Scottish Journal of Residential Child Care

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Editorial

Graham Connelly

As I write this editorial in the midst of a global pandemic, it feels unreal to think how different the world was when I was writing the introduction to our February issue. All our lives have been changed utterly by COVID-19. While the virus itself appears generally to cause only mild symptoms in children, despite emerging evidence that some infected children can become seriously ill, the wider effects of COVID-19 on children and young people are likely to be tragically significant. The UN Children's Fund, UNICEF, has described the health crisis caused by COVID-19 as 'quickly becoming a child rights crisis' (UN, 2020). The problem is particularly acute in low and middle-income countries where financial and infrastructural pressures could have devastating effects on routine health provision, leading to vast numbers of deaths of young children in the absence of concerted efforts by the wealthiest countries. UNICEF also highlights potential impact on access to immunisations and the negative consequences of restrictions on normal living for mental health, education and child protection. Women and girls are likely to be particularly at increased risk of gender-based violence.

The crisis and the effects of lockdown and isolation have unequal consequences, affecting the already disadvantaged economically and socially most. A report by IPPR Scotland (2020) found that 49 per cent of households with dependent children in Scotland — some 300,000 households — were in 'serious financial difficulty' or 'struggling to make ends meet'. While countries varied greatly in their mitigation approaches, a common feature was the rapidity of the introduction of emergency measures, mostly with significantly deleterious consequences for children's normal rights to education, leisure and freedom of association. A survey of 95 professionals in 20 European countries conducted in one week of April 2020, highlighted several ways in which children's rights were impinged by emergency measures, including:

> concerns about the portrayal of children in the media, and the
> way in which they are being blamed or even criminalised, for

being in public spaces. Marginalised children and young people are also particularly impacted by decisions to close public parks and play facilities. This impacts disproportionately on families living in cramped conditions, lacking outside space (garden, terrace, balcony), natural light or the possibility to ventilate, and on a low income; particularly on the children, young people, and women in those households (Centre for Children and Young People's Participation, 2020, p. 9).

There have also been many examples of ways in which potential disadvantages have been reduced or avoided. These have included addressing digital exclusion for families or individual young people by provision of laptops, mobile phones and internet access, and help with getting online and using video conferencing tools. In residential care, there have been reports of workers volunteering to live-in for the duration of the restriction period, or of adjusting shift arrangements to minimise traffic in and out of homes. Some of the changes to everyday living have been regarded by children and adults as definite improvements and there is clearly scope for considering which should become permanent arrangements. Much of the rhetoric about the shutting of schools has been about missed education and home schooling as a poor alternative. But there have also been anecdotal reports of benefits for children in care of not having some of the pressures of going to school (Turner, 2020). As one residential manager told this author: 'The drama of going to school can be stressful for some of our children, but without the pressure of formal education we've been engaging in education and learning at home'. One lovely example of children supporting each other was the story of a nine-year old boy, known to be highly anxious about school, observed sitting on his bed with a 16-year old girl listening to him reading aloud.

Many policy and advice organisations swiftly repurposed to provide support specifically related to COVID-19 and the impact on children and workers of mitigation measures. In Scotland, CELCIS created an Information Point microsite bringing together information and support for children's care and protection. A superb example of young people taking a lead in facing up to their own anxiety and purposefully redirecting it in support of others came from the Good

Shepherd Centre in Bishopton, Scotland. With the help of their media teacher the young people researched positive stories and broadcast a 'positive posters from around the world' series on Twitter (access here). Their 'What If' film is very well worth viewing.

The *Scottish Journal of Residential Child Care* will contribute to our developing understanding of how care experienced children and young people have been affected by the virus and efforts to mitigate its impact. We will be publishing a series of 'special feature' articles on the *SJRCC* web pages in which our correspondents from around the world describe how the everyday lives of children and those who care for them have been changed. We also plan to bring these and other articles together in a special collection later in the year.

The current issue of *SJRCC* was planned to coincide with the annual conference of the Scottish Institute of Residential Child Care, sharing the conference theme, 'the extraordinary ordinary: the power of everyday care'. Though the articles which form this collection were mostly conceived before the virus impacted our lives, the choice of theme could hardly have been more prophetic.

The issue begins with two peer-reviewed research articles. Sheila Ramaswany and Shekhar Seshadri consider the deinstitutionalisation debate in India and conclude that while it is a desirable goal interim measures should be directed at, among other things they enumerate, improving child care institutions, including better physical infrastructure, with smaller and more intimate institutions with better staff-child ratios. Danny Henderson and Robin Dallas-Childs explore what home and belonging mean to young people and how residential child care can provide the conditions for the experience of home and a sense of belonging through care worker-young person relationships, grounded in everyday activities and exchanges.

There then follow eleven shorter articles on the theme of the extraordinary ordinary in caring for children. The scene is set by a poem specially written for this issue by care experienced poet, illustrator and social work student David Grimm. The poem was written in a time before COVID-19, but its verses seem to have so much additional meaning now.

During night terrors, you'd sit by my side, you were supposed to say no.

Instead you let me sit in the comfort of your private work zone.

You didn't complain you just sat there, quiet, with me by your side.

