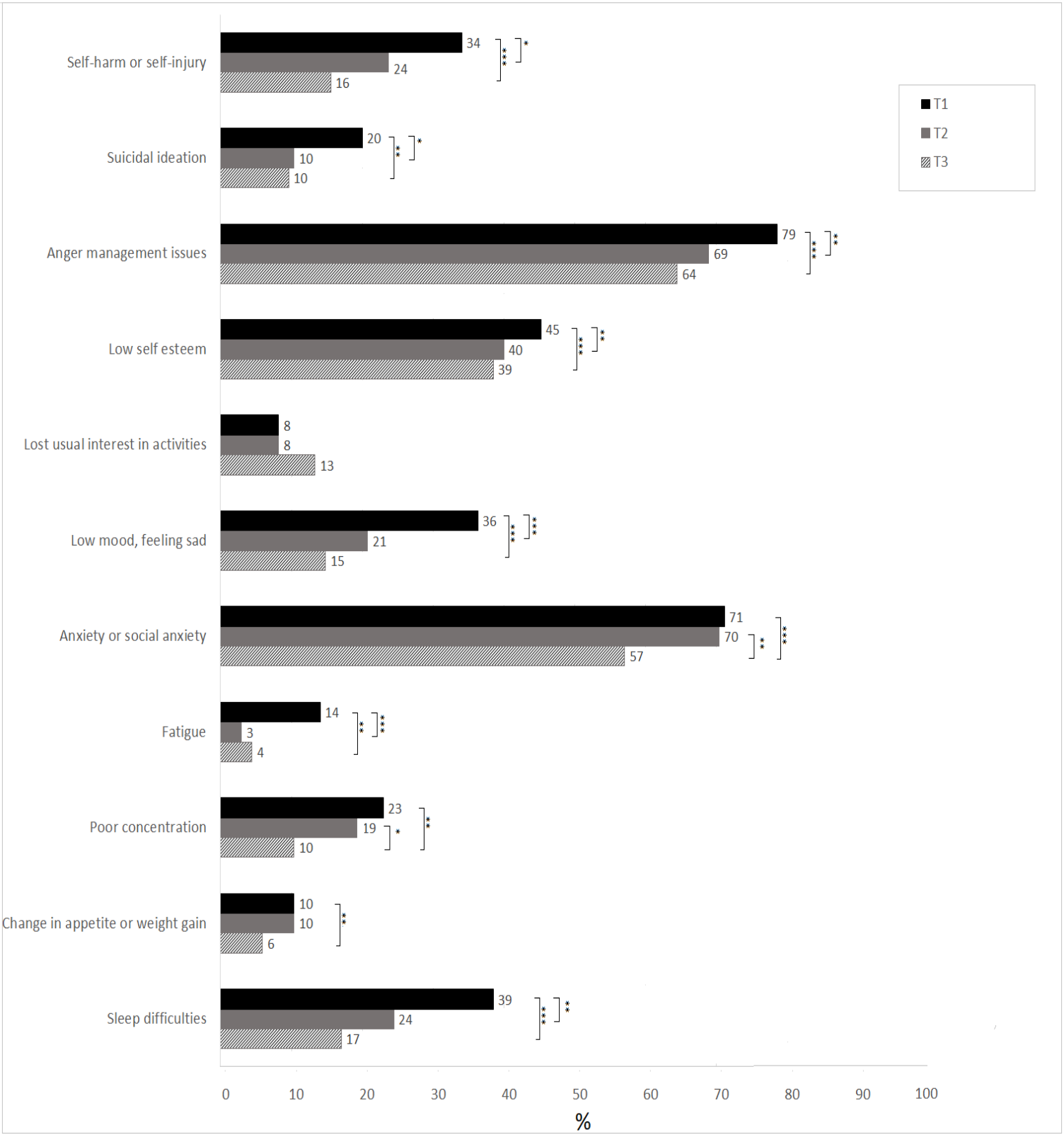
Figure 8: Indicators of conduct disorder [1] among children under the age of 12 subject to residential care CSOs



[1] The behaviours presented are those included within the DSM-V criteria outlined for assessing conduct disorder. The presence of these behaviours in this sample do not indicate that the children have, or would even be diagnosed with,

conduct disorder. They are presented more as an illustration of the complex behaviours presented by this group. Significance levels indicated by: *** p<0.001, ** p<0.01, * p<0.05

Figure 9: Mental health indicators among children under the age of 12 subject to residential care CSOs



Significance levels indicated by: *** p<0.001, ** p<0.01, * p<0.0

References

Australian Government. (2013). *Royal commission into institutional responses to child sexual abuse.* Australian Government. https://www.childabuseroyalcommission.gov.au/

Barter, C. (2003). Young people in residential care talk about peer violence. *Scottish Journal of Residential Child Care*, *2*(2), 39-50. https://www.celcis.org/application/files/9016/2324/8217/Peer_Violence.pdf

Barter, C. (2008). Prioritizing young people's concerns in residential care: Responding to peer violence. In A. Kendrick (Ed.), *Residential child care: Prospects and challenges* (pp. 137-151). London: Jessica Kingsley.

Berridge,D., Biehal, N., & Henry, L. (2012). *Living in children's residential homes.* Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/193634/DFE-RB201.pdf

Bifulco, A., Jacobs, C., Ilan-Clarke, Y., Spence, R., & Oskis, A. (2016). Adolescent attachment style in residential care: The attachment style interview and vulnerable attachment style questionnaire. *British Journal of Social Work. 47,* 1870-1883. https://doi.org/10.1093/bjsw/bcw117

Boel-Studt, S., Schelbe, L., Hansen, M. D., & Tobia, L. (2018). Increasing youth engagement in residential group care: A mixed methods pilot study of a youth-guided incentive program. *Child & Youth Care Forum, 47*(6), 863–860. https://doi.org/10.1007/s10566-018-9465-y

Bogdanova, E. (2017). Russian SOS Children's Villages and deinstitutionalisation reform: Balancing between institutional and family care. *The Journal of Social Policy Studies, 15*(3), 395–406. https://doi.org/10.17323/727-0634-2017-15-3-395-406

Brown, T., Winter, K., & Carr, N. (2018). Residential child care workers: Relationship based practice in a culture of fear. *Child & Family Social Work, 23*(4), 657–665. https://doi.org/10.1111/cfs.12461

Browning, A. S. (2020). The impact of complex and unwanted feelings evoked in foster carers by traumatised children in long-term placements. *Adoption & Fostering, 44*(2), 185-196. https://doi.org/10.1177/0308575920920388

Cahill, O., Holt, S., & Kirwan, G. (2016). Keyworking in residential child care: Lessons from research. *Children and Youth Services Review, 65*(10) 216-223. https://doi.org/10.1016/j.childyouth.2016.04.014

Calheiros, M. M., Garrido, M. V., Lopes, D., & Patrício, J. N. (2015). Social images of residential care: How children, youth and residential care institutions are portrayed? *Children and Youth Services Review, 55,* 159-169. https://doi.org/10.1016/j.childyouth.2015.06.004

Chege, N. (2018). Children's personal data: Discursive legitimation strategies of private residential care institutions on the Kenyan coast. *Social Sciences, 7*(7), 114. https://doi.org/10.3390/socsci7070114

Children's Hearings Scotland. (2021). *Practice and procedure manual v3.2.* Children's Hearings Scotland. https://www.chscotland.gov.uk/media/asnfzbt2/master-2020-practice-and-procedure-manual-v3-2.pdf

Cicchetti, D., & Toth, S. (2005). Child maltreatment. *Annual Review of Clinical Psychology, 1*, 409-438. https://doi.org/10.1146/annurev.clinpsy.1.102803.144029

Connelly, G., & Milligan, I. (2012). *Residential childcare: Between home and family.* Edinburgh: Dunedin Academic Press.

Connelly, R., Playford, C. J., Gayle, V., & Dibben, C. (2016). The role of administrative data in the big data revolution in social science research. *Social Science Research, 59,* 1–12. https://doi.org/10.1016/j.ssresearch.2016.04.015

Cox, R., Skouteris, H., Fuller-Tyszkiewicz, M., Watson, B., Jones, A. D., Omerogullari, S., Stanton, K., Bromfield, L., & Hardy, L. L. (2017). The healthy eating, active living (HEAL) study: outcomes, lessons learnt and future recommendations. *Child Abuse Review, 26*(3), 196– 214. https://doi.org/10.1002/car.2442

Crittenden, P. M. (1992). Quality of attachment in the preschool years. *Development and Psychopathology, 4*(2), 209-241. doi:10.1017/S0954579400000110

DeJong, M. (2010). Some reflections on the use of psychiatric diagnosis in the looked after or 'in care' child population. *Clinical Child Psychology and Psychiatry, 15*(4), 589-599. https://doi.org/10.1177/1359104510377705

Department of Children and Youth Affairs. (2009). *The report of the commission to inquire into child abuse (The Ryan Report)*. https://www.gov.ie/en/publication/3c76d0-the-report-of-the-commission-to-inquire-into-child-abuse-the-ryan-re/

Dixon, J. (2008). Young people leaving residential care: Experiences and outcomes. In A. Kendrick (Ed.), *Residential child care: Prospects and challenges* (pp. 76-92). London: Jessica Kingsley.

Duppong Hurley, K., Lambert, M. C., Gross, T. J., Thompson, R. W., & Farmer, E. M. (2017). The Role of therapeutic alliance and fidelity in predicting youth outcomes during therapeutic residential care. *Journal of Emotional and Behavioral Disorders, 25*(1), 37-45. https://doi.org/10.1177/1063426616686756

Eenshuistra, A., Harder, A. T., & Knorth, E. J. (2019). One size does not fit all: A systematic review of training outcomes on residential youth care professionals' skills. *Children and Youth Services Review, 103,* 135-147. https://doi.org/10.1016/j.childyouth.2019.05.010

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

Forrester, D., Goodman, K., Cocker, C., Binnie, C., & Jensch, G. (2009). What is the impact of public care on children's welfare? A review of research findings from England and Wales and their policy implications. *Journal of Social Policy, 38*(3), 439–456. https://doi.org/10.1017/S0047279409003110

Gander, T., Boonmann, C., Fegert, J. M., Koelch, M., Schmeck, K., Di Gallo, A., Dölitzsch, C., & Schmid, M. (2019). Predictive factors for changes in quality of life among children and adolescents in youth welfare institutions. *Social Psychiatry and Psychiatric Epidemiology, 54*(12), 1575–1586. https://doi.org/10.1007/s00127-019-01724-8

Gayapersad, A., Ombok, C., Kamanda, A., Tarus, C., Ayuku, D., & Braitstein, P. (2019). The production and reproduction of kinship in charitable children's institutions in Uasin Gishu County, Kenya. *Child & Youth Care Forum, 48*(6), 797–828. https://doi.org/10.1007/s10566-019-09506-8

Greger, H. K., Myhre, A. K., Lydersen, S., & Jozefiak, T. (2016). Child maltreatment and quality of life: A study of adolescents in residential care. *Health and Quality of Life Outcomes, 14*(1), 1-17. https://doi.org/10.1186/s12955-016-0479-6

Grey, I., Mesbur, M., Lydon, H., Healy, O., & Thomas, J. (2018). An evaluation of positive behavioural support for children with challenging behaviour in community settings. *Journal of Intellectual Disabilities, 22*(4), 394–411. https://doi.org/10.1177/1744629517716545

Gwynn, C., Meyer, R., & Schaefer, C. E. (1988). The influence of the peer culture in residential treatment. In C. E. Schaefer, & A. J. Swanson (Eds.), *Children in residential care: Critical issues in treatment* (pp. 104-133). London: Van Nostrand Reinhold.

Health Information and Quality Assurance: Social Services Inspectorate. (2017). *The placement of children aged 12 and under in residential care in Ireland.* HIQA SSI. https://www.hiqa.ie/sites/default/files/2017-02/Report-12-and-Under-Inspection.pdf

Hickle, K., & Roe-Sepowitz, D. (2018). Adversity and intervention needs among girls in residential care with experiences of commercial sexual exploitation. *Children and Youth Services Review, 93,* 17-23. https://doi.org/10.1016/j.childyouth.2018.06.043

Hill, M. (2009). *Higher aspirations, brighter futures: Matching resources to needs report.* Glasgow: University of Strathclyde. https://pureportal.strath.ac.uk/en/publications/higher-aspirations-brighter-futures-matching-resources-to-needs-r

Independent Care Review (2020). *The Promise.* https://www.carereview.scot/wp-content/uploads/2020/02/The-Promise.pdf

Jaramillo, L. M. E., Orozco, B. M. A., González, Á. M. M., Tobón, C. V., González, M. N., Monsalve, M. T., Lopera, D. L., & Barros, J. A. C. (2016). Los hijos del Estado: Desventajas sociales ante una larga espera para su adopción. *Estudios de Derecho, 73*(161), 155–179. https://dialnet.unirioja.es/descarga/articulo/6766710.pdf

Jedwab, M., Xu, Y., Keyser, D., & Shaw, T. V. (2019). Children and youth in out-of-home care: What can predict an initial change in placement? *Child Abuse & Neglect, 93,* 55-65. https://doi.org/10.1016/j.chiabu.2019.04.009

Jozefiak, T., Kayed, N. S., Ranøyen, I., Greger, H. K., Wallander, J. L., & Wichstrøm, L. (2017). Quality of life among adolescents living in residential youth care: Do domain-specific self-esteem and psychopathology contribute? *Quality of Life Research, 26*(10), 2619–2631. https://doi.org/10.1007/s11136-017-1603-8

Langeland, W., Hoogendoorn, A. W., Mager, D., Smit, J. H., & Draijer, N. (2015). Childhood sexual abuse by representatives of the Roman Catholic Church: A prevalence estimate amongst the Dutch population. *Child Abuse & Neglect, 46*, 67-77. https://doi.org/10.1016/j.chiabu.2015.04.009

Llosada-Gistau, J., Casas, F., & Montserrat, C. (2016). What matters for the subjective well-being of children in care? *Child Indicators Research, 10*(3), 735–760. https://doi.org/10.1007/s12187-016-9405-z

Lukšík, I. (2018). Resilience of young people in residential care. *Journal of Social Service Research, 44*(5), 714–729. https://doi.org/10.1080/01488376.2018.1479336

Marshall, K. (2014). *Child sexual exploitation in Northern Ireland. Report of the independent inquiry.* RQIA, Northern Ireland. https://www.rqia.org.uk/RQIA/files/37/379f52ad-b99e-4559-847e-e2688e0648c6.pdf

McKibbin, G. (2017). Preventing harmful sexual behaviour and child sexual exploitation for children and young people living in residential care: A scoping review in the Australian context. *Children and Youth Services Review, 82,* 373-382. https://doi.org/10.1016/j.childyouth.2017.10.008

Meltzer, H., Gatward, R., Corbin, T., Goodman, R., & Ford, T. (2003). *The mental health of young people looked after by local authorities in England.* The Stationery Office. https://sp.ukdataservice.ac.uk/doc/5280/mrdoc/pdf/5280userguide.pdf

Midgley, N., Irvine, K., Rider, B., Byford, S., Cirasola, A., Ganguli, P., Katangwe, T., Murdoch, J., Pond, M., Pursch, B., Redfern, S., Richards, Z., Shepstone, L., Sims, E., Smith, C., Sprecher, E., Swart, A. M., Wyatt, S., & Wellsted, D. (2021a). Study Protocol: The reflective fostering programme – improving the wellbeing of children in care through a group intervention for foster carers: a randomised controlled trial: study protocol for a randomised controlled trial. *BMC Trials, 22*(1), 1-23. https://doi.org/10.1186/s13063-021-05739-y

Midgley, N., Sprecher, E. A., Cirasola, A., Redfern, S., Pursch, B., Smith, C., Douglas, S., & Martin, P. (2021b). The reflective fostering programme: evaluating the intervention co-delivered by social work professionals and foster carers. *Journal of Children's Services, 16*(2), 159-174. https://doi.org/10.1108/JCS-11-2020-0074

Milligan, I., Hunter, L., & Kendrick, A. (2006) *Current trends in the use of residential child care in Scotland.* Scottish Institute for Residential Child Care. https://strathprints.strath.ac.uk/10661/1/Trends_in_admission_final_report_submitted.pdf

Monks, C. P., Smith, P. K., Naylor, P., Barter, C., Ireland, J. L., & Coyne, I. (2009). Bullying in different contexts: Commonalities, differences and the role of theory. *Aggression and Violent Behavior, 14*(2), 146-156. https://doi.org/10.1016/j.avb.2009.01.004

Murray, L., Tarren-Sweeney, M., & France, K. (2010). Foster carer perceptions of support and training in the context of high burden of care. *Child & Family Social Work, 16*(2), 149-158. https://doi.org/10.1111/j.1365-2206.2010.00722.x

Nary, M. (2016). *Residential Care in England.* Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/534560/Residential-Care-in-England-Sir-Martin-Narey-July-2016.pdf

Nixon, C., McGarrol, S., Henderson, G., & Kurlus, I. (2021*). Development and piloting of a children's disability toolkit*. Scottish Children's Reporter Administration. https://www.scra.gov.uk/wp-content/uploads/2021/09/SCRA-Disability-Toolkit-Report-2021.pdf

Northern Ireland Executive. (2017). *Report of the Historical Institutional Abuse Inquiry.* The NI Executive Office. https://www.hiainquiry.org/historical-institutional-abuse-inquiry-report-chapters

Porter, R. B., Mitchell, F., & Giraldi, M. (2020). *Function, quality and outcomes of residential care: Rapid evidence review*. CELCIS https://www.sos-childrensvillages.org/getmedia/e128ca09-c55d-4aff-a0d9-2cfc0305e36b/CELCIS-and-SOS-Evidence-review-residential-care.pdf

Quiroga, M. G., Hamilton-Giachritsis, C., & Fanés, M. I. (2017). Attachment representations and socio-emotional difficulties in alternative care: A comparison between residential, foster and family based children in Chile. *Child Abuse & Neglect, 70,* 180-189. https://doi.org/10.1016/j.chiabu.2017.05.021

Rafferty, Y. (2018). Mental health services as a vital component of psychosocial recovery for victims of child trafficking for commercial sexual exploitation. *American Journal of Orthopsychiatry, 88*(3), 249. https://doi.org/10.1037/ort0000268

Rainer. (2007). *Home alone: Housing and support for young people leaving care.* https://archive.crin.org/sites/default/files/images/docs/Rainer_home_alone.pdf

Rubin, D. M., Alessandrini, E. A., Feudtner, C., Mandell, D. S., Localio, A. R., & Hadley, T. (2004). Placement stability and mental health costs for children in foster care. *Pediatrics, 113*(5), 1336-1341. https://doi.org/10.1542/peds.113.5.1336

Schofield, G., Larrson, B., & Ward, E. (2016). Risk, resilience and identity construction in the life narratives of young people leaving residential child care. *Child and Family Social Work, 22*(2), 782-791*.* https://doi.org/10.1111/cfs.12295

Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1-2), 201-269. https://doi.org/10.1002/1097-0355(200101/04)22:1<201::AID-IMHJ8>3.0.CO;2-9

Schuurmans, A. A., Nijhof, K. S., Engels, R. C. M. E., & Granic, I. (2018). Using a videogame intervention to reduce anxiety and externalizing problems among youths in residential care: An initial randomized controlled trial. *Journal of Psychopathology and Behavioral Assessment, 40(2), 344–354.* https://doi.org/10.1007/s10862-017-9638-2

Scottish Government. (n.d.). *Policy: Looked after children.* https://www.gov.scot/policies/looked-after-children/

Scottish Government. (2009). *Higher aspirations, brighter futures: Scottish Government response.* https://www.gov.scot/publications/response-report-national-residential-child-care-initiative-higher-aspirations-brighter/

Scottish Government. (2021). *Education outcomes for looked after children: 2019/2020*. https://www.gov.scot/publications/education-outcomes-looked-children-2019-20/documents/

Sen, R., Kendrick, A., Milligan, I., & Hawthorn, M. (2008). Lessons learnt? Abuse in residential child care in Scotland. *Child and Family Social Work, 13*(4), 411-422. https://doi.org/10.1111/j.1365-2206.2008.00566.x

Shaw, J. (2014). *Residential children's homes and the youth justice system: Identity, power and perceptions.* Basingstoke: Palgrave MacMillan.

Skinner, A. (1992). *Another Kind of Home: A review of residential child care.* Scottish Office.

Smith, M. (2009). *Rethinking Residential Care: Positive Perspectives*. Bristol: Policy Press.

Stein, M., & Munro, E. R. (2008). Transitions from care to adulthood: Messages from research for policy and practice. In: M. Stein & E. R. Munro (Eds.), *Young people's transitions from care to adulthood: International research and practice* (pp. 289-306). London: Jessica Kingsley.

Trickett, P. K., Negriff, S., Ji, J., & Peckins, M. (2011). Child maltreatment and adolescent development. *Journal of Research on Adolescence, 21*(1), 3-20. https://doi.org/10.1111/j.1532-7795.2010.00711.x

Triseliotis, J., Borland, M., & Hill, M. (1998). Foster carers who cease to foster. *Adoption and fostering*, *22*(2), 54-61. https://doi.org/10.1177/030857599802200208

Vacaru, V. S., Sterkenburg, P. S., & Schuengel, C. (2018). Self-concept in institutionalized children with disturbed attachment: The mediating role of exploratory behaviours. *Child: Care, Health and Development, 44*(3), 476–484. https://doi.org/10.1111/cch.12521

Vejmelka, L., & Sabolíc, T. (2015). The potential of institutions for children without parental care: The perspective of the institutional caregivers. *Kriminologija & Socijalna Integracija, 23*(1), 99–128. https://doi.org/10.1007/s10862-017-9638-2

Wendt, G. W., Costa, A. B., Poletto, M., Cassepp-Borges, V., Dellaglio, D. D., & Koller, S. H. (2019). Stressful events, life satisfaction, and positive and negative

affect in youth at risk. *Children and Youth Services Review, 102,* 34-41. https://doi.org/10.1016/j.childyouth.2019.04.028

Woods, H. Y. (2020). *Residential care, stigma and relational alienation. Exploring the lived experiences of children's homes with young people and carers – an ethnographic study* [Doctoral dissertation, University of Nottingham].

Wright, A. W., Richard, S., Sosnowski, D. W., & Kliewer, W. (2019). Predictors of better functioning among institutionalized youth: A systematic review. *Journal of Child and Family Studies, 28*(12), 3245–3267. https://doi.org/10.1007/s10826-019-01527-0

About the authors

Catherine Nixon is a research officer at the Scottish Children's Reporter Administration. Catherine's research interests include child and adolescent risk-taking behaviours, the effects of social exclusion on health and wellbeing, and the role that corporate parents can play in promoting the wellbeing of looked after children.

Gillian Henderson is the information and research manager at the Scottish Children's Reporter Administration. Gillian has contributed widely to knowledge and policy focussed on sibling relationships in the care system, childhood sexual exploitation and the age of criminal responsibility.

Appendix 3: Data extracted from SCRA's CMS for younger children in residential care

The below table provides an overview of the variables extracted from the Case Management System used by the Scottish Children's Reporter Administration to collate all documents received and generated by the Children's Hearings System in order to determine whether statutory intervention is required to support children and families.

Category	Information collected on…	Search information
Child demographics	Sex	Code male, female, unknown
Child demographics	Date of birth	Enter date of birth
Child demographics	Ethnicity	Record ethnicity
Child demographics	Disability	Record whether disability is diagnosed, known or suspected; Also record information about what the known or suspected disability is and how it impacts the child.
Family characteristics	Parental health: learning disability	Record if parent recorded as having a learning disability or if description of learning and communication difficulties are provided within case files.
Family characteristics	Parental health: substance misuse	Record substance misuse, type and whether considered to be problematic. Class alcohol or drug use as misuse if case file describes frequent use and detrimental impact on health and wellbeing. Record alcohol or drug misuse as problematic if references made to individual being unable to adequately care or protect their child, hold down employment etc.
Family characteristics	Parental health: mental ill-health	Record parent as having mental health difficulties if a mental health diagnosis has been received, mental health conditions (i.e. Depression, Anxiety, PTSD, Schizophrenia, Bipolar disorder) are referenced in case files) or it is stated that parent is undergoing mental health/psychiatric treatment (i.e. sees community psychiatric nurse).
Family characteristics	Parental health: physical ill-health	Record parent as having physical ill-health if parent described as having long-term chronic, disabling or life limiting conditions that impact upon their ability to care for their child or impact their quality of living.

Category	Information collected on…	Search information
Family characteristics	Parental offending: offences	Record all references to parents having committed an offence. If offence type is listed record details. Include all references to cautions, being bailed, charged and prosecuted.
Family characteristics	Parental offending: incarceration	Record if parent ever imprisoned, along with details relating to remand and custodial sentences.
Family characteristics	Parental relationships: separated	Record if references to parents having been separated or having experienced repeat periods of separation and reconciliation are mentioned.
Family characteristics	Parental relationships: interpersonal violence	Record if episodes of interpersonal violence or coercive control are evident within the relationship between child's parents. If father is unknown or either parent is absent then code interpersonal violence as being present if the individual is considered to be the child's parent
Family characteristics	Parental experiences of childhood adversity	Record all references to care experience, including episodes of informal kinship care associated with familial stress. Record all references to sexual/physical/emotional abuse and neglect in parental past. Record bereavement if parent lost an immediate family member (i.e. parent, sibling, grandparent, child, partner) or another individual that they consider to be like a parent/sibling. Record all episodes of interpersonal violence between family members or others where it is stated that the parent was present as a child.
Family characteristics	Parental housing instability	Record all references to homelessness and housing instability, including insecure tenancies, periods in temporary accommodation and couch surfing.
Family characteristics	Siblings involved in child protection system.	Record number of full or half siblings, whether they were known to social work services, have been referred to the Children's Hearings System, have been subject to child protection orders or compulsory measures of supervision, or have been placed into care. Record grounds for referral to Children's Hearings System if known.
Child trauma histories	Maltreatment histories	Record all references to sexual, physical and emotional abuse/neglect. For sexual abuse also include concerns relating to age inappropriate and alarming sexual behaviour, i.e. viewing and watching pornography at very young age, self-mutilation and harming of genitals, object penetration by self or others at very young age, sex play that is considered to be re-enactment of behaviours rather than curiosity.

Category	Information collected on…	Search information
Child trauma histories	Exposure to violence	Record if child has witnessed interpersonal violence within the home or the community.
Child trauma histories	Unexplained injuries	Record if it is recorded that the child has had an unexplained injury at any point.
Child trauma histories	Abandonment by parents	Record child as being considered to have been abandoned by parent(s) if biological father (suspected or confirmed) refuses to acknowledge paternity of the child, or if a parent has actively chosen to no longer recognise or have contact with the child.
Child trauma histories	Significant bereavements	Record bereavement if child has lost an immediate family member (i.e. parent, sibling, grandparent, aunt/uncle/cousin) or another individual that they consider to be like a parent/sibling.
Child trauma histories	Number of adverse childhood events (ACEs)	Calculate by summing the number of indicators present from the following list: parental mental ill-health, parental substance misuse, parents separated, parental imprisonment, child experienced significant bereavement, child maltreatment types (sexual abuse, physical abuse, physical neglect, emotional abuse, emotional neglect), child witnessed violence in the home or community, child has been bullied, child has been removed from parental care.
Child trauma histories	Child protection histories	Record all information on how long the child has been known to services, applications for child protection orders, referrals to Children's Hearings System, use of voluntary and compulsory measures of supervision, when the child became formally looked after and details of any permanency proceedings undertaken. For each item record dates that legal measures were enacted, the grounds/reasons that were submitted for consideration by the Children's Hearing System and the type of measure used (i.e. a permanence order, adoption order, residency order).
Child trauma histories	Child placement histories	For each care setting that a child has lived in since becoming a looked after child, record the type of care, the dates that the child lived there, the reasons given for the child being moved from that care setting, the legal basis for the care placement and any restrictions upon contact/disclosure of information, details of any changes in the grounds given, supports provided to parents/caregivers/child and details of any contact with parents and siblings.

Category	Information collected on…	Search information
Health and wellbeing	Risk behaviours: smoking, alcohol use, drug use	For each behaviour code whether it was present or not at T1 (12 months preceding residential care entry), T2 (12 months after residential care entry) and T3 (24 months after residential care entry. For smoking include all tobacco products referenced. For alcohol and drug use record details of substances used, along with where and who consumed with.
Health and wellbeing	Risk behaviours: offending behaviours	Record that the child has offending behaviour if they have been referred to Children's Hearing System or cautioned for an offence-type behaviour. Record details of the types of offence behaviours children were engaging in. If no details of offences are present but there are references to child being referred to youth justice diversion schemes then code as engaged in offence-type behaviour. Record at T1, T2 and T3.
Health and wellbeing	Risk behaviours: sexual behaviours	Record child as engaging in sexual behaviours if they are engaged in non-concerning, age appropriate and consensual sexual behaviour, i.e. kissing, mutual touching/exploration, bodily self exploration. If penetrative sex referenced for <13s then consider this to be sexual exploitation or abuse rather than consensual behaviour if the partner is 3+ years older than the child or considered to be exchanging gifts for sex or is in a position of power. Record at T1, T2 and T3.
Health and wellbeing	Risk behaviours: child considered at risk	Record whether the child's behaviours are considered by professionals to increase the risk of harm to them at home or within the community. Also record whether the child is considered to be aware of the risks that are presented. Record at T1, T2 and T3.
Health and wellbeing	Toileting	Record whether day-wetting, night-wetting and other toileting concerns exist for the child. Record details of other toileting concerns, for instance whether child is soiling, smearing, urinating/defecating in unusual places, hiding urine/faeces/sanitary towels etc. Record at T1, T2 and T3.
Health and wellbeing	Controlling behaviours	Record whether child demonstrates any of the behaviours listed in relation to situations, people, hygiene and food. Examples of control described within case files include references to the child: always needing to be in charge of situations; trying to manipulate events so that they happen in a certain way, even if doing that fails to acknowledge needs/wants of others or any risks to doing things in that way; trying to direct the actions of others; seeking the exclusive attention of others; trying to control interactions between people; refusing to shower/bathe/dress/wash

Category	Information collected on…	Search information
Health and wellbeing	Controlling behaviours (cont.)	hair/clean teeth when asked because they want to be in control of decisions about their body; consistently being controlling around food, i.e. refusal to eat without an obvious reason or hoarding/hiding food. While some files may state that these behaviours are due to a child feeling out of control seeking control, others may refer to the behaviours seen through terms such as manipulative, coercive, "difficult", controlling etc. Record at T1, T2 and T3.
Health and wellbeing	Age-inappropriate sexual behaviour	Record whether the child demonstrates sexual behaviour that is age- and developmentally-inappropriate or considered to be harmful or 'problematic'. This may include references to children demonstrating sexually abusive behaviour towards themselves or others, re-enacting sexual behaviours that are age- and developmentally-inappropriate, groping, fondling or harming genitals or secondary sexual organs of self or others, using or viewing pornography at a very young age and using extremely sexualised language at a very young age, particularly if it is considered the language isn't being used for the purpose of shocking others. Behaviours may or not be described in the context of trauma or re-enactment of sexual abuse, but may describe engaging in sex play, particularly secretive, sex play with other children. Record at T1, T2 and T3.
Health and wellbeing	Mental health indicators	Record if there is evidence of each of the following mental health concerns being present: self-harm or self-injury, suicidal ideation (record if child has stated that they actively wish to die, have attempted or planned suicide, are preoccupied with thoughts of death, suicide or thinking that they would be better off dead), low mood or feeling sad, anxiety or social anxiety, anger management, low self-esteem, lost interest in usual activities, fatigue (record malaise, loss of energy, unable to do usual activities), poor concentration, lack of appetite or change of weight (both losses or gains) and sleep difficulties (insomnia, parasomnia, dysregulated sleep i.e. turning night into day, frequently waking etc.). Record at T1, T2 and T3.
Health and wellbeing	Conduct disorder indicators	Record if there is evidence of truanting, absconding (two or more times within the specified time period, do not record if absconding involves leaving the setting but remaining on the grounds the whole time), breaking curfew, retail theft (i.e. shoplifting), non-confrontational economic crime (i.e. breaking and entering, theft of motor vehicles), confrontational economic crime (i.e. mugging), aggressive behaviour toward others and animals, being deliberately cruel to other people or animals, use of weapons to threaten or harm others (i.e. knives or other makeshift

Category	Information collected on…	Search information
Health and wellbeing	Conduct disorder indicators (cont.)	weapons), perpetrating a forcible sexual act (i.e. performs sexual act without consent and through use of force against others; episode may be described using language of abuse), destroying property through arson or fire-raising, destroying property by other means. For all behaviours employ assessment of frequency, i.e. if child kicks out at family pet once do not code as physical aggression to animals, however if this is described as a frequent occurrence or concern then code. Descriptions of aggressive and violent behaviours may include references to physical or verbal aggression. The terms aggression/aggressive may be seen with or without descriptors of the aggression, i.e. regular taunting or name calling, verbally abusive, punching/hitting/kicking/biting. Record at T1, T2 and T3.

'Nobody does the job cause it's easy'. The factors which empower and inhibit the role of the child and youth care worker

Amanda Ferguson

Abstract

For children and young people living in residential and secure care, there are links between the relationships they have with Child and Youth Care Workers and positive outcomes. This study aimed to explore the perceptions of Child and Youth Care Workers in order to ascertain the factors which enhance and inhibit their ability to have an impact upon the children and young people they support. Six Child and Youth Care Workers from a residential and secure care establishment were interviewed and thematic analysis was used to elicit key themes in the data. The study highlighted three themes: Empowering Factors, Inhibiting Factors and Supportive Practice. The themes suggest that Child and Youth Care Workers have qualities which they feel help them to impact positively upon young people, however there are also many challenges which inhibit this. They also highlight possible areas of development. This data may help residential and secure care establishments to understand the importance of the Child and Youth Care Workers' qualities and the challenges and demands of the role, and to highlight the additional support required.

Keywords

Child and youth care workers, children and young people, residential and secure care

Corresponding author:

Amanda Ferguson Chartered Psychologist and Registered Forensic Psychologist, Kibble Education and Care Centre, Goudie Street Paisley, Amanda.ferguson@Kibble.org

Residential and secure care

Residential and secure care offers young children a safe place to live with other children away from home. It is often the decision of the Children's Hearing System that dictates which environment a young person will be moved to, depending on their level of risk and need. On 31st July 2020, 14,458 children in Scotland were looked after, with 329 within a residential school and 59 in secure accommodation (Scottish Government, 2021).

Children and young people enter into residential and secure care for a number of reasons and under significantly difficult circumstances (Kendrick, 2013). Many young people display challenging behaviour and have experienced a number of placement breakdowns prior to moving into care. A high percentage have also experienced adversity, including abuse and neglect (Stein et al., 2009). Children and young people have different perspectives on their experience of moving into residential and secure care (Morgan, 2009). Some young people perceive the experience as negative, as moving can be a time of significant loss; given that they move from home or placements where relationships and routines have been established (Biehal & Wade, 2000). Many other young people find that residential care meets their needs, as it can provide elements of stability and support (Kendrick, 2013). However, this stability and support can only be achieved through the positive relationships they develop with Child and Youth Care Workers (Bouffard & Little, 2002; Skinner, 1992).

The importance of the child and youth care worker

Several studies have reviewed the effectiveness of residential care in helping young people achieve positive outcomes. Such studies have found that this environment can improve outcomes for children (Knorth et al., 2008; Lee et al., 2011). Knorth et al. (2008) concluded from their meta-analysis that children and young people, after a period of residential care, on average, improve in their psychosocial functioning. Lee et al. (2011) also concluded that some group care environments are effective, however they used a small sample which produced results of varying quality. Although studies discuss the positive results

associated with residential care, they are not yet clear in identifying the specific factors which contribute to such positive outcomes.

Evidence suggests that Child and Youth Care Workers play a significant role in helping young people to manage their difficulties and to live their lives differently by influencing positive behavioural change (Bastiaanssen et al., 2014; Petrie et al., 2006; Ward, 2004). They are said to be an essential component in creating environments which encourage positive development and are viewed as the most important members of staff in a in a young person's life (Bastiaanssen et al., 2012; Knorth et al., 2010; McLaughlin, 2000; Smith et al., 2013). Their role is seen as a responsive form of caring, focusing on the moment in which a behaviour occurs, and they use their knowledge and skills to help the young person learn, experience and practice new thoughts, feelings and behaviours (Gannon, 2014). However, although they are considered important in influencing behavioural development, their role has been neglected in research. Knorth et al. (2010) argued for a greater emphasis in research and practice on the status and personal characteristics of Child and Youth Care Workers. A main issue in exploring the effectiveness of the Child and Youth Care Worker role in residential care is the diversity of care within the residential field, which includes group residential care, daily living groups, education, and family units (Bastiaanssen et al., 2012).

In 2004, Garfat identified characteristics which define the approach of the Child and Youth Care Worker. Although this research was conducted in 2004, it remains relevant as it is the main study exploring Child and Youth Care Workers' characteristics. Garfat (2004) suggested that there were twenty-five key characteristics in this role and 'the use of daily life events' was central. Stuart (2013, p. 295) defines this as the moments which are 'open for therapeutic use when the practitioner and young person engage in exploring its meaning together and learning from each other'. The remaining characteristics, which are categorised into 'being, interpreting and doing', are focused upon the Child and Youth Care Workers' ways of being with and responding to children and young people, how Child and Youth Care Workers interpret the experiences they share with the children and young people, and what they do to help support them. This

approach is viewed as an essential way of working with young people in order to achieve positive outcomes. Other researchers defined some of the important characteristics and skills as including being able to enter into a relationship with the child that involves attachment and belonging (Brendtro et al., 2002; Maier, 1993), to understand the meaning and dynamics of relational practice (Garfat & Fulcher, 2012), and to understand how relationships create the life-space (Gharabaghi & Stuart, 2013).

Although studies have identified the importance of the Child and Youth Care Worker and some of the desired characterises, the specific factors which enable them to have such a positive impact have not been widely explored (Bastiaanssen et al., 2012). Research within Scotland's population of Looked After and Accommodated Children (LAAC) is also particularly limited, and therefore one aim of this study is to explore the factors which enable them to have an impact upon young people in Scottish residential care.

Challenges for the child and youth care worker

Whilst recognising the positive attributes of the care worker, the difficulties of this role must also be considered, particularly as the field of Child and Youth Care has been considered one of the most difficult and emotionally exhausting careers in the human service industry (Krueger, 2002). The factors which appear to contribute to the difficulties of this role include, the diverse range of skills and knowledge the Child and Youth Care Worker is expected to possess, the lack of support from residential organisations and feeling of being 'trapped' in paperwork (Brown et al., 2018; Krueger, 2007). A combination of these factors, along with the challenges of working with young people who present with complex behaviours and needs, can create a highly stressful environment which can lead to Child and Youth Care Workers experiencing exhaustion, burnout, and a sense of hopelessness (McCarter, 2007; Savicki, 2002). Savicki (2002) explained that burnout is common amongst Child and Youth Care Workers and that this may be linked to an exaggerated sense of idealism, that may lead to frustration and disappointment when the difficult reality of the role is experienced.

In addition to these challenges, the Child and Youth Care Work profession has been exposed to stigma and negativity as a result of previous reports of ill practice and abuse within the care system. In 2009, the Ryan report, which investigated the abuse of young people who resided within Irish care facilities, was published. Although this report was focussed upon institutions within the Republic of Ireland, it appears that a culture of fear manifested within the wider care system. Brown et al. (2018) discuss how, despite the care system being reformed, Child and Youth Care Worker practice is now influenced by a 'fearful state of mind', which is exacerbated by organisational policies and procedures (Furedi, 2006; Furedi & Bristow, 2008; Smith, 2009).

As the care system moves towards relationship-based practice, the relationships that Child and Youth Care Workers develop with young people and the way in which they practice has been said to have been negatively impacted upon by the fear of making mistakes (MacDonald et al., 2012; Smith, 2009; Whittaker et al., 2015). It appears that the policies and procedures which were once developed and implemented to keep young people safe, are now having a negative impact upon them and upon the Child and Youth Care Worker role. The second aim of this study is to explore the factors which inhibit the Child and Youth Care Worker, particularly because the research relating to Scotland's population of LAAC is limited.

Research question

What factors empower and inhibit Child and Youth Care Workers to have an impact upon the young people they support?

Methodology

Ethical protocol

After submitting an application for ethical approval, which included a literature review and documentation related to consent and the interview process, the study received full ethical approval. All participants were fully briefed on what was involved in the study and how their data would be used, and advised that

their names would be replaced with a speaker number. They were instructed before the interview that they could decline to engage and/or choose to not respond to any of the questions asked throughout the interview. They were also given an opportunity to take a break when required. All participants provided informed consent to engage in recorded interviews and for their data to be transcribed, anonymised, and used within the research report.

Participants

All (375) Child and Youth Care Workers who worked with young people aged between 11 and 18 years within the residential and secure establishments were offered the opportunity to engage in this study. The invite was sent through an organisation-wide email which included information relating to the study. Eight participants volunteered; however, two participants ceased contact with the researcher prior to the interview taking place and thus, six participants engaged in total. The participants who engaged worked within the residential and secure settings and within houses which accommodated six to eight young people; three of which were mixed gender and two of which were gender-specific. Participants included three male and three female staff. Their ages ranged between 28 and 55 years, with an average age of 39 years, and they had between 1.5 and 11 years' experience with an average of 4.5 years' experience.

Interview schedule

Interviews were carried out at the participant's place of work on a day and at a time suitable for them. The interviews varied in length from 12 to 32 minutes, with an average duration of 23 minutes. A single semi-structured interview schedule, based on the research question, was developed and the central question was 'what factors empower and inhibit you to impact upon the young people you support?' Throughout the interview the participants were prompted to consider the factors which empowered and inhibited the impact they had upon the lives of the young people they cared for. The interview data was then transcribed verbatim, and transcripts were stored securely on a password

protected computer. All participants' names were removed and they were labelled as speakers one to six.

Approach to data collection

This study utilised Braun and Clarke's (2006) thematic analysis process to investigate Child and Youth Care Worker perceptions of the factors which empower and inhibit them to have an impact upon the young people they support. All Child and Youth Care Workers within the organisation were invited to participate, and six of those who volunteered went on to engage in the study.

Data analysis

The transcripts were analysed using a contextualist approach to thematic analysis (Braun and Clarke, 2006). Initial analysis involved repeated reading of and listening to each interview in order to allow the researcher to become familiar with the data. During this process the researcher noted her initial reflections and then generated codes using an inductive coding approach. She then searched, reviewed, defined, and named themes to ensure that they answered the research question and represented the participant's true experience. Although the codes and themes emerged through the participants' data, the researcher's own perspectives, values and theoretical position may have influenced the analysis. In order to mitigate the influence and potential bias of the researcher, the findings were reviewed by the researcher's supervisor.

Results

Three themes and ten subthemes were identified through the analysis.

Themes	**Subthemes**
Empowering Factors	Passion and belief Consistency Adaptability Teaching what is 'normal'

Inhibiting Factors	Managing high demands Paperwork Fear of doing wrong Maintaining relationships
Supportive Practice	Support with paperwork Helping to maintain relationships

Empowering factors

This theme reflects the participants' perceptions of the qualities which help enable them to have a positive impact on the lives of the young people they support. Participants spoke passionately about their role and discussed how factors such as believing they can make a difference and being consistent, adaptable, and teaching about what is normal are key to their role. It is clear from discussions that feeling passionate about the role helps motivate them to continue to attend work and build connections with young people. It is these connections which then instil the belief in them that they can make a difference. Participants also discussed consistency, which they felt was demonstrated through meaning 'what they say' and following through on promises. Engaging with each young person individually was also viewed as important, as well as being able to meet their needs by adapting their role, such as to 'parent' or 'brother'. Other roles included modelling and teaching young people about 'normal life'. The aim of this appeared to be to demonstrate pro-social behaviour and help to instil learning to promote change.