You cared without saying, simply by being.

Moulding our comfort until we can dream.

You make us feel human, when our hope has all gone.

The first themed article in the collection, by Laura Brown, David Grimm and Gregor Clunie, draws on discussions within a Who Cares? Scotland campaign group for care experienced people accessing their care records, but the article is significantly based on the experience of two of the authors who requested records of their own time in care. Hazel Whitters's article, Let Love Liberate our Children to Learn, is written from the context of an early years' centre and focuses on three generations of one family: Holly, her mother and grandmother.

David Lane and Robert Shaw consider the value placed on everyday professionalism and conclude that the key to successful care lies in the values and motivation of the workers.

On a related theme, Niall Reynolds explores the possibilities for social care professionals in adopting systemic approaches in thought to a range of differences and challenges in their practice, and concludes: 'We must begin to embrace these concepts as a new charter toward understanding the fragmented temporality of the present in our everyday "extraordinary ordinary" interactions with others'.

Art psychotherapist, Kerri Samsaidh, is concerned with creating healing environments in residential care, arguing that: 'Working with our hands nourishes the soul and can be applied in a variety of creative tasks for the home including cleaning, cooking, mending, making and baking'. Laura Horvath's article is based on collaborative work with the Child Reintegration Centre in Sierra Leone which transitioned its residential programmes to family-based care.

'The CRC case team conducts traditional assessments and home visits, but also teaches parents and caregivers how to parent well, build financial independence, and become empowered to care for their own children'. Residential manager, Beverley Graham, explores her own leadership journey considering how fear and blame can lead to toxic cultures and suggests tools to develop better awareness for individuals and organisations.

Nick Pike's article considers challenges for residential child care staff implementing an 'ordinary living' policy in a residential special school for children with complex learning difficulties and challenging behaviour: 'Rather than a unit wide child care philosophy, individual staff teams developed local solutions for specific rooms, specific residents and specific staff'. Marianne Macfarlane argues that while research into vicarious trauma, its impact on professionals and the consequences for clients has been limited, strategies have been developed to assist in identifying, preventing and managing symptoms but these strategies are not easily applicable to the residential child care setting, despite residential care staff working alongside young people with complex trauma. Liam Feeney describes the journey undertaken by East Park Home in Glasgow to empower care staff to demonstrate love in their practice, such that it will become a cultural norm so that all children will feel they were loved by those who supported them.

The final article in the themed section, by Shivangi Goenka and Kiran Modi, uses the experiences of a social worker in India to discuss the conditions of children and staff in children's homes, focusing on the gap between what exists in theory in the law and the increase in the intensity of the trauma the children experience. Their article considers the practical gaps in implementing laws and policies and offers suggestions for improvement.

This special issue ends with reviews by Samantha Fiander of two books: Lowborn: Growing Up, Getting Away and Returning to Britain's Poorest Towns by Kerry Hudson and My Name is Why by Lemn Sissay.

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The deinstitutionalisation debate in India: Throwing the baby out with the bathwater?

Sheila Ramaswamy and Shekhar Seshadri

Abstract

In recent times, India has joined the growing global consensus on the need to promote family-based alternatives to institutional care for children. However, despite the UN Guidelines' push for deinstitutionalisation, and in theory, our agreement with its position, it is critical to examine what principles of 'necessity', 'child's best interests', and 'appropriateness' mean in practice and how they actually play out in systemic decisions about alternative care. It makes a case for moving towards feasible forms of residential care for its vulnerable children, rather than merely pushing for de-institutionalization agendas. In order to do this, it provides contexts of institutionalisation and the current state of child care institutions in India; considers child rights and child-centric approaches that take into account children's viewpoints and preferences on placement-related matters; and finally presents the functional challenges of adoption and foster care systems and the limitations in systemic capacities of child welfare systems in the country. The article highlights the importance of making decisions about (de)institutionalisation not only through child care reforms, policies and systems but more critically, through children's participation in their residential and care arrangements, by dialoguing with them to understand their unique situations and universes, their aspirations and desires.

Keywords

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As per country-level figures, it is estimated that approximately 2.7 million children between the ages of 0 and 17 years could be living in institutional care worldwide (Petrowski, Cappa & Gross, 2017). There is the large body of evidence on the adverse developmental and mental health impacts of institutionalisation in children, (Maclean, 2003), (Colvert, Rutter, Beckett, et al., 2008), (Tizard & Rees, 1975), (Chisholm, Carter, Ames & Morison, 1995), (Hodges & Tizard, 1989), (Ellis, Fisher & Zaharie, 2004), (Vorria, Papaligoura, Dunn et al., 2003). Thus, several countries have been working towards developing alternative care, including reducing the number of children in institutional care, and attempting to shift their child protection and care systems to (re)uniting children with families.