Passion and belief

Participants' passion was conveyed through positive statements, including 'I absolutely love my job' (Speaker 1), and 'everyday am, am looking forward to coming to work' (Speaker 2). As well as 'looking forward' to his work, Speaker 2 discussed the connection he has with the young people and how this gives him the belief that he can make a difference:

> Every single child in [the establishment] that I've met, I've got a connection ... I'm not saying I'm the only one, there's loads of staff that

> are great with aw (all) the kids as well but that geez (gives) me the belief, it really does, cause I believe that I can connect with every one of them. So, every day I'll know if there's an issue, I'll find a way round that issue then, lets fix it.

Consistency

Participants discussed the importance of consistency when working with young people. Speaker 1 acknowledged that,

> If you say you're going to do something make sure you do it and even if it's in your own time you just make sure that you're going to do that because they've had adults let them down at every turn so, if you say it, do it.

Adaptability

Participants also discussed the importance of being able to work with each young person individually and acknowledged that they are often changing roles in order to meet their needs. Speaker 6 explained that, 'over the years you learn that you're probably using a different hat for six young people'. Speaker 5 discussed some of these different 'hats', which include, 'the big brother and the wee brother … the parent, the child … the doctor'.

Teaching what is 'normal'

Participants also felt that an important aspect of their role was to teach the young people about 'normal' life. They discussed how they would do this through sharing their own experiences. Speaker 2 stated that 'my experience of growing up is different from the kids in here so you try eh, try to explain to them what I, what we would call normal upbringing in life is'. Speaker 3 also acknowledged the importance of this, whilst reflecting that there is a need to help them learn how life is without making them 'feel bad'. They explained this by stating:

> I wis (was) kina (kind of) worried, worrying aboot (about) aw how much information do you give the kids like, cause a, you don't want to make them feel bad about the fact that you're going out, for dinner with your friends and, and you know but you're like no they need to know like this is normality.

Inhibiting factors

This theme reflects the participants' perceptions of the limitations of their role. They spoke in depth about the challenges they encounter on a daily basis and the impact this has on their ability to support the young people in their care. Participants described their role as including many demands which did not cease when their workday ended. This included working a lot of hours and carrying out work related tasks in their 'own time'. Other demands on individuals included paperwork, which was viewed as crucial, but it was noted that developments were needed to change the structure of this to prevent it from hindering them from being a 'good carer'. Participants also discussed the demanding nature of their role and how this included applying lifesaving practice such as removing ligatures from young people. It appeared that participants felt that life saving techniques were overshadowed by the scrutiny of others. Despite participants noting the high intensity and demanding nature of their role, they continued to be motivated to build and maintain positive relationships with the young people. However, they did appear to feel frustrated that they were unable to do this consistently.

Managing high demands

All participants acknowledged that they go 'over and above' their job role. This includes working over their contracted hours and buying young people their favourite items outwith their working day. Although they acknowledged the benefits of this, they also acknowledged the consequences such as working 'too many hours' and the risk of carrying out extra roles becoming an 'expectation', rather than a 'favour'. Speaker 1 discussed an example of going 'over and above', stating, 'when you're in the shop you're going oh so in so really liked

that I'm going to pick that up and take that in … it's just that going that extra mile again and holding them in mind'. Speaker 3 also discussed examples of doing more than is expected, however they reflected upon the consequences of this: 'a used to go in, in my own time … but then that's just again feeding into doing too many hours and … then yesterday's favour becomes tomorrow's expectation'. Participants stated that to manage the demands they could utilise self-care strategies, but they acknowledged that due to the intensity of the role this was not always possible.

Paperwork

The participants spoke about the impact having to complete paperwork has had upon their ability to care for the young people. Speaker 2 stated 'casefile management hinders the care worker from being a good carer to a child'. Other participants discussed their frustrations regarding the relevance of this paperwork and reflected that there are more innovative ways to record data, that would be less demanding upon their role. Speaker 5 explored this, stating,

> I'm no saying like we don't need to do paperwork cause we do but see the amount of it that we need to do, it's totally unnecessary like am I no better like taking photos of positive experiences and putting them in a file than writing reems and reems of paperwork?

Fear of doing wrong

The participants discussed that as well as working within a demanding environment there is also fear of scrutiny. There was a sense that efforts from staff, particularly those that result in potentially lifesaving behaviours, go unnoticed and/or are scrutinised. Speaker 3 explained this, stating, 'well like … ligature incidents … you end up getting pulled up for something not being done properly'.

Maintaining relationships

Participants spoke about the difficulties of maintaining relationships with all the young people within their care. This is particularly difficult as it appears that when positive relationships have formed between staff and young people those staff members are then expected to manage any difficult behaviours they present with. It is acknowledged that staff are not resentful of this, however they do find that it happens to the detriment of other young people. Speaker 3 stated,

> It's well known that I have a really good connection with a couple of people in particular, if they're struggling it's 'you need to go in and deal with that' and then you end up man marking (The term 'man marking' has been used colloquially to describe high levels of observations/supportive practice. Man marking in the literal sense, would not be an example of child-centred practice) somebody for a long time … I wouldn't change it, but other young people kina (kind of) miss out.

In addition, they reported that maintaining relationships with young people after they have moved on from their care is difficult, and that not providing a continuous level of care goes against what they have been teaching young people, such as to trust them. Speaker 5 explained that,

> you tell these kids the whole time you work with them 'trust me, trust me we have this great relationship, tell me everything', and then they're away and they're phoning and you're like 'sorry hold on something's happening I can't talk to you I need to put the phone down'.

Supportive practice

This theme reflects the participants' perceptions of the additional support they require to enable them to continue to support the young people effectively. Participants did not note significant changes which they felt were required but they did discuss that improvements were required, specifically in supporting them with paperwork and helping them to maintain relationships. It is clear from this theme that staff were eager to continue to maintain supportive relationships with young people and to apply the empowering factors which enable them to

have an impact. It is interesting that despite the inhibiting factors, staff are still demonstrating passion for the role and an interest in going 'over and above' by continuing relationships with the young people who are no longer in their care.

Support with paperwork

Participants felt that more could be done in helping them to complete paperwork. Speaker 2 explained 'what would be brilliant is if you actually had people that were employed to do the paperwork. You know [laughs] and then you could just work with the kids, that would be great'.

Helping to maintain relationships

Participants noted that more could be done to help them maintain relationships with all young people. This includes spending 'protected time (one to one time allocated to spend with that particular young person) with other young people that you don't normally spend time, if even if it was a scheduled thing' (Speaker 3). Speaker 5 also discussed the benefits of having 'protected' time to maintain relationships with young people that have left the service, stating, 'if you did have a wee bit of protective time, you could maintain those relationships then it's not another let down and rejection'.

Discussion

From the results of the study it is evident that Child and Youth Care Workers are passionate about working with children and young people, and that they believe they can have a positive impact upon them. This belief is encouraged through identifying progress and feeling connected to young people. They also value the importance of consistency and adaptability, recognise the need to respond to each young person using an individualised approach, and help to teach young people about life and relationships to try and change their maladaptive views of adults and the world.

Within this study there was value placed on relationships, and it appeared that the Child and Youth Care Workers' qualities helped them to maintain relationships with the young people in their care. Bullock et al. (2006) have suggested that meaningful relationships in the care environment are indicators of positive outcomes, and Garfat (2004) identified that 'being in a relationship' with a young person is important. Gannon (2008) described this as engaging with one another in a manner which impacts upon the carer and the young person. Brendtro and du Toit (2005) also discussed relationships as the foundation of Child and Youth Care Worker practice, with connection being the foundation of broader relationships. Participants identified the importance of this and discussed the positive connections they shared with young people. These appeared to not only benefit the young person but also helped instil belief in the Child and Youth Care Worker that they can have an impact. In addition, the participants expressed a 'love' for their job, which is said to be an important aspect of being a Child and Youth Care Worker (Smith, 2016). Whitfield (1989) described love as 'the most healing of our resources'. Thus, the importance of love has been discussed for some time and all participants appeared to have a genuine love for their role, despite facing many challenges.

When developing relationships, Garfat (2004) stated that Child and Youth Care Workers 'hang out' and 'hang in' with young people. He explains that 'hanging out' is a characteristic defined by the everyday interactions which a Child and Youth Care Worker shares with a young person, and although they may not seem significant, they are hugely influential in the young person's life. By 'hanging out' Garfat (1999) states that Child and Youth Care Workers and young people build relationships of trust, safety, and connectedness. Throughout this study participants discussed spending time with young people, and it was clear that they 'hold' them 'in mind' outside the workplace. The passion staff have for their role was evident, and although participants discussed experiencing many challenges and demands, it appears that they do not give up. Garfat (2004) states that 'hanging in' and not giving up on a young person when 'times are tough' is crucial. Gompf (2003) discusses how this demonstrates staff's commitment and care for the young person, and it is clear to see that participants were committed to the young people they support. When caring for

the young people, participants acknowledged the importance of responding to the complexities of each, using an individualised approach, and adapting their role in order to meet their needs. Michael (2005) highlights that adaptability and flexibility are crucial, and that Child and Youth Care Workers' interactions must be tailored to fit with the individual needs of the young people in order to be effective.

Although staff expressed passion for their role, they did identify challenges which increase the pressures of an already demanding job. These demands include working additional hours and going over and above their specified job role. They also acknowledged that their job can be more difficult due to the increasing demands of paperwork and fear of scrutiny. This is consistent with studies such as Brown et al.'s (2018), where it was identified that staff felt 'trapped' in paperwork, and Steckley's (2012), who discussed that the emphasis on safe practice has increased the focus on paperwork, which in turn has compromised relationship-based practice. Furedi (2006) and McPheat and Butler (2014) also found that Child and Youth Care Workers found it difficult to work in risk-enabling ways due to fear of blame or liability, which is similar to the experience which my participants described. Working with such demands may leave the Child and Youth Care Worker at risk of experiencing burnout, which Savicki (1993, 2002) has noted is prevalent within the Child and Youth Care Worker field. Child and Youth Care Workers may also be particularly vulnerable to this as there may not always be sufficient time for 'self-care' which would help to buffer some of the stressors associated with their role.

In relation to the support which could help decrease the demands of the Child and Youth Care Worker role, participants identified that support with paperwork would have a significant impact on their role. Participants recognised that completing paperwork is crucial, however this could be adapted to make it easier for Child and Youth Care Workers to complete, and more accessible for young people, should they request copies of their files in the future. It was also suggested that having 'protected time' with young people would be beneficial, however it was recognised that this was not always possible to facilitate.

Further research

As the study was exploratory in nature the results produced were widely varied and covered three significant areas. Therefore, further research may benefit from having a more specific focus; particularly to explore what additional supports Child and Youth Care Workers require. The study identified that more support is required; however, it did not have the scope to explore this in depth. In addition, studying the views of young people would be interesting, to identify the factors which are important to them and what changes they feel are required. The aim of this study was to help identify the factors that help and inhibit Child and Youth Care Workers in supporting young people, and as such young people's views would be extremely beneficial. A future qualitative study could also be carried out to compare the views of staff and young people in relation to the factors which empower and inhibit practice.

Limitations

Limitations of this study include the subjective nature of qualitative research and that the researcher's own values, preconceptions and expectations may have influenced the overall analysis. It was also a small-scale study and although the participants varied in gender, length of experience, and work environment (i.e. residential or secure), having a larger pool of participants or limiting the controls (such as, gender or work environment) may have produced different results. However, Grbrich (1998) notes that the size of a sample group in qualitative research is not determined by the need to ensure generalisability, but rather by a desire to investigate fully the chosen topic and provide information-rich data. In addition, although measures to ensure confidentiality were implemented, the researcher and participants were all employees of the same establishment and thus participants may have been reluctant to provide critical or sensitive information.

Conclusion

This research aimed to explore the perceptions of Child and Youth Care Workers and to establish the factors which empower and inhibit them to have an impact

on the young people they support. Overall, it identified that Child and Youth Care Workers have many positive qualities which help them impact upon the young people. However, it also identified that the demands and challenges of their role can inhibit them from feeling like they are 'being a good carer to a child'. In order to overcome such challenges, some suggestions were made to help support the Child and Youth Care Worker to continue to make an impact; however, further consideration is required as to what additional support would be most effective.

References

Bastiaanssen, I. L., Delsing, M. J., Kroes, G., Engels, R. C., & Veerman, J. W. (2014). Group care worker interventions and child problem behavior in residential youth care: Course and bidirectional associations. *Children and Youth Services Review, 39*, 48-56.

Bastiaanssen, I. L., Kroes, G., Nijhof, K., Delsing, M. J. M. H., Engels, R. C. M. E., & Veerman, J. W. (2012). Measuring group care worker interventions in residential youth care. *Child & Youth Care Forum, 41*, 447–460.

Biehal, N., & Wade, J. (2000). Going missing from residential care: Linking biographies and contexts. *British Journal of Social Work, 30*, 211–25.

Bouffard, S., & Little, P. M. D. (2002). Promoting quality through professional development: A framework for evaluation. *Harvard Family Research Project, 8*.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Brendtro, L. K., Brokenleg, M., & van Bockern, S. (2002). *Reclaiming youth at risk: Our hope for the future* (2nd ed.). Indiana: Solution Tree.

Brendtro, L. K., & du Toit, L. (2005) Response ability pathways – Restoring bonds of respect. Pretext Publishers.

Brown, T., Winter, K., & Carr, N. (2018). Residential child care workers: Relationship based practice in a culture of fear. *Child & Family Social Work, 23*(4), 657-665.

Bullock, R., Clough, R., & Ward, A. (2006). *What works in residential child care: A review of research evidence and the practical considerations.* London: National Children's Bureau.

Furedi, F. (2006). *Culture of Fear Revisited*. New York: Continuum.

Furedi, F., & Bristow, J. (2008). *Licensed to hug: How child protection policies are poisoning the relationship between the generations and gamaging the voluntary sector*. London: Civita.

Gannon, B. (2008). *The improbable relationship*. CYC On-Line, 110.

Gannon, B. (2014). *Create positive moments.* CYC On-Line, 118.

Garfat, T. (1999). *On Hanging Out*. CYC On-Line, 8.

Garfat, T. (Ed.) (2004). A child and youth care approach to working with families. New York: The Haworth Press, Inc.

Garfat, T., & Fulcher, L. (2012). *Child & youth care in practice*. South Africa: Pretext Publishing.

Gharabaghi, K., & Stuart, C. (2013). *Right here, right now: Exploring life-space interventions for children and youth.* London: Pearson.

Gompf, K. (2003). Connecting while connecting the dots. *Relational Child and Youth Care Practice, 16*(2), 74-75.

Grbich, C. (1998). *Qualitative research in health: An introduction*. London: Sage.

Kendrick, A. (2013). Relations, relationships and relatedness: Residential childcare and the family metaphor. *Child and Family Social Work, 18*(1), 77–86.

Knorth, E. J., Harder, A. T., Huygen, A. N., Kalverboer,M. E., & Zandberg, T. (2010). Residential youth care and treatment research: Care workers as key factor in outcomes? *International Journal of Child and Family Welfare, 1*, 49–67

Knorth, E. J., Harder, A. T., Zandberg, T., & Kendrick, A. J. (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential and youth care. *Children and Youth Services Review, 30*, 123–140.

Krueger, M. (2002). A further review of the development of the child and youth care profession in the United States. *Child & Youth Care Forum, 31*(1), 13–26.

Krueger, M. (2007). Four areas of support for child and youth care workers. *Families in Society, 88*(2), 233– 240.

Lee, B. R., Bright, C. L., Svoboda, D. V., Fakunmojo, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*, 177–189.

Maier, H. W. (1993). Attachment development is 'in'. *Journal of Child and Youth Care, 9*(1), 35-52.

McCarter, A. K. (2007). The impact of hopelessness and hope on the social work profession. *Journal of Human Behavior in the Social Environment, 15*(4), 107-123.

McLaughlin, M. (2000). *Community counts: How youth organizations matter for youth development.* Public Education Network.

Michael, J. (2005). Life-space supervision in child and youth care practice. In T. Garfat & B. Gannon (Eds.), Aspects of child and youth care practice in the South African context (pp. 49–62).Cape Town: Pretext.

Morgan, R. (2009). *Life in Children's Homes*. Ofsted.

MacDonald, G., Millen, S., McCann, M., Roscoe, H., & Ewart-Boyle, S. (2012). *Therapeutic approaches to social work in residential child care settings*. Social Care Institute for Excellence.

Petrie, P., Boddy, J., Cameron, C., Wigfall, V., & Simon, A. (2006). Working with children in care: European perspectives. Maidenhead, UK: Open University Press/McGraw Hill Education.

Savicki, V. (1993). Clarification of child and youth care identity through an analysis of work environment and burnout. *Child and Youth Care Forum,* 22(6), 441-457. Savicki, V. (2002). *Burnout across thirteen cultures: Stress and coping in child and youth care workers*. Westport CT: Praeger Publishers.

Scottish Government. (2021). *Children's Social Work Statistics 2019/20*.

Skinner, A. (1992). *Another kind of home: A review of residential childcare in Scotland*. HMSO.

Smith, M. (2009). *Re-thinking residential child care: Positive perspectives*. Oregon: Policy Press.

Smith, M. (2016). Editorial. [Joint Special Issue, Love in Professional Practice]. *Scottish Journal of Residential Child Care, 15*(3) and *International Journal of Social Pedagogy, 5*(1), 2-5.

Smith, M., Fulcher, L., & Doran, P. (2013). Residential childcare in practice: Making a difference. Chicago: The Policy Press.

Steckley, L. (2012). Touch, physical restraint and therapeutic containment in residential child care. *British Journal of Social Work, 42*(3), 537-555.

Stein, M., Rees, G., Hicks, L., & Gorin, S. (2009). *Neglected adolescents: Literature review* [Research Brief DCSF-RBX-09-04].

Stuart, C. (2013). *Foundations of child and youth care* (2nd ed.). Dubuque: Kendall Hunt Publishing Company.

Ward, A. (2004). Towards a theory of the everyday: The ordinary and the special in daily living in residential care. *Child and Youth Care Forum, 33*, 209–225.

Whitfield, C. L. (1989). *Healing the child within*. Deerfield Beach, Florida: Health Communications, Inc.

Whittaker, J., Valle, J., & Holmes, L. (Eds.) (2015). *Therapeutic residential care for children and youth*. London and Philadelphia: Jessica Kingsley Publishers.

About the author

Amanda Ferguson is a Chartered Psychologist and Registered Forensic Psychologist and DBT Therapist based at Kibble Education and Care Centre. She works directly with young people across all of Kibble's services, offering intervention, assessment and consultancy, in addition to other roles such as staff training. She has worked at Kibble since September 2017, however she was previously employed by the service, as a Child and Youth Care Worker, in 2012 and spent two years working within this role. She has experience working with an adult population within the Scottish Prison Service, where she worked as a Forensic Psychologist in Training for three years.

What future for voluntary children's residential providers in Ireland?

Martin Power and David Power

Abstract

In Ireland, voluntary provision of children's residential services has a history that predates the foundation of the Irish State. Voluntary providers have thus endured regardless of wars, economic crises, social upheavals, scandals, pandemics, and many other changes. However, the current climate is arguably challenging voluntary providers to their core. Only just being kept afloat by State funding, they are operating against the backdrop of a hollowing out of the third sector, within a mixed economy of provision that is increasingly being dominated by private providers. Moreover, they are, and have been, chronically and comparatively underfunded for many years, and staff are understandably demoralised by the scant progress on pay restoration in line with their counterparts. To compound matters further, the impending regulation of social care workers and proposed inspection regime changes are likely to only increase demands on both providers and staff. This paper is a collaboration between a director of a voluntary children's residential provider and an academic in social care. It uses the director's experiences as a lens to explore and explain the drivers and challenges voluntary residential providers face, and to ask if there is a future for voluntary residential children's providers in Ireland.

Keywords

Voluntary providers, residential childcare, state support, Ireland

Corresponding author:

Dr Martin Power, Director Social Care Programmes, Discipline of Health Promotion, NUI Galway, National University of Ireland, Galway, martin.p.power@nuigalway.ie

Introduction

In the Republic of Ireland there is a long history of health and social care service provision by non-state actors. Indeed, at the time of the foundation of the Irish State in the early 1900s, Catholic religious orders were the main providers of health and social care services, including children's residential services, and this remained so throughout most of the twentieth century (Adshead & Millar, 2003; Harvey, 2007; Mulkeen, 2016; O'Sullivan, 2008). As the numbers entering religious orders declined steadily, particularly from the 1980s onwards, the care workforce became increasingly secularised, and in 2005 the professional title Social Care Worker was given statutory recognition within the Health and Social Care Professionals Act (2005) (Barrington, 2003; Moran, 2013). However, while the opening of a register for social care workers will mark a significant development on the path to the professionalisation of social care work, the register is not expected to open before late 2023 (CORU, 2020; Flynn, 2019; Williams & Lalor, 2001).

In parallel with such developments the infrastructure of children's residential services has also changed dramatically, especially in recent decades. In the late 1990s voluntary providers and religious orders delivered the majority of provision, with limited direct provision by the state (Crimmens, 1998). In the early 2000s, however, the last of the religious providers ceased involvement and provision was by the state or voluntary/charitable bodies which received state funding, mostly under the auspices of the Health Service Executive (HSE) (Darmody et al., 2013; O'Sullivan, 2008). In 2014, the Child and Family Agency (Tusla) was established and responsibility for children's residential centres was transferred to Tusla from the HSE (a brief description of the key agencies is provided at the end of this introduction).

While voluntary providers have thus been a cornerstone of the sector throughout the nineteenth and twentieth centuries, today's landscape is increasingly shaped by private providers (Branigan & Madden, 2020; Mulkeen, 2016). Since 2015, for instance, the number of private services has increased substantially from 92

to 120, while the number of voluntary providers has remained static at 25 (Branigan & Madden, 2020). Indeed, the number of voluntary providers has changed little since the mid-1990s, when 24 residential childcare services were managed by voluntary bodies (Crimmens, 1998). Tusla operated services have similarly remained relatively consistent in number since 2015, decreasing slightly from 41 to 39 services. However, this followed a period of marked public sector reduction, driven by the global crash of 2008, with the retraction of public provision opening up fertile territory for private provision to expand into (Fenton, 2021).

In addition to a general increase in demand for residential services over recent years and an increase in the time children are spending in care, other factors have also contributed to an expansion in services. These include the continued shift away from larger to smaller, more homely placements, more sensitivity in the care system to the needs of vulnerable and marginalised children, increasingly complex cases, and a corresponding focus on enhanced services (Branigan & Madden, 2020). The latter in particular is reflected in the costs of residential placements, which increased from €162million in 2016 to €193million in 2019, with private services incurring 87% of those cost increases, Tusla services 2%, voluntary services 4%, and administrative cost increases accounting for 7% (Branigan & Madden, 2020). Though the increase in the cost of voluntary services was extremely modest, particularly given the impact of the European Working Time Directive in 2018, the occupancy rate simultaneously fell and voluntary providers had the lowest occupancy rates in 2019, at 61% (Tusla 84%, Private 77%).

This latter point is crucial, as it highlights, if indirectly, some of the particular challenges for voluntary providers. Unlike private providers, who are paid on a per-placement basis with financing linked to numbers, voluntary providers 'receive grant-aided funding in line with Service Level Agreements' based upon the capacity of the provider and regardless of occupancy rate (Branigan & Madden, 2020, p. 21). Thus, decreasing occupancy rather than cost increases is

perhaps a better indicator of pressures on voluntary services that are confined by rigid funding agreements.

There are a number of drivers of the pressures on voluntary providers, most notably, chronic underfunding, which is compounded by the absence of pay restoration for staff. More importantly perhaps, pressure can only build further, given the impending introduction of registration for social care workers and potential changes to the inspection regime. This paper is a collaboration between David, a voluntary residential centre director, and Martin, an academic in social care, and it argues that voluntary residential providers are facing an increasingly untenable and unsustainable situation. In fact it is David's opinion that, 'these services are at breaking point, and the future looks bleak for the voluntary providers'.

This paper is divided into two sections. Section one examines the challenges around funding of voluntary providers and the related issue of pay restoration. It draws upon comparisons with similar challenges to the third sector in Scotland, which have resulted in third sector providers handing back contracts and exiting the social care market. Section two explores the broader context of a hollowing out of the third sector in Ireland and the implications of impending changes in social care that are likely to further increase pressures on voluntary providers.

Brief description of key agencies in Ireland

Health Service Executive (HSE). The HSE is the agency responsible for the delivery of public health and social care services in Ireland and it reports to the Minister of Health. In political science parlance, the Department of Health steers and the HSE rows. The HSE is Ireland's largest single employer, with over 100,000 staff, of all types and grades from consultants to cleaning staff. The HSE is partitioned organisationally into a number of divisions, such as 'acute hospitals', 'mental health' and 'primary care', and it is geographically organised by regions (9), local health offices (32) and local health centres. The HSE is also the main funder for many social care services that are delivered by third sector providers (www.hse.ie).

Tusla – The Child and Family Agency. Tusla is the state agency responsible for improving children's lives and wellbeing. Tusla services include child protection and welfare, family support, early years services, and domestic violence. Tusla has over 4,000 staff and an annual budget of over three quarters of a billion euro (www.tusla.ie).

CORU. CORU is Ireland's regulatory agency for health and social care professionals, such as social workers, medical scientists, occupational therapists, and speech and language therapists, with each profession having a registration board within CORU. CORU's role is to protect the public through setting and monitoring educational standards and continued professional development requirements, as well as maintaining a register for each profession and instigating fitness to practice hearings when necessary. CORU has an extensive staff and currently regulates over 20,000 professionals, with more professional registers scheduled for opening over the coming years (www.coru.ie).

The Health Information and Quality Authority (HIQA). The HIQA is the regulatory agency for health and social services and providers, including acute and community healthcare providers, children's services, disability, and older people's residential providers. The HIQA develops standards, registers providers, and carries out inspection and monitoring visits, holding the power to close providers where deemed necessary. Within children's residential services, however, an 'anomaly' exists – the HIQA inspects Tusla services, but Tusla inspects private and voluntary providers.

Voluntary providers and the failing life-support system

If declines in occupancy rates are the canary in the mineshaft for the dangers facing voluntary providers, the causes are firmly located in underfunding. Cost for mainstream placement per week figures between 2017 and 2019 point both to chronic underfunding previously and increasing underfunding comparatively (see Table 1).

Provider type	2017 cost	2019 cost	Difference
Tusla	6,465	6,338	- 127

Private	5,712	6,713	+ 1,001
Voluntary	4,459	4,730	+ 271

Table 1 (figures from Branigan & Madden, 2020, p. 52)

Much of the cost increase for private providers can be attributed to the impact of the introduction of the European Working Time Directive in late 2018, which meant more staff were needed (Branigan & Madden, 2020). This was reflected in an increase in the rate for private mainstream placements per week, from €5,000 to €6,000, and from €6,000 to €6,800 for enhanced placements. In addition, in mainstream placements 'the duration of care was highest in private services', though Branigan and Madden highlight that this conclusion is based on a snapshot of current placements only (Branigan & Madden, 2020, p. 17). It is clear from Table 1 that no corresponding rate increase was offered to voluntary providers, and reducing occupancy was thus perhaps a predictable outcome, since there would be few other avenues available, and as David highlights 'services are widely acknowledged to be under-funded'.

It is a situation that mimics events in Scotland, where Cunningham et al. (2019) found that many third sector social care providers cited chronic underfunding and the failure of funders to provide adequately for the introduction of the Scottish Living Wage as primary reasons for their subsequent handing back of contracts. More worryingly perhaps, '[o]f those organisations that handed back contracts, the majority indicated that the contracts concerned had been held for over ten years' (Cunningham et al., 2019, p. 5). As such, just as in Ireland, where some voluntary providers can trace their history as far back as the mid-nineteenth century, it is often the case that it is long-established organisations that are under pressure and leaving the market.

In Scotland, such challenges, and the handing back of contracts, inevitably impacted significantly on staff retention and recruitment (Cunningham et al., 2019), with similar trends increasingly obvious in Ireland. The extent of these issues is best exemplified by the relationship between funding and staff pay and conditions. Prior to the establishment of Tusla, voluntary residential providers were funded as either Section 38 or Section 39 organisations. While the

legislative basis for these arrangements and their implementation is outdated, complex and ambiguous at best, an obvious distinction was frequently applied in practice (McInerney & Finn, 2015). Employees of Section 38 organisations were effectively entitled to public sector pay scales and benefits, while those in Sector 39 organisations were to be largely aligned with, but not entitled to, such arrangements (McInerney & Finn, 2015). What this meant during the austerity period for example was that:

> despite not being considered as public servants and despite not being entitled to the same terms and conditions as public servants (including pension entitlements) staff in organisations in receipt of Section 39 funding were expected to adhere to the cuts required in public sector and Section 38 funded bodies (McInerney & Finn, 2015, p. 15).

Perhaps unsurprisingly, therefore, McInerney and Finn's (2015) conclusion was that the difference between Section 38 and Section 39 organisations was largely a 'function of finance rather than reflecting a difference in actual services delivered', and was driven by the continued preference for the state's arms-length approach to service provision that was manifest in 'a desire to hold on to "flexibility" by not entering into a more long-term or fixed arrangement' (McInerney & Finn, 2015, p. 14).

With the establishment of Tusla, children's voluntary residential providers were re-categorised and became Section 56 providers. As the economy rebounded in the wake of the austerity period, pay restoration was introduced for Section 38 employees, but a prolonged union campaign was required to secure similar pay restoration for those working under Section 39. However, as voluntary children's residential providers had been re-categorised as Section 56 organisations in 2014, they fell outside agreements on pay restoration for section 39 employees, and unions have now lodged a claim to have them included (FORSA, 2021). Unions have also recently submitted a parallel claim for community and voluntary service workers in other social care services, who have similarly endured pay stagnation and an expansion of precarious employment conditions

(Hurley, 2021). If such developments highlight a hollowing out of the third sector and an increasing shift toward neo-liberal policy agendas, for employees of voluntary children's residential providers they can only add insult to injury. Reasonable expectations of pay restoration, in line with colleagues in the public sector and similarly funded organisations, have now gone unfulfilled not once, but twice, and the situation remains unresolved at this time. Certainly, David is of the view that:

> Over the years the voluntary providers have been asked to do their bit for the country. They were part of the pay cuts with colleagues in the public service. The promise of restoration of pay was there as the country came out of the dark days.

It is perhaps also worthy of note that a recent report by Social Care Ireland (Power & Burke, 2021) regarding challenges to recruitment and retention in social care work, found that pay and conditions were by far the greatest challenge. Indeed, within children's residential services specifically over half (53.7%) of respondents (n=121) highlighted an element of pay and conditions as the single greatest challenge to recruitment and retention (Power & Burke, 2021). Hours and a lack of respect and recognition were the next two greatest challenges noted by children's residential social care workers. The focus on hours can be attributed to the fact that close to half (45.5%) of respondents were regularly rostered for 24-hour shifts (Power & Burke, 2021). Given the negative impacts on morale of the lack of progress around pay restoration, and the message it appears to convey in terms of respect and recognition, there may be little surprise that David's experience is that staff:

> Always provide the best care to young people. They go the extra mile. They pull out all the stops. But, social care teams have started to question their value to the state and the way they are expected to do the same job.

Moreover, pay and conditions, and respect and recognition, have long been cited as particular barriers for social care workers in residential childcare services

(Williams & Lalor, 2001). If in the past these issues were often shaped by the hiring of qualified staff, this is no longer the case, and a degree qualification in social care is now the norm, with many staff holding post-graduate level qualifications (Power & Burke, 2021; Power & D'Arcy, 2018).

In light of the impending introduction of registration and the progression of the professionalisation of social care work, social care workers are likely to have reasonable expectations of improvements to conditions and enhanced status. Not least because registration with CORU will mean social care workers will be regulated in the same way as their social work, occupational therapy, or speech and language colleagues. Moreover, concern around pay and conditions in particular, is only likely to increase with registration, as there will be regular costs such as registration fees and a need for professional indemnity insurance (Byrne, 2016; Howard, 2012). In addition, there will no doubt be expectations that employers will support social care workers in meeting their mandatory continued professional development requirements, either financially or by providing protected time. Thus, the demands on voluntary providers can only increase, potentially challenging voluntary providers' ethos and success in building their organisational family and relationships over the long-term. While David feels that 'the turnover of staff in voluntary providers is so low the organisations must be doing something right', but there can be little doubt that registration and a continued expansion of private provision are likely to make talent acquisition more challenging and costly in the longer-term. This can only disadvantage voluntary providers further.

A low turnover of staff is undoubtedly influenced positively by the familial ethos of voluntary providers and their flat organisational hierarchies, especially in smaller centres where centre directors/managers and social care workers work side-by-side daily. Nonetheless, this also means that in small- or medium-sized centres in particular, directors/managers can be pinch points in increasingly overloaded systems. Indeed, Harvey (2007) noted that since their introduction in the 1990s, service level agreements have meant that 'the list of obligations of the voluntary and community organisation has lengthened, while the list of obligations on the state side has changed little' (Harvey, 2007, p. 15). This is

reflected in David's experience, and it is his opinion that, 'the expectations on the service and the personnel grew and grew. Regulation and risk management became a feature for such organisations, but without the support and back-room teams'.

This experience of an ever-growing weight of expectations and demands was a recurring theme throughout the Handing Back report, which noted that increased administrative and managerial workloads were rarely factored into contracts or payments (Cunningham et al., 2019). Unstable, insecure, or underfunded contracts, recruitment and retention challenges, the need to respond rapidly to changing circumstances and workloads through adjusting rosters or shifting staff areas or responsibilities all involved considerable volumes of administrative and managerial oversight and work (Cunningham et al., 2019). In an Irish context, what this means in day-to-day practice, especially for smaller voluntary providers, is that a limited number of individuals can be largely responsible for a great many things. As David highlights, this can include 'governance, quality of care, human resources, industrial relations, financial control and budgets. The list goes on, including sometimes also putting the bins out, as there is no one else to do it'.

What this means in terms of the future of voluntary providers is even more worrying, as in David's opinion it is clear that, 'the pressure and amount of responsibility that goes with the task is not being resourced to meet regulation and compliance. It is viewed as the organisation's failure of duty to meet standards, but without being resourced to do so'. In Scotland, Cunningham et al. (2019) noted a similar trend of both mounting pressures and chronic and continued underfunding, which forced many providers into running up large deficits before handing back contracts. Regardless of how unenvious a choice running up a deficit is, it is likely a choice few voluntary providers in Ireland would have available. Indeed, stark warnings have been raised in relation to mounting deficits in many disability services in Ireland, as they are similarly voluntary organisations that are solely or largely reliant on state funding (Wall, 2021).

Voluntary residential children's providers, the hollowing out of the third sector, and what the future may hold

In large part, such issues are inevitable in increasingly market-orientated competitive systems. As anyone who has played Monopoly knows, growth and expansion are written into the very fabric of the competitive model. However, for voluntary/charitable organisations the emphasis is on providing a service rather than expanding a business or making a profit. The impact of the marketisation of welfare systems and the hollowing out of the third sector in Ireland is vividly illustrated by recent changes surrounding Local Employment Services. Local employment services have, since their formal establishment in the mid-1990s, received state funding, which is channelled through local providers embedded in communities, to support people from disadvantaged areas into employment (O'Halloran, 2021). However, the Department of Social Protection has recently advised that EU directives on public procurement now require a competitive tendering process to be enacted for such services. This has caused consternation amongst local employment providers and unions, who argue that local employment providers are ill-equipped for competitive tendering models because of both their ethos and funding mechanisms. As one employment service worker observed in a press interview:

> We don't want to make a profit from people. People shouldn't be commodities that we can actually make money from and because of this type of model that they're introducing, that would be exactly what we would provide, but we're not private contractors (Connelly, 2021).

Current services can of course compete in the tendering process. However, this not only goes against their ethos of service provision, but also leaves them at a financial disadvantage, since funding is largely provided on an annual basis and services therefore do not have a stockpile of reserves (Connelly, 2021). Services and staff are therefore unlikely to be comforted by the Minister for Social Protection's suggestion that '[d]epartment officials had given a lot of explanation and none of the potential providers should need to employ a consultant to prepare their tender because they have all been so well-informed' (O'Halloran,

2021). As Glynos et al. (2014) highlighted in relation to such debates around healthcare provision in the U.K., notions that tendering or commissioning processes can be blind to the type of provider, whether state, for-profit or not-for-profit, simply 'deflects attention away from the considerable resources at the disposal of for-profit global health conglomerates' (Glynos, et al., 2014, p. 64). In a similar fashion to local employment services, residential children's services receive annual funding through service level agreements. As such, they too are unlikely to have a reserve of financial resources available to engage consultants or tender writing experts, nor are they likely to have the expertise in-house. While some larger services may have support staff and backroom teams to assist, clearly directors of smaller services cannot add to their already extensive list of responsibilities (Branigan & Madden, 2020). To put this challenge in context - the two highest paid private children's residential provider companies received €15.8 million (approximately £12.6 million) and €11.1 million (£8.9 million) respectively for 2020 (Power, 2022). There may be little surprise then that against such a backdrop David feels that 'a major concern from voluntary providers is the unknown'.

If the unknown is a concern for centre directors/managers, examining developments in the U.K. suggests clearly that Glynos et al. (2014) were correct in their warning. Ofsted's (2021) recent report on the ownership of children's residential providers in the U.K. highlights that over 80% of children's residential homes are now privately owned, with only 5% owned by voluntary providers. Private ownership was also increasingly being concentrated, with only one in eight private providers owning a single home, while the two largest providers owned a total of 302 homes between them, with both having expanded again in the year between March 2020 and March 2021 (Ofsted, 2021). As such, the economies of scale that large companies can enjoy not only make voluntary providers vulnerable, but also other private providers, especially smaller ones. If such developments highlight the increasing neo-liberal penchant in social policy in Ireland and beyond, which emerged with particular force during the austerity period (Allen, 2012; Dukelow & Kennet, 2018; Meade, 2018), it also highlights a problem that has been a consistent feature of the health and social

care policy framework for decades. The lack of input into decision-making and the annual nature of service level agreements, and their predecessor Section 65, funding grants, have long limited voluntary and community organisations' capacity to plan for the long-term and have created 'high entry barriers' for new entrants from voluntary/community organisations (Harvey, 2007, p. 15). This hand to mouth approach to funding provision is perhaps most obvious in the figures noted earlier around the near static number of voluntary providers of children's residential services for over three decades. Indeed, during the more recent period of 2016 to 2019, Tusla closed 9 centres and opened 11, two voluntary providers closed and one opened, while 25 private providers closed and 42 opened. Voluntary provision is therefore remarkably stable, no doubt in part due to its ethos of providing a needed service regardless of concerns over profit or public sector restructuring initiatives and/or neo-liberal agendas.

In contrast, in light of instability overall in the sector and the rapid growth of private provision, the media have begun to question the increasing reliance on private providers. Here, Tusla's response is unlikely to settle nerves in the voluntary residential sector. In a September 2021 interview with *The Irish Examiner*, Tusla's Chief Executive, Mr Bernard Gloster, agreed that there was a concern around the reliance on private providers and advised that a plan to reduce this reliance was forthcoming. This concern was, however, mainly centred around private providers exiting the market at short notice (Baker, 2021). Yet, voluntary providers, who have the longest history of service provision and have demonstrated remarkable stability and the lowest levels of closures/turnover across decades, are not being funded to the same extent as the private providers that Tusla has now expressed concern about an over-reliance upon. Perhaps most worryingly for voluntary providers and their staff was the suggested underlying rationale for concern:

> if that private provider left the market, the state has only one option and that is for us to take over that provision there and then, and you are into very complex matters of employment law and transfer undertaking and lots of other things (Gloster, as cited by Baker, 2021).

A further anxiety around the sustainability of voluntary providers is an impending change of inspection regimes. While Tusla centres are currently inspected by the Health Information and Quality Authority, private and voluntary providers are inspected by Tusla. Mr Gloster observed in the same interview that Tusla funding and inspecting private centres was 'a significant anomaly', which there was also a commitment to resolve (Gloster, as cited by Baker, 2021). The viability of voluntary centres would likely come into question if they were to be inspected by the Health Information Quality Authority, not least because of the extremely limited leeway they have to respond to any failure to meet requirements, especially given chronic underfunding over many years. In David's opinion the situation can be summed up as one where 'many voluntary providers and boards are asked to stand over compliance and finances knowing that we are under resourced and while only the state agencies can solve the problem, there appears to be no appetite from them.'

Conclusion

In seeking to examine the situation confronting voluntary providers and to explore the question of whether they now perhaps face the greatest threat to their long existence as a cornerstone of children's residential provision, we have drawn attention to the marketisation of services, the expansion of private providers, and to similar developments in other jurisdictions. This should not be taken as a criticism of private provision. Rather our aim has been to highlight how increasing marketisation is not a neutral playing field, nor is it provider blind, but instead it is a playing field that privileges private provision over alternative approaches. This is especially the case where voluntary providers are confined by funding mechanisms that clearly limit their capacity to compete if necessary. Moreover, it seems fair to suggest that there is almost a sense that good will is somehow sufficient to keep voluntary providers afloat, and no doubt much of that good will has been squandered by the pay restoration debacle and ever-increasing demands without matching increases in funding.

Voluntary providers who look outward to developments in other countries, or who look inward at developments nationally, particularly the clearly unequal funding afforded to their services and the warnings of a potential collapse of

services in the disability sector, can only feel disheartened, if not completely demoralised. Similarly, social care staff in voluntary providers could be forgiven for looking over their shoulders and wondering whether it is time to abandon ship before it is too late. The irony that market mechanisms are often valued for notions of providing choice seems hard to reconcile with reducing the diversity of provider types in children's residential care. Certainly, where a mixed economy of provision that includes state, private and third sector providers is reduced to state/private, then it is a binary rather than a mixed economy. At the same time, marketisation is also likely to diminish diversity in other ways, as economy of scale demands squeeze out smaller providers. Either way, clearly something has or will be lost. Most importantly perhaps, as David highlights, 'having served the state so well over the years, it would appear that the state is failing the voluntary providers, and also the young people who use the service'.

References

Adshead, M., & Millar, M. (2003). *Ireland as Catholic corporatist state: A historical institutionalist analysis of healthcare in Ireland*. Limerick: Department of Politics and Public Administration, University of Limerick.

Allen, C. (2012). The model pupil who faked the test: Social policy in the Irish crisis. *Critical Social Policy*, *32*(3), 422-439.

Baker, N. (2021). Tusla, chief says level of private residential companies for children is a worry. *Irish Examiner*, September 27th. Retrieved from https://www.irishexaminer.com/news/arid-40706966.html

Barrington, R. (2003). *Health, medicine and politics in Ireland 1900-1970*. Dublin: Institute of Public Administration.

Branigan, R., & Madden, C. (2020). *Spending review 2020: Tusla residential care costs*. Dublin: Department of Children and Youth Affairs.

Byrne, C. (2016). Ready or not? Statutory registration, regulation and continuing professional development for social care workers in Ireland. *Administration*, *62*(2), 9-29.

Conneely, A. (2021). Job fears over tendering process for Local Employment Services. *RTE News*, 29th September. Retrieved from https://www.rte.ie/news/ireland/2021/0929/1249560-employment-oireachtas-committeee/

CORU (2020). *Update on the registration of social care workers* (May, 2020). Retrieved from https://coru.ie/about-us/registration-boards/social-care-workers-registration-board/updates-on-the-social-care-workers-registration-board/update-on-the-registration-of-social-care-workers/

Crimmens, D. (1998). Training for residential child care workers in Europe: Comparing approaches in the Netherlands, Ireland and the United Kingdom. *Social Work Education*, *17*(3), 309-320.

Cunningham, I., Baluch, A., James, P., Jendro, E., & Young, D. (2019). *Handing back contracts: Exploring the rising trend in third sector provider withdrawal from the social care market*. Strathclyde: Coalition of Care and Support Providers Scotland.

Darmody, M., McMahon, L., & Banks, J. (2013). *Education of children in care in Ireland: An exploratory study*. Dublin: The Economic and Social Research Institute and Robbie Gilligan, Children's Research Centre.

Dukelow, F., & Kennett, P. (2018). Discipline, debt and coercive commodification: Post-crisis neo-liberalism and the welfare state in Ireland, the UK and the USA. *Critical Social Policy*, *38*(3), 482-504.

Fenton, M. (2021). Spending review 2020: Tusla residential care costs. *CURAM*, Spring, *56*, 8-13. Retrieved from https://online.fliphtml5.com/wmqes/rpxf/#p=1

Flynn, S. (2021). Social constructionism and social care: Theoretically informed review of the literature on evidence informed practice within the professionalisation of social care professionals who work with children in Ireland. *Child Care in Practice*, *27*(1), 87-104.

FORSA (2021). *Claim lodged for section 56 workers*. FORSA members news bulletin. Retrieved from https://forsatradeunion.newsweaver.com/designtest/b74eeuh35mv

Glynos, J., Speed, E., & West, K. (2014). Logics of marginalisation in health and social care reform: Integration, choice and provider blind provision. *Critical Social Policy*, *35*(1), 45-68.

Harvey, B. (2007). *Evolution of health services and health policy in Ireland*. Dublin: Combat Poverty Agency.

Howard, N. (2012). The Ryan Report (2009). A practitioner's perspective on implications for residential childcare. *Irish Journal of Applied Social Studies*, *12*(1), 37-48.

Hurley, S. (2021). Unions lodge 3% pay claim for community, voluntary sector workers. *RTE News*, 9th November. Retrieved from https://www.rte.ie/news/ireland/2021/1108/1258688-unions-pay-claim/

Joint Committee on Social Care Professionals. (2002). *Final report of the Joint Committee on Social Care Professionals. Government of Ireland*. Retrieved from https://www.lenus.ie/bitstream/handle/10147/46110/10672.pdf?sequence=1&isAllowed=y

McInerney, C., & Finn, C. (2015) *Caring – at what cost? Rebuilding and refinancing the community and voluntary sector*. University of Limerick: Department of Politics and Public Administration.

Meade, R. (2018). The re-signification of state-funded community development in Ireland: A problem of austerity and neo-liberal government. *Critical Social Policy*, *38*(2), 222-243.

Moran, J. (2013). *Unfinished business: Social policy for social care students in Ireland*. Dublin: Orphen Press.

Mulkeen, M. (2016). Going to market! An exploration of markets in social care. *Administration*, *64*(2), 33-59.

Ofsted (2021). *Transparency data – Largest national providers of voluntary and social care (March 2021).* Retrieved from https://www.gov.uk/government/publications/inspection-outcomes-of-the-largest-childrens-social-care-providers/largest-national-providers-of-private-and-voluntary-social-care-march-2021#main-findings

O' Halloran, M. (2021). Minister insists she is not privatising local employment services in request of tenders. *The Irish Times*, July 1st.
O'Sullivan, E. (2008). *Residential child welfare in Ireland, 1965-2008: An outline of policy, legislation and practice: A paper prepared for the Commission to Inquire into Child Abuse*. Dublin: Trinity College.

Power, J. (2022). Tusla to draw up plan to reduce dependence on private residential care. *The Irish Times*, January 10th.

Power, M., & Burke, C. (2021). *Recruitment and retention in social care work: A Social Care Ireland survey*. Dublin: Social Care Ireland. Retrieved from https://socialcareireland.ie/wp-content/uploads/2021/12/Recruitment-and-retention-report-SCI.pdf

Power, M., & D'Arcy, P. (2018). *Statutory registration amongst social care workers survey*. Social Care Ireland. Retrieved from https://socialcareireland.ie/wp-content/uploads/2018/05/Reg-awareness-report-MP-TD-Final-May-2018.pdf

Wall, M. (2021). Analysis: Collapse of voluntary disability providers is major worry for HSE. *The Irish Times*, April 5th.

Williams, D., & Lalor, K. (2001). Obstacles to the professionalisation of residential child care work. *Irish Journal of Applied Social Studies*, *2*(3), 73-90.

About the authors

Dr Martin Power is Director of Social Care Programmes at NUI Galway, a member of the Workers Advisory Group within Social Care Ireland, and an avid armchair rugby fan. Martin has published on risk and regulation, care planning and social care work, particularly professionalisation of the social care workforce.

David Power is Director at Smyly Trust and has qualifications in social care and management, was a President of the Irish Association of Social Care Workers and founding member of Social Care Ireland, as well as representing the profession on the Health and Social Care Professionals Council (CORU) for 8 years.

'I'm not a children and families social worker'. Three mothers' experiences of their children being accommodated under s.25 of the Children (Scotland) Act 1995

Dawn Simpson

Abstract

This qualitative research study used semi-structured interviews to question three mothers about their experience of the use of s.25 of the Children (Scotland) Act 1995 to place their children in care. S.25 is Scotland's non-statutory approach to accommodating children. National and international research has highlighted that the most common entry into care is without a statutory order. Whilst this is often referred to as voluntary care, research in England and other countries has highlighted that parents have not experienced this process as truly voluntary. This was reflected within the findings of the research. Participants' interviews were emotionally charged and give profound insights into the difficulties of such circumstances that would be valuable for professionals involved to consider. The research highlights the value of a rights-based approach when working in partnership with parents, promoting the use of advocacy and legal support, assessing parents' capacity to understand s.25, providing written and spoken support, and viewing s.25 as an ongoing discussion, not a single event.

Keywords

S.25, Non-statutory care, objection, voluntary care, parental rights, advocacy, Scotland

Corresponding author:

Dawn Simpson, Social Worker, Small Steps to Wellbeing Team, South Ayrshire Council, Dawn.Simpson@south-ayrshire.gov.uk

Introduction

Removing a child from their parents is one of the most significant decisions a local authority can make (Burns et al., 2016). This act has significant human rights implications. It intervenes in the private space of families and challenges the notion of individuals' rights to freedom, privacy, and family life (Houston, 2012; Ife, 2008). Yet, removing a child has the potential to give them and their families protection and support in times of crisis (Transparency Project, 2019). This can only occur in accordance with the law, ensuring proportionality and justified reasonable action in line with Article 8 of the European Convention on Human Rights 1998.

In 2020, in Scotland nearly three quarters of the children who entered care and lived away from home did so through s.25 of the Children Scotland Act 1995 (CSA) (Scottish Government, 2021a). S.25 is a non-statutory order that allows a local authority to accommodate a child if nobody has parental responsibility for the child, they are lost or abandoned, or the person who is their carer is prevented from providing suitable accommodation or care. If a person who has parental responsibilities and rights for the child and is willing and able to provide, or arrange to provide, accommodation, objects to the plan, the child cannot be accommodated. The application of this legislation in practice will be explored in this paper.

An analysis of European and North American countries reflects the findings in Scotland that non-statutory care is the most used approach to accommodate a child (Burns et al. 2016; Cusworth et al. 2019). Despite this, there is little knowledge about its use that informs legal and administrative practice and policy (Burns et al., 2016). In Scotland there has been little research and no case law established following the use of s.25. In contrast, in England there have been concerns that the use of their equivalent legislation, s.20 of the Children Act 1989 (CA 1989), is misinterpreted and at times misused (*Williams and another v London Borough of Hackney*, 2018). Multiple authors have identified the need for research to learn from parents about their experiences of voluntary style

arrangements to accommodate their child (Burns et al., 2016; Pösö et al., 2018).

Non-statutory care is often referred to as voluntary care in practice and research. The definition of voluntary is 'proceeding from the will or from one's own choice or consent' and 'having power of one's free choice', which in legal terms includes 'acting of one's own free will without valuable consideration or legal obligation' (Mirriam & Webster, 2022). Yet, research has highlighted that parents do not describe non-statutory care as voluntary (Burns et al., 2016; Pitt 2015; Pösö et al., 2018). However, practitioners often refer to a parent 'consenting' to 'voluntary' care. There is a dissonance between the language of legislation and that of practice, given that neither of the words 'voluntary' or 'consent' appear in the legislation. Not objecting and consenting are different things and consent is not necessarily given voluntarily. The use of language and the experiences of parents will be explored in this paper.

To gain insight into parents' experiences of s.25 in Scotland, within this small-scale qualitative study three mothers were interviewed whose children were accommodated using this measure. The participants in this research each had either a physical or learning difficulty and each of their children had been in care for over a year. Each participant was accompanied by an advocacy worker and a semi-structured approach to interviewing guided the conversation. Each participant has been given a pseudonym to protect their identity. Throughout this research the term voluntary is used only to reflect research, practice, or participants' language.

Literature review

In Scotland, the CSA promotes minimal intervention when engaging in a family's life and safeguarding children (Scottish Government, 2006). In practice the aim is to work in partnership with families with no statutory order. When removing a child from parental care there are four approaches available to social workers. The least restrictive intervention is s.25 of the CSA. S.25 enables a child to be removed from their home without a legal order if the person with parental

responsibilities does not object and has capacity to make an informed decision. They can later object at any point, necessitating that local authorities return their child to their care. If the child has been accommodated for at least six months, a person with parental responsibilities can give fourteen days' notice of their intention to remove the child. The second option to remove a child requires the local authority to refer the child to the Scottish Children Hearing system. This is a legal care and justice system for children who have offended or have wellbeing needs. A Children's Reporter would seek to establish grounds to place a child on a CSO. If grounds are established at a Children's Hearing or at a Sheriff Court, a panel of trained volunteers decide if a child should be subject to a statutory order and whether this should be at home or away. However, unlike a Child Protection Order (CPO) or s.25 this process is not immediate. The third option enables an application to a Sheriff or a Justice of the Peace for a CPO under s.37 of the Children's Hearings (Scotland) Act 2011. The fourth and final option, in instances where the time taken to apply for a CPO could endanger a child's safety, is where police can remove a child from parental care for up to 24 hours through an Emergency Protection Order (EPO) under the CSA 1995 s.61.

Overwhelmingly, the use of non-legal orders to place children in care appears most common. In Scotland around half of the children who entered care in 2015-2017 were accommodated under s.25 (Scottish Government, 2019a). In England over half of the children who enter care between 1992 and 2011 were accommodated under s.20 (McGrath-Lone et al., 2016). In addition, research across eight countries identified that the most consistent form of entry into care was without a legal order (Burns et al., 2016). Unlike a CPO, EPO or CSO, there is no independent body overseeing the use of s.25, or any time limitations. Whilst a social worker can make an application to the Reporter for the Children's Hearing to seek a CSO, this is dependent on the social worker making the referral. There are no legal requirements or guidance that necessitate making a referral. As such there could be a risk of drift and no independent assessment of the child's need to live away from home. Within s.25 (6) (a) (ii) a parent has the right to object to plans, but within current guidance there is no discussion as to how to construct this objection - is it actions, words, or feelings? Interestingly,

the language within the legislation requires a parent to actively object, leaving no space for parents to be passive or neutral. As such, how do different local authorities interpret the legislation and assess parents' capacity to object?

To gain consent, relevant information should be shared, understood, and accepted without coercion (Holm, 2015; Scottish Government, 2019b). The individual must be able to weigh up their options and have a clear understanding of the nature, purpose, and consequences of their decisions (Kinton, 2009; Scottish Government, 2019b). Yet, for parents to make an informed objection to their child being placed in care they must assert themselves when making a decision, and communicate their thoughts. Adults' experiences of poor childhoods, and psychosocial difficulties such as unemployment, poverty, domestic violence, substance misuse, and mental health difficulties can lead to poor coping skills in times of chronic stress (Kojan, as cited by Slettebø, 2013, p.580; Tavormina and Closey, 2017; van der Kolk, 2015). Therefore, to what extent would a parent being presented with s.25 to place their child in care be stressed, with this impacting their reasoning, communication, and capacity to make an informed decision? Few (2010) questions how feasible informed consent is (or objection) from parents in such challenging or traumatic circumstances.

England's equivalent legislation to s.25 is s.20 of the CA89, the founding principal of which was to provide accommodation for a child based on clear parental agreement and 'operate as far as possible on the basis of partnership' (*Williams and another v London Borough of Hackney*, 2018, p. 10). Burns et al. (2016) highlighted the attributes of these arrangements as short term, with less adversarial processes, greater potential for partnership, and greater opportunity for family support and respite. The terms 'voluntary' and 'partnership' imply a mutually informed agreement with a shared balance of power and responsibility within the relationship. Scotland's statutory guidelines make reference to s.25 'as a service which parents may seek to take up voluntarily' (Scottish Government, 2004, p. 23). Alternatively, Child Protection guidelines classify s.25 under 'voluntary accommodation', with the aim to 'keep a child safe whilst concerns about a child's safety, or reports or suspicions of abuse or neglect, can

be assessed' (Scottish Government, 2021b, p. 103). This suggests a different ethos, as one of support as opposed to protection.

In practice non-statutory style legislation such as s.25 is, nationally and internationally, often referred to as voluntary care (Burns et al., 2016). Many have cautioned however that this is not, and should not be considered, a distinctly voluntary arrangement (Burns et al., 2016; Pitt, 2015; Pösö et al., 2018). In England these concerns date back to 1980, in *Lewisham L.B.C. v Lewisham Juvenile Court Justices*, who argued 'voluntary care is not a wholly accurate term, but in common use' (The Law Commission, 1987, p. 6). Research has highlighted that some parents experience s.20 as a helpful provision, negating the need for formal care proceedings and providing stability for older children who could not live at home, or respite for children with additional needs (Ryan & Tunnard, 2018). Yet, case law and research highlight that some parents have not experienced it as a voluntary partnership (*A Child: Use of s.20 CA 1989*, 2014; *Coventry City Council v C, B, CA, CH*, 2012; *N (Children) (Adoption: Jurisdiction)*, 2015; *Worcestershire County Council v AA*, 2019).

In England a review of s.20 noted concerns that the legislation was being misinterpreted (*Williams and another v London Borough of Hackney*, 2018). Lady Hale noted:

> At first sight section 20 might be thought not to require the active agreement of those with parental responsibility […] positive and informed consent of a parent must be obtained. Submission in the face of asserted state authority is not the same as consent. In this context […] nothing short of consent will suffice. (p. 18)

This highlights that the social worker's role is to assess a parent's capacity to consent and to consider the social worker's own influence on the parent's decision making. English case law highlights social workers' duty to ensure parents have capacity to make an informed decision regarding s.20 (*A Child: Use of s.20 CA 1989*, 2014; Few, 2010; Freel, 2010). Lady Hedley states that any

consent given should consider the principles of section 3 of the Mental Capacity Act 2005 (*London Borough of Hackney* v *John Williams and Anor,* 2017). Parents' circumstances and capacity, alongside their emotional, physical, and mental wellbeing should be taken into account. Lady Hedley further advises not doing so breaches parents' human rights and is 'compulsion in disguise' (p. 46). Yet, there are repeated incidents whereby parents did not have their right to object explained to them, or consent was obtained from parents who lack the capacity to do so (*Research in Practice*, 2016; Thomas, 2018). This resulted in parents being awarded compensation in two separate cases (*Herefordshire Council v AB,* 2018; *Re CA [A Baby],* 2012), where children were accommodated shortly after birth without informed consent.

Research has highlighted that parents have experienced undue pressure to consent (*Research in Practice*, 2016; Thomas, 2018) and often do not understand their right to object to their child remaining accommodated (*Herefordshire Council* v *AB,* 2018). The perceived knowledge, authority, and position of a social worker can inadvertently influence parents (Gambrill, 2001; Miley et al., 2001), with parents often believing that social workers have the power to remove children from their care (Few, 2010). In instances of the use of non-voluntary orders, parents are often presented with the option to consent or go to court (Pitt, 2015). This challenges the notion of s.25 being truly voluntary, as parents may perceive attending court as a threat rather than an opportunity to present their perspective and have the evidence independently judged. These factors have led Burns et al. (2016, p. 3) to refer to non-legal orders as a form of 'soft coercion'.

There has been significant discussion in family courts and the media surrounding the long-term use of s.20. Whilst councils have argued this is in line with the principles of minimal intervention (*A Child: Use of s.20 CA 1989*, 2014; *Coventry City Council v C, B, CA, CH,* 2012; *LB* v *The London Borough of Merton,* 2013), Lady Hale identified that this has led to parents and children going without legal and advocacy support, and children's care plans drifting with no consideration of who should retain parental responsibilities (*Herefordshire Council* v *AB,* 2018).

A judgement by the president of the Family Division on s.20 led to recommendations for change (*Research in Practice*, 2016). Guidelines were published in April 2016 that prompted local authorities to review all s.20 arrangements. Following this there was a rise in the number of care applications. The Care Crisis Review (Thomas, 2018) surveyed nearly 1,000 practitioners, including social workers, lawyers, and judges, and concluded that the new s.20 guidelines had resulted in an increase in care orders and a reduction in s.20 arrangements. Some practitioners raised concerns that the changes undermine the principle of minimal intervention, and as a result some judges do not distinguish between working in partnership with families and poor practice. Many practitioners advised that anticipation of court criticism has influenced practice and decision making within local authorities. However, it was not established if this was to the benefit of children and their families.

Research methods

Whilst s.20 guidance has evolved to protect parents' rights, this only occurred following criticism about the misuse of s.20. Despite the similarities between s.20 and s.25, similar guidance has not been developed in Scotland. When considering s.25, it appears that whilst legislation is clear its use in practice is challenging. This research therefore sought to gain insight into Scottish practice through interviewing parents and learning about their experiences of s.25, thereby gaining insight into their understandings of and attitudes towards the legislation. It is hoped that discussing a very sensitive topic with parents could help inform and improve practice. The small-scale nature of this research means that generalisations cannot be made, but conclusions can be drawn. The research took place during September 2018 to September 2019, with parents from two neighbouring local authorities being interviewed. It was approved by the University of Stirling ethics committee.

In my practitioner role as a social worker I have used s.25 to find alternative care for children. Indeed, my experience led me to choose to research s.25. Adopting my role as researcher challenged me to consider only the perspectives of parents, unlike in practice where a child's experience is paramount (CSA 1995

s.16). Supervision and reflective logs helped me to consider the conflict and impact of my role as both researcher and practitioner on the research. This supported me to think like a researcher as well as a social worker.

To access participants I partnered with an advocacy service. An advocacy worker agreed to contact parents who used their service and who had been presented with s.25 to place their children in care. Guidelines advise that all parents whose children are accommodated should have access to advocacy support (Mellon, 2017). Parents were asked if they wanted to participate in the research. The advocacy worker's existing relationships with participants appeared to promote trust in the researcher, whilst enabling participants to have familiar and accessible emotional and practical support before, during, and after the interview. This was fundamental, as each participant's experience of s.25 evoked difficult and sometimes unresolved memories and feelings. Three women whose children were accommodated under s.25 were interviewed. Their pseudonyms are Amy, Barbara, and Carol. To enable anonymity any identifying information has been changed or removed. Unfortunately, this approach excluded participants without advocacy support, who may advocate for themselves or were not able to access support.

Each participant had at least one known learning, physical, emotional, or mental health difficulty that could impact their communication, understanding and/or memory. The three participants had four children in total, each of whom had been accommodated for over a year. There was no social work plan for any of the children to return to their parents' care. This reflects findings from Booth et al. (2006) that parents with disabilities are disproportionally represented amongst parents whose children have been accommodated and are least likely to have their children return home. Amy wanted her child to return to her care, but Barbara and Carol did not, due to their children's behaviour placing them at risk.

Disappointingly no fathers participated in this research. Whilst two fathers had parental responsibilities and rights for the children discussed neither the advocacy worker nor the mothers had contact with either father. Research has

highlighted that the relationship between the mother and child is prioritised in instances of child welfare concerns (Brandon et al., 2017). Cusworth et al.'s (2019) research highlighted that of 123 children who became looked after immediately or soon after birth, nearly half had the information for their fathers missing from case records. The lack of involvement of fathers highlighted in research, potentially through choice or due to the actions of mothers and professionals, is reflected in the advocacy service. They received significantly less referrals for fathers involved in child protection concerns, and at the time were not actively working with any fathers who had involvement in the use of s.25.

The three participants each took part in a semi-structured interview. Each participant was accompanied by an advocacy worker. One participant, Carol, was also accompanied by her friend for support. Questions were asked sequentially but were adapted in response to participants' cues, words, tone of voice, body language, and so on. All interviews were audio recorded with consent from participants. Each interview generated rich and useful information and was transcribed verbatim. A content and thematic approach was used to analyse the data. Applying a content analysis to participants' verbatim responses enabled themes to be established by counting the frequency of words and topics discussed (Gray, 2018) and documenting them in a table (see appendix 1). Used independently, content analysis can disregard the meaning, depth, and richness of what is said and the context in which it was spoken. To guard against this, an inductive approach enabled themes to emerge from the data. This helped guard against my instinct to identify findings through a social work lens.

The content analysis was carried out alongside current research, legislation and guidance, and colour coded to identify four common themes. The four themes were:

- The ethos of s.25
- Informed objection
- S.25 as an ongoing process
- Professional support

The ethos of s.25

Partnership was advocated as the key principle in the use of non-mandatory orders. Yet, this research highlighted contrasting experiences. An analysis of this finding highlighted that the relevance of the language, subsection of legislation, and circumstances are significant when considering each participant's experience of partnership.

There appeared to be no common language when discussing s.25. 'Signing the form' was the most common term used when referring to s.25. Whilst neither the legislation nor child protection guidance requires a form to be signed, in England case law for the equivalent legislation recommends a signature. Barbara showed ambivalence when discussing signing the form:

> *It was good to get told you have to sign the form but on the other hand I've said it verbally why did I have to sign it? Social work explained that because I said it, they needed proof, so I signed it… It didn't bother me signing it but I would have rather just said 'Aye go ahead'.*

This suggests that other parents may find signing a form to consolidate their choice too difficult. Yet, participants' emphasis on signing a form could imply it gave them something tangible to process.

Under s.25 (1) (b), social workers asked for Amy to agree for her child to be moved to a foster family due to their concerns regarding her child's welfare in her care. Amy said it was a 'voluntary' arrangement, but her experience suggests it did not feel truly 'voluntary':

> *They basically told me I had to sign [my child] over voluntary cause if I didn't sign him over voluntary they were going to take it to court and send the police to my house… I was hesitant to do it voluntary. I didn't want to sign my child over… they weren't listening to me. [My friend] forced me to sign the form. I had no choice because I didn't want the police at the door... I didn't want to do either to be honest, but I was kind of basically pushed…So I did sign it voluntary…*

Barbara and Carol each requested that their child be cared for by the local authority after experiencing multiple assaults from their children over a long period of time. The local authority's different responses to each mother appears to impact the subsection of the legislation whereby the child is legally accommodated. Their differing experience highlights contrasting experiences of partnership.

Under CSA95 s.25 (1) (c) Barbara described a partnership agreement with social work for her child to be accommodated where she felt and appeared informed of her rights:

> *I knew I couldn't have [my child] here anymore. But I would still have had the control of everything. Social work explained everything to me and told me what it all meant and everything before I signed it….*

In contrast, Carol had no understanding or knowledge of the legislation, her rights or the arrangement that enabled her child to be placed in care:

> *I would like it explained to me, what it is for. I'm not a children and families social worker. I do not know the legislation to follow. But I would like to know what it meant.*

For Carol, social workers were unwilling to accommodate her child:

> Carol: *'I told [the social workers] I didn't feel safe anymore. I'd been abused for five years. I suppose I was hoping things would get better as you would as a parent.'*
>
> Carol's friend: *'I had to say right, look [Carol] is a vulnerable adult… social work are not interested, so I phoned them up, I said [Carol] is going to stay with me and I will leave the child here.'*
>
> Carol: *'If that night hadn't have happened I would be dead by now. Definitely.'*

This suggests her child was accommodated under s.25 ss.1 (b) when a child is considered 'abandoned'. Whilst both participants identified love for their children and similar experiences of violence from their child, the differing responses from

local authorities lead to two strikingly different narratives, one of child abandonment and one of safeguarding. This was despite both parents requiring safeguarded.

Informed objection

Two fundamental rights parents have within s.25 are, (6) (a) (ii) their right to object, and if they do not object, ss.6 (b) their right to remove their child from accommodation. Barbara clearly understood her choices and their potential outcomes:

> *It did feel good that I had that decision to make as I knew the social worker couldn't just sign those forms and that's the good thing about it. Because you know, I knew they couldn't just walk in and lift [my child], it didn't matter what [my child had] done.*

Amy did not understand what her choices were and what the outcomes could be. This was evident when she describes what she thinks would have happened if she objected:

> Amy: *'I know they would have to apply for an order to remove [my child] out of my care and obviously the court would give them that order. Social work will end up, turning up at my door with police to take [my child] away…'*
>
> Advocacy: *'Did you know that the judge could say yes or no?'*
>
> Amy: *'I thought if social work applied for an order the judge gives them that order… That's why I refused. If I knew it didn't work that way I wouldn't sign it over voluntary.'*

This raises concern that Amy could not make an informed objection as she did not understand the potential outcomes of her choices.

Both Amy and Carol were unaware if and how they could remove their child from care:

> *Once you sign [your child] over you can't really change your mind.*

(Amy)

It was never been discussed with me. Not one little bit… You know- it was awful, my mind was, will I have [my child] back, will I not da da da da…I didn't know how to get them back… I probably would have went to social work to try for social work get them back.

(Carol)

Evidently not all participants had an understanding of their rights to make an informed objection to the use of s.25.

S.25 as an ongoing process

Barbara had a clear narrative of what happened when her child was accommodated, identifying discussions surrounding s.25 as an ongoing process. After her child was accommodated her advocacy worker and social worker regularly discussed what she had agreed to, and what her parental rights were. This helped her during times of doubt or mistrust:

Barbara's advocacy worker: *'In [her] mind for all she had signed the form she was of the understanding later, that maybe they had taken away all her rights for [her child] and she couldn't understand that for a while…'*

Barbara: *'Yeah- I was thinking does that mean everything is taken away from me.'*

Unlike Barbara, Amy and Carol described the use of s.25 to accommodate their child as a singular event. They had no clear narrative of what happened and had little or no memory of their discussions with social workers about s.25 before or after their child was accommodated:

[After my child was in care] they never really spoke about the voluntary or nothing, all I knew is I sent [my child] over that was it. Then it never really got discussed much.

(Amy)

> *I went and talked with the social workers… But I eh, did I sign something that night? …I think I blanked it out. But I do remember thinking I don't know if I'm doing the right thing. But then I know I have to do this… nobody came back and talked to me and said anything about that…It was pretty much [my child] is in care and that was it.*
>
> (Carol)

Professional support

Barbara identified discussions with legal, advocacy and social work about s.25 as valuable in her trusting in the process:

> *My social worker said call your advocacy worker to go get advice… Phone about and get advice. Phone us even to think. What I'm telling you, advocacy will tell you and they did. So I thought well she's not lying.*

Amy and Carol did not describe the social worker who discussed the use of s.25 to accommodate their children as a helpful or informative support, and neither recalls being encouraged to seek legal support. Amy and Barbara signed a form stating their agreement to s.25. None of the parents received a copy of the form or any written information regarding s.25. Amy reflected:

> *I think I could have had more time. I think they could have supported me a lot better than they did... They could have explained everything in more details. They could have made me understand it more.*

Each participant's children were later placed on a CSO. Amy advised it took over a year before she attended a children's panel. During this time she had no support from advocacy or legal and was unaware that she had the right to remove her child from local authority care.

> *I'm still struggling to this day because I didn't understand what was on that voluntary form. Because they never really discussed it, they just told me to sign [my child] away voluntary. I done that, I just didn't read the form… it's been difficult since and difficult to this day. They want me to meet the adopters, but how can I want [my child] home.*

All participants showed upset and pain over losing the care of their children. For Amy and Carol, the expressions on their faces, the emotion in their voice, and their unclear narrative showed visceral feelings of unresolved grief, anger and distress.

> *To be honest my head was so fucked up, I didn't know what day it was, I didn't know what I was going to do, I didn't know what to do, do I go to work, do I not go to work. I couldn't think straight for a very long time.*
>
> (Carol)

Discussion

The finding that two out of the three participants' children were accommodated under s.25 due to the risks their child posed to them was unexpected. Barbara and Carol reported being assaulted and threatened by their children repeatedly over many years. This is often referred to as adolescent to parent violence (APV) and is one of the most understudied forms of family violence (Maclean, 2016; Simmons et al., 2018). In circumstances of APV parents have a right to be safe and free from harm. This could lead to the parent no longer being able to care for their child in order to keep themselves safe. Yet despite the concerns for a parent's, and potentially sibling's, right to be free from harm this would be considered as abandonment under s.25 (1) (b). This highlights an emphasis on parental responsibilities as opposed to acknowledgement of the risks to a parent's welfare.

All three participants had an additional need. They all expressed a wish to have a partnership approach with social workers, yet only one participant experienced this. Wilkins and Whittaker (2017) have identified that social workers felt disingenuous working in partnership with parents and thought it could lead to less focus on the child. They also felt parents with learning difficulties lacked the capacity to manage a participatory approach. Given that the majority of parents whose children are accommodated have a learning difficulty (Booth et al., 2005) this could decrease the likelihood of a rights-based partnership approach when using s.25.

Participants' experiences of s.25 did not fit with the concept of a voluntary partnership. Pösö et al.'s (2018) research in Finland demonstrated that parents displayed different levels of voluntarism with respect to their child's care arrangements. They identified strong voluntarism, where parents recognised a need for help. This sounded akin to Barbara and Carol's experiences. Weak voluntarism involved a forced submissive acceptance of the plans. This reflects Amy's experience of not making an informed voluntary decision. Whilst Finland's childcare system is different, applying Pösö et al.'s (2018) levels of voluntarism theory to the participants gives a more honest account of the nature of the partnership they experienced. The complex and transient nature of s.25 suggests a need to develop a more transparent language which reflects the level of partnership or arrangement that has led to a child being accommodated.

The language in s.25 legislation and guidance is contrary to the language used in practice. Practice refers to consent, yet legislation seeks objection. Objection in itself is not defined, and at worst this could allow parents' 'submissive acceptance' to be assessed as a lack of objection to their child being accommodated. This highlights the risk of s.25 being misinterpreted or misused. Discussion with the two local authorities' training departments where this research took place highlighted that s.25 was briefly discussed in child protection training, but there was no practice guidance on the use of s.25.

Van der Kolk's (2015) research into trauma highlights that if a person is unsupported, feelings of anxiety, fear and anger can increase and impact on their capacity to reason. In order for them to respond calmly to any perceived threat they must feel genuinely safe, not just through the physical presence of others, but by being 'truly heard, seen and held in the mind of others' (p. 1369). Barbara appeared to gain security once she sought additional support from her advocate and lawyer. Without a sense of safety, a person can go into fight or flight mode, or if all else fails they may disengage from what is happening, including their awareness shutting down and disassociating from others (Levine, 1997; van der Kolk, 2015). Yet, disassociation (van der Kolk, 2015) and submissive acceptance (Pösö et al., 2018) could present as a parent who does not object. Amy and Carol both struggled to recall what happened, with their

memory and reflections being at times incoherent. Therefore, to what extent did their experience impact on their capacity to reason, and on their right to choose not to make an informed objection to place their child in care under s.25? This challenges the ethics of the minimal order principle in such circumstances.

The participants' experiences of s.25 occurred over a period of approximately half a day to two days. Only one was directed towards advocacy and legal support. These services have been identified as particularly valuable by parents with learning difficulties (Booth & Booth, 2005). Parents with learning difficulties' communication needs mean that they require more time to build a positive relationship with their social worker (Booth et al., 2005). This helps the social worker learn their communication style and needs. Yet, evidence suggests social work skills are often seen as transferrable and they are given neither the time nor specialist training to help them learn specialist skills for communicating with parents who have learning difficulties (Booth & Booth, 2005; Booth et al., 2005; Guinea, 2001).

Participants highlighted that the sole form of communication about s.25 was verbal. However, for parents with learning or communication difficulties, a dependence on spoken communication is unreliable (SCLD, 2015). Parents benefit from written information and time to process the information in order to make an informed decision (Mencap, 2002; SCLD, 2015). In England recent guidelines on s.20 have not explicitly identified it as an ongoing process. Participants all noted that they would have benefited from written information alongside ongoing verbal discussions and access to legal or advocacy support to help inform them of their rights. Despite the increased likelihood that a parent being presented with s.25 is likely to have a learning difficulty the processes do not appear to be designed for their needs.

Participants highlighted the benefit of having a clear narrative of what happened, and their role within this, as well as the detrimental impact of being without one. Lawler (2008, as cited by Brandon et al., 2017, p. 62) argues that a person's identity is formed by their life narrative. Brandon et al.'s (2017) research highlighted how fathers' life narratives informed their sense of self-efficacy and

their hopefulness, and shaped their own identities. A repeated telling of a story or an incident in a person's life has the potential to create meaning and prompt a turning point (McAdams, 2013). This is significant as some people can struggle to recall traumatic incidents and without a coherent narrative can struggle to recover (van der Kolk, 2015). Participants' experiences highlighted that support from professionals who they trust also provides them with a clear and accurate narrative of their child being accommodated under s.25. Helping parents understand what happened and why is significant to the rights, and potentially the wellbeing, of both parent and child.

The sample size of this research is very small, and whilst the findings cannot be generalised it is observed that they echo concerns within English practice of their equivalent legislation. A larger population of participants across Scotland would in future be beneficial.

Conclusion

When a parent is faced with the possibility that their child may be accommodated, they face the challenging prospect of their family being separated. This is a difficult situation which profoundly impacts on an individual's human rights and wellbeing. A review of literature highlighted that in Scotland there is little research regarding the use of s.25, and that the legislation and guidance does not reflect the complexities of its use. Nor were there any guidelines, targeted training, or policies within the local authorities where this research took place.

This research interviewed three mothers about their experience of the Children (Scotland) Act 1995 s.25. The absence of fathers within the research was in part due to the small proportion of fathers referred to advocacy. This highlights concerns that fathers are often not involved or included during child protection proceedings. An unexpected finding was that two out of the three participants' children were accommodated due to the risks the child posed to the parent. This highlighted a need to better understand child to parent violence and how best to support and respond to families in need.

Overall, the research highlighted a disparity between the language of the legislation, guidance, practice, and parents' experiences. Only in the guidance is the word voluntary used, yet only one parent described a voluntary experience. Parents frequently referred to the legislation as signing the s.25, yet this is not requested in legislation. No parents referenced the use of the word object, as stated in legislation. Indeed, some parents did not have all the information needed to make an informed decision and were unaware of their ability to object at the time or later. The research findings demonstrated that the parent with the most professional support to advocate for her and inform her of her rights had a clear narrative about what happened and reported the best working relationship with her social workers. In contrast, the other two parents were not aware of their rights, had no independent support, and did not have a clear narrative of what happened. Although each parent expressed a loss and grief for what had happened, those who did not have independent support showed greater signs of distress during the interview.

The findings evidence the need to ensure a human rights approach to supporting parents whose children are accommodated under s.25. The findings highlighted the need for local authorities to develop clear and consistent training and practice that promotes a rights-based approach to ensuring parents can make an informed decision. In situations of discussing the use of s.25, consideration should be given to a parent's capacity, the influence of the social worker, the emotional impact of the circumstances, and their impact on a parent's decision making. Parents may benefit from having written information about s.25 and should always be encouraged to seek legal and advocacy support. Fundamentally, this discussion should not be a singular event, the use of s.25 should be an ongoing rights- and welfare-based discussion that reaffirms a parent's choices and narrative of events.

Whilst the small sample size meant that the findings from the research cannot be generalised, they provide valuable insights and understanding into parents' experiences. Participants' varied experiences of the use of s.25 highlighted how their understanding of the legislation and their rights were often influenced by their social worker. This suggests it would be beneficial for future research to

understand what informs social workers' knowledge, understanding and use of s.25 in practice across multiple local authorities, and how children experience the use of s.25.

References

A Child: Use of s. 20 CA 1989. (2014). EWFC 775. *British and Irish Legal Information Institute*. http://www.bailii.org/ew/cases/EWFC/HCJ/2014/775.html
Adults with Incapacity (Scotland) Act 2000. https://www.legislation.gov.uk/asp/2000/4/part/4

Anderson, C., Quirnoz-Onate, D., & Gibbons-Wood, L. (2017). *Social Work Law in Scotland* (3rd ed.). Edinburgh: Thomson Reuters.

Booth, T., & Booth, W. (2005). Parents with learning difficulties in the child protection system: Experiences and perspectives. *Journal of Intellectual disabilities*, *9*(2), 109-129.
Booth, T., McConnell, D., & Booth, W. (2005). Temporal discrimination and parents with learning difficulties in the child protection system. *British Journal of Social Work*, *36*, 997-1015.
Brandon, M., Philip, G., & Clifton, G. (2017). *'Counting fathers in': Understanding men's experiences of the child protection system.* University of East Anglia. https://www.uea.ac.uk/centre-research-child-family/child-protection-and-family-support/current-projects/-counting-fathers-in-

Burns, K., Pvsv, T., & Skivenes, M. (2016). *Child welfare removals by the state: A cross-country analysis of decision-making systems.* London: Oxford Scholarship Online.

Coventry City Council v C, B, CA, CH. (2012). *British and Irish Legal Information Institute*. http://www.bailii.org/ew/cases/EWHC/Fam/2012/2190.html

Cusworth, L., Biehal, N., Whincup, H., Grant, M., & Hennessy, A. (2019). *Permanently progressing? Building secure futures for children in Scotland. Children looked after away from home aged five and under in Scotland: experiences, pathways and outcomes.* Outcomes Summary. Stirling: University of Stirling.

Few, C. (2010). Baby K's unlawful removal: Practice issues in the emergency protection of children. Letter to the editors. *Child Abuse Review*, *19*, 169–171.

Freel, M. (2010). Baby K's unlawful removal: Practice issues in the emergency protection of children. *Child Abuse Review*, *19*, 158-168.

Gambrill, E. (2001). Social work: An authority-based profession. *Research in Social Work Practice*, *11*(2), 166–175.

Gray, D. (2018). *Doing research in the real world* (4th ed.). London: SAGE Publications Ltd.

Guinea, S. (2001). Parents with a learning disability and their views on support received: A preliminary study. *Journal of Learning Disabilities*, *5*(1), 43–56.

Herefordshire Council v AB. (2018). *EWFC 10. Family Law Week*. https://www.familylawweek.co.uk/site.aspx?i=ed188876

Holm, S. (2015). *Informed consent: Ethical and legal issues*. Chichester: John Wiley and Sons Ltd.

Houston, S. (2012). Engaging with the crooked timber of humanity: Value pluralism and social work. *British Journal of Social Work*, *42*, 652-668.

Ife, J. (2008). *Human rights and social work: Towards rights-based practice* (2nd ed.). Cambridge: Cambridge University Press.

Kinton, M. (2009). *Coercion and consent monitoring the Mental Health Act 2007-2009*. London: TSO.

Levine, P. (1997). *Waking the tiger: Healing trauma the innate capacity to transform overwhelming experiences*. Berkley: North Atlantic Books.

London Borough of Hackney v John Williams and Anor. (2017). *EWCA Civ 26. Family Law Week*. https://www.familylawweek.co.uk/site.aspx?i=ed175679

Maclean, K. (2016). Reflections on the non-accidental death of a foster carer. *Adoption and Fostering Journal*, *40*(4), 325-339.

McGrath-Lone, L., Dearden, L., Nasim, B., Harron, K., & Gilbert, R. (2016). Changes in first entry to out-of-home care from 1992 to 2012 among children in England. *Child Abuse and Neglect*, *51*, 163-171.

McAdams, D. P. (2013). Life authorship: A psychological challenge for emerging adulthood, as illustrated in two notable case studies. *Emerging Adulthood*, *1*(2), 151–158.

Mellon, M. (2017). *Child protection: Listening to and learning from parents*. IRISS. https://www.iriss.org.uk/resources/insights/child-protection-listening-and-learning-parents

Mencap. (2002). *Am I making myself clear? Mencap's guidelines for accessible writing*. London: Mencap.

Merriam-Webster. (2022). *Voluntary.* https://www.merriam-webster.com/dictionary/voluntary

Miley, K., O'Melia, M., & DuBois, B. (2001). *Generalist social work practice: An empowering approach* (3rd ed.). Boston: Allyn & Bacon.

N (Children) (Adoption: Jurisdiction). (2015). EWCA Civ 1112. *Family Law Week*. https://www.familylawweek.co.uk/site.aspx?i=ed150974

Pitt, L. (2015). *How voluntary is voluntary accommodation?* Family Law Week. https://www.familylawweek.co.uk/site.aspx?i=ed146296

Pösö, T., Pekkarinen, E., Helavirta, S., & Laakson, R. (2018). 'Voluntary' and 'involuntary' child welfare: Challenging the distinction. *Journal of Social Work*, *18*(3), 253-272.

Re CA (A Baby). (2012). EWHC 2190. *Family Law Week*. https://www.familylawweek.co.uk/site.aspx?i=ed99434

Research in Practice. (2016). *Impact of the Family Justice Reforms: Phase 3 - exploring variation across 21 local authorities.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/534875/Impact_of_the_Family_Justice_Reforms__Exploring_variation_across_LAs_-_f....pdf

Ryan, M., & Tunnard, J. (2018). *Care Crisis Review: options for change*. London: Family Rights Group.

Sapsford, R., & Abbott, P. (1996). Ethics, politics and research. In: R. Sappsford, & V. Jupp, (Eds.), *Data collection and analysis* (pp. 317-412). London: SAGE.

Scottish Consortium of Learning Disabilities (SCLD). (2015). *Supporting parenting: Refreshed Scottish good practice guidelines for supporting parents with learning disabilities*. Glasgow: SCLD.

Scottish Government. (2004). *Scotland's children - The Children (Scotland) Act 1995 regulations and guidance: Volume 1 support and protection for children and their families*. Edinburgh: The Stationary Office Limited.

Scottish Government. (2019b). *Informed consent in healthcare settings*. Edinburgh: Scottish Parliament Information Centre.
Scottish Government (2021a). *Children's social work statistics Scotland.* [Email from R. Kanevski] Personal Communication, 20 December 2021.

Scottish Government. (2021b). *National guidance for child protection in Scotland*. https://www.gov.scot/publications/national-guidance-child-protection-scotland/

Simmons, M., McEwan, T., Purcell, R., & Ogloff, J. (2018). Sixty years of child to parent abuse research: What we know and where to go. *Aggression and Violent Behaviour*, *38*, 31-52.