According to the United Nations 2009 'Guidelines for the Alternative Care of Children' (UN General Assembly, 2009), 'alternative care is any arrangement, formal or informal, temporary or permanent, for a child who is living away from his or her parents'. The guidelines state that the provision of alternative care should be based on the principles of necessity, the child's best interests, and appropriateness, that is, in accordance with their individual needs and situation. Furthermore, the Guidelines state the following:

- The use of residential care should be limited to cases where such a setting is specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests (UN General Assembly, n.d., para 21);

- alternative care for young children, especially those under the age of 3 years, should be provided in family-based settings. Exceptions to this principle may be warranted in order to prevent the separation of siblings and in cases where the placement is of an emergency nature or is for a predetermined and very limited duration, with planned family reintegration or other appropriate long-term care solution as its outcome (UN General Assembly, n.d., para 22);

- While recognizing that residential care facilities and family-based care complement each other in meeting the needs of children, where large residential care facilities (institutions) remain, alternatives should be developed in the context of an overall deinstitutionalization strategy, with

precise goals and objectives, which will allow for their progressive elimination…States should establish care standards to ensure the quality and conditions that are conducive to the child's development, such as individualized and small-group care, and should evaluate existing facilities against these standards. Decisions regarding the establishment of, or permission to establish, new residential care facilities, whether public or private, should take full account of this deinstitutionalization objective and strategy (UN General Assembly, n.d., para 23).

The objective of this paper, however, is neither to present discussions on the effects of institutionalisation on child development and mental health nor to 'demonise' child care institutions, nor to make a strong case for deinstitutionalisation. Despite the UN Guidelines' push for deinstitutionalisation and in theory, our agreement with its position, it is critical to examine what principles of 'necessity', 'child's best interests', and 'appropriateness' mean in practice and how they actually play out in systemic decisions about alternative care.

The aim of this paper, therefore, is to argue in favour of India moving towards feasible forms of residential care for its vulnerable children; and in doing so, to engage in a realistic exploration of residential care provided by child care institutions, and methods of deinstitutionalisation through alternative care systems. The objectives are therefore to discuss key parameters on which, in India, decisions of de-institutionalisation, need to be predicated, namely: contexts of institutionalisation and current state of child care institutions, child rights and child-centric approaches that consider children's viewpoints and preferences on placement-related matters, the functioning of adoption and foster care systems and other child welfare systems in the country. It thus makes a case for moving towards feasible forms of residential care for its vulnerable children, rather than merely pushing for de-institutionalisation agendas.

Contexts of children's institutionalisation in India

Many societal influences have led to the development of institutional care, for children, across the world (Browne, 2009), namely:

- Lack of community-based workers, such as social workers/nurses/health workers, who, according to research, are the best persons to help prevent abandonment and violence in the community;

- Lack of home-based assessments (and interventions) for children in need of care and protection, and their families;

- Inadequate free universal prevention services to reduce child abuse, neglect, and abandonment;

- Insufficient targeted interventions for families at high risk of child abuse, neglect, and abandonment;

- Slow development of high-quality foster care (and adoption) systems.

The above factors are applicable to India as well, where large proportions of the population live in difficult socio-economic conditions. As a result, there is a considerable proportion of children at risk: their families do not have the economic capacity to provide for the basic needs of children; and/or such families are likely to be dysfunctional with socio-economic problems leading to alcohol abuse and domestic violence, which in turn result in children being abused, neglected or abandoned.

Research from European countries shows that in the last 20 years, children are institutionalised, broadly due to one (or more) of the following reasons: (i) abandonment; (ii) disability; (iii) neglect and abuse (Maclean, 2003). These tend to form some of the common reasons for institutionalisation of children in India too (with runaways and those trafficked for labour and sex work forming sub-categories of abused and neglected children).

In India, there are two other sub-groups of children who tend to be institutionalised: (i) Children in conflict with the law are placed in (State) Observation Homes, for varying time periods, ranging from days to weeks or months, for alleged offences they have committed; (ii) Adolescents who run away from home when they find themselves in romantic relationships, so as to 'marry' or be in a relationship with the person of their choice (something they would not generally be permitted to do by their parents and caregivers; the current Indian laws on child sexual abuse also do not allow for nuanced

interpretation of minors engaging in sexual activity). Both these categories of institutional children tend to be from vulnerable backgrounds, often from experiences of neglect and abuse, and follow varying pathways of vulnerability, in turn bringing them in contact with legal and child care systems in the country.

Children may reside in institutions for varying periods of time, ranging from days or weeks to months and years — depending on whether the child care system is able to trace available family members and social networks and establish their reliability and ability to take care of the child. Such vulnerable children, including institutionalised children, are governed by the Juvenile Justice (Care and Protection) Act 2015, which aims at catering to their basic needs through proper care, protection, development, treatment, social re-integration, by adopting a child-friendly approach in the adjudication and disposal of matters in the best interest of children and for their rehabilitation through processes provided, and institutions and bodies established (Ministry of Law & Justice, 2016).

Current state of child care institutions in India

As per 2018 estimates there are more than 9,500 institutions hosting over 370,000 children in India (Ministry of Women & Child Development, 2018). Following a Supreme Court order in 2015, there was a mapping and review of the state of child care institutions across the country. The emergent report highlighted the lack of staff and infrastructure, the poor quality of care provided to children, in terms of counselling, life skills, training, educational interventions and health support for children; furthermore, it was pointed out that institutions had no concept of rehabilitation, reintegration, deinstitutionalisation and independent living, and no long-term vision for children (Ministry of Women & Child Development,2018). Incidents in certain institutions have also reflected that sexual, physical and emotional abuse of children is rampant.