Slettebø, T. (2013). Partnership with parents of children in care: A study of collective user participation in child protection services. *The British Journal of Social Work*, *43*, 579-595.

Tavormina, M., & Clossey, L. (2017). Exploring crisis and its effects on workers in child protective services work. *Child and Family Social Work*, *22*, 126-136.
The Law Commission. (1987). *The Law Commission working paper no. 100 care, supervision and interim orders in custody proceedings*. https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2016/08/No.100-Family-Law-Review-of-Child-Law-Care-Supervision-and-Interim-Orders-in-Custody-Proceedings.pdf

Thomas, C. (2018). *Care crisis review: Factors contributing to national increases in number of looked after children and applications for care orders*. London: Family Rights Group.

Transparency Project. (2016). *Section 20 of the Children Act 1989 – A guidance for parents and professionals*. http://www.transparencyproject.org.uk/press/wp-content/uploads/2016/02/s20guidancefeb16.pdf

van der Kolk, B. (2015). *The body keeps the score: Mind, brain and body in the transformation of trauma*. [Kindle ebook]. London: Penguin.

Wilkins, D., & Whittaker, C. (2017). Doing child-protection social work with parents: What are the barriers in practice? *British Journal of Social Work, 48*(7): 2003-2019. From: https://academic.oup.com/bjsw/article-abstract/48/7/2003/4781588?redirectedFrom=fulltext&login=false

Williams and another (Appellants) v London Borough of Hackney (Respondent). (2018). *Supreme Court*. https://www.supremecourt.uk/cases/docs/uksc-2017-0037-judgment.pdf

Worcestershire County Council v AA. (2019). *Family Law Week*. https://www.familylawweek.co.uk/site.aspx?i=ed201867

About the author

Dawn Simpson graduated as a Social Worker at the University of Strathclyde. For five years she worked as a children and families social worker for East Ayrshire Council. Following that she worked as a Functional Family Therapist for three years in a newly formed pan Ayrshire team. During this time she completed her MSc in Applied Studies with the University of Stirling and published an article with SJRCC entitled: Beware of the big bad storyteller: An exploration of the therapeutic potential of bedtime reading from the perspectives of young people and residential workers. She started working in the newly formed Small Steps Social Work team based in secondary schools across South Ayrshire.

Appendix 1

Theme Analysis:

Themes	Amy	Barbara	Carol	Total
Parents' understanding of s.25	0	8	0	8
Parents' misunderstanding of s.25	20	1	3	24
Parents' rights	2	10	9	21
Contact	4	3	3	10
Partnership	0	2	2	4
Trust in social work	0	8	0	8
Mistrust in social work	4	4	5	13
Parents' emotional distress	16	8	16	40
Struggling to remember the use of s.25	5	0	12	17
What happens after s.25	8	5	2	15
Parents advising on service change	7	3	9	19
Lack of support	16	0	16	32
Support - Legal, advocacy and support	0	15	2	17
Mental health	0	17	4	21

Listening to care leavers: A case study involving 435 care leavers and 100 child protection key stakeholders in 5 States of India

Kiran Modi and Gurneet Kaur Kalra

Abstract

A research study by Udayan Care (Beyond 18: Leaving Child Care Institutions-Supporting Youth Leaving Care, A Study of Aftercare Practices, 2019), in India, reveals that even though, as per the Juvenile laws of India, 'care-experienced' youth (care leavers) are mandated to receive aftercare services to age 21, and in certain cases to 23, the state of affairs for this section of disadvantaged youth needs to evolve. The study is based on a mixed method approach which uses a descriptive design to collect data from 435 care leavers and 84 key informants from five states of India. This paper investigates the emotional difficulties these young adults face when reaching 18 years of age, as they need to leave their care-settings without many options or support. It also highlights the factors causing emotional distress due to gaps in policies, systems and practices in Indian juvenile laws and practice. The focus of policies and stakeholders needs to be directed towards providing reasonable support for the emotional wellbeing of care leavers along with other domains essential for aftercare, including housing, physical health, independent living skills, education and vocational skills, social support and interpersonal skills, financial independence and career, emotional wellbeing, identity, and legal awareness.

Keywords

Aftercare, mental health, alternative care, care leavers, emotional wellbeing, India

Corresponding author:

Dr Gurneet Kaur Kalra, PhD, Assistant Manager, Advocacy and Research at Udayan Care, Delhi, India, gurneet.kalra89@gmail.com

Introduction

Moving from being a teenager to entering adulthood is a huge leap even for an individual with a normal and healthy childhood and adolescence, brought up under the shelter of their family. It is much more challenging for young care leavers, who are transitioning out of child care institutions and moving towards adulthood, to embrace an independent life once they reach the age of 18 years. For a care leaver growing up in alternative care, without a cohesive family set up and support, braving the sudden thrust into adulthood is hugely taxing. There is immense fear and apprehension in such youth, alongside their unpreparedness for the outside world. During their stay in a formal care setting, there is often a share of adverse experiences for the children growing up there, in addition to the baggage of the past trauma that they carry, increasing the negative impact on their troubled selves and leaving them in greater need of handholding and care when they step into adulthood, when the imminent separation from the home causes them re-traumatisation. These care leavers struggle with the lack of housing support, health care, educational and vocational skills training, legal aid, emotional wellbeing and social and interpersonal skills support, and job placements, all of which are indispensable for independent living.

As reflected in UK research, many care leavers face greater difficulties and disadvantages, as compared to other young people, when they embark upon the journey into adulthood, and find themselves lacking in education, employment, and training (EET) (Biehal et al., 1995; Broad, 1998; Dixon & Stein, 2005; Dixon et al., 2006; Stein & Carey, 1986). These studies indicate that a significant number of care leavers encounter obstacles, in terms of both finding and sustaining EET options in the early years of aftercare. Furthermore, for some this will continue into later adulthood, leading to long-term unemployment and other difficulties, including homelessness, mental health problems, and risky behaviours such as offending and drug and alcohol addiction, thus placing them at greater risk of social exclusion (Cheung & Heath, 1994; Dixon et al., 2006). Another study in the city of Chicago, provides evidence of the lack of attention paid to emotional support by professionals, and highlights the impact that this had on the young people's experiences (Courtney et al., 2011). Care leavers are

often unheard, and deprived of basic facilities, with their unaddressed trauma leading to long-term impacts on their emotional wellbeing (Adley, 2014). International studies in the mental health of care leavers have consistently shown that self-stigma and public stigma impact their ability to access mental health services. It has also been found that self-stigma affects an adolescent's self-identity, self-efficacy, and interpersonal relationships. This influences self-sufficiency once youth leave care (Guillen et al., 2017). Care leavers may also not reach out for help after transitioning, as they do not have reliable support networks (Mann-Feder & White, 2003).

Bhattacharjee (2020) highlighted the changing context of reintegration practices in South Asia and explored boys' and girls' experiences of stigma and discrimination from community members, revolving around social and cultural norms and narratives on masculinity and femininity that denied their victimhood. This research found that children sexually exploited in Kathmandu chose to 'integrate' into a new community to overcome isolation, exclusion and non-acceptance from their families and communities of origin and, in so doing, experienced emotional and financial independence. Unfortunately, in India, one cannot find much empirical evidence regarding those challenges and struggles. Only a few standalone studies, from districts, states, and facilities, have been conducted, most of which are qualitative in nature; furthermore, most studies do not explore the multiple dimensions of aftercare. One of the studies points out the lack of positive adult interaction, from consistent carers, limiting the ability of care leavers to develop personal confidence and key social skills (Modiet al., 2016). Findings from another study showed that care leavers perceive independent living as both opportunity and challenge, as after leaving institutional care they faced several difficulties at their workplace, in household management, while finding accommodation, and in establishing their official identity (Keshri, 2021). Dutta (2016) developed and described a framework for intervention, aiming for it to be an effective policy document, as it emphasised the interlinkages between the individual and the environment, with a view to improving the social reintegration of youth transitioning out of care. It also looked at social reintegration as a long-term process and not merely as happening at the transition point of youth leaving care.

In India, The Juvenile Justice (Care and Protection of Children) Act 2015 (JJ Act), Juvenile Justice (Care and Protection of Children) Model Rules 2016, and the Integrated Child Protection Scheme (ICPS) 2009-10, mandate the provision of support and mentoring for youth without families brought up in care institutions. The JJ Act 2015 emphasises that 'it is crucial for a young adult to be provided with financial and non-financial support in order to facilitate child's reintegration into the mainstream of the society in the manner as may be prescribed'. These provisions include support in the areas of housing, education, vocational training, and physical and emotional health. The National Policy for Children, 2013 (NPC) refers to 'child protection' as one of its priorities and recognises vulnerable categories of children who need intervention, but does not explicitly recognise the vulnerabilities of children leaving child care institutions and the need for aftercare. To link policy objectives to actionable programmes, the National Plan of Action (NPA) was formulated in 2016. In the context of children in institutions, the NPA prioritises 'providing adequate and appropriate infrastructure and ensuring safety and security of children in all residential care facilities established under domestic laws'. However, the NPA also did not make any specific reference to children leaving institutions on attaining majority.

Echoing similar views, even the National Youth Policy, 2014, states that,

> While the government is working to create support and rehabilitation systems for youth at risk, it is essential to simultaneously build systems to ensure that youth are not forced to put themselves into situations that constitute a physical or mental risk.

The Child Welfare Committees (CWC), Juvenile Justice Boards (JJB), or the children's courts can order aftercare up to the age of twenty-one or, if required, twenty-three years of age, and they are also mandated to review the effectiveness of aftercare while monitoring the progress of every child and youth. The State Child Protection Society (SCPS) is responsible for developing programmes for aftercare and maintaining a database, whereas the District Child Protection Unit (DCPU) develops aftercare-related database at the district level to share with SCPS, and CWC implements the aftercare programme by identifying organisations to provide the aftercare services, maintaining a

database of organisations willing to provide the same. Despite being supported by law to receive aftercare services up to the age of 21, and in some cases 23, as per need, care leavers in India are in a disadvantaged position just after the age of 18, due to the lack of a supportive ecosystem, lack of awareness in themselves, as well as the functionaries, and inadequate budgeting.

Sphere of aftercare: Reflections from Beyond 18 study

This paper is based on a comprehensive national study, titled 'Beyond 18, Leaving child care institutions – A Study of Aftercare Practises in Five States of India (2019),' conducted by Udayan Care, a non-government organisation in India, in collaboration with UNICEF and Tata Trusts. The study elaborates upon the state of aftercare services in India, across five states, namely, Delhi, Gujarat, Karnataka, Maharashtra, and Rajasthan. It gives a comprehensive overview of relevant policy and laws, national schemes, and budgetary allocations concerning care leavers, in these five States. It also covers existing practises, as well as analysis of exhaustive surveys, conducted with 435 care leavers and 84 key informants on the issues faced by care leavers.

This study developed a specific framework, called the 'Sphere of Aftercare,' that considers the eight essential and interdependent domains that require focus in order to support care leavers, depending on their individual needs, which emerged out of the surveys. These domains include housing, physical health, independent living skills, education and vocational skills, social support and interpersonal skills, financial independence and career, emotional wellbeing, identity, and legal awareness. The research team evolved this framework based additionally on a secondary review of various frameworks and life domains of aftercare used across different countries, as well as practice-based understanding from Udayan Care's own experience of running and managing 17 child care institutions and two aftercare facilities in four states of India. This 'Sphere of Aftercare' is a comprehensive ideology of rehabilitative support and services for care leavers, transitioning out of care, which shows clearly how all the domains are independent as well as interdependent, thereby providing holistic support to a care leaver.

Figure 1 Sphere of Aftercare

The emotional turmoil that care leavers face

Emotional wellbeing refers to the emotional quality an individual experiences and is influenced by a variety of demographic, economic, and situational factors. Enhanced emotional wellbeing is perceived to contribute to increased coping ability, self-esteem, performance, and productivity at work (Kahneman et al., 2010). In the case of care leavers, it also includes emotional preparation to leave care, as most carry the baggage of past traumatic experiences (issues related to trust, trauma, anxiety, aggression, attachment issues, and sexuality), along with new insecurities that are likely to open up before them, once they are independent of the care system.

Emotional impact on care leavers commences even before coming into the care system as they share common scars of traumatic experiences. The harms of institutionalisation are stated by several studies as the youth's growing up needs not being adequately met, their past traumas not appropriately addressed, and an adequate future pathway being far from chalked out with their participation (Sherr et al., 2017). They end up lonely at child care institutions, figuring out puberty and the onset of adulthood by themselves, struggling with various kinds of emotional voids, including past traumas not having been addressed, trust

issues, disrupted education, vocational skills and relationships, along with developmental delays and lack of individual attention and training in life skills and employability. A large percentage of care leavers exit from child care institutions without even basic documents, such as identity papers, a bank account, voter card, and PAN card, the absence of which affects their 'idea of the self' immensely, often leaving them in deep self-doubt and emotional turmoil, greatly affecting their mental health.

Research methodology

The methodology of this paper has been derived from the 'Beyond 18' study. The study followed a mixed methods approach with a descriptive research design that used quantitative and qualitative methods of inquiry in tandem. It used a diverse set of tools for data collation for better understanding of the lives and experiences of care leavers, as well as capturing the views of key informants that is the child protection functionaries of these various states.

Time duration

Udayan Care conducted a pilot study in Delhi through 47 care leaver interviews and 13 key informant interviews (KIIs), to explore the status and quality of aftercare services in Delhi. After reviewing and strengthening the tools with the support of UNICEF, Tata Trusts and Shri Deep Kalra, this research was conducted in 2018 in five states of India, namely, Maharashtra, Karnataka, Gujarat, Rajasthan, and Delhi, with a report entitled 'Beyond 18' being completed and published in 2019.

Ethical approval and limitations

The research protocol, along with the study's design, methodology, and tools, were approved by the 'Suraksha Independent Ethics Committee' through its 'Committee for Scientific Review and Evaluation of Biomedical Research'. This study presented certain limitations, such as the inability to sample care leavers from rural locations, and non-inclusion of care leavers with special needs. The

youth who didn't receive aftercare support were referred to as non-receivers, and these were under-represented in the study sample as many care leavers, who had aged out of child care institutions, could not be reached because of unavailability of information about their whereabouts, reflecting the lack of any follow-up system in the child protection system.

Sample and data collection

Care leavers

Participants in the 'Beyond 18' study were children in need of care and protection who had attained the age of 18 years and had exited a child care institution in one of the five states under study. A total of 435 care leavers, who had grown up in a child care institution and were older than 18 years of age, were contacted. A stratified convenience sampling method was used for conducting the interviews, based on the care leaver's age, sex, and type of child care institution (government or non-government). The process of selection of respondents involved the following steps:

In the first step: The research team approached governmental and non-governmental organisations (NGOs) engaged in aftercare and child care services, as well as local District Child Protection Unit and Child Welfare Committee members, to obtain the names and contact details of young adults who fulfilled the criteria mentioned above.

In the second step: Care leavers were stratified based on their age (18–21 years, 22–25 years, and 26 years and above), their gender/sex, and the type of child care institution they had lived in (governmental or non-government organisation) with an aim to have proportionate representation wherever possible. The sample comprised 55% male care leavers and 45% female care leavers.

Key informants

For a more complete understanding of aftercare in the state, along with care leavers the study focused on a sample of 84 key informants, both male and

female. As it was important to consider a wide variety of viewpoints and experiences, key informants included representatives of various child care institutions (governmental and non-governmental), aftercare providers and programme managers, social workers, case workers, practitioners, experts, policy-makers, activists, and scholars in child and youth protection. Another set of perspectives was provided by state officials: representatives of the Department of Social Justice and Empowerment, and of the Department of Women and Child Development, Child Welfare Committee members, Juvenile Justice Board members, district child protection officers, state child protection officers, district women and child development officers, child welfare officers, and probation officers.

Table 1 provides an overview of the number of care leavers and key informants in each state who participated, when the research was conducted, and the key informant interviews (KIIs) which took place in each state.

State	Total care leavers	Period of research	KIIs
Delhi	55	February–April 2019	10
Gujarat	84	November 2018–May 2019	20
Karnataka	108	April–December 2018	14
Maharashtra	107	April–October 2018	20
Rajasthan	81	September 2018–April 2019	20

Table 1 Research Overview

Findings and results

Participants' demographics

In the 'Beyond 18' study, the sample size was 435 care leavers and 84 key informants that is people working on the ground in child protection across these states. There was a variation between sates in terms of gender composition, with Maharashtra having a significantly higher representation of males. All the care leavers involved in this study were between the ages of 17 and 30, with 72% in the age group of 18 to 21 years; only one care leaver was 17 years of age. Nearly 48% of the care leavers were from government institutions and 52% were from non-government organisation run institutions. Those care leavers who had received aftercare services or support on one or more occasions from a state government or a non-government organisation run aftercare programme were designated 'aftercare receivers', whereas non-receivers are those who haven't received any form of aftercare service. Around 73% of all care leavers received aftercare services in at least one of the domains of the 'Sphere of Aftercare', amongst which 46% of care leavers received aftercare from government aftercare programmes, with others receiving support from a non-government organisation supported programme.

Emotional Wellbeing Index

Even though all domains of aftercare are correlated, this paper highlights the findings of one domain of the sphere of aftercare, i.e. emotional wellbeing. The emotional wellbeing section in the 'Beyond 18' study encapsulates the cognitive and functional distress among care leavers, and the reasons for this, as measured through the Emotional Wellbeing Index. There is quantitative evidence that the state of the emotional wellbeing of care leavers has an impact on other domains, including being strongly connected to the Academic and Career Index, indicating an impact on education and work life. The Emotional Wellbeing Index was found to be positively correlated (Pearson correlation coefficient significant at alpha level = .01) to the Aftercare Quality Index (AQI) and the Academic Career Index (ACI), indicating an impact on education and work life, as

mentioned in the main study. The data evidence also indicates that emotional distress results in poor social relationships, which further increases vulnerability, as care leavers fail to establish a social support structure for themselves.

The Emotional wellbeing Index was also found to be moderately correlated to the child care institutions' Life Index (Pearson correlation coefficient significant at alpha level = 0.05), where the child care institution Life Experience Index is a composite score that factors in continuity of education, association with family, stability or instability through multiple placements, feelings of empowerment, and involvement in the planning of their future life. Every domain in the 'Sphere of Aftercare' is interrelated, and somewhere at the root of it all is the mental healthcare required to ensure emotional wellbeing. Unavailability or negligence with respect to any of the other domains tends to impact upon the overall mental and emotional wellbeing of the care leavers, with poor mental health potentially leading to poor education outcomes, inability to retain a job, lack of development of life skills, unstable social relationships, and so on. Human possibilities are immense, and an individual's potential can only be explored and fulfilled when they are safe, secure, and in control of their own lives. Therefore, children who have not had positive experiences in child care institutions are likely to fare worse in most domains of aftercare, and are likely to have thwarted social and interpersonal relations, lesser career prospects, and underdeveloped skills to sustain independently. They are, in short, more likely to have a challenged aftercare experience and a difficult time afterwards.

Emotional distress

The Emotional Wellbeing Index used in this study revealed the following insights. The study emphasised the great urgency to support care leavers and analysed the multiple gaps in law and practice needing to be filled to offer adequate support to care leavers. Over 61% of care leavers faced recurring emotional distress, including 86% of care leavers in Delhi, 63% in Rajasthan, and 54% in Gujarat, who faced emotional distress that made them sad or tense. One in every five respondents in Delhi and Gujarat reported multiple symptoms of distress. Various indicators of distress taken into account within this study

included mood dys-regulation, anger/irritability, feeling worthless, helpless, anhedonia, harmful/violent thoughts, tiredness, work functioning, sleep disturbances, disturbance in food intake, affected daily functioning, need to push for everything, and harmful/violent behaviour. Across states, more females reported distress, in terms of cognitive, emotional, and functional mental health issues, as compared to males, where 84% of male care leavers had a satisfactory Emotional Wellbeing Index as compared to 78% of female care leavers. One of the key informants stated that, 'with no aftercare homes for female CLs in at least 3 of these States (Only Delhi and Maharashtra have one aftercare Home for Women), they get pushed to living in shelter homes for destitute women, where their unique needs are not met'.

As the findings further show, their emotional wellbeing has a profound impact on their functioning in almost all other domains of independent life. For some of them, emotional distress resulted in poor relationships with others, leading to increased vulnerability as they failed to establish a social support structure for themselves. One-third of all care leavers did not feel empowered since their sense of individual agency had not been developed. While the overall Index for the majority of care leavers is satisfactory, the study indicated consistent stress and worry in care leavers across the board, primarily owing to anxiety with respect to future settlement. Considering that care leavers have been removed from the mainstream, it is unsurprising that they can be doubly susceptible/vulnerable at this age of transition, almost on the verge of breaking down or giving up, or pushing themselves so hard that they begin to live with chronic mental ailments which in the long run will also adversely affect their physical health. Care leavers as children were uprooted from their place of belonging and have witnessed the loss of relationships, which has a profound impact on their personal confidence in developing relationships and trust in others. Most care leavers experience re-traumatisation, as they are unwittingly pushed into adult life without adequate preparation and with limited resources. These mental disorders pose a threat to normal day-to-day functioning, potentially resulting in drug addiction, involvement in crime, low self-esteem, or withdrawal from activities necessary for social reintegration (Guillen et al., 2017). One of the care leavers stated,

> I have no social life at present, I don't have friends to speak with nor any informed adults who can support and guide me to make important decisions in my life. I feel lonely often and I have barely left home since returning from the child care institution, and have eventually become habituated with this lifestyle.

Female care leavers reported getting easily tired, having mood dys-regulation, sleep and food disturbances, whereas more male care leavers reported having violent thoughts and the need to push for everything. The care leavers, especially male care leavers, face a deficit in social skills, such as effective communication, leadership, conflict management, self-esteem, knowledge of legal rights and duties, gender neutrality. This has an impact on the overall quality of life of care leavers, which ultimately disturbs their mental health. Our findings mirror those of Barn (2010), who noted that any challenges which care leavers face, such as unwillingness or inability to continue their education, difficulty in forging or maintaining relationships, failure to keep a job, and so on, are embedded to some extent in their poor emotional health along with a lack of resilience. It was unexpected to see that symptoms of emotional and cognitive distress were higher among those respondents who have been receiving aftercare as compared to the non-receivers. Also, care leavers from government child care institutions showed more symptoms of emotional and cognitive distress as compared to the care leavers from non-government organisations' child care institutions. This may be due to the fact that the majority of the receivers lived in government institutionalised care settings, which may not have allowed them their freedom, and this may be leading to their higher distress. One of the care leavers stated, 'I was not able to step out of the institution to play or meet my family. Nobody listened to my issues and I felt very lonely as I didn't have anyone to talk to'.

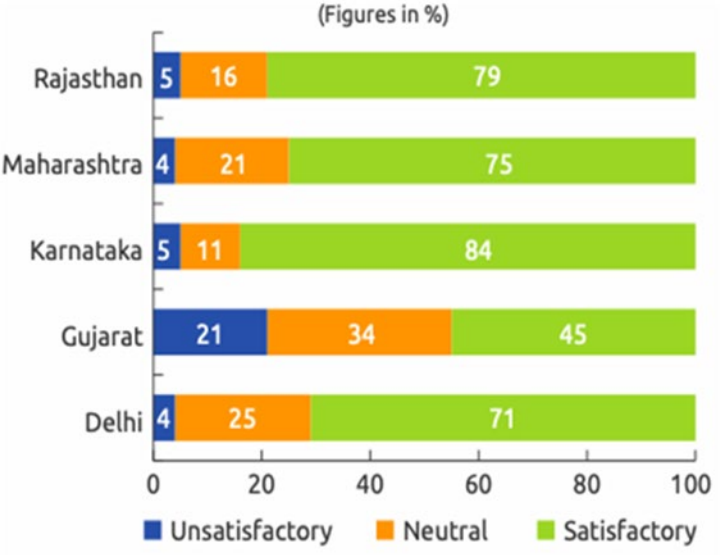


Figure 2: Emotional Well-Being Index by State

The in-depth interviews substantiated the quantitative findings of the study. The pressures to become financially independent without having any financial security, to acquire and manage independent housing, and to integrate into wider society led to anxiety and stress. One of the female respondents reported, 'lack of guidance and financial support has greatly impacted my mental and physical health'. She also complained of chronic depression, inability to sleep, and social anxiety, leading to distancing from friends. She was concerned that she might be developing depressive symptoms as she was unable to sleep and preferred to isolate herself from her friends.

Access to mental health services

It was found that access to mental health services declined during the transition from child care institutions to life outside care settings, and 78% of care leavers did not seek professional help for emotional distress. A quarter of all care leavers receiving aftercare services sought professional mental health assistance, in comparison to 10% of non-receivers. In Gujarat, a shocking 86% of care leavers did not seek any professional help. In Maharashtra, more than a quarter of care leavers facing mental health issues did not seek any professional or non-professional support, whereas in Delhi, 51% of the care leavers sought

assistance from professionals who are licensed social workers, psychologists, or doctors. It was found that most of the youth who are out of the care system tend to approach non-professionals such as friends, family members, mentors and acquaintances. This substantiates that although counsellors and professional social workers are available in child care institutions during childhood, this is not the case when transitioning into adulthood. One of the care leavers expressed that 'I cannot trust anyone now. I talk to people only if it is really required'. Another care leaver stated that,

> I was never able to develop meaningful social relationships and emotional bonds with any of the caregivers at the child care institutions, which made me believe that I don't belong anywhere. I lack confidence and can't even share my feelings with anyone.

Care leavers may also not reach out for help after transitioning as they do not have a reliable support network (Mann-Feder & White, 2003). Moreover, being aware of the symptoms and accepting that professional intervention is required is another challenge.

The life of children living in child care institutions is full of struggle and challenges in various domains, such as emotional trauma, trust issues, unwillingness to continue education, and an inability to forge and maintain relationships, which are partially rooted in their poor emotional health and lack of ego-resiliency. Unfortunately, qualified counsellors were not always available in aftercare homes, with staff ill-equipped to adequately resolve the emotional issues of care leavers. Most key informants shared that the stigma related to psychological disorders often discouraged care leavers from seeking assistance. In one of the aftercare homes, the welfare officer fills the role of mentor as well as counsellor for the children. A few key informants also suggested that Delhi has the best mental health services, compared to the other states, but they were not available to child care institutions and aftercare homes, such that access is quite difficult. These key informants believed that nobody prioritises the mental health of these children, youth, and caregivers. Educating caregivers and care leavers on how to identify symptoms and encouraging them to seek

help without feeling stigmatised would be an important step in the system addressing the issues identified above. One of the key informants stated,

> What should actually happen is that from 16 onwards children should be prepared about the ruthless world. Mental health preparedness is as important as getting vocational skills. It is very important that the children in child care institutions should interact with children who stay with families. They should be linked with the outside world.

Another key informant reported that, 'Poor mental health affects other aspects of adult life. Some care leavers pick up jobs but leave them the next day,' as they do not feel ready to cope with the new pressures of working life.

Discussion and conclusion

Care leavers at this tender time and age of entering the world of adulthood face several concerns relating to exploring themselves, fitting into the world, dealing with several tropes of addiction, and peer pressure, while needing to perform well to land themselves good grades and jobs. The kind of mental health problems at this age emerge from severe pressure, fear of failure, inability to cope, broken relationships, and fragmented psychological states, leading to borderline depression, thoughts of suicide, and chronic anxiety attacks. The levels of severity might be different, according to the capacity of individuals to deal with stressful situations.

The research by Udayan Care across five Indian states found that there are several areas which need to be addressed, with respect to youth, across all domains in the 'Sphere of Aftercare', when they leave care. After experiencing separation from families and close control and lack of transition preparedness at the child care institutions, they are suddenly expected to transition to the mainstream without proper housing, healthcare, education and vocational skills, legal awareness, and social and interpersonal skills. The lack of the basic necessities of life and the absence of any family or institutional support makes them highly vulnerable and impacts their integration into mainstream society. But most importantly, there is a need to fully understand the emotional condition

of care leavers, and more particularly their space of unstable self-identity, which often goes ignored or unnoticed. Repressed anxiety might intensify later in life and ruin those opportunities that the individual is capable of earning and is deserving of achieving. This, therefore, led us to the understanding that the focus of stakeholders has to be rooted in providing adequate support for uplifting the emotional wellbeing of care leavers, alongside other aspects. Ensuring emotional wellbeing is most important because the success of all other domains of the sphere also depend on this emotional space and other domains cannot be addressed without sound emotional wellbeing.

Given the relationship between state and the care leaver, and the unique vulnerabilities these youth face, the government should recognise them as a distinctly vulnerable population within the legal and policy framework of the country. One of the prime interventions is to provide the appropriate reserved seat for care leavers at national and state level in educational institutions for higher education and in jobs. The research also recommends redefining the reach of the aftercare programme to include support across all domains of the 'Sphere of Aftercare'. The findings show that the experiences, values, knowledge and skills accumulated during childhood in child care institutions have a direct and profound impact on the experiences and outcomes of care leavers' adult lives. Therefore, adequate investments to ensure better quality care, individual aftercare care planning, education, and targeted skilling during childhood are needed, which allow for a smoother transition into independent living, resulting in better outcomes. The study recommends strengthening existing individual care plans, effective implementation of existing policy and law on aftercare, establishing a grievance redressal system, post-aftercare follow up and support, capacity building on transition planning and aftercare, building effective linkages and convergence for aftercare between various ministries at union level, and departments at state level, and strengthening the voices of care leavers in India.

Implications for practice and the way forward

Given the unique vulnerabilities these care leavers face, the government should recognise them as a clearly vulnerable population within the policy and legal

framework of the country. Reaching out to care leavers and supporting them in their journey of life requires several levels of participation and improvement in policies and planning, by the functionaries of the child protection system. While improvement in the short-term can be achieved through engaging with caregivers, mental health experts, and personal advisors, the emptiness in the lives of these children in society requires an empathetic and deep understanding of their need for support systems. Supporting the coming of age of these individuals requires keen attention to training them in life skills, resiliency building, and developing coping skills to deal with adversity.

There is a need for planning and preparation for successful transition at the child care institution level. Immense attention, concern, and responsibility is required on the part of the functionaries to take care of these young adults and to provide highly empathetic understanding, transition planning and training, for when care leavers leave the child care institutions and step out into the larger world to become a part of the mainstream. This sadly does not happen, due to a lack of understanding of their needs and requirements, or a lack of awareness of legal provisions on the part of the stakeholders.

On the basis of the ICP (Individual Care Plan) and other assessments of the child before leaving any child care institution, there must be an Individual Aftercare Plan (IAP) developed for every care leaver, in order to ascertain their unique needs and thereby determine the nature of aftercare services required. This should be developed with the voices of care leavers in mind. Emotional wellbeing and mental health care support should be accessible to all care leavers through professional, specialised counsellors, alongside continuous support for individual and group counselling therapy. Resilience-building through counselling and pre-marriage counselling may be provided, since as children most care leavers may have not lived in a family, and hence are unable to internalise the nuances of family life once mainstreamed. They require marriage counselling to address the impact of past trauma and its influence on societal relationships.

The many gaps in society and systems that leave this potential group of youth abandoned, uncared for, and unaccompanied in their journey of life needs to be identified as a continuous process and addressed tirelessly to build bridges over

the missing links. A common echo of all care leavers interviewed in this study has been the development of physical spaces and platforms, created with support and recognition from the state government and district administrations, where aftercare youth can form peer networks and mentoring relationships. More realisation at community level is required to ensure care leavers access to and participation in all other avenues of life – receiving of vocational training, opening up to educational opportunities, looking forward to jobs, an identity, self-sufficiency, and strong and stable relationships. Before anything, these individuals need to be counted in the larger scheme of things, and their voices need to be heard, with programmes being designed to help them channel their strengths and energies towards building a beautiful world both around and within them.

Acknowledgement

Ms Manjima Biswas has provided support in developing this paper.

References

Adley, N., & Kina, V. J. (2017). Getting behind the closed door of care leavers: Understanding the role of emotional support for young people leaving care. *Child & Family Social Work*, 22, 97-105.

Barn, R. (2010). Care leavers and social capital: Understanding and negotiating racial and ethnic identity. *Ethnic and Racial Studies*, 33(5), 832–850. doi:10.1080/01419870903318896

Bettmann, J. E., Mortensen, J. M., & Akuoko, K. O. (2015). Orphanage caregivers' perceptions of children's emotional needs. *Children and Youth Services Review*, *49*, 71-79. https://doi.org/10.1016/j.childyouth.2015.01.003.

Bowlby, J. (1982). Caring for children: Some influences on its development. In R. S. Cohen, S. H. Weissman, & B. J. Cohler (Eds.) *Parenthood*. New York: The Guilford Press.

Courtney, M. E., Dworsky, A., Brown, A., Cary, C., Love, K., & Vorhies, V. (2011). *Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 26*. Chicago, IL: Chapin Hall Centre for Children at the University of Chicago. Retrieved from

https://www.chapinhall.org/sites/default/files/Midwest%20Evaluatio_Report_4_10_ 12.pdf

Dutta, S. (2016). Institutional care in India: Investigating processes for social reintegration. *Children and Youth Services Review*, *66*, 144–153. doi:10.1016/j.childyouth.2016.05.010

Dutta, S. (2017). Experiences of young Indian girls transiting out of residential care homes. *Asian Social Work and Policy Review*, *11*, 16-29.

Dixon, J. (2016). Opportunities and challenges: Supporting journeys into education and employment for young people leaving care in England. *Revista Española De Pedagogía, 74*(263), 13-29. http://www.jstor.org/stable/24711266

Gypen, L., Vanderfaeille, J., Maeyer, S., Belenger, L., & van Holen, F. (2017). Outcomes of children who grew up in foster care: Systematic review. *Children and Youth Services Review*, *76*, 74–83.

Juventas Organisation. UNICEF. (2015). *Leaving Institutional Care: Analysis of Policies, Institutional Framework and Practice*. Ministry of Labour and Social Welfare. https://www.unicef.org/montenegro/media/2641/file/MNE-media-MNEpublication26.pdf

Keshri, A. K. (2021). Life after leaving institutional care: Independent living experience of orphan care leavers of Mumbai, India. *Asian Social Work and Policy Review*, *15*(3), 255-266.

Kunc, N. (1992). The need to belong: Rediscovering Maslow's hierarchy of needs. In R. A. Villa, J. S. Thousand, W. Stainback, & S. Stainback (Eds.), *Restructuring for caring and effective education: An administrative guide to creating heterogeneous schools* (pp. 25–39). Paul H. Brookes Publishing. Washington DC. https://psycnet.apa.org/record/1992-97650-001

Ministry of Women and Child Development. (2020). *Guidelines for after care of children under ICPS*. Online at: https://nipccd-earchive.wcd.nic.in/sites/default/files/PDF/Guidelines%20For%20After%20Care%20of%20Children%20under%20ICPS.pdf

Sherr, L., Roberts, K. J., & Gandhi, N. (2017). Child violence experiences in institutionalised/orphanage care. *Psychology, Health & Medicine*, *22*, 31-57. doi: 10.1080/13548506.2016.1271951

Udayan Care. (2019). *Beyond 18 leaving child care institutions: A study of aftercare services*. https://www.udayancare.org/upload/Reports/2019-20/Full%20report_%20Beyond%2018.pdf

About the authors

Dr Kiran Modi, PhD, is the Founder and Managing Trustee of Udayan Care, Delhi India. – icbjournal@udayancare.org

Dr Gurneet Kaur Kalra, PhD, is an Assistant Manager of Advocacy and Research at Udayan Care, Delhi, India. – gurneet.kalra89@gmail.com

Assessing social and emotional difficulties of children in residential care settings: A systematic review of strengths-based measures

Danielle Day, Sarah Elgie, Christopher Robinson

Abstract

The number of children in residential care in England has increased over recent years. Studies have shown that these children often have poorer emotional wellbeing and social outcomes compared to their peers. It is therefore crucial that the care these children receive is informed by the child's own needs. Strengths-based measures seek to use a collaborative approach to assess a young person's areas of strength, and to use these to help the young person during times of adversity. The current research sought to systematically review existing strengths-based measures used in residential care settings. Results showed that there were four measures in total, including strengths-based questions. Psychometrics and the usability of these measures are discussed.

Keywords

Systematic review, strengths-based measures, residential care

Corresponding author:

Danielle Day, Assistant Psychologist, Keys Group, Danielle.day@keys-group.co.uk

Introduction

Across England, there are 78,150 children in care, 12,175 of whom currently reside in a residential care setting (Ofsted, 2020). These figures have risen over recent years and are reportedly higher than other European countries such as Hungary, Denmark, and Sweden (Jackson & Cameron, 2011). The children and young people coming into care have often suffered significant adverse traumas which can have detrimental effects on their physical, emotional, and social development (Parry et al., 2021). Specifically, research has shown that 80% of young people who experienced maltreatment and trauma throughout their childhood met the diagnostic criteria for at least one psychiatric disorder by the age of 21 (Leslie et al., 2010). In addition, by the age of 16, only 14% of looked after children in England achieve five passes at A*-C in their GCSEs, compared to 65% of children with no experience of being in care (Bazalgette et al. 2015). These statistics are considerably lower than those of looked after children in countries such as Denmark and Sweden; however, these countries also report significantly lower levels of attainment for looked after children compared to their age equivalent peers (Jackson & Cameron, 2011).

Many young people in care are also at risk of exploitation and engagement in criminal activity. Worryingly, young people in care often make up a large proportion of those in youth and adult forensic services and homeless communities, due to a lack of secure relationships and appropriate support throughout their childhood (Brannstrom et al., 2017). This partly contributes to the predominantly negative characterisation of looked after children, which in turn impacts upon the young person's emotional wellbeing and can compromise the effectiveness of future intervention (Patricio et al., 2019). Research conducted into the social perception of residential care showed children residing in these services were frequently assigned negative attributes regarding their assumed behavioural, social, and emotional presentations (Calheiros et al., 2015). These social perceptions are frequently informed by the young person's educational attainment and their family's socioeconomic status, whereby lower attainment and status increased negative perception (Patricio et al., 2019). This further aligns with previous conclusions arrived at by the American Psychological

Association (2003), wherein the strengths and competencies of those considered to have lower socioeconomic status are frequently overlooked. It is therefore important that once a young person moves into a residential care setting they receive the correct care and support, that seeks to maximise their strengths and positive attributes, to reduce the effects of their early traumas on future wellbeing. In order to achieve this, residential care homes must utilise appropriate methods of assessment as this process not only aids in decision-making about the young person's care (Salvia & Ysseldyke, 1995), but also helps to ensure interventions are appropriate and effective.

There are several different models of assessment, each with different assumptions regarding gathering data and utilising information to inform intervention (Epstein, 1999). For young people with social and emotional difficulties many of these assessment methods are focused on deficits and problems, highlighting what is 'wrong' with the child's functioning, such as the Child Behaviour Checklist (Achenbach, 1999), as opposed to focusing on their strengths and attributes, or adverse experiences. With this population already facing negative social perception (Calheiros et al., 2015) further focus on areas of deficit could result in the young person being stereotyped in a way that impacts upon professionals' general view of their ability to achieve, and thereby the support offered. Research has shown that certain stereotypes cause people to behave and respond in stereotype-consistent ways (Chen & Bargh, 1997). This stereotyped response can cause the individual to conform to the behaviours of the original stereotype, thus causing a cycle of behaviour that matches other people's expectations (Jussim, 1986). If professionals predominantly assess and focus on young people's deficit areas, it is possible that they will begin to view the individual as predominantly having deficits, and to provide support accordingly. Using the cycle described by Jussim (1986), the young person will likely then begin to conform to their stereotype, thus increasing problematic behaviours. This process is known as a self-fulfilling prophecy (Rosenthal & Jacobsen, 1968). If, however, the young person's strengths were the focus of assessment it is possible that the cycle would increase the likelihood of them viewing themselves more positively and beginning to adjust their behaviours in line with their strengths.

Strengths-based practice offers a holistic and multidisciplinary approach that focuses on the collaborative exploration of an individual's strengths and abilities and how they can be used to aid them in times of adversity (Department of Health and Social Care, 2019). This collaborative process allows potential risks to be explored and managed in a way that maximises benefits and reduces potential negative consequences for the individual. This approach holds the individual at its core and allows them to take control of their situation and to be leaders in their own lives, which increases motivation and engagement with services and interventions (Kemp et al., 2014). It further seeks to empower the individual, rather than labelling them with faults (Saint-Jacques, Turcotte & Pouliot, 2009).

An assumption of strengths-based practice is that all individuals have unused resources that can help them in times of adversity (Saleebey, 1992). Peterson and Seligman (2004) created the Values-in-Action (VIA) classification which identified 24 character strengths and six universal virtues. They state that all individuals possess between three and seven of these character strengths, which are known as their signature strengths (Peterson & Seligman, 2004), with later research showing that use of the signature strengths in innovative interventions increased happiness levels for six months and beyond compared to the placebo control (Seligman et al., 2005). It is believed that strengths are malleable and therefore can be successfully used in strengths-based interventions that target areas of wellbeing (Peterson & Seligman, 2004).

Strengths-based interventions are informed by a strengths-based assessment, which seeks to gather information about the individual's skills and abilities, through means of discussion and observation. The aim is to highlight these untapped resources and use them to aid the young person's progression. The assessment process supports clinicians to recognise that even those children presenting with the most challenging behaviours have strengths that can be built on when implementing interventions (Epstein, 1999).

Whilst the approach has gained traction in the field of family and social care over recent years, there appear to be significant gaps in knowledge with respect to the correct application of the approach (Kemp et al., 2014). This is thought to be

due to existing literature not providing robust information about the means of assessing and alleviating risk or the appropriate application of strengths-based interventions (Staudt, Howard & Drake, 2001). As mentioned, many of the existing assessment tools used for looked after children focus on deficits and labelling the individual's problem areas (Mason, Chmelka & Thompson, 2012). There are also some assessment tools that seek to identify both deficits and strengths, such as the Strength and Difficulties Questionnaire (Goodman, 1997). The purpose of this systematic review is to review the existing measures used to assess children in a looked after setting. Specifically, the review seeks to analyse strengths-based measures that are currently available for this population by looking at the measures in terms of psychometric properties, usability, age range, areas of focus, and costs. The paper aims to highlight which strengths-based measures are available and appropriate for use with the population of looked after children.

Method

Search strategy

Prior to conducting the systematic literature review, an initial search of existing literature on strengths-based measures was conducted using Google Scholar. The purpose of this initial search was to source any existing reviews of the current literature, as well as to determine appropriate search terms. Based on previous reviews and the aims of the current paper, the search terms shown in Table 1 were used to conduct this review. The literature search was conducted using EBSCOhost, which allowed for a simultaneous search through the following databases: APA PsychInfo, APA PsychArticles, APA PsychNet, Medline, Child Development and Adolescent Studies, and Psychology and Behavioural Sciences collection. A total of 959 articles were found, with a further seven being sourced through Google Scholar. After the removal of non-English, secondary and duplicate sources, a total of 966 articles remained.

	‘Measuring' or 'measurement' or 'assessment' or 'assessing'
AND	‘Children' or 'child' or 'young people' or 'youth'
AND	‘residential care’ or 'out of home services'

Table 1 Search terms used in systematic review

Figure 1 shows the process through which studies were selected for the review. With the remaining 966 outputs, titles and abstracts were scanned using the inclusion and exclusion criteria (Table 2) to ascertain their relevance to the review. A total of 925 records were excluded due to irrelevance to the topic and failing to meet the inclusion criteria. A total of 41 outputs remained, of which the full text was screened and further assessed against the eligibility criteria. Following this full text screening, a further 23 outputs were excluded for not meeting the inclusion criteria of the review. Eighteen outputs remained and were included in the literature review. The reference sections of these 18 outputs were further scanned with respect to the inclusion criteria, however there were no additional articles deemed suitable. A total of 18 outputs detailing 12 assessment tools met the inclusion and exclusion criteria and will be used in this review. Details of these 18 outputs can be found in Table 3.