Such issues have led to India joining the growing global consensus on the need to promote family-based alternatives to institutional care for children. However, there is currently considerable debate around the issue of deinstitutionalisation in the country, not least because of contextual and systemic challenges that bring into question feasibility on the one hand, and children's best interests on the other.

The underlying reasons why children in institutions in general, and in India in particular, have developmental and mental health problems, pertain to institutional environments and the quality of care (This sub-section is based on the authors' work and experiences in child care institutions in India, through the implementation of the Community Child & Adolescent Mental Health Service Project, Dept. of Child & Adolescent Psychiatry, NIMHANS). Broadly speaking, in the Indian context, we have observed three critical aspects to the quality of care in institutions, as discussed below.

(i) Physical infrastructure, human resources and availability of basic needs refer to the physical spaces of the institution, in terms of size, layout of spaces and maintenance of these spaces, as well as access to basic needs such as food and healthcare. While the Juvenile Justice Act 2015 contains stipulations about the numbers of children that an institution can house, based on its size, and facilities (toilets, living spaces, food etc.), there are certain other physical aspects that directly impact child development and psychosocial wellbeing. Play spaces are an example of these, especially considering the spatial and mobility restrictions that institutionalised children are subjected to daily. Due to safety and security issues pertaining to children, and concerns about them running away, have either made no provision for such spaces or do not allow children to access such spaces for physical and free play. It has also been frequently observed that boys' institutions are more likely than girls' institutions, to have large open spaces for play, thus reflecting gender biases in the architecture of institutions, which in turn impact the nature and type of play and exercise that institutionalised girls and boys have access to. Consequently, children are negatively impacted not only in terms their physical growth, but also (gender) identity development, and their emotional states, for physical play and exercise are known to help children give vent to mental stressors.

(ii) Provision of opportunities for optimal development is about institutional children having access to activities that focus on education, social skills, life skills, leisure and recreation, in accordance with their age and developmental stage. In institutions for children 0 to 6 years of age, and those with disabilities, for instance, there requires to be intensive implementation of early stimulation activities to help children develop skills in key developmental domains (physical,

speech and language, social, emotional and cognitive development); in institutions for the average child, between seven and 18 years, there should be opportunities for education and social development, including training in life skills. Many institutions in India are unable to provide such developmental opportunities to children — due to staff attitudes of apathy and indifference towards children's welfare, lack of staff awareness and training on child development, and/or paucity of resources. When children are bound to live in institutions for (relatively) long periods of time, with limited exposure to social spaces and experiences, without adequate engagement, there are likely to be three negative consequences: firstly, children become restless and frustrated, following which they are constantly pre-occupied with getting out of the institution (whether or not they have a family to return to); secondly, they are hindered from developing adequate social and interpersonal skills, and other life skills; thirdly, their (pre)existing developmental, emotional and behaviour problems are likely to be exacerbated, also leading to new developmental and mental health problems. Thus, lack of opportunity and engagement in institutions would explain, to a considerable extent, the higher rates of developmental delays and deficits and mental health problems found in institutionalised children.

(iii) Staff attitudes and responses to children are perhaps the most critical issue, particularly in the light of the attachment issues observed in institutionalised children. While staff-child ratios may be unfavourable in many institutions, this is not the only reason for poor quality of care. The often-paternalistic response of institution staff to problem behaviours is thus not appropriate or helpful. For instance, there tends to be an attitude, also articulated to children, of 'how we have provided you with everything…and you still behave like this'. Inherent in this expectation of gratitude is also the notion that children do not actually have the right to access survival needs; and that the provision or rather, the conferring of these rights are therefore conditional (upon their 'good' behaviour). This attitude that emerges from the lack of a rights-based approach is also discriminatory in that it reflects that children in institutions do not enjoy the same rights as those living with their families with regard to survival needs.

As discussed, children in institutions have pre-existing vulnerabilities due to difficult and traumatic experiences, also causing them to have poor socio-emotional skills and difficult behaviours. They therefore require validation of their difficult experiences and their feelings of fear, rejection, isolation, or sadness as the case may be. The expectation that staff have, namely that children 'should now be happy' because they have apparently been 'removed' from their hostile (home) environments, is an unreasonable one. Inherent in this expectation is the idea that: i) children should be unaffected by past experiences; ii) children should flip the memory switch and 'forget' about problematic family circumstances; and iii) they should magically adjust to the new environment, because after all, it offers everything by way of survival needs, through better facilities than what they were accustomed to at home.

In short, staff, in a majority of our child care institutions, lack the understanding, orientation, and skills to assist children with difficult and traumatic experiences. Consequently, and due to untreated mental health issues and unresolved trauma, children who already come from difficult circumstances, may even experience a deterioration in their mental health. These aspects of quality of care are in addition to those stemming from attachment issues and consequent emotional difficulties that children experience due to severance of family ties, in the form of separation, rejection, abandonment, relinquishment to an institution and lack of predictability. Multiple changes in institutions and in caregivers also contribute to children's destabilising experiences and hinder them from finding suitable (substitute) attachment figures as they move through life—and the impact of poor attachment relationships on socio-emotional outcomes of institutional children(Vorria et al., 2003), (Muhamedrahimov, Palmov, Nikiforova et al., 2004),(McLaughlin et al., 2012), (Smyke, Zeanah, Gleason et al., 2012) is well documented in the literature.