Inclusion Criteria	Exclusion Criteria
Written in English	Outcome measure designed solely for educational settings
Measure of children and young people	Measures used only in adult populations
Outcome measure can be used at least two time points to measure progress	Doesn't refer to a tool, scale, or measure of young people
Used for a wide range of children, not a specific disorder	
Article refers to most recent version of outcome measure	

Table 2 Inclusion/exclusion criteria

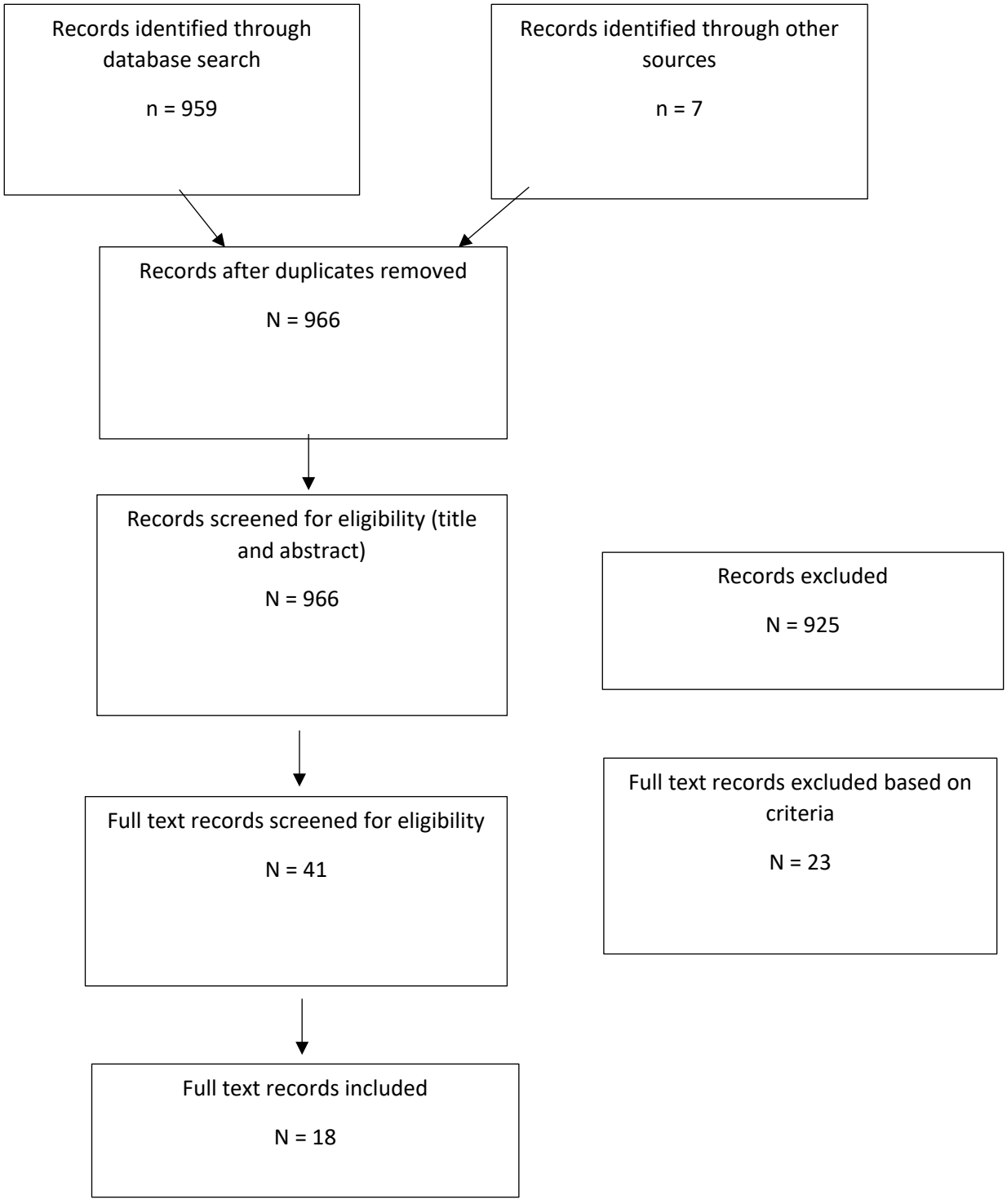


Figure 1 PRISMA Diagram of study flow

Characteristics of included outputs

The 18 outputs were published between 1996 and 2019. The papers detailed a total of 12 outcome measures. The 18 outputs covered the following outcome measures:

- Behavioural and Emotional Ratings Scale -2 (BERS-2)
- Residential Care Youth Needs Assessment Questionnaire (RCYNA)
- Strengths and Difficulties Questionnaire (SDQ)
- Achenbach System of Empirically Based Assessment (ASEBA)
- Child and Adolescent Needs and Strengths Assessment (CANS)
- Brief Assessment Checklist (BAC-C/BAC-A)
- Devereux Scales of Mental Disorders (DSMD)
- Child and Adolescent Functional Assessment Scale (CAFAS)
- Ohio Youth Problems, Functioning, and Satisfaction Scales
- Child and Adolescent Behaviour Assessment (CABA)
- Health of the National Outcomes Scale for Children and Adolescents (HoNOSCA)
- Assessment Checklist for Adolescents/Children (ACA/ACC)

Details of the papers and assessment tools referenced are shown in Table 4. The outputs were scanned to elicit further details about the assessment tools. Specifically, the search sought to identify which of the measures were strengths-based tools, also considering psychometric properties, usability, age range, areas of focus, and costs of use.

Author	Title	Measure
Ballesteros-Urpi et al. (2018)	Validation of the Spanish and Catalan versions of the health of the nation outcomes scale for children and adolescents (HoNOSCA).	Health of the National Outcomes Scale for Children and Adolescents (HoNOSCA)
Buckley & Epstein (2004)	The behavioural and emotional ratings scale-2 (BERS-2): Providing a comprehensive approach to strength-based assessment.	The Behavioural and Emotional Ratings Scale -2 (BERS-2)
Calheiros et al. (2011)	Assessment of needs of youth in residential care: Development and validation of an instrument.	Residential Care Youth Needs Assessment Questionnaire (RCYNA)
Calheiros & Patricio (2012)	Assessment of needs in residential care: Perspectives of youth and professionals.	Residential Care Youth Needs Assessment Questionnaire (RCYNA)
Chng et al. (2019)	Examining the relationship between the needs of children and young persons living in residential care and critical incidents using the Singapore CANS assessment tool.	Child and Adolescent Needs and Strengths Assessment (CANS)

Gimple & Nagle (1999)	Psychometric properties of the Devereux scales of mental disorders.	Devereux Scales of Mental Disorders (DSMD)
Hodges & Wong (1996)	Psychometric characteristics of a multidimensional measure to assess impairment: The child and adolescent functional assessment scale.	Child and Adolescent Functional Assessment Scale (CAFAS)
Hurley et al. (2015)	Convergent validity of the strength based behavioural emotional rating scale with youth in a residential setting.	The Behavioural and Emotional Ratings Scale -2 (BERS-2)
Janssens & Deboutte (2009)	Psychopathology among children and adolescents in child welfare: A comparison across different types of placements in Flanders, Belgium.	Achenbach System of Empirically Based Assessment (ASEBA) Strengths and Difficulties Questionnaire (SDQ)
Liu et al. (2014)	Profiles of needs of children in out-of-home care in Singapore: School performance, behavioural and emotional needs as well as risk behaviours.	Child and Adolescent Needs and Strengths Assessment (CANS)
Mason et al. (2012)	Responsiveness of the strengths and difficulties questionnaire in a	Strengths and Difficulties Questionnaire (SDQ)

	sample of high risk youth in residential treatment.	
Morn et al. (2017)	Reliability and validity of the child and adolescent behaviour assessment (CABA): A brief structured scale.	Child and Adolescent Behaviour Assessment (CABA)
Ogles et al. (2001)	The Ohio scales: Practical Outcome Assessment.	Ohio Youth Problems, Functioning, and Satisfaction Scales
Reynolds & Kamphaus (2004)	Behaviour assessment system for children: Assessment for Effective Intervention.	The Behavioural and Emotional Ratings Scale -2 (BERS-2)
Rodrigues et al. (2019)	Psychological adjustment of adolescents in residential care: Comparative analysis of youth self-report/strengths and difficulties questionnaire.	Strengths and Difficulties Questionnaire (SDQ) Achenbach System of Empirically Based Assessment (ASEBA)
Tarren-Sweeney (2013a)	The assessment checklist for adolescents-ACA: A scale for measuring the mental health of young people in foster, kinship, residential and adoptive care.	Assessment Checklist for Adolescents/Children (ACA/ACC)

Tarren-Sweeney (2013b)	The brief assessment checklist (BAC-C, BAC-A): Mental health screening measures for school aged children and adolescents in foster, kinship, residential and adoptive care.	Brief Assessment Checklist (BAC-C / BAC-A)
Smith & Reddy (2002)	The concurrent validity of the Devereux scales of mental disorders.	Achenbach System of Empirically Based Assessment (ASEBA)

Table 3 Details of review outputs

Results

The articles were scanned to assess usability and the psychometric properties of the 12 outcome measures. Table 4 details the designated age, area of focus, number of items, who completed the measure, and the cost of the measures.

	Age range / years	Areas of focus	Number of items	Completed by:	Cost
Achenbach System of Empirically Based Assessment (ASEBA)	CBCL 6-18 YSR 11-18 TRF 6 - 18	Syndrome and DSM orientated scales	CBCL 113 YSR 112 TRF 113	Caregiver, teacher, youth	Yes
Assessment Checklist for Adolescents/Children (ACA)	ACC: 5-11 ACA: 12-17	Emotional states, behaviours, traits, manners of relating to others (7 clinical	105	Caregivers	Free to registered users

		scales, 2 self-esteem scales)			
Brief Assessment Checklist (BAC-C / BAC-A)	BAC-C: 4-11 BAC-A: 12-17	Interpersonal difficulties, attachment difficulties, insecure relating, social, behavioural and emotional dysregulation, trauma related anxiety and dissociation, abnormal responses to pain, overeating and related food maintenance behaviours, sexual behaviour problems, self-injury, and suicidal behaviours and discourse	20	Caregivers	Freely downloadable
Behavioural and Emotional Ratings Scale -2 (BERS-2)	11-18	Interpersonal strengths, functioning at school, affective strength, intrapersonal strength, family involvement, and career strength	58 carer, 58 young person, 52 teacher	Self-report, parent, teacher	Costs involved
Child and Adolescent Behaviour	5-18	Externalising, internalising, and risk behaviours	32	Self-report, caregivers	Costs involved

Assessment (CABA)					
Child and Adolescent Functional Assessment Scale (CAFAS)	5-18	Thinking problems, self-harm, substance use, home, school, behaviours towards others, mood, emotions, community. Caregiver material needs and social support		Self-report, caregivers	yearly fixed rate and nominal fee for each assessment
Child and Adolescent Needs and Strengths Assessment (CANS)	6-20	Core domains: 1. Life Domain Functioning 2. Youth Strengths 3. Acculturation 4. Caregiver Strengths & Needs 5. Youth Behavioural/Emotional Needs 6. Youth Risk Behaviours Additional domains available	50 core items, personalised packages available	Caregivers	Cost involved
Devereux Scales of Mental Disorders (DSMD)	5-18	Conduct, attention, delinquency, anxiety, depression, autism, acute problems, externalising composite, internalising	111	Caregivers and teachers	Free download

		composite, critical pathology composite			
Health of the National Outcomes Scale for Children and Adolescents (HoNOSCA)	5-18	Behaviour, impairments, social, symptoms	15	Self-report (13+), caregivers	Free download
Ohio Youth Problems, Functioning, and Satisfaction Scales	5-18	Functioning, hopefulness, satisfaction, problem severity (restrictiveness of living completed by AW)	48	Self-report, caregivers, agency workers	Free
Residential Care Youth Needs Assessment Questionnaire (RCYNA)		Living situation, social and family relationships, physical and psychological health, behaviour and skills, education and employment behaviours	168	Caregivers	Cost?
Strengths and Difficulties Questionnaire (SDQ)	2-17	Psychological attributes (emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, prosocial behaviours), impact supplement, follow up	25	Self-report, caregiver, teachers	Online version involves cost, manual is free

		questions after intervention			

Table 4 Characteristics of outcome measures

On looking further into these 12 outcome assessments, it became apparent that a number of them were deficit-focused. Of the 12 measures, only four were identified as being strengths-based or as including a strengths-based addendum. The psychometric properties of these four outcome assessments are shown in table 5.

	Population norms	Internal consistency	Inter-rater reliability	Test-retest reliability
Assessment Checklist for Adolescents (ACA)	Age and gender specific norms	Clinical scales .76 to .90 Self-esteem scales .76 to .90	Not reported	Not reported
Behavioural and Emotional Ratings Scale -2 (BERS-2)	Representative of children nationwide	TRS: .84 to .92 PRS: .79 to .88 YSR: .95 to .97	TRS: not reported PRS .50 to .63 YSR: .50 to .63	Short-term .84 to .98 Long-term .53 to .79
Child and Adolescent Needs and Strengths Assessment (CANS)	US and Singapore children	Not reported	.85 to .99	Not reported
Strengths and Difficulties Questionnaire (SDQ)	British normative sample, Dutch normative sample	PRS: .70 YSR: .64	Parent youth agreement is favourable	.70+

			for most scales	

Table 5 Psychometrics of strengths-based measures

Discussion

This review focuses on those strengths-based measures that are routinely used within the looked after children population. The results of the review initially showed 12 assessment tools that are often used within this population, however upon further exploration many of them were in fact deficit-based. As a result, the current review was successful in identifying only four outcome assessment tools that are strengths-based or have a strengths-based addendum. With research highlighting the importance of strengths-based practice and its ability to motivate young people to achieve their goals (Kemp et al., 2014), it is a surprise that there are currently so few measures available that seek to highlight potential areas of strength of young people in residential services. The measures that have been highlighted as strengths-based have some advantages, but also some limitations. Some of these strengths and limitations are discussed below.

With regard to the extent to which the four measures assess strengths, some of the tools are fully strengths-based, whilst others contain strengths-based questions along with deficit-focused areas. For example, the Strengths and Difficulty Questionnaire (SDQ) measures both a young person's area of strengths and of deficit (Janssens & Deboutte, 2009). Specifically, only five of the 25 questions relate to strengths (prosocial behaviours). Whilst this measure is often widely used within the target population, and is psychometrically sound, it places greater emphasis on young people's deficit areas, which can often result in areas of strength being relatively overlooked when assessing need and planning interventions.

Similarly, the Assessment Checklist for Adolescents (ACA) is predominantly deficit-based, however upon request the suppliers can provide a 30-item supplementary strengths checklist for the adolescent version of the measure (Tarren-Sweeney, 2013). This supplementary checklist however is not widely cited within the literature, suggesting it is a tool that is not frequently used

alongside the ACA. In addition, whilst the psychometric properties of the ACA are well-established in the literature, the strengths-based supplementary checklist has not yet been assessed for its reliability or validity. This highlights a potential area for future research to focus on, to contribute to the growing knowledge of strengths-based measures.

The Child and Adolescent Needs and Strengths assessment (CANS) looks at the young person holistically, assessing their strengths and areas of need in a balanced ratio. Research has suggested that this approach increases placement stability as it encourages collaborative working across services and increases resources in areas of need (Conradi et al., 2011). However, the measure is only completed by the caregivers, thereby depleting the opportunities to hear the young person's voice. Allowing young people to have a say in their care empowers them to feel in control of their own lives. This increases motivation and engagement with services (Kemp et al., 2014). The lack of opportunity for young people's voices to be heard is also a limitation with the ACA, which is also solely completed by caregivers. In contrast to the above three measures, the BERS-2 is specifically strengths-based, with all domains and questions seeking to highlight the individual's areas of strength to inform intervention.

Considering the usability of the tools, some of the measures would be more suited to routine assessment than others. For example, the SQD consists of only 25 questions, making it a short measure that can be completed quickly and allows the carer to become familiar with the questions. In contrast, the ACA is a 105-item measure that requires more time to complete. At present, many services seek to be able to track and monitor progress over a period of time, and larger item measures may not be able to achieve this as efficiently (Wolpert et al., 2012). It is therefore possible that the ACA may be more suited to more in-depth assessments rather than repeated reviews. However, the strengths-based supplementary checklist consists of 30 items, which increases its ease of use in routine practice.

At first glance, the above results would appear to conclude that the BERS-2 would be the most appropriate measure, as it is psychometrically sound, fully strengths-based, and captures the views of the young person along with those of

their carers. However, the BERS-2 is not specifically designed to be used with children in a residential care setting, and some of the questions, for example relating to family involvement, may be inappropriate for the target population. Items such as 'I get along well with my family' (Epstein, 2004) may be distressing to ask of young people who are estranged from their family or who are facing difficulty understanding why they cannot live with their families. The BERS-2 is perhaps more suited for use with students within an education provision.

It is important that the tools used to assess looked after children are sensitive to the adversity and trauma they have experienced prior to moving into care. Of the measures highlighted, the ACA is the only measure originating from the looked after children population (Denton et al., 2017). The measure is also an age-specific assessment tool that allows for appropriate understanding of behaviours from a trauma-informed perspective. The measure is also sensitive to the difficulties young people have faced and understands how these difficulties may present in terms of behaviours observable by caregivers.

In conclusion, it is apparent from this literature review that there are few strengths-based measures suitable for routine use within the looked after children population. Of the measures that were identified, the ACA, along with the strengths-based supplementary checklist, appears to be most appropriate for use due to the core measure being psychometrically sound and rooted in the looked after children population. Unfortunately, the strengths-based addendum to this measure is not frequently cited and is yet to be psychometrically researched. Further research is needed to assess the psychometric properties of the strengths-based supplementary checklist and to understand if this can be used as a standalone measure, or only in conjunction with the ACC/ACA.

It is important to note that there could be additional measures detailed in papers outside of this review that did not fit within the inclusion/exclusion criteria employed. However, it is clear from the current review that there no entirely strengths-based measures have been developed for use within looked after children's services. Whilst this review has highlighted some potential measures that could be used within residential care settings, it has also identified an

outstanding need for a solely strengths-based measure that is rooted within child residential care settings.

References

Achenbach, T. M. (1999). The Child Behaviour Checklist and related instruments. In M. E. Maruish (Ed.). *The use of psychological testing for treatment planning and outcomes assessment* (pp. 429–466). Lawrence Erlbaum Associates Publishers.

American Psychological Association. (2003). Resolution on poverty and socioeconomic status. *Roeper Review, 25*, 103-105.

Ballesteros-Urpí, A., Pardo-Hernández, H., Ferrero-Gregori, A., Torralbas-Ortega, J., Puntí-Vidal, J., Tàpies Olivet, P., Izaguirre Eguren, J., Vergés Balasch, P., Lara Lloveras, A., Bertomeu, S., Peramiquel, M., Herreros, V., Vidal, À, Font, E., Romero, S., Garcia, M., Lázaro, L., & Morer, À. (2018). Validation of the Spanish and Catalan versions of the Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA). *Psychiatry Research, 261*, 554-559.

Bargh, J. A., Schwader, K. L., Hailey, S. E., Dyer, R. L., & Boothby, E. J. (2012). Automaticity in social-cognitive processes. *Trends in Cognitive Sciences, 16*(12), 593-605.

Bazalgette, L., Rahilly, T. and Trevelyan, G. (2015) Achieving emotional wellbeing for looked after children: A whole system approach. London: NSPCC.

Brännström, L., Vinnerljung, B., Forsman, H., & Almquist, Y. B. (2017). Children placed in out-of-home care as midlife adults: Are they still disadvantaged or have they caught up with their peers*? Child Maltreatment, 22*(3), 205–214.

Buckley, J., & Epstein, M. (2004). The Behavioural and Emotional Rating Scale-2 (BERS-2): Providing a comprehensive approach to strength-based assessment. *The California School Psychologist, 9*(1), 21-27.

Calheiros, M. M., Lopes, D., & Patrício, J. N. (2011). Assessment of the needs of youth in residential care: Development and validation of an instrument. *Children and Youth Services Review, 33*(10), 1930-1938.

Calheiros, M., & Patrício, J. (2014). Assessment of needs in residential care: Perspectives of youth and professionals. *Journal of Child and Family Studies, 23*(3), 461-474.

Calheiros, M. M., Garrido, M. V., Lopes, D., & Patrício, J. N. (2015). Social images of residential care: How children, youth and residential care institutions are portrayed? *Children and Youth Services Review*, *55*, 159-169.

Chen, M., & Bargh, J. A. (1997). Nonconscious behavioral confirmation processes: The self-fulfilling consequences of automatic stereotype activation. *Journal of Experimental Social Psychology*, *33*(5), 541-560.

Chng, G. S., Yip, W. F., Pek, L., Ting, M. H., & Chu, C. M. (2019). Examining the relationship between the needs of children and young persons living in residential care and critical incidents using the Singapore CANS assessment tool. *Developmental Child Welfare, 1*(3), 217-232.

Epstein, M. H. (1999). The Development and validation of a scale to assess the emotional and behavioural strengths of children and adolescents. *Remedial and Special Education, 20*(5), 258-262.

Gimpel, G. A., & Nagel, R. J. (1999). Psychometric properties of the Devereux scales of mental disorders. *Journal of Psychoeducational Assessment, 17*, 127-144.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry, 38*, 581-586.

Hodges, K., & Wong, M. M. (1996). Psychometric characteristics of a multidimensional measure to assess impairment: The Child and Adolescent Functional Assessment Scale. *Journal of Child and Family Studies, 5*(4), 445-467.

Hurley, K. D., Lambert, M. C., Epstein, M. H., & Stevens, M. (2015) Convergent validity of the strength-based behavioural and emotional rating scales with youth in a residential setting. *Journal of Behavioural Health Services and Research, 42*(3), 346-354.

Jackson, S., & Cameron, C. (2011). Young people from a public care background: Pathways to further and higher education in five European countries. *International Journal of Multidisciplinary Perspectives on Higher Education, 4*(1), 143-145.

Janssens, A., & Deboutte, D. (2009). Psychopathology among children and adolescents in child welfare: A comparison across different types of placement in Flanders, Belgium. *Journal of Epidemiology Community Health, 64*, 353 – 359.

Jussim, L. (1986). Self-fulfilling prophecies: A theoretical and integrative review. *Psychological Review, 93*, 429–445.

Kemp, S. P., Marcenko, M. O., Lyons, S. J., & Kruzich, J. M. (2014). Strength-based practice and parental engagement in child welfare services: An empirical examination. *Children and Youth Services Review, 47,* 27-35.

Leslie, L. K., James, S., Monn, A., Kauten, M. C., Zhang, J., & Aarons, G. (2010). Health-risk behaviours in young adolescents in the child welfare system. *Journal of Adolescent Health, 47*(1), 26-34.

Liu, D., Tan, M. Y. L., Lim, A. Y., Chu, C. M., Tan, L. J., & Quah, S. H. (2014). Profiles of needs of children in out-of-home care in Singapore: School performance, behavioural and emotional needs as well as risk behaviours. *Children and Youth Services Review, 44,* 225-232.

Mason, W., Chmelka, M., & Thompson, R. (2012). Responsiveness of the Strengths and Difficulties Questionnaire (SDQ) in a sample of high-risk youth in residential treatment. *Child and Youth Care Forum, 41*(5), 479-492.

Morin, A. L., Miller, S. J., Smith, J. R., & Johnson, K. E. (2017). Reliability and validity of the child and adolescent behaviour assessment (CABA): A brief structured scale. *Child Psychiatry & Human Development, 48*, 200-123.

Ofsted. (2020). Main findings: Children's social care in England 2020. Ofsted https://www.gov.uk/government/publications/childrens-social-care- data-in-england-2020/main-findings-childrens-social-care-in- england-2020

Ogles, B., Melendez, G., Davis, D., & Lunnen, K. (2001). The Ohio Scales: Practical outcome assessment. *Journal of Child and Family Studies, 10*(2), 199-212.

Patrício, J. N., Lopes, D., Garrido, M. V., & Calheiros, M. M. (2019). The social image of families of children and youth in residential care: A characterization and comparison with mainstream families with different socioeconomic status. *Journal of Family Issues, 40*(15), 2146-2178.

Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and Virtues: A handbook and classification.* New York, NY: Oxford University Press.

Reynolds, C. R., & Kamphaus, R. W. (2004). *Behaviour assessment system for children* (2nd ed.). Circle Pines, MN: American Guidance Service.

Rodrigues, S., Barbosa-Ducharne, M., Del Valle, J., & Campos, J. (2019). Psychological adjustment of adolescents in residential care: Comparative analysis of youth self-report/strengths and difficulties questionnaire. *Child and Adolescent Social Work Journal, 36*(3), 247-258.

Rosanbalm, K. D., Snyder, E. H., Lawrence, C. N., Coleman, K., Frey, J. J., van den Ende, J. B., & Dodge, K. A. (2016). Child wellbeing assessment in child welfare: A review of four measures. *Children and Youth Services Review, 68*, 1-16.

Rosenthal, R., & Jacobson, L. (1968). *Pygmalion in the classroom*. New York: Holt, Rinehart & Winston.

Saint-Jacques, M., Turcotte, D., & Pouliot, E. (2009). Adopting a strengths perspective in social work practice with families in difficulty: From theory to practice. *Families in Society, 90*(4), 454-461.

Saleebay, D. (1996). The strengths perspective in social work practice: Extensions and cautions. *Social Work, 41*(3), 296-305.

Salvia, J. & Ysseldyke, J.E. (1995). Assessment (6th ed.). Boston: Houghton Mifflin.

Seligman, M. E. P., Steen, T. A., Park, N., and Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychology, 60*, 410–421.

Smith, S. R., & Reddy, L. A. (2002). The concurrent validity of the Devereux scales of mental disorders. *Journal of Psychological Assessment, 20*(2), 112-127.

Staudt, M., Howard, M., & Drake, B. (2001). The operationalization, implementation and effectiveness of the strength perspective: A review of empirical studies. *Journal of Social Service Research, 27*(3), 1-21.

Tarren-Sweeney, M. (2013a). The Assessment Checklist for Adolescents — ACA: A scale for measuring the mental health of young people in foster, kinship, residential and adoptive care. *Children and Youth Services Review, 35*(3), 384-393.

Tarren-Sweeney, M. (2013b). The Brief Assessment Checklists (BAC-C, BAC-A): Mental health screening measures for school-aged children and adolescents in foster, kinship, residential and adoptive care. *Children and Youth Services Review, 35*(5), 771-779.

About the authors

Danielle Day (Assistant Psychologist), Dr Sarah Elgie (Clinical Psychologist) and Dr Chris Robinson (Clinical Psychologist) work for a large provider of children's residential care and are in the process of reviewing the outcome measures used

to assess and monitor children's progress whilst in their care. They are passionate about improving the outcomes for children in residential homes and in particular, the use of strengths-based measures.

The origins of residential child care services in Scotland

Andrew Kendrick

Abstract

This paper describes the origins of residential care services for children and young people in Scotland. It focuses on the early history of orphanages, children's homes, industrial schools, and reformatory schools. Starting with the establishment of Heriot's Hospital for orphan children in Edinburgh in 1659, a small number of orphanages opened across the country. However, it was not until the second half of the 19th century that there was a more rapid expansion of orphanages and children's homes. In the 19th century, there were also developments to remove children and young people from prisons. Industrial schools and reformatory schools were set up to accommodate young offenders or those on the edges of crime. Care for children in these institutions was unbending, employing rigid rules and regulations. The main features of discipline were described as conformity, respect for authority through intimidation, and the widespread use of corporal punishment, as well as moral rectitude through religious teaching. While there are continuing tensions and issues in the provision of residential care, there have been clear improvements in quality and standards. The rights of children and young people are now central, and, for some children and young people, residential care can offer a positive, caring and loving environment.

Keywords

Orphanages, children's homes, reformatory schools, industrial schools, history, group care, Scotland

Corresponding author:

Andrew Kendrick, Professor Emeritus, University of Strathclyde, Glasgow, andrew.kendrick@strath.ac.uk

Introduction

When I was asked to undertake a review of the development of care services in Scotland from 1900 to the present day for the Scottish Child Abuse Inquiry, it soon became apparent that the origin of many residential services for children took place before 1900, and as such it felt important to discuss their early history (Kendrick et al., 2021). While the 18th and 19th centuries saw Scotland's distinctive approach to the boarding out of children under the Poor Law, they also saw the development of a range of residential services for children and young people.

There has been a long history of providing relief for the poor, sick and vulnerable in institutions in Scotland, going back to medieval times (Hall, 2006). These institutions had a variety of functions and a range of names: hospital, spittal, Maison Dieu, infirmary, almshouse, and bede-house (McCallum, 2014). While there is little information about children in these institutions, Cage refers to the Trinity Hospital in Edinburgh, established about 1460, for 'the sick, pilgrims, orphaned children, aged and infirm poor' (Cage, 1974, p. 176). Durkan also mentions the 'blew freris', poor children maintained in St George's Hospital in Dunkeld in the 16th century (Durkan, 1959, p. 275). Most children and young people at that time were placed alongside adults in hospitals, poorhouses, and prisons.

Triseliotis (1988) noted that the development of residential institutions for children in Scotland lagged behind their development in England, with White (1973) suggesting that there was an aversion to institutions in Scotland. While some orphanages were established in the 17th, 18th and early 19th centuries, it was not until the latter half of the 19th century that there was a rapid expansion of residential institutions for children and young people.

Building upon early examples, a range of residential services for children was established over the course of the 19th century. These included orphanages, industrial and reformatory schools, rescue homes, refuge homes and Magdalene asylums, institutions for disabled children, hospitals, and convalescent homes.

In considering residential care in the past, it is also important to recognise that broader, societal attitudes to children and the understanding of children and

childhood have changed over time (Elsley, 2017). Children were expected to conform, respect authority, and obey religious teachings. Some practices, such as corporal punishment, were acceptable in the past, and could be used routinely to enforce discipline. However, this is not to condone past abuse and cruelty as simply something of its time.

In this paper, I will focus on the development of orphanages and children's homes, and industrial schools and reformatory schools, although, as we will see, the names and roles of different institutions could overlap. Some of the residential establishments for children and young people set up in the 19th century still exist today, having transformed over the years in line with legislation and improvements in quality and standards.

Orphanages and children's homes

Orphanages had a long history in Europe, with institutions being established in different countries from the 16th century (Jacobi, 2009). In Scotland, while there were some early institutions for orphan children in the 17th and 18th centuries, it was not until the second half of the 19th century that there was a more rapid expansion of orphanages and other establishments, setting the foundations of residential child care in Scotland.

Possibly the first residential institution specifically for children in Scotland was Heriot's Hospital in Edinburgh. George Heriot was born into an established family in Edinburgh. He was a goldsmith and jeweller to the royal family, hence his nickname 'Jinglin' Geordie (Lockhart, 2009). On his death, he left a legacy in his will 'to be imployit for the mantinance relief bringing vp, and educatioune of puire fatherles bairnes friemen's sones of the Towne of Edinburgh' (Bedford, 1859, p. 262). The hospital was modelled on Christ's Hospital in London, and opened in April 1659, caring for 30 children, which rose to 43 in September of the same year (Lockhart, 2009, p. 60). The hospital continued to grow over the years, and in 1844 cared for some 180 children (Lockhart, 2009, p. 151). Heriot's Hospital in its turn became a model for other establishments in Scotland, such as the Merchant and Trades Maiden Hospitals and George Watson's Hospital in Edinburgh, and Robert Gordon's Hospital in Aberdeen.

In 1728, Andrew Gairdner, Treasurer of Trinity Hospital in Edinburgh, which he described as the Old People's Hospital, stressed the need for charity for orphans and poor children, and he made a proposal to erect an 'Orphan's Hospital' (Gairdner, 1728, p. 34). The Orphan Hospital opened in 1735, and by 1785, following the building of additional accommodation, was caring for 130 orphan children (Tod, 1785, p. 3). At the end of the 18th century, there were attempts to stop the encroachment of industrial activity around the hospital, but in 1828 the death of ten children, attributed to the unhealthy environment, led to the decision to move to a healthier spot, and in 1833, the Dean Orphan Hospital was opened.[11]

Another early orphanage opened in Dundee in the early 19th century. The Dundee Orphan Institution was set up by public subscription and supported by doctors, mill owners, ministers, merchants, and estate owners. The tragedy of the Tay Ferry disaster, in which 17 lives were lost, gave impetus to the fundraising. A property was bought on Paradise Road, which in September 1815 opened for the care of nine boys and 12 girls (Glass, 2015, p. 7). Soon this building was deemed too small and, in 1818, a larger property in Small's Wynd was purchased, continuing as the orphanage until 1870, through financial crises and the granting of a Royal Charter (Glass, 2015, p. 14). Small's Wynd itself became too small, and the Dundee Royal Orphan Institution moved to the specially built Carolina House on Broughty Ferry Road, providing a home and school for 55 children (Glass, 2015, p. 23).

The second half of the 19th century saw a major upheaval in the provision of hospitals and orphanages. The 27 endowed hospitals across Scotland, ranging in size and revenue, came under increasing scrutiny. The wealth of some of the hospitals, based on the investments of the governors, became a matter of public concern. Concerns about the quality of education in the Hospitals were also raised (Checkland, 2000, p. 68). Following several Acts of Parliament, the welfare and educational elements in the hospitals were separated (Highet, 1969; Kerr, 1962). Because of this, the endowed hospitals were taken forward in a number of different ways. Several became day schools or boarding schools.

[11] This is now Modern Two, one of the buildings of the Scottish National Gallery of Modern Art.

Others, such as the Dundee Royal Orphan Institution and the Edinburgh Orphan Hospital, continued as orphanages, and Donaldson's School continued as an establishment for deaf children.

This period also saw the founding of a number of new orphanages and children's homes. White (1973) argues that there were three main reasons for this. Under the Poor Law, children only received support from the parish up until the age of 14, and at this point many were forced onto the street. 'Quarrier's Homes (1871), Ponton House (1865) and some of the Church of Scotland Homes (c.1904) were originally set up for this purpose' (White, 1973, p. 6). Linked to this, there was an increase in philanthropic concerns about the plight of vulnerable children, exacerbated by the economic slumps of the 1880s and 1890s, which led to 'more children on the streets' (White, 1973, p. 71).

Initially, children could only be boarded out or placed in institutions with the consent of their parents. Increasingly, however, children were separated from their parents against their parents' wishes (Hill et al., 1991, p. 191). There was a progressively more interventionist approach, driven by various societies set up to prevent child cruelty. Children were removed from parents who were deemed unfit, either due to physical or mental ill health, or because of 'intemperate or profligate habits' (Skelton 1876, pp. 76-77). By the end of the 19th century, over a third of children were separated from their parents for such reasons (Levitt, 1983, p. 369).

Some of the new orphanages developed into extremely large institutions. William Quarrier began his work with street children in Glasgow in the 1860s and opened Renfrew Lane Home in 1871. Two more homes and a night refuge followed. In 1878, the Orphan Homes of Scotland opened with two cottages and a central building incorporating a school and a church. It grew to a village with some 40 cottages, a school, church, workshops and farms (Magnusson, 2006, p. 47). Aberlour Orphanage was established in 1875 when 'four mitherless bairns' were placed together in a cottage on the banks of the Lour (Divine, 2013, p. 12). It subsequently moved to a purpose-built orphanage: 'The Orphanage was entirely self-sufficient, self-contained, produced its own food. It was a world unto itself and carefully managed its contact with the wider society' (Divine, 2013, p. 13).

Other children's homes were smaller, and Abrams describes the Whinwell Children's Home in Stirling, founded by Annie Croall in 1883, as such: 'With beds for around 40 boys and girls, it was typical of the small town orphanage, well known in the community and almost totally reliant on donations for support' (Abrams, 1998, p. 81).

The third reason White gave for the expansion of orphanages at this time was the influx of Irish immigrants, especially after the famines of the 1840s and 1850s. Aspinwall described how the arrival of large numbers of poor, Irish migrants 'overwhelmed the small, insignificant ecclesiastical structures of the Catholic Church in the west of Scotland' (Aspinwall, 1982, p. 44). O'Hagan noted that, following an epidemic of cholera, a 'Catholic Orphan Institution' was opened in Glasgow in 1833 attached to St Mary's Church in Abercromby Street in the East End of Glasgow (O'Hagan, 2002, p. 111). 'Continued concern for the religious upbringing of children prompted the [St Vincent de Paul] Society to take a special interest in the work of Catholic Orphanages and reformatories' (McHugh, 1990, p. 233; see also, Aspinwall, 1986). The large Smyllum House orphanage was opened in 1864 as a successor to St Mary's, Abercromby Street.

In the 18th, 19th and early 20th centuries, care for children in orphanages and children's homes was unbending and institutional, with rules and regulations rigidly enforced. This, however, was similar to all schools, where the main features of discipline were described as conformity, respect for authority through intimidation and the widespread use of corporal punishment, and moral rectitude through religious teaching (Munn, 2000, pp. 386-387). The older boys and girls in the Orphan Hospital in Edinburgh in the 1730s had little leisure time. The boys were spinning and weaving and the girls were knitting and garment making. Starting at 6 o'clock in the morning, they alternated their work with lessons, until 8.00 o'clock at night (Richardson, 1949, p. 160).

Day-to-day life in Quarrier's Orphan Homes involved the children in 'the cleaning, scrubbing, polishing, cooking and mending regime,' which started at 5am for older children (Magnusson, 2006, p. 47). Children were marched to breakfast, to school, to church, and to bed, and 'everything was done at a set time and in a set way' (Magnusson, 2006, p. 130). Punishment could be excessive and cruel. However, those who had lived there acknowledged

camaraderie, friendship and a family feeling among the children in the cottages. Magnusson considered that Quarriers Orphan Homes, at its best, cared for children 'lovingly and positively', and, at its worst, was 'guilty of inflexibility, regimentation and, sometimes, downright cruelty' (Magnusson, 2006, p. 117).

O'Brien reported on the similar accounts of three men who had been in the institutional care of the Daughters of Charity of St Vincent de Paul in the 1920s, one of whom was in Smyllum Orphanage. Routine, discipline, and religious practice were the hallmarks of institutional life. Punishment included the cane or strap, as well as deprivations such as going to bed without supper, or other humiliations. 'Expressions of tenderness were not part of the Sisters' regular care practice, but this did not mean they were entirely absent either' (O'Brien, 2017, p. 186).

Contemporary reports, however, tended to be more positive. Tod described the introduction of a number of trades into the Edinburgh Orphan Hospital in the 1780s (for example, shoe making, tailoring, bookbinding, and hat making):

> After the hours of their education in reading, writing, arithmetic and religion, they are all pleasantly employed in useful work, suited to their ages; which by gentle activity gives strength and vigour to their little bodies, and by early exertions, brightens the rising genius of their young minds (Tod, 1785, p. 4).

In 1910, for his work for the Royal Commission on the Poor Laws and Relief of Distress, Parsons visited Smyllum Orphanage and admired the beautiful grounds and the large and well-kept dormitories and playrooms: 'The children are most carefully trained and sympathetically looked after by the Sisters… Both boys and girls are well and warmly clothed' (Parsons, 1910, p. 99).

Reformatories and industrial schools

Alongside orphanages and children's homes, another important and overlapping sector of residential care in the 19th century was that of the reformatories and industrial schools. Prisons in England and Scotland were notorious for their squalid conditions, corrupt administration, and poor quality staff (Coyle, 1991; Dobash, 1983). In the 19th century, however, many children and young people

were housed in prisons (Ralston, 2017). Conditions for them were repressive and harsh, and young people frequently became mentally ill, often being driven to suicide. They could be kept in solitary confinement or prevented from speaking to other prisoners, and were frequently punished, including being placed in irons or in dark punishment cells (Cameron, 1983, p. 103).

Over the course of the 19th century, a more reformative approach to juvenile delinquency was adopted, as it started to be viewed as a social problem, with young offenders requiring training rather than punishment (Ralston,1988). William Brebner, governor of Glasgow's Bridewell Prison, established a separate regime for juvenile offenders, and efforts were made to teach them a trade. Further, he proposed a separate institution, and in 1838 the Glasgow House of Refuge for Boys was opened (Coyle, 1991). A refuge for girls followed in 1840. However, Ralston (1988) notes that these institutions catered for both criminal and destitute children.

Parallel to these developments there were arguments that there should be a focus on children not yet involved in crime but on the edges of it. Industrial schools were considered a particularly Scottish response to this. Sheriff William Watson and Alexander Thomson of Banchory in Aberdeen, and Thomas Guthrie in Edinburgh, were highly influential in calling for proper education and industrial training (Ralston, 2017). The first industrial feeding school was opened in Aberdeen in 1841, with a school for girls following in 1843. These were quickly followed by day industrial schools in other towns and cities in Scotland. Although Sheriff Watson and Thomas Guthrie supported a non-residential principle, with children returning home at night, other industrial schools established dormitories for children, and this was accelerated by legislation in the 1860s.

Initially, there was no clear distinction between reformatory and industrial schools (Ralston, 2017). From the mid-1850s, the sector was increasingly regulated through legislation, which led to standardisation and the appointment of a national inspectorate, which, as far as it could, imposed a uniformity of approach. In 1866, the Reformatory Schools Act 1866 and the Industrial Schools Act 1866 consolidated UK legislation (Kelly, 2016). This legislation, however, created a new blurring of the role of the two types of school. Children under twelve charged with a criminal offence could now be kept out of prison through

placement in an industrial school (Ralston, 1988, p. 51). Unlike the original, voluntary, day industrial schools, by the 1870s most children were placed by magistrates, and few returned home at night (Ralston, 2017, p. 154).

The number of industrial schools rose rapidly, and by 1883 there were 34 such schools in Scotland. Parker attributed this increase to the funding base for the schools, and the fact that children could be placed on a wide range of grounds, including delinquency, vagrancy, begging, being in the company of thieves, and moral danger (Parker, 2017, pp. 1-2; see also Urquhart, 2005). Indeed, the managers of some industrial schools employed agents to procure children from the streets to ensure a supply of new pupils (Kelly, 2019, p. 136). In addition, the precursors of the Royal Scottish Society for the Prevention of Cruelty to Children (RSSPCC)[12] 'vigorously rescued neglected children who were reported to them or discovered wandering destitute on the street, making it their business to direct them promptly, via the burgh court, to institutional care in an industrial school' (Kelly, 2016, p. 73). Magdalene asylums, lock hospitals and refuges were also developed in an attempt to eradicate prostitution and the sexual exploitation of girls, and to treat those with sexually transmitted diseases (Thor, 2018, p. 349; see also Mahood, 1990). Such girls and young women tended to be considered prostitutes, and even if they were victims of child sexual assault they were still viewed as a sexual danger once their 'innocence had been violated', and 'were often sent to Magdalene institutions, rescue homes, industrial schools or children's homes' (Davidson, 2001, p. 72; see also Mahood, 1995).

In contrast to these wide-ranging issues, there were 'narrowly prescribed grounds' for placement in a reformatory school, not least that before placement in the reformatory the young person had to serve 14 days in prison (later reduced to 10 days) (Kelly, 2019, p. 111). Kelly argues that the 'Scottish distaste for child imprisonment felt by both the judiciary and "enlightened public opinion" resulted in the flourishing of industrial schools north of the border at the expense of reformatories' (Kelly, 2019, p. 130). In the 1880s there were 11

[12] Following the establishment of the Society for the Prevention of Cruelty to Children in London in 1884, branches were set up throughout Scotland. In 1889, the Glasgow and Edinburgh organisations joined to form the Scottish National Society for Prevention of Cruelty to Children. A Royal Charter was granted in 1921, to form the RSSPCC.

reformatory schools, only a third of the number of industrial schools (Parker, 2017, p. 11).

Among the Catholic community, the religious teachings of the industrial schools caused concern. Thomas Guthrie's refusal to allow Catholic religious instruction led to the establishment of the United Industrial School of Edinburgh, which admitted both Protestant and Catholic children and provided them with appropriate religious instruction (Mackie, 1988). Stack describes the depth of fear about the proselytisation of Catholic children and the political lobbying that took place to gain concessions in the reformatories and industrial schools legislation to ensure that Catholic children would be placed in Catholic institutions (Stack, 1997). Catholic reformatory and industrial schools were opened across Scotland (Aspinwall, 1982; McHugh, 1990). Aspinwall, however, identified the very poor conditions in the Catholic institutions, reflecting the poverty and social standing of the Catholic community. 'Saving children from perilous conditions and Protestant proselytism may have been laudable objectives but the infrastructure was inadequate' (Aspinwall, 2008, p. 90; see also Aspinwall, 1992).

Lloyd highlighted that despite the philanthropic basis of the founders of the reformatory and industrial schools, the regimes were harsh. There was a limited diet, an austere environment, a harsh routine of hard work, and severe discipline (Lloyd, 2000, p. 256). Urqhart gives an account of the Mars Industrial Training Ship in Dundee, which had a primary purpose of training naval recruits. The boys were expected to provide their own day-to-day care and were taught seamanship skills and trained in gun, rifle, and cutlass drill: 'The aim of the institutions was to produce hard-working, responsible and compliant adults, and it was argued that this could only be achieved through a tightly structured system of incarceration, industrial training, religious instruction, education and discipline' (Urqhart, 2005, p. 41).

Driven by changes in legislation, Ralston described how reformatory schools 'became increasingly penal institutions for hardened offenders,' so that by the 1870s they 'were subject to the criticisms made of prisons in the 1840s' (Ralston, 2017, p. 163). Meanwhile, industrial schools were increasingly acting in a reformatory role for young offenders.

By the end of the 1800s, there were some 5,500 children and young people in 43 industrial schools and reformatories in Scotland (Kelly, 2016, p. 72). These developments led to a decrease in the number of juveniles in prison over the second half of the 19th century, from 1,062 in 1856, to 618 in 1896 (Barrett, 1900, p. 47). Ralston argues that the 'experiments with industrial and reformatory schools were arguably the most innovative philanthropic developments in mid-nineteenth century Scotland' (Ralston, 1988, p. 44). Watson, writing in 1896, was a little less positive in his conclusion. He states that though they had not lived up to the claims of their 'early admirers' in terms of emptying prisons, and though 'they have not achieved such success as this, as little can they be reckoned failures' (Watson, 1896, p. 306).

Conclusion

In this paper, I have looked back at the origins of residential child care services in Scotland, some 350 years ago, and at developments through to the beginning of the 20th century. Many things have changed dramatically, while other issues echo through the years.

We no longer have the large, institutional hospitals, poorhouses, orphanages and schools of the 18th and 19th centuries. Gone, for the most part, are the rigid and harsh routines of residential care, where the individuality of children and young people was lost under unyielding rules, regulations, procedures, and schedules. Gone are the expectations that any person of supposed good character can care for vulnerable and troubled children and young people. Undoubtedly, some children and young people did benefit from their time in such residential institutions; many others experienced cruelty and serious abuse.

The intrinsic tension between care and control continues to confound residential work with children and young people, and to create barriers to their empowerment and their voices being heard. Legislation and policy, however, now recognises the rights of children and young people. Standards have embraced not only the physical environment and cleanliness, but also the quality of care and support, involvement in decision-making, and confidence in the people and organisations who provide care and support. We recognise the

central role of relationships in allowing children and young people to flourish in residential care, and the need for reflective and trauma-informed practice.

For all our advances over the centuries, we have still not managed to produce a society that provides a safe and secure environment for all children. So many children in Scotland continue to live in poverty, experience violence and abuse, and suffer from stigma and social exclusion. We still need to find effective ways to support them, and for some children and young people, residential care can offer a positive, caring and loving environment.

References

Abrams, L. (1998). *The orphan country: Children of Scotland's broken homes from 1845 to the present day*. Edinburgh: John Donald Publishers Ltd.

Aspinwall, B. (1982). The formation of the Catholic community in the West of Scotland: Some preliminary outlines. *Innes Review*, *33*(33), 44-57.

Aspinwall, B. (1986). The welfare state within the welfare state: The Saint Vincent De Paul Society in Glasgow, 1848-1920. *Studies in Church History, 23*(4), 445-459.

Aspinwall, B. (1992). Children of the dead end: The formation of the modern Arch-Diocese of Glasgow, 1815-1914. *The Innes Review 43*(2), 119-44.

Aspinwall, B. (2008) Catholic realities and pastoral strategies: Another look at the historiography of Scottish Catholicism, 1878-1920. *Innes Review, 59*(1), 77-112.

Barrett, R.M. (1900). The treatment of juvenile offenders: Together with statistics of their numbers. *Journal of the Royal Statistical Society, 63*(2), 183-271.

Bedford, F.W. (1859). *History of George Heriot's Hospital with a memoir of the founder, together with an account of the Heriot Foundation Schools, by William Steven, D.D.* (New edition revised and enlarged by F. W. Bedford). Edinburgh: Bell & Bradfute.

Cage, R. A. (1974) *The Scottish Poor Law, 1745-1845.* PhD thesis, University of Glasgow.

Cameron, J. (1983) *Prisons and punishment in Scotland from the middle ages to the present*. Edinburgh: Canongate.

Checkland, O. (2000). Education in Scotland, philanthropy and enterprise. In H. Holmes (Ed.), *Scottish life and society: A compendium of Scottish ethnology: Institutions of Scotland: Education* (pp. 65-83). East Linton: Tuckwell.

Coyle, A. (1991). *Inside: Rethinking Scotland's prisons*. Edinburgh: Scottish Child.

Davidson, R. (2001) "This pernicious delusion": Law, medicine, and child sexual abuse in early-twentieth-century Scotland. *Journal of the History of Sexuality, 10*(1), 63-77.

Divine, D. (2013). *Aberlour: Narratives of success*. Durham: Durham University.

Dobash, R. P. (1983). Labour and discipline in Scottish and English prisons: Moral correction, punishment and useful toil. *Sociology, 17*(1), 1-27.

Durkan, J. (1959). Care of the poor: Pre-reformation hospitals. *The Innes Review, 10*(2), 268–280.

Elsely, S. (2017) *Review of societal attitudes of children for the Scottish Child Abuse Inquiry.* Edinburgh: Scottish Child Abuse Inquiry. https://www.childabuseinquiry.scot/media/1275/societal-attitudes-review-susan-elsley-may-2017.pdf

Gairdner, A. (1728). *An historical account of the Old People's Hospital, commonly called, the Trinity Hospital in Edinburgh; Also, proposals how to raise a fond [sic] for the maintenance of widows and orphans, under the title of a charity-bank.* Edinburgh.

Glass, W. (2015). *200 years of Carolina House Trust formerly Dundee Royal Orphan Institution*. Dundee: Carolina House Trust.

Hall, D. (2006). 'Unto yon hospital at the tounis end': The Scottish medieval hospital. *Tayside and Fife Archaeological Journal, 12*, 89-105.

Highet, J. (1969). *A school of one's choice: A study of the fee-paying schools of Scotland*. London: Blackie & Son Limited.

Hill, M., Murray, K., & Rankin, J. (1991). The early history of Scottish child welfare. *Children & Society, 5*(2), 182-195.

Jacobi, J. (2009). Between charity and education: Orphans and orphanages in early modern times. *Paedagogica Historica: International Journal of the History of Education, 45*(1-2), 51-66.

Kelly, C. (2016). Continuity and change in the history of Scottish juvenile justice. *Law, Crime and History, 6*(1), 59-82.

Kelly, C. (2019) *Juvenile justice in Victorian Scotland*. Edinburgh: Edinburgh University Press.

Kendrick, A., Lux, E., McGregor, S. & Withington, R. (2021). Development of children's care services in Scotland: Report for the Scottish Child Abuse Inquiry. Edinburgh: Scottish Child Abuse Inquiry. https://www.childabuseinquiry.scot/research/research-reports/development-of-childrens-care-services-in-scotland/

Kerr, A. J. C. (1962). *Schools of Scotland*. Glasgow: MacLellan.

Levitt, I. (1983). Welfare and the Scottish Poor Law 1890-1948. PhD thesis, University of Edinburgh.

Lloyd, G. (2000). From ragged to residential schools: Schooling away from home for troubled and troublesome children. In H. Holmes (Ed.), *Scottish life and society: A compendium of Scottish ethnology: Institutions of Scotland: Education* (pp. 254-272). East Linton: Tuckwell.

Lockhart, B. R. W. (2009). *Jinglin' Geordie's legacy: A history of George Heriot's Hospital and School* (350th Anniversary Edition). Edinburgh: John Donald.
Mackie, P. (1988). The foundation of the United Industrial School of Edinburgh: 'A Bold Experiment'. *The Innes Review, 39*(2), 133-150.

Magnusson, A. (2006). *The Quarriers Story: A History of Quarriers.* Edinburgh: Birlinn Limited.

Mahood, L. (1990). *The Magdalenes: Prostitution in the nineteenth* century. London: Routledge.

Mahood, L. (1995) *Policing gender, class and family: Britain 1850-1940*. London: UCL Press.

McCallum, J. (2014). 'Nurseries of the poore': Hospitals and almshouses in early modern Scotland. *Journal of Social History, 48*(2), 427-449.

McHugh, M. (1990). The development of the Catholic community in the Western Province (Roman Catholic Dioceses of Glasgow, Motherwell, and Paisley) 1878-1962. PhD thesis, University of Glasgow.

Munn, P. (2000). Discipline in Scottish school. In H. Holmes (Ed.), *Scottish life and society: A compendium of Scottish ethnology: Institutions of Scotland: Education* (pp. 383-396). East Linton: Tuckwell.

O'Brien, S. (2017). *Leaving God for God: The Daughters of Charity of St Vincent de Paul in Britain, 1847-2017.* London: Darton, Longman and Todd, Ltd.

O'Hagan, F. (2002). The contribution of the Religious Orders to education in Glasgow during the period 1847 – 1918. PhD thesis, University of Glasgow.

Parker, R. (2017). Some early economic threads in the history of children's homes. *Scottish Journal of Residential Child Care, 16*(3), 1-16.

Parsons, C. T. (1910). *Report to the Royal Commission on the Poor Laws and Relief of Distress on the condition of the children who are in receipt of the various forms of Poor Law relief in certain parishes in Scotland.* London: His Majesty's Stationery Office.

Philp, R. (1998) *A keen wind blows: The story of Fettes College*. London: James & James (Publishers) Ltd.

Ralston, A. G. (1988). The development of reformatory and industrial schools in Scotland, 1832-1872. *Scottish Economic and Social History, 8*(1), 40-55.

Ralston, A. G. (2017) *Opening schools and closing prisons: Caring for destitute and delinquent children in Scotland 1812* – 1872. London: Routledge.

Richardson, J. (1949). Some notes on the history of the Dean Orphan Hospital. *The Book of the Old Edinburgh Club, 27*, 155-168.

Skelton, J. (1876). *The boarding-out of pauper children in Scotland: With an introduction on pauperism, and a note on local inspection.* Edinburgh: William Blackwood and Sons.

Stack, J. (1997). The Catholics, the Irish delinquent and the origins of reformatory schools in Nineteenth Century England and Scotland. *Recusant History, 23*(3), 372-388.

Thor, J. (2018). Magdalene establishments in nineteenth-century Edinburgh. *Ecclesiastical History Society*, January 2018. https://eccleshistsoc.wordpress.com/2018/01/03/magdalene-establishments-in-nineteenth-century-edinburgh/

Tod, T. (1785). *An account of the rise, progress, present state and intended enlargements, of the Orphan Hospital. To which is added, poetical meditations on various subjects.* Edinburgh: John Donaldson.

Triseliotis, J. (1988). Residential care from a historical perspective. In J.E. Wilkinson & G. O'Hara (Eds.), *Our children: Residential and community care* (pp. 4-21). London: National Children's Bureau (Scottish Group).

Watson, J. (1896). Reformatory and industrial schools. *Journal of the Royal Statistical Society, 59*(2), 255-317.

White, K. (1973). *Residential child care past and present: A study of different types of residential care for children in Edinburgh and Hull with a comparative historical background*. MPhil dissertation, University of Edinburgh.

About the author

Andrew Kendrick gained his PhD in Social Anthropology from the London School of Economics in 1984. In 2001, he was appointed Professor of Residential Child Care in the Scottish Institute for Residential Child Care at the University of Strathclyde. Before this, he was Senior Lecturer in Social Work at the University of Dundee. He has carried out a wide range of research on children in care, child

welfare and child protection. He has been involved in a number of government inquires and reviews on residential child care and safeguarding children in care. From 2013, he chaired the national stakeholder group on the historic abuse of children in care up until his retirement in 2019. He is now Professor Emeritus in the Centre for Excellence for Children's Care and Protection at the University of Strathclyde.

Research with residential childcare practitioners: Early reflections of managing harm in a qualitative diary study

Bethany Jay

Abstract

Qualitative audio diary methods are an effective tool to explore emotions in social research as the method helps to elucidate diverse and sequential emotional experiences. Diary methods provide opportunities for research to be conducted over time in hard-to-reach settings, with hard-to-reach groups, producing rich data on sensitive topics. However, diary methods also provide ethical challenges, especially for novice researchers. Residential childcare practitioners are an important workforce that support looked after children and young people in residential children's homes, and this article reflects on the initial ethical challenges of using an audio diary method to study their emotional experiences. By exploring the ethical processes of minimising harm in a diary study with practitioners this article informs future diary research and highlights the potential use of audio diaries in future residential childcare practice.

Keywords

Diary methods, residential childcare practitioners, group care, reflective practice, ethics, managing harm

Corresponding author:

Bethany Jay, Graduate Research Assistant, Manchester Metropolitan University, Manchester M15 6GX, b.jay@mmu.ac.uk

Introduction

Residential childcare practitioners (RCPs) are an important workforce who provide care to looked-after children and young people in residential children's homes. The therapeutic relationships RCPs have with looked-after children and young people in residential care are paramount to positive outcomes and development, impacting on the therapeutic milieu in the residential homes (Care Inquiry, 2013; Garfat and Gharabaghi, 2019; Munro, 2011; Parry et al., 2021b; Robinson et al., 2017). RCPs' relational work with a vulnerable and at times volatile population is intrinsically emotional and complex (Burbidge et al., 2020; Cameron and Das, 2019; Seti, 2008). There is a paucity of research that conceptually considers residential childcare practitioners' everyday emotional experiences; this study addresses this gap using diary methods.

Diary methods

In this study an audio diary was utilised to answer the research questions, defined as: 'audio recordings of participants' responses and reflections over a period of time.' (Crozier & Cassell, 2016, p. 399)

This was implemented by participants recording their emotional reflections about work on a weekly basis on their mobile phones. Participants were prompted by the lead researcher on a weekly basis via messenger to record their audio diaries. Qualitative audio diaries enable researchers to explore topics in rich detail and complexity, including how they evolve over time. Diaries provide opportunities for research within hard-to-reach settings, with hard-to-reach groups, and produce ethical yet raw data on sensitive topics (Cucu-Oancea, 2013; Kenten, 2010). Residential children's homes are complex, sensitive, and private settings (Berridge et al., 2012) and RCPs are a hard-to-reach, practitioner population, working long and unsociable shifts (Colton and Roberts, 2007). Although novel, this method is longitudinal and widely considered burdensome for participant and researcher (Bartlett & Milligan, 2015; Bolger et al., 2003).

Ethical challenges with diary methods

Ethics are integral to all research and require careful consideration. Implementing diary methods to explore practitioner emotion in residential childcare could be harmful as participants are asked to continually reflect and ruminate on sensitive topics around working with vulnerable, looked-after children and young people (Cucu-Oancea, 2013). Research must be honest, transparent, caring, respectful, and enact rigor and accountability (Universities UK, 2019). To ensure this research was committed to the highest ethical standards of integrity, careful planning and ethical provision was paramount (ESRC, 2015). This article reflects on this planning and provision, purposed to minimise participant and researcher harm in a diary study with RCPs. The wider implications and potential opportunities audio diaries hold for residential childcare practice are also considered.

Harm to the participant: Managing the burden of diary methods

Diary methods have been identified as having therapeutic benefits for participants and providing a space for reflective outlet (Ryan, 2006). Reflective practice is a key facet of care work, yet RCPs are often subsumed with administrative demands such as daily logs and risk assessments, like other practitioners employed in allied health and social care settings (Mack, 2022). Thus, diaries present an opportunity for practitioners to refine their reflective practice through diary research, along with the added potential for cathartic release and therapeutic outcomes (Howard, 2012). This indicates that diaries may be successful as an employee support mechanism in residential childcare, offering an alternate means of therapeutic provision for staff to deal with the emotional impact of their work. This is important as working with trauma in residential care has been found to impact staff wellbeing (Burbidge et al., 2020). Therefore, diaries could be a tool for practitioners to reflect on and comprehend the emotional impact of their work, alongside having the potential to reveal prevailing emotional themes that can be brought to staff supervision.

Despite the participatory benefits of diary methods in research, engaging participants in self-reflection which is associated with emotional intelligence and competency (Gill, 2014), they are considered burdensome, which may render participating RCPs vulnerable to harm through overwhelming data collection responsibilities. Like other longitudinal qualitative methods, diary methods collect data over a longer period and in regular intervals, in comparison to one-off qualitative interviews, therefore nurturing higher levels of participant attrition, fatigue, and data omissions (Bartlett & Milligan, 2015; Cottingham & Erickson, 2020). To reduce this burden and minimise the risk of harm, provisions were put in place to make the diary method less onerous for participants. For example, the duration of RCPs' diaries and the time intervals between each entry were carefully selected as an eight-week, weekly diary. These provisions were chosen in comparison to more frequent provisions, like twice a week entries or daily diary entries, to maintain the sequential and temporal benefits of frequent emotional recall whilst reducing the regularity of everyday diarising, providing participants with longer intervals away from data collection (Bernays et al., 2014; Herron et al., 2019).

Literature has also emphasised that qualitative diary methods should take suitable formats that reduce the potential burden to participants, and subsequent harm in research (Waddington, 2005). Consequentially, an audio diary, on a mobile application, was nominated, whereby RCPs dictated their emotional reflections from the foregoing week at work. Data collection took place during 2021-2022, during the COVID-19 pandemic. This is considered more streamlined and quicker, in comparison to written qualitative diaries, minimising risk of harm with a less burdensome diarising process (Bartlett, 2012; Brandt et al., 2007; Crozier & Cassell, 2016). Although data was collected on a personal device, it was managed confidentially, upholding code 2.3 of the SSSC's (2016) code of practice and were recorded, and stored on a GDPR compliant mobile application software, with end-to-end encryption. Once uploaded, audio recorded data was also transferred to a secure research server and subsequently destroyed following transcription. Consent from organisations was granted, but this study did not require children or young people's consent as they were not participating and were unidentifiable to the researcher as no

personal details were included. In addition, guidance was offered to participants in the form of documentation, initial meetings with the researcher, which included a run through of recording diary entries, and through established lines of communication for queries. Participants were encouraged to use autonomy regarding the emotional content and duration of the diary entries.

It has been acknowledged that using mobile application software for research poses ethical dilemmas with respect to data management and protection (Mazzetti & Blenkinsopp, 2012). However, in this study, the benefit of audio diary methods reducing the burden of written diary methods was emphasised due to the large written and administrative workload across the residential childcare sector, arising from the bureaucratic demands of continually recording care, incidents, risk, and so forth (McMillan, 2020). Therefore, within the context of conducting research with RCPs, an audio diary method was considered the best fit. RCPs were encouraged to take control of their reflections, producing authentic, multivocal and rich diary entries whilst narrowing the potential burden, using technology and carefully selected diary intervals. In doing so, participants exercised agency and autonomy in each individual diary entry, choosing the length of entry, the content, and whether negative or positive emotions were discussed. By implementing qualitative longitudinal methods in this way, both previous evidence and the occupational demands of RCPs are recognised (Janssens et al., 2018). This also suggests that if audio diaries were to be employed as an emotional support mechanism for RCPs in practice, similar formatting and provisions may need to be considered to make the programme both suitable and ethical.

Non-maleficence and right to privacy: An ethical conflict

As with alternative qualitative methods, ethical tensions around confidentiality were present, with the research adopting a protective approach. A protective approach to confidentiality, to minimise harm to participants and ensure practitioners were unidentifiable, involves extensive anonymisation of results, thereby preserving participant trust and reducing harm (Surmiak, 2016). This approach, whilst minimising harm for all, is argued to compromise data integrity

(Tilley & Woodthorpe, 2011). However, with research on RCPs' emotions, supporting vulnerable looked-after children and young people who have often experienced complex trauma, a multitude of adverse childhood experiences, and/or possible placement breakdowns in previous social care settings (Berridge et al., 2012), a protective approach to confidentiality provision is paramount. Ergo, all entries were anonymised with pseudonyms and detailed reflections diluted when participants' identifiable details were provided. Omission of data during anonymisation was chosen carefully, to assure context was not lost, whilst minimising risk of harm to participants.

If a safeguarding concern was raised whereby the researcher felt, through participants' emotional reflections, that someone was at risk of harm, or going to be, protection of the public and others took precedence and confidentiality would have to be broken (Cowburn, 2005). Therefore, in qualitative diary methods with RCPs the researcher continually manages the ethical boundaries between participant confidentiality and public protection to minimise harm, following each individual diary entry, week-by-week. Ethical research respects an individual's right to privacy (NIHR, 2020). Confidentiality breaches overturn participants' rights to privacy and create an ethical conundrum. The study is endorsing RCPs' freeform and authentic emotional expression, but with the capacity to invade participants' privacy, revealing their emotional expressions to others and producing significant moral contention. As with all research methods, this conundrum can be resolved by observing ethical principles on a spectrum or hierarchy. By measuring participants' right to privacy in relative importance to the principle of non-maleficence, breaches of confidentiality are justifiable for the majority (Aluwihare-Samaranayake, 2012; Page, 2012). It is essential to safeguard and protect looked after children and young people, ahead of maintaining participating RCPs' confidentiality in residential childcare research. Therefore, for the greater good, breaches of confidentiality are justified.

Harm to the researcher: Managing the researcher-participant relationship

Diary research with RCPs constructs knowledge with practitioners, fostering equitable relationships as participants, as opposed to the researcher, are in control of every diary entry, and therefore the data (Bartlett & Milligan, 2015, p. 70; Roberts, 2011). However, the relationship between researcher and participant required to support participants in revealing honest and complex emotional expression in diaries uncovers ethical questions. Although the researcher-participant relationship is more equitable and shared as participants are controlling data collection, there is the possibility of researcher harm (Williamson et al., 2020). Along with many other qualitative methods, transcription of diary data is cited as time-consuming and resource intensive for researchers (Williamson et al., 2015). Diary entries ranged anywhere from 5 minutes to 30 minutes and were emotive; recalling trauma, assault, and prevention of suicidal behaviour, to name a few (Coles & Mudlay, 2010; Cottingham & Erikson, 2020). Therefore, there was a significant chance of the researcher suffering from secondary traumatic stress (Kiyimba & O'Reilly, 2016; Nikischer, 2019). The potential for harm during transcription was identified and frequently discussed and planned for in doctoral supervision (Kendall & Halliday, 2014; Petillion et al., 2017). Suitable support networks for the researcher were established during the research proposal stages to create robust procedures minimising researcher harm. The researcher also approached the study 'at the hyphen' of the insider-outsider debate (Dwyer & Buckle, 2009, p. 60). This fashioned an ethical layer protecting the researcher by reducing harm through active researcher reflexivity and an understanding of their similarities to and differences from diary participants. Managing harm to the researcher through diary methods in residential childcare is like managing harm when using other qualitative methods, emphasising the need for reflexivity and support.

As diary methods have therapeutic elements, the researcher continually and sensitively established boundaries and reaffirmed roles during data collection and debrief, reminding participants of their role as a researcher, following suggestions from previous literature indicating qualitative longitudinal research can blur boundaries in the researcher-participant relationship (Day & Thatcher, 2009; Duncombe & Jessop, 2002; Kendall & Halliday, 2014; Treanor et al., 2021). Relational boundaries suggest a power imbalance, with the researcher

constructing rules for participants to follow (de Smet et al., 2020). This created another ethical dilemma as diary methods were intended to yield equal relations, yet due to ethical provision and role affirmation a power imbalance is perpetuated by the researcher (Bartlett & Milligan, 2015). Therefore, managing boundaries in the researcher-participant dyad is time-consuming and complex. To overcome pressures and burdens, previous literature has called for more in-depth reflexivity and participant-focused approaches (Attuyer et al., 2018). As diary methods facilitate participant control over data collection it is argued to be a participatory methodological approach. Additionally, in-depth reflexivity was enabled in this study through the researcher's own reflective diary. The researcher has previous work experience as an RCP in independent children's homes, and therefore the impact of their previous work experience and subsequent preconceptions were continually acknowledged. The researcher's previous work experiences also counteracted possible power imbalances, situating the researcher 'at the hyphen', with similar workplace experiences to those of participants (Dwyer & Buckle, 2009, p. 60; Thurairajah, 2019).

Conclusion

This diary study was part of a larger doctoral study exploring residential childcare practitioners' emotion management. Diary methods can reveal rich data on sensitive and important matters like practitioners' emotions in residential children's homes. Diary methods also raise ethical challenges for the researcher to manage. Like all research, minimising harm is critical to ensuring integrity (ESRC, 2015; Universities UK, 2019). This article reflected on the ethical procedures conducted to safeguard individuals and minimise harm, emphasising the importance of researcher reflexivity and appropriate management of the researcher-participant relationship by drawing on the experience of studying RCPs with qualitative research methods. Using diary methods for emotion research with RCPs has indicated an opportunity for the therapeutic use of diaries in residential childcare practice. Whether used for staff supervision or for therapeutic practice with children and young people, diaries used in practice may be most suited to an audio format for ethical and

streamlined dictated reflection. Therefore, this research informs future diary methods in social research with RCPs and future use of audio diaries as a potential support mechanism in residential childcare practice.

References

Alaszewski, A. (2006). Using diaries for social research. London, UK: Sage Publications.

Aluwihare-Samaranayake, D. (2012) Ethics in qualitative research: A view of the participants' and researchers' world from a critical standpoint. *International Journal of Qualitative Methods, 11*(2), 64-81. DOI: 10.1177/160940691201100208.

Attuyer, K., Gilroy, R., & Croucher, K. (2018). Establishing long-term research relationships with older people: Exploring care practices in longitudinal studies. *Ageing & Society, 40*(5), 1064-1083. DOI: 10.1017/S014468X18001538.

Bartlett, R. (2012). Modifying the diary interview method to research the lives of people with dementia. *Qualitative Health Research, 22*(12), 1717-1726. DOI: 10.1177/1049732312462240.

Bartlett, R., & Milligan, C. (2015) What is diary method? London: Bloomsbury Academic.

Bernays, S., Rhodes, T., & Terzic, K. J. (2014) Embodied accounts of HIV and hope: Using audio diaries with interviews. *Qualitative Health Research, 24*(5), 629-640. DOI: 10.117/1049732314528812.

Bolger, N., Davis, A., & Rafaeli, E. (2003). Diary methods: Capturing life as it is lived. *Annual Review of Psychology, 54*, 579-616. DOI: 10.1146/annurev.psych.54.101601.145030.

Brandt, J., Weiss, N., & Klemmer, S. R. (2007). Txt 4 l8r: Lowering the burden of diary studies under mobile conditions. Retrieved from: txt 4 l8r: Lowering the Burden for Diary Studies Under Mobile Conditions (stanford.edu)

Burbidge, C. E., Keenan, J., & Parry, S. (2020). "I've made that little bit of difference to this child": Therapeutic parents' experiences of trials and triumphs in therapeutic children's homes. *Journal of Workplace Behavioural Health, 35*(4), 256-278. DOI: 10.1080/15555240.2020.1821205

Cameron, J. R. & Das, R. K. (2019). Empowering residential carers of looked after young people: The impact of the emotional warmth model of professional childcare. *British Journal of Social Work, 49*, 1893-1912. DOI: 10.1093/bjsw/bcy125.

Care Inquiry. (2013). Making not breaking: Building relationships for our most vulnerable children. Retrieved from: https://thecareinquiry.wordpress.com/

Coles, J., & Mudlay, N. (2010). Staying safe: Strategies for qualitative child abuse researchers. *Child Abuse Review, 19*, 56–69. DOI: 10.1002/car.1080.

Colton, M., and Roberts, S. (2007). Factors that contribute to high turnover among residential child care staff. *Child & Family Social Work, 12*, 133-142. DOI: 10.1111/j.1365-2206.2006.00451.x

Cottingham, M. C., & Erickson, R. J. (2020). Capturing emotion with audio diaries. *Qualitative Research, 20*(5), 549-564. DOI: 10.1177/1468794119885037.

Cowburn, M. (2005). Confidentiality and public protection: Ethical dilemmas in qualitative research with adult male sex offenders. *Journal of Sexual Aggression, 11*(1), 49-63. DOI: 10.1080/13552600512331298284.

Crozier, S. E., & Cassell, C. M. (2016). Methodological considerations in the use of audio diaries in work psychology: Adding to the qualitative toolkit. *Journal of Occupational and Organizational Psychology, 89*(2), 396-419. DOI: 10.1111/joop.12132.

Cucu-Oancea, O. (2013). Using diaries – A real challenge for the social scientist. *Procedia – Social and Behavioural Sciences, 92*, 231-238. DOI: 10.1016/j.sbspro.2013.08.665

Day, M., & Thatcher, J. (2009). "I'm really embarrassed that you're going to read this …": Reflections on using diaries in qualitative research. *Qualitative Research in Psychology, 6*(4), 249-259. DOI: 10.1080/14780880802070583

de Smet, S., Rousseau, C., Stalpaert, C., & de Haene, L. (2020). "I look at you and see you looking at me": Role boundaries in a dynamic research relationship in qualitative health research with refugees. *Qualitative Health Research, 30*(7), 1083-1100. DOI: 10.1177/1049732320910411.

Duncombe, J., & Jessop, J. (2002). 'Doing rapport' and the ethics of 'faking friendship.' In M. Mauthner, M. Birch, J. Jessop, & T. Miller (Eds.), Ethics in qualitative research (pp. 107-122). London, UK: Sage Publications.

Dwyer, S. C. & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods, 8*(1), 55-63. DOI: 10.1177/160940690900800105.

ESRC. (2015) Research Ethics Framework. Retrieved from: https://esrc.ukri.org/files/funding/guidance-for-applicants/esrc-framework-for-research-ethics-2015/

Garfat, T., & Gharabaghi, K. (2019). Characteristics of a relational child and youth care approach revisited. *CYC-Online*, ISSN 1605-7406, pp. 7-45. Retrieved from: https://www.researchgate.net/publication/334974760

Gill, G. S. (2014) The nature of reflective practice and emotional intelligence in tutorial settings. *Journal of Education and Learning, 3*(1), 86-100. DOI: 10.5539/jel.v3n1p86

Herron, R., Dansereau, L., Wrathall, M., Funk, L., & Spencer, D. (2019). Using a flexible diary method rigorously and sensitively with family carers. *Qualitative Health Research, 29*(7), 1004-1015. DOI: 10.1177/10497323188116081.

Howard, N. (2012). The Ryan report (2009). A practitioner's perspective on implications for residential child care. *Irish Journal of Applied Social Studies, 12*(1), 38-48. DOI: 10.21427/d7wf0r.

Janssens, K. A. M., Bos, E. H., Rosmalen, J. G. M., Wichers, M. C., & Riese, H. (2018). A qualitative approach to guide choices for designing a diary study. *BMC Medical Research Methodology, 18*(140), 1-12. DOI: 10.1186/s12874-018-0579-6

Kendall, S., & Halliday, L. E. (2014). Undertaking ethical qualitative research in public health: Are current ethical processes sufficient? *Australian and New Zealand Journal of Public Health, 38*(4), 306-310. DOI: 10.1111/1753-6405.12250.

Kenten, C. (2010). Narrating oneself: Reflections on the use of solicited diaries with diary interviews. *Forum: Qualitative Social Research, 11*(2). DOI: 10.17169/fqs-11.2.1214.

Kiyimba, N., & O'Reilly, M. (2016). The risk of secondary traumatic stress in the qualitative transcription process: A research note. *Qualitative Research, 16*(4), 468-476. DOI: 10.1177/1468794115577013.

Mack, B. M. (2022). Addressing social workers' stress, burnout, and resiliency: A qualitative study with supervisors. *Social Work Research, 46*(1), 17-29. DOI: 10.1093/swr/svab032

Mazzetti, A., & Blenkinsopp, J. (2012). Evaluating a visual timeline methodology for appraisal and coping research. *Journal of Occupational Organisational Psychology, 85*, 649–665. DOI: 10.1111/j.2044-8325.2012.02060.x

McMillan, N. (2020). Moral distress in residential child care. *Ethics and Social Welfare, 14*(1), 52-64. DOI: 10.1080/17496535.2019.1709878

Munro, E. (2011). The Munro review of child protection: Final report – a child centred system. London, UK: Department of Education. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

National Institute for Health Research. (2020). Research ethics in social care: Methods review. Retrieved from: https://www.sscr.nihr.ac.uk/wp-content/uploads/SSCR-methods-review_MR024.pdf

Nikischer, A. (2019) Vicarious trauma inside the academe: Understanding the impact of teaching researcher and writing violence. *Higher Education, 77*, 905-916. DOI: 10.1007/s10734-018-0308-4.

Page, K. (2012). The four principles: Can they be measured, and do they predict ethical decision making? *BMC Medical Ethics, 13*(10). DOI: 10.1186/1472-6939-13-10.

Parry, S., Williams, T., & Burbidge, C. (2021b) Restorative parenting: Delivering trauma-informed residential care for looked-after children. *Child and Youth Care Forum*. DOI: 10.1007/s10566-021-09610-8.

Parry, S., Williams, T., & Oldfield, J. (2021a). Reflections from the forgotten frontline: The reality for children and staff in residential care during COVID-19. *Health and Social Care*, 1-13. DOI: 10.1111/hsc.13394.

Petillion, W., Melrose, S., Moore, S. L., & Nuttgens, S. (2017). Graduate students' experiences with research ethics in conducting health research. *Research Ethics, 13*(3-4), 139-154. DOI: 10.1177/1747016116677635.

Pritchard, K. and Whiting, R. (2012). Autopilot? A reflexive review of the piloting process in qualitative e-research. *Qualitative Research in Organizations and Management, 7*(3), 338-353.

Roberts, J. (2011). Video diaries: A tool to investigate sustainability-related learning in threshold spaces. *Environmental Education Research, 17*(5), 675–688. DOI: 10.1080/13504622.2011.572160

Robinson, F., Luyten, P., & Midgley, N. (2017). Child psychotherapy with looked after and adopted children: A UK national survey of the profession. *Journal of Child Psychotherapy, 43*(2), 258-277. DOI: 10.1080/0075417X.2017.1324506.

Ryan, E. (2006). Finding a new voice through health adversity. *Journal of Language and Social Psychology, 25*(4), 423-436. DOI: 10.1177/0261927X06292768

Seti, C. L. (2008). Causes and treatment of burnout in residential child care workers: A review of the research. *Residential Treatment for Children & Youth, 24*(3), 197-229.

Scottish Social Services Council. (2016) Codes of practice: For social service workers and employers. Retrieved from: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjW0_GCzLv2AhUFYsAKHetBCEUQFnoECBMQAQ&url=https%3A%2F%2Fw

ww.sssc.uk.com%2F_entity%2Fannotation%2F15ceb040-c1d5-980d-a948-cb7e1aa06cea&usg=AOvVaw0MbnG_2wKwWZzS7vSoiG82

Surmiak, A. (2018). Confidentiality in qualitative research involving vulnerable participants: Researchers' perspectives. *Forum: Qualitative Social Research, 19*(3), 12. DOI: 10.17169/fqs-19.3.3099

Thurairajah, K. (2019). Uncloaking the researcher: Boundaries in qualitative research. *Qualitative Sociology Review, 15*(1), 132-147. DOI: 10.18778/1733-8077.15.1.06

Tilley, L. & Woodthorpe, K. (2011). Is it the end for anonymity as we know it? A critical examination of the ethical principle of anonymity in the context of 21st century demands on the qualitative researcher. *Qualitative Research, 11*(2), 197-212.

Treanor, M. C., Patrick, R., & Wenham, A. (2021). Qualitative longitudinal research: From monochrome to technicolour. *Social Policy & Society, 20*(4), 635-651. DOI: 10.1017/S1474746421000270

Universities UK. (2019). The concordat for research integrity. Retrieved from: https://www.universitiesuk.ac.uk/sites/default/files/field/downloads/2021-08/Updated%20FINAL-the-concordat-to-support-research-integrity.pdf

Waddington, K. (2005). Using diaries to explore the characteristics of work-related gossip: Methodological considerations from exploratory multimethod research. *Journal of Occupational and Organizational Psychology, 78*(2), 221-236. DOI: 10.1348/096317905X40817

Williamson, E., Gregory, A., Abrahams, H., Aghtaie, N., Walker, S., & Hester, M. (2020). Secondary trauma: Emotional safety in sensitive research. *Journal of Academic Ethics, 18*, 55-70. DOI: 10.1007/s10805-019-09348-y.

Williamson, I., Leeming, D., Lyttle, S. & Johnson, S. (2015). Evaluating the audio-diary method in qualitative research. *Qualitative Research Journal, 15*(1), 20-34. DOI: 10.1108/QRJ-04-2014-0014.

About the author

Bethany Jay is a 2nd year post-graduate researcher and graduate research assistant in social care and social work at Manchester Metropolitan University.

Emerging Adulthood: Exploring the implications for care experienced young people and those who care for them

Kenny McGhee and Sarah Deeley

Abstract

In this paper, we aim to explore some of the notions and concepts around 'emerging adulthood'; what this might mean for Scotland's care experienced young people; and what this might mean for those who care for them. Societally, transition to adulthood is a longer, more extended process than it was a few decades ago. Young people now generally live longer with their parents who tend to help with ongoing practical and financial support, as well as providing ongoing emotional and relational support and security. Changes in access to secure well-paid employment and to affordable housing and accommodation have been cited as key influencing factors. However, despite recent changes in domestic policy and legislation, too many young people growing up in alternative care – in foster care, residential care and kinship care – continue to experience their transitions from care to adulthood to be accelerated and abrupt. We set the context by exploring some definitions and offering some reflections on the concept of emerging adulthood, and what this might mean for young people transitioning from care to adulthood and interdependence. The challenges faced by our young people, and the need for extended care has become even more amplified as the impacts of the COVID-19 pandemic have hit home - and as the fragility of supports, and the structural disadvantages that many care experienced young people face, have been laid bare.

Keywords

Emerging adulthood, leaving care, transitions, care experienced young people, ageing out of care, Scotland

Corresponding author:

Kenny McGhee, Throughcare and Aftercare Consultant, CELCIS, University of Strathclyde, Kenny.mcghee@strath.ac.uk

Emerging adulthood and emerging identity

The contextual framing for 'emerging adulthood' draws upon the work of Arnett (2000), who proposed that 'emerging adulthood is ...a new conception of development for the period from the late teens through the twenties, with a focus on ages 18-25' (p. 469). His contention was that this was a distinct period in a young person's development, influenced by societal factors, and involving an extended period of identity exploration and consolidation. The notion that emerging adulthood is neither childhood and adolescence nor full adulthood is reflected in the often fluid and contradictory familial and societal expectations, which, along with bureaucratic and structural thresholds, can govern everyday life during this stage:

> Economic and social changes in the developed West, as well as the prolongation of educational requirements in many fields of work have resulted in a significant shift in the age at which young people enter adult roles. By now a significant percentage of young people remain at home and are financially dependent on parents until the end of their 20's (Mann-Feder, 2019, p. 13).

Arnett argues that for many young people, having left some of the constraints and dependencies of childhood but not yet been subjected to the full gamut of responsibilities that come with adult life, there are multiple opportunities to explore a range of possibilities, in terms of life and work experiences which inform their developing sense of identity.

As Mann-Feder contends, this suggests that identity consolidation is something that doesn't happen until the mid to late 20's: 'The theory of emerging adulthood asserts that identity consolidation is a relatively late accomplishment and that exploration and instability dominate individual development throughout the 20's. According to Arnett, this reflects social and economic changes and therefore is not universal' (2019, p. 13). These notions of emerging adulthood, or prolonged adolescence (Erikson, 1968), are mostly located within the context of industrialised societies, with Erikson commenting that the psychosocial

moratorium granted to young people in such societies has allowed young adults a freedom to explore different roles and identities in order to find their niche (as cited by Reifman et al., 2007)

Social and economic changes have generally extended the transition from adolescence to adulthood in 'western/global North' countries: 'This extended transition to adulthood, the gap in the life span that it has created, and the need for postsecondary educational credentials and individualized life trajectories are what have given rise to emerging adulthood' (Schwartz, 2016, p. 312). These social and economic changes, over the last few decades or so, have meant that we tend to enter the employment market, get married, and start living on our own, later than previous generations. In comparison to previous generations, for example, there have been a range of inter-connected social and economic factors creating significant changes in transitions to adulthood for the general population. These external factors include the increase in school leaving age; more young people continuing into tertiary education; accumulation of student debt; delayed entry into the labour market; minimum wage and zero hours contracts; and less access to affordable housing and accommodation.

Lerner cautions against the assumption of a new universal life stage, observing that 'to qualify as a developmental stage, emerging adulthood must be both universal and essential…' (as cited by Cote, 2014, p. 13), whilst others have noted that emerging adulthood is not culturally universal, and that although it may be 'a useful synonym for the prolonged transition to independent adulthood, it does not take into account the social and economic conditions that have produced extended transitions' (Schoon & Schulenberg, as cited by Cote, 2014, p. 179).

Arnett's theory does have its critics, most notably Cote, who rather dramatically describes it as 'the dangerous myth of emerging adulthood' (Cote, 2014), going on to identify the harm these assumptions can do to some young adults if policymakers are misinformed about what is causing the transition to adulthood to be prolonged. Cotes primary criticism suggests that Arnett regards emerging adulthood is a distinct psychosocial stage, and one which doesn't give enough

credence to the broader social and economic context. He argues that this assumption leads to an ever-increasing marginalisation of those who continue to pursue the more traditional routes to adult life through early entry to the labour market. Due to a lack of personal and family resources, not all young people will be able to take advantage of available opportunities, such as further and higher education opportunities, internships, and gap years for example (Cote, 2014).