Thus, despite differences between child care institutions, certain factors are generally common to institutional life, namely isolation, regimentation, an unfavourable child/caregiver ratio, lack of psychological investment by caregivers, and limited stimulation (Zeanah, Nelson, Fox et al., 2003).

Children's perceptions: The right to decide where to live

While the large body of literature on alternative care and child care institutions, mostly focuses on adverse developmental and mental health outcomes from institutionalisation of children, making a case for alternative forms of care for vulnerable children, there are also studies to show that the increased rates of emotional and behavioural problems experienced by institutional children may be a combination of the results of their early experiences of deprivation, neglect and abuse, and of the adverse conditions of institutional rearing (Roy, Rutter, & Pickles, 2000). Exposure to early-life stressors leads to neurobiological changes that increase the risk of psychopathology in both children and adults (Nemeroff, 2004). Therefore, adverse outcomes in child development and mental health cannot be attributed solely to children's institutional experiences.

As legitimate as studies and viewpoints are, on adverse psychosocial outcomes for institutionalized children, they represent adult opinions and perspectives on institutionalised children. There is little research on the lived experiences of children in institutions i.e. in terms of how they say their lives in the institution are vis-à-vis living at home with parents and other family or in adoptive and foster care homes. In some institutions, children do report that they are happy and well cared-for, that they have better conditions than they would at home. We assume that such children would be relatively few in number but given the paucity of research, we are uncertain about what the numbers may actually be.

Some of our current understanding, that there are well-functioning institutions and children who are happy in them, is drawn from anecdotal reports of field workers and our own experiences in the field of child protection and mental health. Below are some examples that are fairly common in the Indian child protection and welfare system wherein the nature of children's circumstances leads them to prefer institutional living over family life. The case examples are drawn from the Community Child and Adolescent Mental Health Service Project and Swatantra Services, Dept. of Child and Adolescent Psychiatry, National Institute of Mental Health and Neurosciences:

- Child A was adopted soon after her pre-school years and by the age of 14, she was orphaned as her parents died in an accident. Given that by now,

she was used to a superior education system and a comfortable home, she was offered the opportunity to continue in an elite boarding school in India. She, however, refused and insisted on going back to the institution she was adopted from as she still had friends and social bonds there. (This case example is from a discussion of the Community Child & Adolescent Mental Health Service Project team with Judge & Chairperson of the Juvenile Justice Committee, Supreme Court of India [August 2019, New Delhi]).

- Child B, aged twelve years, refused to be placed in adoption, despite his institution having found prospective adoptive parents for him. He said he was happy in the institution, well-cared for, with many friends, and that he had no wish to leave and start afresh with a family.

- Child C, aged eleven years, was placed in foster care. Some months later, he returned to the institution he was from, saying that he wished to reside in the institution. His reasons were that the institution encouraged his talent in sports, while the foster parents pressured him regarding his academics; he also said that he enjoyed the 'freedom' of the institution, preferring to be with many children rather than staying with 'two adults', that is the foster parents.

- Child D, aged 16 years, was known to return to a certain transitional child care institution multiple times as he came there voluntarily, every time he experienced abuse and distress in his family. He repeatedly returned believing that the institution afforded him a safe space, where he was 'respected' as he given leadership responsibilities and 'importance'.

- Child E, aged thirteen years, after repeated experiences of child labour, was forcibly repatriated to her family by the child welfare committee. The child was insistent on staying on at the institution, where she reported that she could avail of schooling and other basic needs; she also reported that if she went back home, she would be sent into child labour again.

- Child F, aged 17 years, had been placed in the institution by her mother, several years before. When the mother decided that she wanted her home, the child refused to return home, reporting that her mother had been abusive and discriminatory towards her, throughout her early childhood.

She also said that the institution (staff) were her family now and that the institution was her home.

- Child G, aged 17 years, ran away from home to be with someone in a romantic relationship (and to 'marry'). When apprehended by the police with on-going POCSO Act charges on the boy, the child was placed in an institution. For reference, the Protection of Children from Sexual Offences (POCSO) Act, 2012 was enacted to provide a robust legal framework for the protection of children from offences of sexual assault, sexual harassment and pornography, while safeguarding the interest of the child at every stage of the judicial process. It is also applicable in cases where minors allegedly engage in 'consenting' sexual relations, resulting in the male (whether adolescent or adult) is charged with perpetrating child sexual abuse. She refused to return home to her parents, for fear that they would not permit her (even at a later stage) to be with the person of her choice, and that they might get her to marry someone else. She therefore decided she would rather be in the institution until she attained the age of 18, so that she was then free to make her choices.