However, more recently other writers have strongly countered this by contending that emerging adulthood is '…not just a sociological transition period but a biological life-history phase' (Hochberg & Konner, 2020). They note that the prolonged dependency and frequent confusion of emerging adults in modern societies is not solely attributable to the complexity of our societies, but also to the fact that they are, intrinsically and physiologically, not yet adults. A literature review (O'Rourke et al., 2020) commissioned by the Scottish Sentencing Council concluded that the adolescent brain continues to develop into adulthood and does not reach full maturity until approximately 25-30 years of age. Findings confirm that areas of the brain governing emotion develop sooner than those which assist with cognitive abilities and self-control. This imbalance explains the increased risk-taking and emotionally driven behaviour commonly attributed to young people. So, we pause to consider:

> Are young people generally staying at home longer because of the delay in achieving a consolidated 'adult' identity, with that being a distinct psychological stage?
>
> Or, are young people staying longer simply because the accumulative impact of social and economic factors mean that achieving a sense of adulthood and consolidated identity through traditional routes is simply much less attainable for many?

Regardless of the theoretical positioning and jousting that some academics may engage in, the current changes and trends mean that young people, more generally, are staying much longer in the family home across most developed countries. That is the trend. That is the reality.

This is where we begin to turn our attention directly to care experienced young people and care leavers. Scotland has progressive and enabling policy and legislation, with the ability to 'stay put' in Continuing Care arrangements being available to eligible young people up to the age of 21, and with the potential for ongoing Aftercare support up to age 26. (Scottish Government, 2013, 2014). However, despite this, the average age for young people leaving care in Scotland is still just over 17 years (CELCIS, 2015). This is in stark contrast to the average age for the general population leaving the family home in Scotland, which is around 26 years (A Way Home Coalition, 2019). This aligns with the average age of young people leaving the family home across other European countries, which is 26.4 years (Eurostat, 2021). Across the UK people are living with their parents for longer than they used to, with living with parents now being the most common living arrangement for young adults (ONS, 2017).

Many of our care experienced young people won't, and don't, have the opportunity to positively delay or prolong transitions to adulthood by 'staying put' or 'continuing care by remaining in an alternative care family home' - certainly not until their mid to late 20's:

> While transitions are not timed in a very precise way in the lives of many young people, timing may become notably 'out of synch' for care leavers, who may often have to attempt 'accelerated and compressed transitions to adulthood' sooner and faster than their peers not in care (Gilligan, as cited by Mann-Feder & Goyette, 2019, p. 54).

We need to bear this in mind when we talk glibly about 'poorer outcomes' and 'outcomes gaps' for care experienced young people. Too often they are judged against the societal norm when they '…probably had to traverse the most arduous developmental process (and) then move on to have their outcomes measured against some normative ideal with very little accommodation of difference' (Horrocks, 2002, p. 335). This talks to the often very different trajectories, and very real unfair and unrealistic expectations, and is an issue that also vexes practitioners, who can often see what are perceived as unfair

expectations and comparisons, where our care systems often fail to take account of changing realties.

Adolescence generally is being drawn out as young people stay in school longer and have more difficulty in entering the job market and earning a stable income that would enable them to secure and sustain their own accommodation. Transition to adulthood can be a lengthy process marked by frequent reversals and contradictions that make young people both children and grown-ups at the same time. However, our systems, our policies, and our practice remains stuck, and at times unable to effectively comprehend and engage with young people in a way which appropriately recognises some of the complexities and contradictions of becoming an adult.

The complex and often-conflicting array of issues, influences, and expectations can also weigh heavily on the emotional timbre of the work, potentially affecting workers, and the engagements and relationships they are able to form with the young people in their care:

> … if that (young) person is hearing us harp on about how they should be doing more and maybe subconsciously we're pushing them out the door and we're telling them to 'be an adult, be an adult'… so maybe they're like that, 'oh, I've got to go' (McGhee, 2017, p. 11).

Arguably, this creates an uneven playing field for care leavers. Whilst the transition to adulthood for the general population has become prolonged, more complex, and personalised, our care systems have yet to meaningfully take these changes into account (Goyette, 2019). They remain aligned with overly simplistic chronological concepts and legislative triggers and thresholds, which continue to accelerate young people from care to instant - and in many cases damaging versions of – adulthood (Stein, 2012, 2019).

Care leavers are expected to make multiple, accelerated abrupt transitions when they are often least able to cope (Stein, 2012). Leaving care too early, without proper levels of support, and with all the pressures and responsibilities that come with 'instant adulthood' is traumatic and damaging. Leaving care later

matters because leaving care too young is at odds with normative, cultural, and neurobiological development (Stein, as cited by SCLC, 2017)

We've highlighted that the goal of financial and residential independence for the general population has generally become a much longer-term outcome, generally with extended practical, financial, relational, and emotional support. We have mentioned a number of factors that may influence the age at which young people enter adult roles. Consider now the impact that trauma may have on that transition, where childhood is comprised of severe and sustained adversity, or persistent disruption and unsettlement (Common Weal, 2021).

Impact of unresolved childhood trauma

Young people transitioning from care to adulthood can be an inherently disenfranchised group, with early traumatic life experiences, often unresolved, impeding the negotiation of age-appropriate developmental milestones and the consolidation of a stable and healthy identity (Yancey, as cited by Mann-Feder & Goyette, 2019).

Any toxic stress experienced in those early years – addiction, sexual, physical, emotional abuse, neglect, domestic violence, unexpected death or injury to someone they are close to – could potentially affect and damage the basic structures of a developing brain (Perry, 2006). Many of our children and young people currently in care, transitioning from care, or care experienced, have experienced neglect and/or trauma prior to their transition into care, which can have long-term, or indeed, lifelong, consequences (Robinson & Brown, 2016). Even when it is for all the right reasons, for a child or young person entering the care system is in itself traumatic: 'It occurs in the context of failed relationships with significant others, and imposes an overwhelming loss on a child, no matter at what stage it occurs. It is amongst the greatest personal tragedies that any child can face' (Mann-Feder, 2007, p. 2).

With each move and change in living circumstances that follows that first point of entry, there is the potential for additional trauma. The independent review

into Scotland's care system heard from young people 'that being taken into care and growing up in the "care system" was among the most traumatising experiences they had ever had… living with strangers and moving multiple times' (*The Promise*, 2020, p. 7). Every move affects that child or young person's sense of felt security. Tarren-Sweeney (2010, 2017) describes this reverberating impact of impermanence and within-care adversity as having a detrimental impact on young people's mental health. The importance of consistency and predictability of care are critical to healthy development into adulthood. Bolinger et al. (2021) explore the importance of placement stability, not simply measured by length of time in placement, but in terms of the consistency of relationships with well supported adults during the time spent in an individual placement, describing this as a 'felt sense of stability' (Bolinger et al., 2021, p. 12).

The importance of developing a sense of 'felt security' for young people, provided through consistency of care, in an environment which is predictable and consistent, cannot be over-stated (Skinner, 1992). Skinner recognised that for most young people parental support carries on into their twenties, even where this may be intermittent. Young people in care also need this support, arguably even more so. Yet, this is too often denied to our looked after young people because of the way care is designed and delivered. As stressed in the Care Review, overcoming trauma requires a foundation of stable, nurturing, loving relationships (*The Promise*, 2020). As far back as 1992, Skinner argued that we needed to take a much longer-term view and see beyond the bureaucratic constructs of age-related triggers and thresholds, and overly simplistic chronological timescales.

Until recently, contrary to Skinner's aspirations, leaving care was seen as an event rather than a process, with young people expected to undertake living on their own after a 'crash course' in practical skills, being pushed out in a way that has little to do with 'readiness' to assume an adult lifestyle (Mann-Feder, 2019). Supporting successful transitions from care is not just about practical skills. The importance of emotional readiness, resilience, and ongoing relational support is fundamental (Scottish Government, 2013). Deep-rooted issues around unresolved childhood trauma can also impede young people's abilities to make

use of available support and services (Burgess, 2007), not due to their explicit and implicit memories of said trauma (Robinson & Brown, 2016):

> Issues connected to loss, rejection, lack of a stable home base and breakdown of care placements, can affect the young person's ability to engage with peers and supportive adults. This can lead to social isolation and make participating in some interventions problematic (Burgess, 2007, p.44).

It begs the question as to why we remain tied to overly simplistic chronological triggers and thresholds when they are at odds with what we know about the impact of childhood trauma, about young people's development, and about notions of emerging adulthood.

Transitions to interdependence

The transition to adulthood can be a lengthy process, marked by frequent reversals and contradictions that make young people both children and grown-ups at the same time. For most it is not a linear journey, and as the pandemic has shown, the precariousness of many young adults' situations can warrant an unplanned return to the family home (Pinsker, 2020). Too often our policies talk about preparing looked after young people for 'independence and independent living'. However, most people rely on family, partners, parents, children, colleagues, friends, and neighbours for support. As Lee writes, '[a]dults can move in and out of dependency as they move through life' (2001, p. 23).

When considering the situation for young people transitioning from care, Moodley et al. (2018) contend that independent living is wholly antithetical to human nature, and we need to shift away from neoliberal ideals, that are entrenched in our own policies with expectations of independent living, to a more realistic notion of interdependent living.

We already recognise this in policy, here in Scotland, as the Staying Put Scotland Guidance states: 'The notion of independence is perhaps better expressed as "interdependence", more accurately reflecting the day-to-day reality of an

extended range of healthy inter-personal relationships, social supports and networks' (Scottish Government, 2013, p. 5). This reflects international research and academic writing, highlighting the importance of relationships and interdependence, and recognising that the term 'independence' is inappropriate in the context of young people's transitions (Moodley et al., 2018).

Social support networks are noted as fulfilling an important function for young people on their journeys to adulthood (Wade, 2008), providing 'the emotional, psychological, physical, informational, instrumental, and material assistance provided by others to either maintain well-being or promote adaptation to difficult life events' (Dunst & Trivette, as cited by Sulimani-Aidan, 2018). A crucial point is that for many young people '…their interpretation of "independent" does not exclude receiving support; rather, it is the avoidance of dependence' (Moodley et al., 2018, p. 4).

If we accept that emerging adulthood is a time to explore possible identities, enabling young people to develop a consolidated sense of self, a secure identity which brings with it psychological and emotional resilience, then the importance of extended care, and ongoing relational support for our care experienced young people, cannot be over-stated. The African phrase Ubuntu - I am because we are – encapsulates that notion. Some authors use the term 'interdependence' or 'interconnectedness' as Western synonyms for Ubuntu. Or perhaps, closer to home, the Scottish phrase of 'we're a' Jock Tamsons bairns' - with its egalitarian sentiment and belief that all people are equal, with a shared feeling of fellowship, community, or interest - reflects similar notions of our intrinsic common bonds and shared connections. The development of resilience is incumbent upon having positive, interdependent relationships, thus enabling a range of positive social, emotional, and moral experiences, which emphasise 'social connections as the crucible of personhood' (van Breda, 2018, p. 8).

Scotland's 'Promise'

In 2021, Scotland is being challenged to think differently about how we care for our young people, and particularly those looked after in alternative care settings.

The work of the Independent Care Review, culminating in *The Promise*, makes clear statements in relation to what is expected for our care experienced young people. It is clear that in its view parenting does not stop when young people reach the age of 18, and that Scotland must continue to create greater equity and opportunity for care experienced young adults (The Promise, 2020).

Actions must reflect 'the ongoing responsibility for the children for whom it has had parenting responsibility and whose family life has been disrupted by the decisions of the State' (The Promise, 2020, p. 118). In doing so, this must see young people who are currently in the care system staying in their care setting as they enter adulthood and when ready being fully and completely supported to move on (The Promise Scotland, 2021). The worthy intentions of *The Promise* in relation to young people transitioning from care to adulthood echo the already existing legislative and policy responsibilities and calls to action (Scottish Care Leavers Covenant, 2015), but this is not without its critics (McGhee & Waterhouse, 2019; Common Weal, 2021). A lack of detail in what needs to change and how, and an underestimation of the complexities involved, give rise to a more cautious appraisal of what *The Promise* may be able to deliver (Common Weal, 2021).

Our care system does not exist in a vacuum, and our ongoing responsibility must take into account the changing socio-economic and socio-demographic trends within which our care systems exist: 'Care is also political. It is impossible to separate the care we experience formally or informally from the context of the services and policies in which these take place' (Smith, 2021, p. 4). To realise the ambitions of *The Promise* our systems and processes must take account of, and incorporate, the concepts surrounding emerging adulthood. This must start by moving away from overly simplistic, bureaucratic, chronologically driven transitions and thresholds. Closing the 'outcomes gap' will only be achieved if we close the input gap – and that must include ensuring we set the care of our looked after young people in the context of emerging adulthood, thereby designing our care, services, and supports to meet care experienced young people's needs into adulthood.

Conclusion

Scotland has been at the forefront of some very informed and creative thinking around our duties, responsibilities, and obligations to our care experienced children and young people, going back many years, and now going forward with *The Promise*. However, we would contend that if Scotland wants to be truly transformational in its practice and approach, consideration must also be given to an applied understanding of emerging adulthood as both a psychological and a sociological concept. This must transcend not only social work and care services but also the full range of 'corporate parents' (Scottish Government, 2015) who have responsibilities to our care experienced young people. However, our systems, our policies, our practice remains stuck and, at times, appears unable to effectively comprehend and engage with young people in a way which appropriately recognises some of the complexities and contradictions of becoming an adult. Adaptive changes in how we think must be enabled and supported by the required technical re-alignments which address the unhelpful legislative and bureaucratic constructs which continue to inflict 'instant adulthood' on our care experienced young people. This will require consistent coordinated activity across a range of inter-connected areas at different levels, and an increasing understanding and use of active implementation approaches (Blase, 2009; Burke et al., 2012).

Service structures, supports, and responses must be focused on the evolving psychological and social developmental needs of our care experienced young people, rather than bound by unhelpful fixed, social, and bureaucratic constructs. When we intervene in children's lives, in families' lives, dramatically, by placing children into alternative care for care and protection purposes, we need to consider the long-term impacts and consequences – and our long-term obligations and commitments. Quite simply we need to change the frame – and provide our care experienced young people with predictability, consistency and continuity of care and support into adulthood, acknowledging that attaining a healthy functioning interdependent sense of adulthood is generally a much longer journey than our current systems and processes are designed for.

That change must reflect the ongoing responsibility Scotland has for the children for whom it has had parenting responsibility and whose family life has been disrupted by the decisions of the State (*The Promise*, 2020, p. 118). As Smith (2021) contends, care is not an intervention, but a continuous series of relationships involving a moral and emotional investment from workers. How that manifests itself for our care experienced young people must see a fundamental philosophical shift in how we conceptualise and discharge our responsibilities to them, to 'our' children, alongside practical changes to our systems and structures.

When we reflect on the oft trotted out corporate parenting mantra, 'would this be good enough for your child or young person?' we would argue that we can only fully realise this if we adopt an applied understanding of emerging adulthood in how we respond to, and deliver, the care that all of Scotland's young people deserve.

References

'A Way Home Scotland' Coalition. (2019). *Youth homeless prevention pathway: Improving care leavers' housing pathways* https://www.celcis.org/files/2715/7348/4299/Youth_Homelessness_Prevention_Pathway.pdf

Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist, 55* (5), 469-480. http://jeffreyarnett.com/ARNETT_Emerging_Adulthood_theory.pdf

Arnett, J. J. (2007). Afterword: Aging out of care—Toward realizing the possibilities of emerging adulthood. *New Directions for Youth Development, 113* https://onlinelibrary.wiley.com/doi/10.1002/yd.207

Blase, K. (2009) *Technical assistance to promote service and system change* https://files.eric.ed.gov/fulltext/ED577840.pdf

Bolinger, J., Mendes, P., and Flynn, C. (2021). Stability in residential care in NSW, Australia: The role of the workforce. *Scottish Journal of Residential Child Care 20*(2) (pp.1-13)

Burgess, C. (2007). *Staying afloat: Effective interventions with young people in South Ayrshire.* Stirling: Social Work Research Centre, University of Stirling.

Burke, K., Morris, K., and McGarrigle, L. (2012). *An introductory guide to implementation: Terms, concepts and frameworks.* Dublin: Centre for Effective Services.
https://www.lenus.ie/bitstream/handle/10147/306846/Guide%20to%20implementationconceptsframeworks.pdf?sequence=1&isAllowed=y

CELCIS. (2015). *Housing options and care leavers: Improving outcomes into adulthood.* Glasgow: CELCIS
https://www.celcis.org/application/files/7114/3938/6983/Inform-Housing_Options_and_Care_Leavers.pdf

Common Weal. (2021). *Empty promise? A critical analysis of the Scottish Government's strategy for children in care* (Common Weal Policy Paper)
https://commonweal.scot/wp-content/uploads/2021/08/Empty-Promise.pdf

Côté, J. (2014). The dangerous myth of emerging adulthood: An evidence-based critique of a flawed developmental theory. *Applied Developmental Science, 18*(4), 177-188
https://www.researchgate.net/publication/268447076_The_Dangerous_Myth_of_Emerging_Adulthood_An_Evidence-Based_Critique_of_a_Flawed_Developmental_Theory

Eurostat Online. (2021). *Age of young people leaving their parental household*
https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Age_of_young_people_leaving_their_parental_household

Hochberg, Z., and Konner, M. (2020). *Emerging adulthood, a pre-adult life-history stage.* Front. Endocrinol. 10:918. doi: 10.3389/fendo.2019.00918
https://www.frontiersin.org/articles/10.3389/fendo.2019.00918/full

Independent Care Review. (2020). *The Promise*
https://www.carereview.scot/wp-content/uploads/2020/03/The-Promise_v7.pdf

Mann-Feder, V. (2007) Youth aging out of care: An overview. *New directions for youth development, 113*, (pp.1-7)
https://onlinelibrary.wiley.com/doi/epdf/10.1002/yd.197

Mann-Feder, V., & Goyette, M. (Eds.) (2019). *Leaving care and the transition to adulthood*. New York: OU Press.

McGhee, J., & Waterhouse, L. (2020). *#KeepThePromise – or childcare without parents* https://sceptical.scot/2020/10/keepthepromise-or-childcare-without-parents/

McGhee, K. (2017). Staying put and continuing care: The implementation challenge. *SJRCC*, 16(2) (pp.1-19)

https://www.celcis.org/files/4215/0641/7391/2017_Vol_16_2_McGhee_K_Staying_Put_and_Continuing_Care_The_Implementation_Challenge.pdf

McGhee, K., Lerpiniere, J., Welch, V., Graham, P., & Harkin, B. (2014). *Throughcare and aftercare services in Scotland's local authorities: A national study.* CELCIS Research Report RR2014:4 http://www.celcis.org/media/resources/publications/Throughcare-and-aftercare-in-scotlands-local-authorities.pdf

Mendes, P., & Moslehuddin, B. (2006). *From dependence to interdependence* https://onlinelibrary.wiley.com/doi/pdf/10.1002/car.932

Moodley, R., Raniga, T., & Sewpaul, V. (2020). Youth transitioning out of residential care in South Africa: Toward ubuntu and interdependent living. *Emerging Adulthood, 8*(1), 45-53. doi:10.1177/2167696818812603 https://www.researchgate.net/publication/329807095_Youth_Transitioning_Out_of_Residential_Care_in_South_Africa_Toward_Ubuntu_and_Interdependent_Living

National Trauma Training Programme https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/

Office of National Statistics. (2017). *Milestones: Journeying into adulthood* https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/milestonesjourneyingintoadulthood/2019-02-18

O'Rourke, S., Whalley, H., Janes, S., MacSweeney, N., Skrenes, A., Crowson, S., MacLean, L., & Schwannauer, M. (2020). *The development of cognitive and emotional maturity in adolescents and its relevance in judicial contexts* https://www.scottishsentencingcouncil.org.uk/media/2044/20200219-ssc-cognitive-maturity-literature-review.pdf

Perry, B. D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children: The neurosequential model of therapeutics. In N. B. Webb (Ed.), *Working with traumatized youth in child welfare* (pp. 27–52). New York: The Guilford Press.

Pinsker, J. (2020). *The new boomerang kids could change American views of living at home* https://www.theatlantic.com/family/archive/2020/07/pandemic-young-adults-living-with-parents/613723/?utm_source=newsletter&utm_medium=email&utm_campaign=atlantic-daily-newsletter&utm_content=20200720&silverid-ref=NjY5MzkyMzMxNTE3S0

Reifman, A., Arnett, J., & Colwell, M. (2007). *Emerging adulthood: Theory, assessment and application* https://jyd.pitt.edu/ojs/jyd/article/viewFile/359/345

Robinson, C., & Brown, A. M. (2016). Considering sensory processing issues in trauma affected children: The physical environment in children's residential homes. *Scottish Journal of Residential Child Care 15*(1) (pp. 6-18) https://www.celcis.org/application/files/8316/2308/6835/002._2016_Vol_15_1_Robinson_Considering_Sensory_Processing.pdf

Schwartz, S. (2016) *Turning point for a turning point: Advancing emerging adulthood theory and research* https://journals.sagepub.com/doi/abs/10.1177/2167696815624640

Scotland's Commissioner for Children and Young People. (2008). *Sweet 16: The age of leaving care in Scotland.* Edinburgh: SCYPP. http://www.sccyp.org.uk/uploaded_docs/leaving%20care%20young%20persons%20for%20web%20200803.pdf

Scottish Care Leavers Covenant. (2017). *Walking the walk: Two years on*, 1st Annual Conference Report https://static1.squarespace.com/static/55c07acee4b096e07eeda6e8/t/5a831daf71c10b977a192bd5/1518542259579/SCLC+Conference+2017+report+FINAL.pdf

Scottish Government. (2013). *Staying put Scotland: Providing care leavers with connectedness and belonging*. Scottish Government Guidance http://www.scotland.gov.uk/Resource/0043/00435935.pdf

Scottish Government. (2014). *Children and Young People (Scotland) Act 2014* https://www.legislation.gov.uk/asp/2014/8/contents/enacted

Skinner, A. (1992). *Another kind of home*. Edinburgh: HMSO.

Smith, M. (2021). *What is Care?* (Common Weal Policy Paper) https://commonweal.scot/wp-content/uploads/2021/10/What-is-care.pdf

Stein, M. (2005). *Resilience and young people leaving care: Overcoming the odds*, Research Report. York: Joseph Rowntree Foundation. http://eprints.whiterose.ac.uk/73176/1/Document.pdf

Stein, M. (2012). *Young people leaving care*. London: Jessica Kingsley.

Stein, M. (2019). Supporting young people from care to adulthood: International practice. *Child & Family Social Work 24*, 400–405. https://onlinelibrary.wiley.com/doi/abs/10.1111/cfs.12473

Sulimani-Aidan, Y. (2018). Qualitative exploration of supporting figures in the lives of emerging adults who left care compared with their non care-leaving peers. *Child & Family Social Work*, Vol.24, Issue 2, (pp 247-255) https://doi.org/10.1111/cfs.12609

Tarren-Sweeney, M. (2010). It's time to re-think mental health services for children in care, and those adopted from care. *Clinical Child Psychology and Psychiatry, 15*(4), 613–626.

Tarren-Sweeney, M. (2010). Mental health services for our most vulnerable children. *Clinical Child Psychology and Psychiatry*, *22*(4), 521–523.

The Promise Scotland. (2021). *The Promise Plan 21-24* https://thepromise.scot/plan-21-24-pdf-standard.pdf

van Breda, A. D. (2018). A critical review of resilience theory and its relevance for social work. *Social Work/Maatskaplike Werk, 54*, 1–18. doi:10.15270/54-1-611 file:///C:/Users/gxb12175/Downloads/611-1779-2-PB.pdf

About the authors

Kenny McGhee is the Throughcare and Aftercare Lead based at CELCIS at the University of Strathclyde. Kenny works with local authorities, care providers and other stakeholders at local and national level to close the gap between policy and practice for young people transitioning from state care to adulthood and interdependence. Prior to joining CELCIS in 2012, Kenny worked for many years in local authority settings as a practitioner, trainer and manager of specialist services for young people.

Sarah Deeley is a Consultant with the Improving Care Experiences Hub, based at CELCIS at the University of Strathclyde. Sarah works with local authorities, care providers and other stakeholders at local and national level to support the implementation of complex change programmes and improve the experience of care experienced children, young people and those who care for them. Sarah is a qualified Social Worker with practitioner and management experience across local authority and Residential Child Care settings.

The 19th Kilbrandon Lecture (University of Strathclyde, 27 January 2022): A rights-respecting approach for children who offend: Building on Kilbrandon's vision

Claire Lightowler

Abstract

This lecture was the second to be live-streamed as a webinar during COVID-19 restrictions. Dr Lightowler argued that the experiences of children in conflict with the law demonstrates that we need urgent action of a scale not seen since the Kilbrandon Report (1964). Children in conflict with the law are exposed to significant trauma, adversity, stigma, and injustice. These issues are often exacerbated by contact with the very systems and services intended to support them. Dr Lightowler will demonstrate the transformative change that could be achieved if Scotland viewed children in conflict with the law as rights-holders and devoted greater attention to upholding their rights. The lecture was followed by commentaries by Professor Ursula Kilkelly and Ms Ruth Kerracher, and a vote of thanks by Minister for Children and Early Years in the Scottish Government, Ms Claire Haughey MSP.

Keywords

Children's rights, youth justice, Children's Hearing system, children in custody

It's an absolute honour to be delivering the 19th Kilbrandon lecture; to follow on from the inspirational lecturers that have gone before me. And we all of course build on the incredible work of Lord Kilbrandon. I'm delighted, and feel a great sense of responsibility, to have this opportunity to talk about children involved in offending. These children tend to be misunderstood, can be hidden from view, and we often fail to hear their voices, and discussions about them can be highly emotive and simplistic. I'll attempt to share what we know about children involved in offending in Scotland, bring these children into clearer view for you and to amplify their voices and experiences. It's important that you're here, wherever you are, because these children desperately need change from us all.

Last week I had a brilliant discussion with members of Youth Just Us, the steering group for the Youth Justice Voices project which seeks to amplify the voices of young people with care and justice experience. I asked them what it was most important for you to hear about and their views determined the focus of the lecture, and many of the points within it. You'll hear more from Youth Justice Voices later.

The issues I'll talk about are complex and emotive. They're close to many of you listening today and can be difficult to face, particularly as we sit in our rooms alone listening. So please do step back if it gets too much. My former colleagues at the Children and Young People's Centre for Justice (CYCJ) offer support, guidance, training and produce a range of resources which you may find useful if you want to learn more and take action following the lecture. Fiona Dyer, the Director of CYCJ, would be delighted to hear from you. Please do also reach out to me if you'd appreciate it.

So, let's start, by reflecting on the work of the Kilbrandon Committee and how this has set the foundations for where we go next.

Kilbrandon: The foundation for where we go next

For me, what was, and continues to be, ground-breaking about the work of Kilbrandon is the underpinning ethos and principles of the Children's Hearing system it recommended, which was created as a result. Kilbrandon recognised that offending behaviours by children were to be seen as an indicator of concern for the child, that the offending demonstrated a need for care, protection, and education. Kilbrandon advocated a focus on needs not deeds; arguing that like children in need of protection from others, children involved in offending should be responded to in the same way and by the same system. Both groups were in 'rouble', 'the normal upbringing processes having, for whatever reason, fallen short' (Kilbrandon Committee, 1964, para 15). Kilbrandon argued that it is not helpful to separate out, or treat any differently, children who come to our attention with the label of 'offender' from those labelled 'victim', because the needs are the same, and of course children who offend, are almost always victims too. This principle is so fundamental to our Children's Hearing System which seeks to support the child and respond to their needs based on what the needs are, regardless of the deeds.

The principles Kilbrandon articulated in 1964 continue to inform and often guide decision making by practitioners and policy makers. There can't be many examples of committee reports which are still referenced in day-to-day policy and practice 60 years later. The foundations Kilbrandon laid means there is a common approach, understanding and set of principles shared amongst professionals and volunteers across Scotland on which we can build.

Kilbrandon came before concepts of children's rights and notions of participation were understood and established but was ahead of his time in creating an approach which saw offending as indicating need and in emphasising the focus should be on the best interests of the child. However, given the strength of this legacy and the vision of Kilbrandon, how come we so often fail children who offend in Scotland?

I'm going to argue that Scotland could do better for children involved in offending. That it is within our reach to do so. We have strong foundations to build on, but we need to pay attention to these foundations, reflecting on what we are trying to achieve, what we're doing and why. We need a scale of change that we've not seen since Kilbrandon, and there is a need for strong and brave advocates to speak up and think about these children; to make the case for why they need support and resources devoted to them if we are to improve their lives and the lives of all of us. I hope to convince you to become such an advocate, if you're not already, to speak more loudly and clearly if you already are, and to give you all greater insight and understanding. In short that's the destination I'm hoping we reach this evening, and now I'm going to talk through the evidence which takes us there.

Who are the children who offend?

I've focused this lecture specifically on children, meaning those up to 18 years old, because there are specific issues associated with the legal and social status of being a child. n There is considerable complexity about the circumstances in which 16 and 17 year-olds are considered children in Scotland and when they're not.[13] Whilst my focus tonight is on children there is also a need to consider the specific needs of young people involved in offending as a separate group too, and encouragingly there are developments such as new sentencing guidelines which recognise the need for a different approach for those up to age 25.

So, I'm going to focus on children, those under 18 years old. If we think about children who offend who are we talking about? Well, we're talking about children. Nearly all children commit a low-level offence at some point in their

[13] It's important to acknowledge legal complexity about the status of 16 and 17 year-olds in Scotland, meaning that in some contexts and in some legislation they have specific protections due to their status as a child, whilst in others they do not. Also, some 16 and 17 year-olds are regarded as children while others are not in respect of whether they can be referred to the Children's Hearing System. The deciding factor is whether children have previously had contact with the CHS, not their needs or maturity. In practice this means that a 16 year-old might end up in court rather than the CHS simply because the system missed identifying them as in need of support when they were younger.

childhood. Based on self-reported data, the Edinburgh Study of Youth Transitions and Crime found that over 90% children offended at some point in their childhood.[14]

Over half of children when they were aged 12 reported causing physical harm to another (usually a sibling); around a quarter reported engaging in graffiti, shoplifting and fare dodging. Whether we like it or not offending is a majority experience for children as they test boundaries, develop, and grow. This is important because there are consequences of othering and labelling a child as an 'offender' when nearly all children are. Low-level offending may result in intervention by parents, teachers, peers and so on, but the offending most children are involved in does not normally lead to, or need, a formal justice response.

When reference is made then to 'children who offend' in policy documents, practice guidance, in the press, we usually mean children in contact with agencies and organisations because of their offending, or because they are

[14] Source: https://www.edinstudy.law.ed.ac.uk

accused of offending. Given that nearly all children offend, I use the term 'children in conflict with the law' which more clearly identifies that we're talking about children who structurally have a conflictual relationship with the law, be that as accused, charged, sentenced etc. Children can of course be 'in conflict with the law' but be innocent of any offence. When talking with children and young people we've found the term 'children in trouble with the police' can be more understandable and relatable. But it is not just children's contact with the police that we're interested in, let's look at this first though, as the police are usually the first point of contact for children in conflict with the law.

Since the creation of Police Scotland, we no longer have data about the number of children charged with committing an offence, so this is now a bit old, but in 2012-2013, 5% of children were charged by the police with committing an offence, so about 24,000 children (Scottish Government, 2013). The 5% of children who are charged are not always committing more serious offences or engaging in a more significant pattern of offending than the other children who are also offending. The Edinburgh Study found that only 32% of who self-reported as serious offenders when they were aged 17 were ever known to social work or the children's hearing system (McAra & McVie, 2010, p. 189). Instead, certain children are more likely to come into conflict with the law.

- Children who are economically-deprived are 2.7 times more likely to face adversarial police action than more affluent children who commit the same frequency and severity of offence (McAra & McVie, 2005, p. 25).
- One in nine young men from the most deprived communities have spent time in prison by the time they are 23 years old (Houchin, 2005).
- 81% of children under the age of 12 who were reported to the Children's Hearing System displaying a pattern of offending behaviour had parents who were deemed to pose a risk to them (either due to domestic violence, substance misuse, mental health issues, criminal behaviours, abuse, or neglect) (Henderson et al., 2016).

- The behaviours of care experienced children are more likely to be reported to police and to attract a criminalising response, even when trauma related or involving minor offending (Scottish Parliament, 2018).
- Children in residential childcare in Scotland continue to be criminalised for vandalism or very low-level behaviours which include trashing rooms or throwing things at people, that in other family settings would not be met with a formal justice response (Nolan & Moodie, 2016).

Children in conflict with the law in Scotland are the most vulnerable children. There's a lot going on here, but one of the things that appears to happen is that people see a child in need and are understandably concerned, they feel the need to do something and respond primarily to the vulnerabilities or due to concerns about managing risk, but where offending is part of the picture, our responses draw children ever further into conflict with the law. For example, whilst half of all children at age 12 have caused physical harm to another person, and this is usually a sibling, in most family settings this is likely to be dealt with within the family. There may be punishment and consequences but very rarely would this lead to a criminal record. For children in care, though, such incidents are more likely to be viewed through a lens of assault, with the police called. So, the same actions have different long-term consequences, with the more vulnerable children being more likely to be drawn into a justice process.

If offending by children was truly understood and entirely responded to an indicator of need and contact with justice focused organisations and professionals helped them, this wouldn't be a major issue. However, the flaw is that once a child becomes known as engaging in offending behaviour then their behaviour is seen through this lens, it becomes increasingly difficult for them to escape this label and it leads to all kinds of negative consequences. Parents might want their child to avoid the labelled child, teachers might be more likely to see school exclusion as an appropriate response to behaviours, the child may be excluded from activities and things they love as a punishment or as an attempt to manage risk. We might start to see a child's behaviour in a certain frame – risky, frightening, threatening – meaning we miss the fact that the child

is in distress or that they are being exploited, with issues of child criminal exploitation, where children are exploited and manipulated to commit criminal acts, a well-documented and often missed underlying issue. We might also stop seeing the whole child, with the focus on offending behaviours encouraging us to miss that a child is also fun, is interested in art, drama, football, has all kinds of strengths, skills, and good qualities. We can miss the child, and we can all do this in our personal and professional lives- often for understandable reasons and concerns.

This process of labelling and excluding takes away the very things that can help a child develop good and positive interests and relationships with others. The more we exclude a child who is beginning to become known for offending behaviours the more we can push them into further offending as the only way of finding meaning, relationship, things to do; and if they're going to be seen as an offender anyway sometimes it can become easier to just go with it – 'what's the point?'

> After I got excluded from school, I started robbing houses, stealing cars, drinking every day, smashing stuff up (Nolan et al., 2018).

Responding to children in conflict with the law

One of the most profound findings of the Edinburgh study is that the key determinant of whether a child will continue offending or not is whether they have had contact with the Children's Hearing System. Children who don't come to the attention of the Children's Hearing System are more likely to stop offending, compared to children committing the same offences, at the same frequency, and from similar backgrounds. There are also indications that even more informal channels, such as Early and Effective Intervention (EEI), which is a multi-agency response to low-level offending, has the same effect, in this case acting to escalate children on to the Children's Hearing System that may have otherwise stepped away from offending (Gillon, 2018). These are horrifying

findings because they indicate that despite the best of intentions where we intervene in response to offending it often makes things worse, at least in relation to future offending behaviours. This suggests we need to be extremely cautious about unintended consequences in relation to labelling, stigma, 'up-tariffing' and escalating system contact (Cohen, 1985; Peeters, 2015; Richards, 2014; Schur, 1973).

We have a major problem then. Scotland's approach to children in conflict with the law often makes things worse, and the more we try to focus on 'preventing offending' by individual children the more likely we are to unhelpfully label, stigmatise and draw children ever further into conflict with the law. But, of course, we absolutely want to, and should be, doing all we can to prevent children coming into conflict with the law in the first place. So, how do we do this, without the negative consequences.

Children's Rights

What I came to realise is that we need a new way of thinking, new foundations to underpin our approach. In the Rights Respecting? report I explore whether Children's Rights offer us a way to re-think and re-frame, to strengthen our foundations (Lightowler, 2020). I concluded that Scotland would benefit from making the focus of our approach with children in conflict with the law, about upholding their rights- wherever they are and whichever organisation or agency they are interacting or supported by.

The response to children in conflict with the law since Kilbrandon can be seen as a balancing act between welfare and control, with sometimes the balance tipping more in one direction and some-time the other, but both approaches contribute to the problems I've described. Instead, then what if we focus on upholding rights and ensuring children have right-respecting pathways, journeys, experiences, interactions, relationships?

Something happens when we focus on children as rights-holders and on the role of others to defend their rights; rather than thinking about children as troubled,

challenged, vulnerable or challenging. It can be a powerful re-labelling, a new non-offending identity, which has the potential to help a child and those around them think differently about who they are. They are a rights holder and those around them have responsibilities to defend their rights. Of course, a child may still be vulnerable and challenging, all these things may still be true, but a focus on rights can help to put the onus on the 'system', agencies, organisations, professionals, politicians and so on to ensure rights are upheld rather focus on the deficits of a child or family – which these vulnerable or challenging type labels can do. However, well meaning.

> We stigmatise people to get money to deliver services to destigmatise them. (Paul Gilroy, Crossreach)

Making upholding rights our purpose means we don't have to label children as 'vulnerable' or a 'risk of offending' and so on to provide care, services, and support. Instead, the State is required to ensure all children have access to the education, health care, good quality standard of living and so on which they are entitled to, paying particular attention to those least likely to have their rights upheld.

Of course, the evidence is clear these things – education, health care, decent standard of living etc- rights set out in the United Nations Convention on the Rights of the Child (UNCRC), all contribute to preventing future offending, but at an individual level we do not need to stigmatise children, families, or communities. Instead, we focus on ensuring rights are upheld. We prevent offending by respecting the rights of children.

Reframing our purpose as upholding rights is not a panacea though, obviously if rights are not respected, then simply saying someone has rights it not just meaningless but painful and potentially traumatising. I'm reminded of the incredible rights-respecting primary school I visited in Wales, which reported that when their empowered, rights aware children moved on to secondary school the children struggled as they met a culture which did not acknowledge or respect their rights (Lightowler & Gillon, 2019). It's not enough to re-frame what we do around rights, we need to make rights real.

In the Rights Respecting? report I explored how Scotland was doing at respecting the rights of children in conflict with the law, and specifically whether we were compliant with UNCRC. UNCRC is an international agreement the UK has already committed to, but the Scottish Government is also planning to

incorporate it into Scots law, strengthening the opportunity for legal challenge when rights are not upheld. I identified 11 areas where improvements were needed if we are to respect the rights of children in conflict with the law and comply with UNCRC. The report details what could be done to make progress on each of these. They're all important and none more so than others.

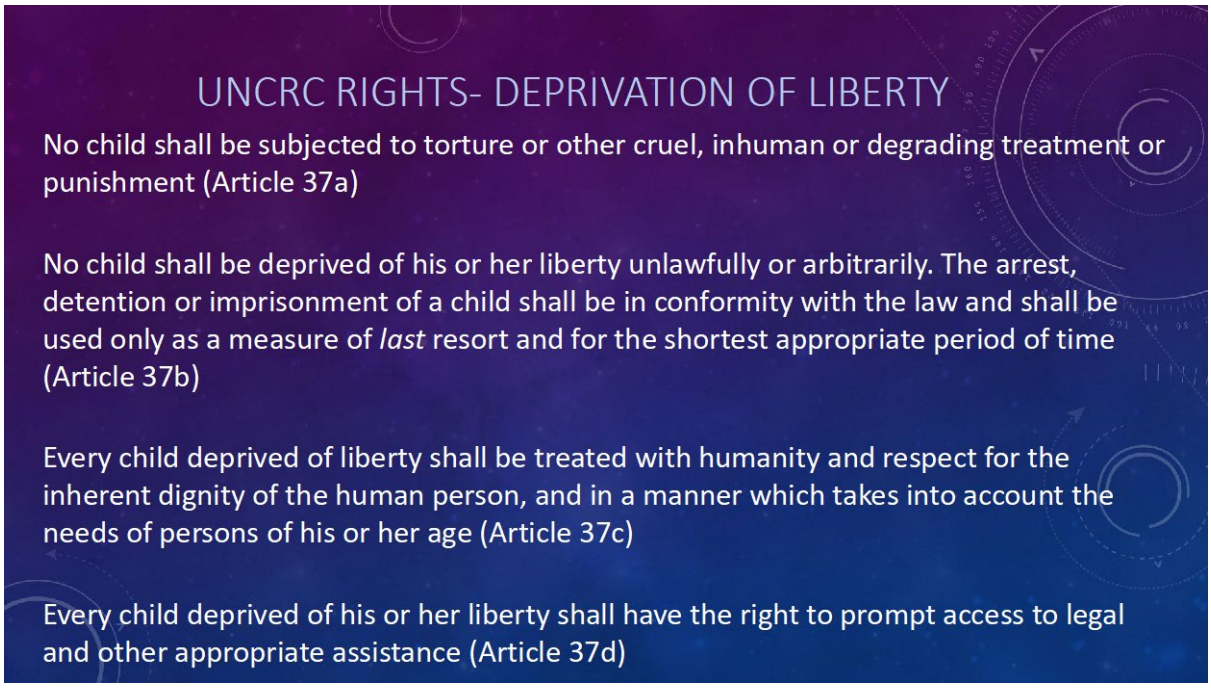
I am going to focus on two issues which were identified by Youth Just Us[15] the most important that you hear about tonight - children in prison and children's participation.

Children in prison

There are many areas where our approach is going badly wrong, but one of the clearest is for our children in a Young Offenders Institution or a prison. It is nearly always the case now that those under 18 in custody will be in Polmont Young Offenders' Institution, but they can and at times are placed in other prisons. For shorthand I'm going to talk about children in prison to mean both things. Children aged 16 and 17 can be placed in prison in Scotland, with younger children considered to require deprivation of liberty for their safety and/or the safety of others - placed in secure care.

We've seen a significant and welcome reduction in the number of children in prison, for instance in 2010-11 there were 658 children who left prison that year, and in 2019-20 there were 136 children who left prison, a reduction of 79% (Scottish Government, 2020).