Another context in India, leading to questions on the deinstitutionalisation alternative care option is with regard to children who come into conflict with the law. It has been observed in fieldwork (Community Child & Adolescent Mental Health Service Project, Dept. of Child & Adolescent Psychiatry, National Institute of Mental Health & Neurosciences) that institutions for such children function more as detention centres than as centres for rehabilitation, tending to be apathetic, judgemental and punitive as opposed to providing opportunities for behavioural transformation, including guidance and counselling, vocational, and life skills training. However, merely releasing these children or deinstitutionalising them is not a panacea for their problems—because they often return to dysfunctional home environments which also fail to provide them with the requisite care and transformation opportunities. Thus, neither institutionalisation nor deinstitutionalisation, in their current manner of implementation, is beneficial to them. But given the difficult circumstances they are drawn from, well-run institutions are more likely to be able to provide them

with developmental opportunities for growth and change than their already limited home environments.

At primary and secondary levels, Indian child protection systems tend to view their role as deinstitutionalising and repatriating children, that is as re-uniting (runaway or institutionalised) children with their family. While the intention is not wrong, what is problematic are the underlying premises of the repatriation decision: i) that families are always, and under every circumstance, the (only) best places for children to be; (ii) all families/caregivers are loving and caring and simply by virtue of being parents/caregivers would not engage in harmful actions towards their child. Such assumptions prompt us to question our interpretations of 'safety and best interests of the child'; they do not systematically examine the nature and capacities of family systems to care for children. Failure to engage in such systematic (assessment) processes frequently results in a revolving door syndrome, wherein children who are simply repatriated, without necessary mental health and psychosocial intervention, will leave home again.

Therefore, in any situation of vulnerable children, where placement decisions are involved, implementation of psychosocial assessments, both of an individual child as well as the family (home study), are critical. The decision to deinstitutionalise a child needs to be made on a case by case basis, in recognition of each child's unique universe and context; and more importantly, in the light of the frameworks of child rights and child's best interests, it is imperative for placement and repatriation issues to be discussed with children, so they can express their concerns and viewpoints, including preferences for places of stay. The issue of choice must be applicable mainly to older children, meaning at least seven years and above, who are at a developmental stage that allows them to communicate their thoughts, feelings and viewpoints. Furthermore, a successful deinstitutionalisation effort, especially with regard to older adolescents would, in addition to (residential) placement, necessitate implementation of vocational training and psychosocial rehabilitation programmes in institutions, to prepare these individuals to leave the institution and successfully be reintegrated into society.

If deinstitutionalisation is based solely on the adult world's perceptions of 'the best interests of the child', it runs the risk of violation of children's rights; for, if children are unhappy with their placements and repatriation arrangements (whether institutional or otherwise), then any research and policy on alternative care and deinstitutionalisation, no matter how well-intentioned, is rendered meaningless. Furthermore, the Child Rights Convention (CRC) views implementation of the child's best interests as being linked with the children's right to express their views.

More specifically, article 12 of the CRC (United Nations, 1989) emphasizes that the state must in accordance with their age and maturity, allow children the right to express their views freely; and that they should be provided with opportunities to be heard in judicial and administrative proceedings, either directly, or through appropriate representatives, in accordance with the laws of the country (United Nations, 1989).

Adoption and foster care issues in India

Child care institutions, in developed and developing countries, have a long history relative to the short history of deinstitutionalisation efforts, which began only in the 1980s, through a heavy reliance on foster care and adoption systems. Rutter's studies on adoption and foster care show that institutionalised children demonstrate a significant catch-up in psychological functioning following adoption (Rutter & Team, 1998), (Rutter et al., 2007) .

However, one of the key reasons why deinstitutionalisation has not progressed much is due to the challenges of foster care (Herczog, 2017) and adoption. Despite more professional recruitment of foster care families, the tradition and culture of foster care is not very strong as not many families willing to provide foster care. Meanwhile, due to the evolution of individual children's rights and recognition of their developmental needs, as well as the complexity of needs of the children requiring foster care, the demands on fostering have grown considerably (Herczog, 2017). Several Eastern European countries invested in the development of new models were introduced such as foster care by relatives or close neighbours, and periodic, temporary and specialised foster care, specialised foster care for young children, through specialised training on care of

young children, especially those with disabilities, increased cash allowances for foster parents and systematic invitations to prospective adoptive/ foster care parents and families to participate in information meetings (Legrand, 2015). Despite such efforts in foster care and adoption, limited reductions in numbers of institutionalised children (of about 10%) were achieved as other challenges, capacity to identify, reach and support the most vulnerable families, still remained (Legrand, 2015).

While legal adoption has a relatively long history in India, formal foster care is at a very nascent stage in India, with the above-described policy reforms still not taken shape. One of the few studies on foster care in India conducted in order to assess the prospects for implementing foster care as an alternative to institutional care available to orphaned and abandoned children has documented barriers perceived by families, such as ability to foster a child, particularly attachment concerns, including the adjustment of the child into the foster family, background of child (health and religion issues), social pressure/judgment and family receptivity to foster care (Forber-Pratt, Loo, Price & Acharya, 2013). In 2016, the Ministry of Women and Child Development released model guidelines for foster care (Ministry of Women & Child Development, 2016); many states in the country are currently engaged in developing rules and procedures for foster care, which are largely to be implemented by child welfare committees in coordination with the child care institution staff, who are not a highly trained and skilled workforce. Such issues compound the difficulties to deinstitutionalisation.

With regard to adoption, the existing campaigns and awareness programmes in India have barely been visible and are mostly known only to government functionaries. Unlike the scale of campaigns implemented on child (sexual) abuse, right to education and disability, to name a few, adoption campaigns are relatively few in number. Between April 2018 and March 2019, there were only 4,027 in-country and inter-country adoptions (CARA, 2019), which are woefully low for a populous country such as India. Perhaps the numbers of children in institutions are not high enough to place adoption (and foster care) on agendas for national-level campaigns and movements. That said, paradoxically, for those families that are keen to adopt, the long waits despite the existence of many

thousands of institutionalised children in need of a home, the complex legal and bureaucratic procedures of adoption serve as hindrances to adoption.

Apart from the inadequate policy and systemic efforts to promote adoption, the relatively conservative family culture in India does not support adoption, let alone promote it as an ideal or even an equal option to a biological child. Interestingly, Indian folklore and mythology is filled with stories of adoption, planned or accidental, including successful stories of single parent adoptions. While the stories vacillate between adoption due to childlessness and in order to ensure the child's welfare, they somehow maintained the primacy of the child. But as time went by, the notion that adoption is only for couples who cannot conceive a child, became the norm. There are those who adopt children out of choice (and despite having biological children), because they believe in the philosophy of adoption, in that of children needing a family; however, these numbers are few as compared to those who feel compelled to adopt due to the inability to bear children. The stigma associated with infertility, and the socio-cultural concepts of the conjugal bond that entail the task of producing children, make adoption a problematic alternative for childless couples who prefer to seek assisted conception (Bharadwaj, 2003). Adoption therefore continues to remain a less desirable option because 'the links between an adopted child and the social parent become a public, vocal, and visible admission of infertility' (Bharadwaj, 2003, p.1867). Consequently, today, adoption in India, is largely restricted to some pockets of the urban upper middle class, whose families tend to be more enlightened and therefore open to the idea of adopting a child; there are peri-urban and rural families also coming forward to adopt children, but their reasons have more often than not tended to stem from the desperation to have a child, either due to the social stigma of childlessness or the need for economic support and care during illness and old age.

Finally, interestingly, and unfortunately, while the adoption (and foster care) promotion agenda in India should ideally further the deinstitutionalisation objective, it may also do so in a negative manner: while adoption started out with the objective of providing childless parents with children and homeless/vulnerable children with families, in the wake of deinstitutionalisation, it is also being used as a tool to 'push' children out of institutions. Our extensive

field experience through our community-based initiatives for child protection and mental health (refer to in the Community Child & Adolescent Mental Health Service Project and Swatantra Services, Dept. of Child & Adolescent Psychiatry, National Institute of Mental Health & Neurosciences), have found poor pre-adoption counselling processes and inadequate preparation of prospective adoptive parents and children, including unsystematic home studies that yield inaccurate information on the abilities of a family to parent or adopt; thus, pushing the adoption (or foster care) agenda, merely to serve the purpose of reduction of numbers within child care institution, has serious consequences for the success of the adoption, particularly the well-being of the child.

Systemic capacities

UNICEF initiated child care reforms in 22 countries in the regions of Eastern and Central Europe and Central Asia, with the aim of prioritising and supporting family and transitioning from institutionalisation to community-based care. Key reforms included policy and legislative changes, introduction of new services, increased public funding, quality assurance for improved coordination and decision-making processes, 'gatekeeping' functions to respond to children at risk, and establishment of family benefits, child-care support services and family welfare services   (Legrand, 2015). Some countries undertook major legal and reform measures, to shift from centralised child protection systems based on warehousing children in large institutions to preventive and alternative services, decentralisation of service provision, case management, and quality control. They brought their fragmented child protection systems under the responsibility of one single structure at national level; and focussed on capacity development for local child protection services, for case management and gate keeping (single entry points) by bringing qualified social workers and mainstream case management. Support and alternative care services were provided for prevention of child separation from families; alternative care services aimed to provide quality services to children for whom separation from their parents was unavoidable (Legrand, 2015).

Despite these social and economic reforms in this region most countries still depend on institutionalised child care. Government data from 21 of these

countries reflects that rate of children being institutionalised since 2000, has been fairly stable. 31,000 children were in institutional care, with under five per cent of these being orphans. While children with disability and ethnic minorities may account for these numbers, this situation reflected that the most vulnerable families, due to discrimination and bureaucratic red tape, were unable to avail of the government aid and support they required, by way of social protection systems (such as cash transfers, services and social work), in order to be able to cope with their economic crises and prevent being separated from their children(Legrand, 2015).

From a systemic point of view, the factors that hindered Central and Eastern European and Central Asian countries from implementing child care reform to do away with institutionalisation and adopt strongly community-based care are applicable to the Indian context, wherein the social protection system is weak because: i) it is poorly skilled, with inadequate understanding of childhood, child development and vulnerability; ii) it contends with masses of vulnerable children also due to India's large population size, a majority of which still contends with severe socio-economic problems and paucity of basic needs; (iii) it does not have access to adequate government financial aid schemes to be able to provide families with the assistance required for them to keep children at home and provide for developmental needs and opportunities rather than abandon, institutionalise or send them to child labour. Indeed, selection criteria and vulnerability analysis for providing targeted social protection interventions, such as cash transfers, may be difficult for a country such as India, due to its sheer population size and the magnitude of its needs.