[15] See https://www.cycj.org.uk/tag/youth-just-us/



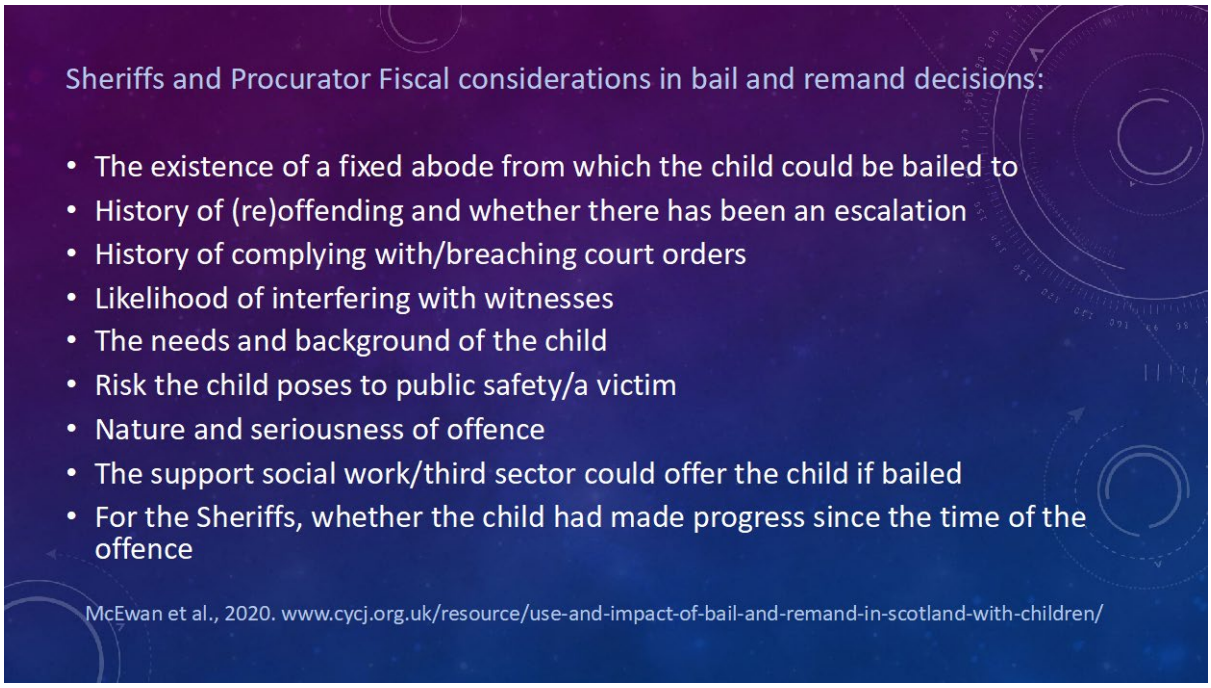
But there's still over 100 children or so a year who leave prison and there are serious concerns about the children who go to prison and their experiences – their rights are not respected throughout.

Taking one day - 7 January 2022 - there were 15 children in prison. Of these, 11 were untried, one was awaiting sentence and three were sentenced.[16] This means 11 children were in prison who had not been found guilty of an offence, and one child had been found guilty, but hadn't yet been given a sentence, which might involve custody, but which might not. This status of being in prison before being sentenced is known as being 'on remand'; 80% of the children in prison were on remand on 7 January 2022.

This is not an unusual day, since January 2021 between 76-94% of children in prison were on remand (compared with about 40% of adults).[17]

[16] Source: Scottish Prison Service, https://www.sps.gov.uk/Corporate/Information/SPSPopulation.aspx

[17] Source: CYCJ: https://www.cycj.org.uk/what-we-do/children-in-remand-in-scotland/



Research with sheriffs and procurators fiscal about the decision to use remand rather than release a child on bail shows that the decision is not always about the risk a child poses to others. Sometimes the decision is based on the child's needs and the lack of services and supports in the community. Specifically, a response to a child being homeless or a lack of supervised bail being available in their local authority (McEwan et al., 2020). So, like the pattern we saw earlier, those who are most vulnerable are more likely to go to prison: suggesting a major breach of Article 37b of the UNCRC that deprivation of liberty should be a measure of last resort.

The experience of being in prison is horrific but being on remand is additionally so because you don't know how long you're going to be there and potentially you don't know whether you're going to be found guilty.

> Aye, see when you're waiting to get sentenced its torture cos you don't know what's going to happen and you just want sentenced to get it over and done with but when you get sentenced it's 'oh fuck,' then you get used to it (child in prison on remand) (McEwan et al., 2020).

When you're on remand, because you are not guilty of any offence, no specific offence focused work can be undertaken, and there's a range of prison activities and supports you are not able to access. It's often referred to as wasted time.

> When I was on remand I was locked up 23 hours a day it's not good...then when I got convicted I'm oot all the time, I'm never in my room, only at night... remand's boring, you only get the gym and rec and that's it, or a visit, there's no work parties, there's no nothing (child in prison on remand) (ibid.).

Time on remand is and can feel long for a child, which has psychological consequences as well as practical ones.

> [They can be] in custody for 110, 140 days so that person's liberty is at stake for quite a period of time…and of course a remand for a young person might be particularly…because a week's a long time in politics but three months is a desperately long time if you're a young person (sheriff) (ibid.).

> Remand is a disaster, all the stuff we know about remand - first it's the seven-day lie down which is enough to scupper a lot of stuff or sow the seeds, anything more than seven days you start to like lose tenancies, benefits claims screwed up, education - the course you fought to get them on is gone because of heavy demand. It just has knock on effects, they're taken out of society you know (social worker) (ibid.).

The bail and remand research these quotes are from was conducted before the pandemic, but obviously there are significant consequences of this which has compounded an already serious issue.

Her Majesty's Inspectorate of Prisons for Scotland worked with others to conduct a survey in 2021 of the children in Polmont YOI. It found some distressing statistics about children's experience in prison. 67% of the children had less than

2hrs a day out of their cell, suggesting cruel, inhumane, and degrading treatment, if not meeting the international definition of torture (HMIPS, CYCJ, C&YPCS, 2021). Eighty-three percent of children reported not having enough to do and just under half felt stressed or anxious *all* of the time. These experiences would be difficult to cope with for anyone, but these children entered prison with already significant challenges, for instance, nearly one in four had previously attempted suicide, 85% had been excluded from school (one at age 5!) and 42% were care experienced (HMIPS, CYCJ, C&YPCS, 2021). There are also hidden stories of children who've ended up in prison because they have been trafficked into the country, or because they've been exploited by criminal gangs, there's a powerful article by Karen Goodwin from *The Ferret* about children from Vietnam who were trafficked in this way and ended up in prison, but these stories are hard to find and sometimes because 16 and 17 year-olds can look like tough, strong, aggressive, scary men, we miss what's happened to them (Goodwin, 2021).

Covid-19 has compounded the issues because we have considerable court delays meaning children are likely to be on remand for longer periods, through various lockdowns children in prison were unable to have face to face contract with family, friends or legal representatives, access to education and activities were reduced. In such circumstances young people tell us that those in prison increasingly resort to using substances to self-medicate, pass the time and psychologically at least, escape. With the use of spice rife, even amongst children and young people who never used it before prison. There are also concerns about how children already hidden from view have been further isolated from us all. Most of the children we lock up in prison have not been found guilty, most are not accused of committing the most serious offences. On average the children in prison in 2019-20 were there for two months (Scottish Government, 2020, data table D3).

What are we doing taking such traumatised children, exposing them to extreme additional trauma, giving them new issues to deal with, and then returning them

to the community, with no or little support. There are of course children who don't return to the community.

Since 2009, two children and 25 young people aged 18-25, 56% of whom were on remand, have died in prison.[18]

Deprivation of liberty is not always used as a measure of last resort, as the only option to keep others safe when we'd considered every other thing we could do to manage, what are sometimes risks needing to be managed. There are very few children for whom deprivation of liberty is the only way we could keep others safe. If we respected children's rights throughout their lives, there would be fewer still. However, where this really is the only option Scotland has secure care centres, which are more clearly child-centred, educational focused spaces capable of delivering a trauma-informed approach.

[18] Source: Scottish Prison Service, https://www.sps.gov.uk/Corporate/Information/PrisonerDeaths.aspx

> Secure is more likely to help me if I was in there for a long period of time. I've been in and out, in and out of prison…This place doesn't help me. I'd be better in secure (child in prison).
>
> A wee boy tried to kill himself the other day... He [judge] sent him here for seven days when he should be in secure. He's just a wee boy not cut out for prison (child in prison) (Nolan et al., 2018).

Of course, children do not always experience secure care in a positive way, but from what we know of the experience and outcomes, they are significantly better than for those who go to prison instead. Secure care is not always considered as an option, and there have been issues before about the availability of secure care places, or a perception that they're not.

During the pandemic, when there was grave concern for the health and wellbeing of all those in prison, some people were able to be released early. Over 340 adults were, but just one child was – largely because such a high proportion of children in prison are on remand, and those on remand were not able to be released early under this scheme.[19] I think it's telling that as far as I can tell, there was no specific consideration paid to the children in prison and what could be possible for those on remand in terms of transferring them to supported community settings or to secure care – which during the pandemic was better able to support access to leisure facilities, education and contact with family and professional supports. We are talking about a small group of children, so it was, and still is, do-able to look at each individual child, considering on a case-by-case basis whether children as a minimum be transferred to secure care. There is nothing in the public record to suggest it was given serious consideration, that these children were really thought about when developing

[19] Source: Scottish Prison Service, https://www.sps.gov.uk/Corporate/Information/covid19/covid-19-information-hub.aspx

responses to the pandemic. One example of why strong and brave advocates are needed.

The Scottish Government has committed to deliver the recommendation of the Independent Care Review that no child should be in a YOI or prison by 2024, but given the impacts of Covid-19, the additional mental health issues, the court delays, the disruptions in relationships, there is a real urgency to address this immediately.

This was one of the two issues identified by Youth Just Us as being most important to them. The final issue I'll address is that of participation.

Children's participation

Article 12 of the UNCRC sets out that children should be given the right to express their views in matters affecting them, and that their views should be given due weight in accordance with their age and maturity; and in particular they should be given the opportunity to be heard in any judicial or administrative proceedings affecting them.

The conversation I had with Youth Just Us members highlighted how important relationships were to them, they wanted people to spend time with them to build a relationship. They referenced a huge range of people as being important to them – their peers, mentors, panel members, social workers, safeguarders, Action for Children workers – and what they want from you is for you to give them time, listen to them, challenge where their best interests are not being served, and to fight their corner. Their comments echoed research done with children and young people in the justice system at the early stages of the pandemic.

> Spend time with me…Encourage me to do things even though I mostly say no, but I really like it when a few staff come in & sit with me, make me laugh & even discuss my past (child with previous experience of the youth justice system) (Nolan, 2020).

There is no doubt that many children and young people, particularly those in conflict with the law, have been even more isolated and had relationships disrupted during the pandemic. There have obviously been some amazing and creative work to maintain connections, the Youth Justice Voices project itself being valued as hugely important to the young people I spoke with as it moved online quickly, ensured members had what they needed to communicate, developed creative activities, and responded in an individual way to each person involved in the group.

The group explained to me how they want to be involved in decisions which affect them and which they have expertise on. They mentioned how even now Scottish Government consultations like the bail and remand consultation (Scottish Government, 2021) out just now involves a process designed for professionals with no meaningful opportunities provided for children and young people to have their say, despite how important the issue of bail and remand is for them. They also shared how they want to ensure children currently in care and justice settings can have their voices heard too, for instance, to be asked what activities they want to do, given opportunities to do classes in drama, art,

music, whatever is important to them, and not have their opportunities limited when they are the only one who wants to do these things – citing the example of being in residential care and having to do what the majority wanted, often football.

What is also important is that children can participate in justice processes – particularly in children's hearings and in court. It's estimated that over 60% of children in conflict with the law have a speech, language, or communication need. You can perhaps imagine how children who offer monosyllabic answers, avoid eye contact, struggle to find the right words and potentially going to be perceived if their needs are not understood, and often they aren't. Even without a specific need, children at a children's hearing or at court for offence reasons are almost certainly likely to be experiencing stress, making it challenging for them to process what is happening, especially when you consider the language being used in these settings.

Whilst a couple of areas of Scotland have youth courts, most children who go to court will experience a standard adult court setting, with little, if any, accommodation made to recognise that they're a child. In 2019-20, 1,208 children were prosecuted in the courts, a fact often hidden by the focus on the Children's Hearing System, with 2,840 children referred to CHS on offence grounds in the same year.[20] Not surprisingly children report they didn't understand what happened at court.

> I was in court the day after my 16th birthday and didn't know what was happening…I just didn't have a clue (child in prison) (Nolan et al., 2018).

We're not even ensuring children understand the justice processes they experience, but we need to do more than that, they are to have opportunities to speak, to have their voice heard, to feel able to explain their point of view. We're

[20] Source: SCRA, Online Statistical Dashboard, https://www.scra.gov.uk/stats/?=undefined&areas%5B%5D=Aberdeen%20City&areas%5B%5D=Aberdeenshire&areas%5B%5D=Angus

a million miles away from this in the courts, and in many of our interactions with children in conflict with the law.

I've covered a lot of ground here. I hope it's made you think and better understand our children in conflict with the law. But most importantly I hope you do something with what you've heard today to ensure these children have their rights respected, and wherever possible, that you include them in your relationships, in your schools, in your communities. Kilbrandon gave us such strong foundations, an approach built around the best interests of the child, a focus on responding to offending as an indicator of need, and a system which doesn't separate children who offend out from other children in need of care, protection, and support. We've lived with these principles for 60 years so there's a depth of understanding about what this means and why it matters. But we need to tend to the foundations and extend them to ensure children's rights, participation and inclusion are truly embedded throughout every stage of every child's journey. This needs more than just thinking and understanding. As a young person said to me last week, 'Stop talking about it and do something about it'. This is just a lecture. These are just words. But you are a listener, whoever you are, whatever job you do, whatever community you live in. You can do something with these words. These children really need you to be brave for their rights.

References

Cohen, S. (1985). *Visions of social control: Crime, punishment and classification*. Cambridge: Polity Press.

Gillon, F. (2018). *Early and effective intervention (EEI) in Scottish youth justice: Benevolent principles and unintended consequences* (Unpublished doctoral dissertation). University of Strathclyde. https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.766947

Goodwin, K. (2021). Trafficked: Concerns over criminalisation of young Vietnamese found in cannabis factories. *The Ferret*. https://theferret.scot/concerns-raised-over-trafficked-vietnamese/

Henderson, G., Kurlus, I., & McNiven, G. (2016). *Backgrounds and outcomes for children aged 8 to 11 years old who have been referred to the Children's reporter for offending*. http://www.scra.gov.uk/wp-content/uploads/2016/03/Backgrounds-and-outcomes-for-children-aged-8-11-years-old-who-have-been-referred-for-offending.pdf

HMIPS, CYCJ, C&YPCS. (2021). *Year of childhood: Pre-inspection survey 2021*. https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/HMIPS%20Year%20of%20Childhood%20Pre-inspection%20Survey.pdf

Houchin, R. (2005). *Social exclusion and imprisonment in Scotland*. https://www.scotpho.org.uk/media/1847/social-exclusion-and-imprisonment-in-scotland-2005.pdf

Kilbrandon Committee. (1964). *Report of the committee on children and young persons, Scotland* (cmnd 2306). https://www.strath.ac.uk/humanities/schoolofsocialworksocialpolicy/thekilbrandonlectures/report/

Lightowler & Gillon (2019). *Children's rights and youth justice in Wales*. https://www.cycj.org.uk/learning-from-wales-childrens-rights-inclusion-youth-justice/

Lightowler, C. (2020). *Rights respecting: Scotland's approach to children in conflict with the law*. Glasgow: CYCJ. https://www.cycj.org.uk/wp-content/uploads/2020/01/Rights-Respecting-Scotlands-approach-to-children-in-conflict-with-the-law.pdf

McAra, L., & McVie, S. (2005). The usual suspects? Street-life, young people and the police. *Criminology and Criminal Justice*, *5*(1), 5-36. https://doi.org/10.1177/1466802505050977

McAra, L., & McVie, S. (2010). Youth crime and justice: Key messages from the Edinburgh study of youth transitions and crime. *Criminology and Criminal Justice, 10*(2), 211-230. https://doi.org/10.1177/1748895809360971

McEwan, D., Maclean, H., Dyer, F., Vaswani, N., & Moodie, K. (2020). *Use and impact of bail and remand in Scotland*. Glasgow: CYCJ. http://www.cycj.org.uk/resource/use-and-impact-of-bail-and-remand-in-scotland-with-children/

Nolan, D., & Moodie, K. (2016). *Between a rock and a hard place: Responses to offending in residential childcare*. https://cycj.org.uk/wp-content/uploads/2016/10/Responses-to-Offending-in-Residential-Childcare.pdf

Nolan, D., Dyer, F., & Vaswani, N. (2018). Just a wee boy and not cut out for prison: Policy and reality in children and young people's journeys through justice in Scotland. *Criminology and Criminal Justice*, *18*(5), 533-547. https://doi.org/10.1177/1748895817745347

Nolan, D. (2020). *'Spend time with me': Children and young people's experiences of Covid-19 and the justice system*. Glasgow: CYCJ. https://www.cycj.org.uk/resource/spend-time-with-me-children-and-young-peoples-experiences-of-covid-19-and-the-justice-system/

Peeters, R. (2015). The price of prevention: The preventative turn in crime policy and its consequences for the role of the state. *Punishment & Society*, *17*(2), 163-183. https://doi.org/10.1177/1462474514560392

Richards, K. (2014). Blurred lines: Reconsidering the concept of diversion in youth justice systems in Australia. *Youth Justice*, *14*(2), 122-139. https://doi.org/10.1177/1473225414526799

Scottish Government (2013). *Scottish policing performance framework, annual report 2012-13.* http://www.cycj.org.uk/wp-content/uploads/2014/05/SPPF-2012-13.pdf

Scottish Government (2020). *Scottish prison population: Statistics 2019-2020*. https://www.gov.scot/publications/scottish-prison-population-statistics-2019-20/

Scottish Government (2021). *Bail and release from custody arrangements: Consultation*. https://www.gov.scot/publications/consultation-bail-release-custody-arrangements-scotland/

Scottish Parliament (2018). *Age of criminal responsibility (Scotland) bill: Policy memorandum.* https://archive2021.parliament.scot/S5_Bills/Age%20of%20Criminal%20Responsibility%20(Scotland)%20Bill/SPBill29PMS052018.pdf

Schur, E. (1973). *Radical non-intervention: Rethinking the delinquency problem*. Englewood Cliffs, NJ: Prentice Hall.

Response by Ursula Kilkelly

Thank you, Claire, for such a powerful address this evening. I think it is really fitting that your lecture tonight has focused on an area where I think we have

seen less than the usual ambition from Scotland and what I would like to do in my response is to build on what you told us this evening from the perspective of the international human rights and children's rights framework.

International law makes clear that rights-respecting youth justice and detention requires consideration to be given to the rights of the child. I would like, in my remarks, to give you a flavour of the work that I have been doing in this field that I think very much complements the philosophy that Claire has set out. The starting point of this is that the children's rights approach is fundamentally about rights for *all* children in *all* circumstances. It is a non-judgemental and universal approach to all children under 18 years, as defined by the UNCRC, regardless of their needs and complexity, regardless of their behaviour. This is a universal approach that puts children first. It is a fundamental, child-centred approach and it speaks to the specific circumstances and characteristics and needs of children *as* children. So, these are fundamental building blocks on which the rights-based approach can be built.

Research that I have undertaken recently in relation to detention has helped to inform my thinking around five areas where rights can be brought to bear on youth justice. While I developed this model in relation to detention it has resonance in the wider youth justice context and draws on some of the existing principles of children's rights.

The first area of rights focus is Provision: this idea is that whether through early intervention or through diversion, children have a right to have their basic needs met, whether that's their rights to care, health, education, development, play, leisure, these are basic, fundamental rights to which all children are entitled. So, children's right to have their basic needs be met must be fulfilled.

The second is in relation to Protection insofar as children have a right to be protected from harm. They also have a right to be protected from other risks to their own welfare, to recovery when they have suffered harm whether that's self-harm, or harm from others. And this looks to divert children through

prevention and early intervention to spaces that are safe for them to be able to fulfil their rights.

The third area of rights is Participation, whether we're talking about due process rights in court, whether we're talking about children with a right to a say about decisions made about them individually, or whether we're talking about involving them, giving them a voice, hearing what they have to say and acting on it in policy matters. The development of new approaches to empower and build children's capacity to engage and participate in decisions about matters that affect them is absolutely key to rights-based youth justice.

The fourth, and possibly a new area of rights in youth justice is Partnership. In this respect, we need to work with young people, as partners in the youth justice process, but we also need to partner with families, with communities to secure the implementation of rights-based youth justice. In this respect, we need to network, to co-ordinate and to collaborate right across the children's sector, the criminal justice sector, health, education, all of these areas, working together. This makes partnership a really fundamental aspect of rights-based youth justice.

And the final area of rights in youth justice is Preparation. I refer to this mostly with regard to the importance of preparing children for leaving care and custody, but also for leaving the justice system. This is crucially important for children, who have a right to be supported and enabled to transition safely back into their communities and families, where possible, in a safe way and in a way that will allow them to fulfil their potential. So Preparation really speaks to that goal.

Looking at the implementation of these five P's, my research has identified how best to advance these rights in youth justice. What we know, for instance, is that we need explicit commitments to a rights-based approach in law and policy at a national level. In that sense, we need clear direction, clear ambition, from government so that the foundation is set in law and policy: this must be a whole system approach. We also need resources of course and frequently these follow the direction set by law and policy.

But we also need people. And that's where I think this evening's lecture is so critically important where over 200 people have taken the time to listen to what you have to say, Claire. Together, we need to use our ambition, and fundamentally, our collective leadership to put children's rights at the heart of youth justice.

Response by Ruth Kerracher

Thank you, Claire, for such an important lecture. You've really highlighted how we need to reframe not only how we support children in conflict with the law but also how we perceive children and young people more widely. I hope your words spark action so that as a nation we start to realise *all* of our children are active rights holders.

As Claire mentioned she had the pleasure of meeting Youth Just Us, a steering group of phenomenal young people. Young people involved in this project have experience of both the care and justice systems in Scotland and a real desire to not only be heard but to have their views acted on. Young people aged 16-25 have been involved in the project since 2019, influencing change and steering what Staf and CYCJ's national participation project Youth Justice Voices has become today.

Before I go on to provide a more formal response to the lecture, which includes the views of Youth Just Us members, I wanted to highlight a few things which struck myself and the group. Upon meeting Claire many of the young people shared that they had never heard of Kilbrandon. They also wondered why they had not been asked to contribute to and influence a lecture like this before, which is ultimately talking about their experiences and what needs to change in Scotland. They believe that young people's voices should be at the heart of all future lectures, and they too should be able to lead responses and direct questions to everyone here today. So, again, I want to thank Claire for not just taking the time to listen to Youth Just Us but also ensuring that their views were represented and influenced the content of the lecture we've heard today.

It is clear that what you set out in your rights-respecting approach is based on years of learning, research and evidence. You build upon the ground-breaking work of the Kilbrandon committee, recognising that offending behaviour is an indicator of concern for the child - demonstrating the need for care and protection – and with the focus on needs, not deeds, there is the opportunity to respond from the same children's hearing system.

But Claire goes further to acknowledge that we need to do better - recognising that children and young people are in fact in conflict with a system. The members of Youth Just Us pointed out children are in conflict with many systems – particularly when they grow up in poverty. This is the first point that Youth Just Us wanted to highlight in the response – the impact that poverty has on many children and families' basic human rights and needs in Scotland. It is their belief that it is often the root cause of children and families coming into contact with multiple systems in the first place, whether that's care, justice, welfare or housing.

This is why the emphasis on changing how we regard and respond to children and young people is vital. We need to see children and young people as rights holders, and, like Claire has suggested, professionals', services' and ultimately the system's role should be to protect and uphold these rights - treating children as children – not by labelling and escalating their contact with the justice system or worse still locking traumatised children in adult systems and prisons which strip children of some of the most important relationships, experiences, and years of their lives.

At Youth Just Us we have had many discussions around the issues Claire has highlighted. Young people continually tell us that they are in a legal system they do not understand. To quote one young person: 'It diminishes your sense of self-worth and identity'. The language used, formal processes, jargon, legal terms, and complex systems, let alone scary settings like court, can feel alien and inhumane. To quote another: 'It's almost easy to forget someone is a person let alone a child'.

Claire has eloquently highlighted many of the concerns, but she has also pointed to community alternatives and more appropriate spaces and approaches which can manage risk and help people to overcome harm when required. Members of Youth Just Us have suggested that we need to make community alternatives more meaningful, so they enable children and young people to move on and strengthen skills and qualifications as opposed to punish. Their key ask is for adults and professionals to take the time to build positive relationships, to provide safe and creative spaces where they can express themselves and develop as a person. Which to me highlights the important role that universal youth work, community learning development and youth-led participation projects can have on people's lives.

Like Claire has highlighted along with the members of Youth Just Us we know a lot of the answers already. Children and young people have also told us time and time again what needs to change – which is evident when they complain of being asked the same questions in adult spaces with no feedback or payment for their expertise. Participation is greater than that.

Thank you once again to Claire for her emotive lecture – you've certainly inspired me. Hopefully if we reframe our thinking, we will see children and young people as assets to our communities and rights holders who should shape the supports, services and policies which affect them. Or in simpler terms as one of our young people said we don't need people to be brave…

> We don't need superheroes. We just need people to respect our rights and uphold their responsibilities, ask us, 'what can I do to help?'

Thank you again to Claire and for this opportunity to respond. I have questions I would like to ask on behalf of Youth Just Us.

- What can we learn from other countries internationally? This is in reference to examples of where you value their approach to rights and justice.

- Secondly, and this is perhaps more rhetorical, but maybe you might have a response to this: 'Rights are on the walls across schools why are they not across all the walls of the justice system?'

Reply by Claire Lightowler

Thank you, both of you for those fantastic contributions that have taken us to two very different places: the kind of international perspective and the children and young people's perspective. I think what's clear across all of it is that there's so much to draw on. So, in terms of the questions, where can we learn? Well sort of everywhere. And in other countries, but also good practice in Scotland, good practice locally, good interactions - there's some amazing work from everywhere, I think. And Ursula will know all about particular pockets in particular countries, but my experience is there isn't one country that has it all solved, that has something, a model and approach, that you can just take and apply. And, as I've tried to articulate, we have real strengths in Scotland that we can build on - so learn, yes, but don't try and replicate. Try and learn and grow and interact in a culture, in an ethos, that is Scottish, that is responsive to Scottish children, in Scottish communities. And I think that's a bit different from traditional models of taking an idea and a concept and applying it. Often negative things come from that because cultures are different, attitudes are different, approaches are different. So, whilst there is really good practice in individual countries, I think it's more reflecting, learning, growing, building and developing our practice, with openness and awareness of learning elsewhere.

I see that there's a question about that and about whether Scotland's approach makes things worse, and whether this is limited to Scotland. Well absolutely not - I can't think of an example of a country when it's responding to children's offending that doesn't involve some element of stigma and labelling and the system contact kind of issues I've talked about. But that doesn't mean that Scotland doesn't have that issue to address, and I think sometimes we don't face up to that in Scotland. I've focused on Scotland, because I am here, I am

working here, I want to improve things here, but it's no reflection, it's no comparison with other jurisdictions. Hopefully that answers that question. What was your other question, Ruth?

[Ruth Kerracher: Young people are making the comment that if you see across schools as you see in Wales you've got rights all over the walls, why is it any different for children and young people in the justice system, why do we not know about their rights?]

Excellent point: I think that goes back to the kind of fundamental point I was trying to make: we don't think about these children as rights holders. That way of thinking is quite new, it's quite new across lots of settings: really embedding what that means is quite new for many people, many practitioners, on a day-to-day level, so it takes a bit of time to think through. My work has been about children in conflict with the law, but I needed to take a year's sabbatical to really give myself time to think about, what would a rights-respecting approach look like? I'm totally aware that I'm so lucky to be in that position - hardly anyone else is going to have that opportunity, and certainly not busy practitioners doing their day-to-day job of interacting with children and families, they're not going to have that time and space and luxury to think in that way, so it's a privileged position to be in. So it's totally understandable that that's not filtered through, that people are grappling with what that means, but I think it does go to the root of, we need a reframing that recognises these children as rights holders and in all these settings that the purpose is about upholding rights, and what that looks like. Unicef has done quite a lot of work about rights-respecting schools but I've not heard the same phraseology about justice settings. And I don't know how comfortable I am with that phraseology in certain justice settings. Could you have a rights-respecting prison for children? I don't know - you can have rights-respecting practice, but there are some settings and some circumstances for which that doesn't necessarily sit easily and comfortably, so I think there's things to be really teased out there. But what's really important is that children know their rights, and that they understand their rights, and understand and are empowered to use their rights. What was impressive about the school was, they

would say, 'I have a right to play', and they would navigate, 'Well what's your right?' And they were talking about how they needed to respect the teacher and the teacher had rights too, so it was a really complicated and sophisticated understanding of what that meant in their circumstances.

Vote of thanks by Claire Haughey MSP

It's my absolute pleasure to thank Dr Lightowler for delivering this year's Kilbrandon lecture, and all those who have helped to make it happen.

Claire, in delivering your lecture tonight you have demonstrated your deep knowledge and, more importantly, your passion when it comes to supporting children in conflict with the law. I don't think there is anyone who could fail to be moved – and motivated – by that lecture?

I am struck by your commitment to ensuring that children are seen and responded to, as children, first of all. That they have their rights respected, that they are really included, and their voices are amplified. You have illustrated the need for deeper reform so that we create the legal system that children and young people in Scotland need and deserve.

It is important to reflect on the journey Scotland's care and justice sector has been on in the past decade or so. Thanks to the tireless work of volunteers, professionals, and experts, we have seen the levels of harm and levels of offending by young people drop sharply. We have established programmes such as the Whole System Approach. These are preventative, rehabilitation-focused, and proven to make a difference.

Our work in this area will continue and intensify. As we set out in our latest Programme for Government, we are committed to safeguarding young people within the youth justice system. We support a presumption against under-18s in the Criminal Justice System, keeping them out of young offenders' institutions where possible and appropriate, while ensuring that victims receive the support they need. Last June we published a new Vision for youth justice. The priorities

and actions have been hugely influenced by both Claire's own 'Rights-Respecting' report in 2020, and by The Promise. But critically, Scotland's priorities have been informed by children and young people with experience of the care and justice system.

I have had the privilege of meeting with members of Youth Justice Voices. It is important that we not only listen to those voices, but also act on what we are being told.

Within Government we are working with partners to address many of the issues highlighted in tonight's lecture, including the number of under 18s in young offenders' institutions, particularly those on remand. In doing so, we need to give close attention to the Children's Hearings System, to secure care access and to community alternatives provision in Scotland. Legislative reforms will be required alongside the much-needed policy and practice change.

I hear and respect those voices who urge us to go further and faster. I share many of those ambitions. As we continue to make progress, our focus naturally shifts to those young people whose circumstances and behaviour are the most complex and challenging. It is essential for their safety and wellbeing, and for the safety of their communities, that we get our approach right.

All of us attending this evening can be grateful to you, Claire, for the unique perspective you have brought to this year's lecture. You have challenged us all this evening and I thank you for that.

We must approach these issues with care but move at pace where we can. My colleagues and I will hold your vital insights and challenges in our minds as we take reforms forward.

You spoke about the need for strong and brave advocates to speak up. This is a role for all of us, and I for one support that ask and accept the role.

Turning now to those who have helped make tonight happen, I would like to thank the Principal, Sir Jim MacDonald, for his introduction, and Professor

Jennifer Davidson for chairing this evening. I also very much appreciated the contributions of Professor Ursula Kilkelly and Ruth Kerracher, and I am very grateful to the young people who worked with Ruth to help her shape her response. Thanks also to Fiona Dyer and the Children and Young People's Centre for Justice for your crucial work with young people and professionals on the rights of children in conflict with the law.

On behalf of the Scottish Government, I would like to convey my gratitude for the continuing support given to this lecture series by the university's School of Social Work and Social Policy. Many thanks in particular to Raymond Taylor for organising tonight's lecture, Nadia Mitchell for the support from the University events team, and Alan McLeave for ensuring that things have run smoothly this evening. Finally, my sincere appreciation goes to all of you who have joined us for tonight's lecture. Particularly, those directly involved in the hearings system as panel members, reporters, social workers, teachers and in many other roles. You have made an enormous difference to the lives of thousands of children and their families. Our unique and valued Children's Hearings system will continue to evolve and thrive thanks to your dedication.

About the Kilbrandon lecturer

Dr Claire Lightowler is an academic particularly known for her work in children's rights and youth justice. She was director of the Children and Young People's Centre for Justice (CYCJ) at the University of Strathclyde from 2013-2021. Among her publications is the report, Rights Respecting? Scotland's Approach to Children in Conflict with the Law, which explored whether Scotland was complying with the United Nations Convention on the Rights of the Child (UNCRC) and what it would look like if children's rights formed the basis of Scotland's approach to children in conflict with the law. Through this work Claire became increasingly aware of the need for children and young people accused of offending to have specialist legal representation informed by knowledge about child development and trauma. Dr Lightowler is currently studying law at the University of Edinburgh.

About the respondents

Ursula Kilkelly is a professor of law with an established profile in children's rights and youth justice. She is Head of the College of Business and Law at University College Cork, Ireland. Ursula's research expertise is in international children's rights law, with additional expertise in youth justice and detention. She is co-editor, with Professor Stefaan Pleysier of KU Leuven, of the journal *Youth Justice*. Ursula teaches International Children's Rights and Juvenile Justice on the LLM in Children's Rights and Family Law and supervises LLM and PhD students in these areas. In 2010, she founded the Child Law Clinic, which provides research services to those litigating children's rights. In June 2019, the Minister for Children and Youth Affairs re-appointed Ursula for a second term as Chairperson of the Board of Management of Oberstown Children Detention Campus, Ireland's national facility for the detention of children referred by the courts.

Ruth Kerracher has a degree in community education and is Youth Justice Participation Lead at Youth Justice Voices run in partnership by the Scottish Throughcare and Aftercare Forum (Staf) and the Children and Young People's Centre for Justice (CYCJ). Funded by the Life Changes Trust, this is a national participation project for young people aged 16-25 with experience of the care and justice systems in Scotland which aims to influence change by enabling young people to creatively amplify issues and recommendations for change with policymakers, managers, corporate parents, and the Scottish Government. Led by a steering group of young people called Youth Just Us in the community and Inside Out in HM Prison and Young Offenders' Institution Polmont, the project received a commendation award from the Howard League in 2020 and played a critical role in ensuring that the Scottish Government's most recent Youth Justice Vision and Action Plan was shaped and informed by young people.

Claire Haughey MSP has been the Member of the Scottish Parliament for Rutherglen since 2016. She was appointed Minister for Children and Young People in May 2021 and was previously Minister for Mental Health. A mental

health nurse by profession, Ms Haughey was a clinical nurse manager before her election to Parliament.

Book review

Book title

The Criminalisation and Exploitation of Children in Care Multi-Agency Perspectives

By Julie Shaw and Sarah Greenhow

Publisher: Routledge, 2020

ISBN: 9780367025274

Corresponding author:

Dan Johnson, Clinical Director and Forensic Psychologist, Kibble Education and Care Centre, dan.johnson@kibble.org

The Criminalisation and Exploitation of Children in Care focuses on responses to children and young people in residential and foster care who are at risk of criminalisation and/or exploitation and abuse. This is an important and complex issue that practitioners often have to navigate, with high stakes and without clear guidelines.

The book explores how children and young people who are care experienced can receive criminal charges both internally regarding incidents within their home but also externally, i.e. through incidents in the community. They present evidence that shows care experienced children and young people are more likely to receive criminal charges than those who are not. The book essentially aims to explain the key factors that contribute to the criminalisation and exploitation of children in care, and in turn what elements of multi-agency working can increase the likelihood of positive outcomes.

The book is in essence an in-depth research report exploring the authors' qualitative research, undertaken with 36 practitioners who were working within the context of Multi-Agency Safeguarding Hubs (MASH) and collaborating agencies in a single county in the north of England. Prior to discussing the results of their research, they review the literature regarding care experienced children in England, and the factors involved in both the criminalisation and exploitation of these children. The review is comprehensive and will prove useful to anyone interested in the subject. They also provide a thorough review of multi-agency working in an English context and highlight the familiar finding that most serious case reviews following harm to children call for agencies to work together more effectively. They describe the MASH model as a response to this and the barriers it has faced in implementation and practice which will be familiar to anyone who has worked in a multi-agency context.

The results of the research are explored across approximately 60 pages and provide a level of depth that will be of interest to those studying the field. They split their findings between criminalisation and exploitation. Regarding criminalisation: they highlight how participants identified systemic problems that provide a context for the increased criminalisation of young people. These included the marketisation of care and how this can lead to underconfident and poorly paid staff. Also, participants viewed the police as making decisions that

felt defensive and risk averse. The authors conclude that the care system exacerbates the vulnerabilities of children in its care, rather than successfully supporting them to overcome their challenges and thrive. Regarding exploitation: the authors describe participants' views of further systemic problems that contribute to exploitation. These include the difficulties involved in providing permanent and protective relationships over the long term, and the apparent dichotomy of profit-making and safeguarding. They conclude that the failure of the state to protect children amounts to system abuse. Some, if not all, of the themes and factors described across both criminalisation and exploitation are likely to resonate for many workers in residential and foster care. Hearing about others who have difficulty navigating systemic difficulties may be reassuring for readers, as well as perhaps dismaying.

The authors look at whether multi-agency and specifically MASH teams are one of the answers to reducing criminalisation and exploitation. They conclude that the idealised version of multi-agency working is very different from the real practice due to limited resources, turnover of staff and conflicting agendas from different agencies.

The actions the authors call for in response to all their findings are numerous. Regarding criminalisation they ask for a review of private providers of residential care and a shift to high quality public provision. They also suggest that the instability of care due to children moving homes are ultimately due to an insufficient provision of excellent care due to an ideological retreat from residential care. As a response they suggest that residential care should not be a last resort and be seen instead as a positive and preferred choice where the needs of the child indicate it. They suggest that the low-status and risk averse nature of English residential care contributes to the quick and normalised involvement of the police in minor criminal matters. They view a root cause of this as inadequate staffing numbers and training and contrast it with the highly educated and high-status social pedagogues in Northern European residential settings. The authors call for government to enhance the status of residential care rather than 'abandoning responsibility for outcomes to the for-profit concerns that currently monopolise the sector'.

Their calls to action regarding exploitation focus on improving multi-agency collaboration and highlight the Contextual Safeguarding approach that has been implemented in a few sites, including since the book was published. They ultimately conclude that the best practice occurs in those collaborations where the most trusting relationships were established. The parallels between this and the importance of relationships in effective residential care are clear and reassuring.

The book is an excellent review of the issues at a strategic and policy level. It will be invaluable to those studying the subject or involved in strategic decisions regarding exploitation and criminalisation both in England and Scotland. Readers who are seeking practical and front-line advice are likely to be disappointed but could still find the reflections and themes salient, familiar, and perhaps useful to guide their own individual thinking and practice.

The publisher of this book supplied a free e-copy for review.

About the author

Dan is a forensic psychologist who has worked in residential and secure care for over ten years. He has completed research including that which seeks young people's views on their experiences of care. He is currently working to increase trauma informed care in residential and education services.

Book review

Book title

The Children of Looked After Children: Outcomes, Experiences and Ensuring Meaningful Support to Young Parents In and Leaving Care

By Louise Roberts

Publisher: Policy Press

ISBN: 978-1447354307

Corresponding author:

Emma Young, Research and Evaluation Associate, CELCIS, emma.young@strath.ac.uk

Published in March 2021, *The Children of Looked After Children* draws together findings from a four and a half year research study looking at parents in and leaving care in Wales. Funded by Health and Care Research Wales, the research was undertaken by Dr Louise Roberts within the Children's Social Care Research and Development Centre (CASCADE) at Cardiff University.

In drawing together the study findings, Roberts seeks to bring attention to parents in and leaving care; provide a space for their voices; and to use the findings from the research as a tool to support practitioners and services when thinking about policy and practice relating to parents in and leaving care. In *The Children of Looked After Children* Roberts provides a discussion and critique of the role of the state as a parent, its interactions with parents in and leaving care, and asks the reader to engage in their own questioning of the states parenting competency.

The Children of Looked After Children is structured around three core thematic areas: outcomes, experiences and supports. Drawing on both primary data collected through the 'Voices study' and secondary analysis of data collected through the School Health Research Network health and wellbeing survey (Long et al., 2017) and the Welsh Adoption study (Anthony et al., 2016) a comprehensive picture of the issues relating to parents in and leaving care is presented. Within the narratives of the parents and professionals included there are stories of resilience, transformation, 'success', and the joys of parenting presented. However, the prevailing themes included the increased likelihood of pregnancy and parenthood for care experienced young people, experiences of 'disadvantage and adversity', limited and inconsistent supports for parents, and a heightened risk of their child(ren) being separated from them (Roberts, 2021, p. 124). Discussing these findings Roberts revisits the question of the role of the state as a parent, the relationship of this to the concept of parenting 'success' and the relationship between parents in and leaving care and the state as parent.

In the final pages of the book a letter to the reader from Jen, a care experienced parent and member of the 'Voices' study research advisory group, is shared. In her letter Jen shares her own experiences of being a parent in and leaving care,

reflecting on the decisions taken about her and her child, and the immediate and enduring impact of these decisions:

I can't and don't regret having my children. I just wish things had been different. I wish that I had met people earlier who made me realise I'm not a bad person. I wish I had known my legal rights a bit more. All of the things that I had later in life, the chance, the support, the relationship, the family, I wish I had that earlier (Roberts, 2021, p. 142).

Jen finishes her letter to us by calling to action 'anyone and everyone who can make a difference' (Roberts, 2021: p.142). Roberts too brings the book to a close by emphasising the urgent need for attention at both local and national levels to begin addressing the poor outcomes, disadvantages and challenges evidenced within her findings.

Overall, *The Children of Looked After Children* brings renewed focus to parents in and leaving care, expanding the existing body of knowledge by advancing our understanding of the outcomes, experiences and supports related to parents in and leaving care. Additionally, through the concept of 'success' Roberts challenges the reader to consider the interconnection between the 'success' of the states parenting with that of the parent in and leaving care. In doing so Roberts argues that parenting 'success' for young people in and leaving care is indicative of the state's own parenting 'success', moving the discussion away from individual parenting behaviour and instead questioning the accountability of the state as a parent.

Since the publication of *The Children of Looked After Children*, Roberts and colleagues have begun implementing the recommendations for policy and practice through the co-production of *The Charter* for best practice when supporting parents in and leaving care. Aimed at Corporate Parents The Charter seeks to get their commitment to best practice when working with parents in and leaving care. Whilst sign-up to the charter in itself will not lead to the scale of policy and practice change evidenced as needed within Roberts's findings, this research alongside The Charter is raising the profile of parents in and leaving care within the consciousness of the sector; a key step in building the readiness needed for change. In addition, Roberts provides evidenced recommendations for immediate development of national and local data, increased policy

recognition and development and practice guidance for supporting young people in and leaving care with their sexual health and as parents. As such *The Children of Looked After Children* offers an accessible, yet comprehensive overview of current issues relating to parents in and leaving care and would be of interest and value to health and social care practitioners, researchers and policy makers interested in support for care experienced people into adulthood, early family support and child protection. Having said this, I would recommend to everyone that if you read nothing else, do skip to p.139 and read Jen's letter.

This review is of the e-version of this book, acquired via open access download.

References

Anthony, R., Meakings, S., Doughty, J., Ottaway, H., Holland, S., & Shelton, K.H. (2016). Factors affecting adoption in Wales: Predictors of variation in time between entry to care and adoptive placement. *Children and Youth Services Review*, *67*, 184–90.

Long, S., Evans, R., Fletcher, A., Hewitt, G., Murphy, S., Young, H., & Moore, G. (2017). A comparison of substance use, subjective wellbeing and interpersonal relationships among young people in foster care and private households: A cross sectional analysis of the School Health Research Network survey in Wales. *BMJ Open*, *7*(2), e014198.

Roberts, L. (2021). *The children of looked after children: Outcomes, experiences, and ensuring meaningful support to young parents in and leaving care.* Bristol: Policy Press.

About the author

Emma Young is a Research and Evaluation Associate at CELCIS. She supports CELCIS to embed, use and develop evidence across our work. In addition to her role at CELCIS Emma is also undertaking a part-time PhD in the School of Social Work and Social Policy at the University of Strathclyde focussed on exploring professional responses to mothers in and leaving care in pregnancy and in parenthood.