Consequently, child social protection systems in India, such as child welfare committees, juvenile justice boards and other components of the government Integrated Child Protection Scheme (ICPS), cannot be expected to address the issue of deinstitutionalization through the already unscientific, unsystematic methods of repatriation and family reunification, they are currently using. Deinstitutionalisation, as described above, requires a much greater, consolidated, systematic effort by policy-makers on the one hand and field-level workers and service providers on the other. It has been found that less wealthy countries, with lower levels of spending on public health and social services, tend

to have higher numbers of institutionalised children, especially because of a lack of counselling services to prevent abandonment, and due at-risk parents having poor access to social services (2006)—and India is a case in point.

Implications for the deinstitutionalisation debate in India

Based on the above discussions, the deinstitutionalization debate cannot (solely) centre around the 'institution versus family' argument. The issue is not whether the child is within a family or an institution setting but that the child's safety, developmental and mental health needs are met optimally. In principle, of course families are the best places for children because under normal and healthy circumstances, families provide a scaffolding for optimal development of children by way of basic nurturance, attachment experiences, security, affirmation and opportunity. Since we do not live in such a utopian world, and in a country like India, a considerable population still continues to live in poverty, child care institutions need to continue to exist.

As erstwhile discussed, many child care institutions in our country do not function optimally. It is pertinent to note, however, that there is also a certain proportion, even if smaller, of child care institutions that are well-functioning. Also, but for the existence of child care institutions, many children would be on the street with no access to basic needs, and many are likely to be engaged in child labour. Vilifying all child care institutions because they do not functional optimally, thus moving towards complete deinstitutionalisation, is therefore neither a feasible nor a practical one.

There are several instances where parents, due to abject poverty (not an uncommon condition in India), request that their children to be placed in institutions, because they are unable to meet even the most basic needs of their children, so child care institutions have also enabled vulnerable children to avail of health care and educational opportunities. In fact, global data shows that of the estimated eight million children in institutions, most are not orphans – about 50 to 90 per cent have at least one living parent; most children are placed there not as orphans but due to poverty; apart from their own limitations pertaining to

HIV and other illnesses, parents also see institutions as being a means to provide better care and education for their children (Petrowski et al., 2017).

Based on experiences of other developing countries that have made efforts to deinstitutionalise children, it is important for India to understand the sheer scale of child care reforms that deinstitutionalisation would take; that this is not about piecemeal efforts at family reunification by child care workers who are currently working in individualistic, somewhat whimsical ways with limited knowledge of child development and childhood adversity, with poorly conceptualised frameworks and methodologies to analyse vulnerability of children in difficult circumstances, and little adherence to standardised operating procedures and protocols to assess and assist cases of children in institutions. Given the size of the country's population, and the complex dynamics of socio-economic problems and the diverse nature of its demographics, deinstitutionalisation in India calls for a national commitment backed by state funding—in order to rehabilitate and repatriate children, support families with financial aid and other welfare services that will equip them to care for their children, and to implement large scale quality adoption and foster care programmes. The implementation of such large-scale child care reforms in a country that has had a limited culture of child protection, would take time, not least because children's value in many parts of India lies in their economic utility, rather than in their individual identity, personhood and rights.

Therefore, if we reduce the deinstitutionalisation debate to maintaining children in institutions (or not), and base our actions on reducing the numbers of institutionalised children and institutions because the latter are all believed to be harmful for the development of children, especially without weighing up the feasibility of other alternative care options, we would be throwing the baby out with the bathwater!

While, for certain reasons, deinstitutionalisation is a desirable goal, and preparatory measures must include systems strengthening at various levels, the interim measures should be directed at: (a) improving our child care institutions, including how to provide for better physical infrastructure, smaller and more intimate institutions with better staff-child ratios, age-appropriate developmental

activities and engagement for children that will promote optimal growth and development, and enhanced staff skills and sensitivities; (b) making decisions about (de)institutionalisation not only through child care reforms, policies and systems but more critically, involving child participation. In the end, dialoguing with children to understand their unique circumstances and universes, their aspirations and desires, is what should ultimately guide us to making placement decisions that would truly be in the interest of every individual child. Else we will be throwing the baby out with the bathwater.

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Home and belonging: Mapping what matters when moving on

Robin Dallas-Childs and Danny Henderson

Abstract

Senses of home and belonging are closely linked to feelings of security, connection and positive identity for young people in residential childcare. Following the delivery of a number of workshops by the authors with residential care staff and care experienced young people, this article presents our reflections on the concepts of home and belonging. We explore what home and belonging mean to young people and how residential child care can provide the conditions for the experience of home and a sense of belonging through care worker-young person relationships, grounded in everyday activities and exchanges. We reflect on some of the consequences for the sector if we take these ideas seriously. The findings of the Independent Care Review in Scotland provides some hope for a broader consensus around the centrality of relationships in Scottish care, though there are significant systemic challenges to translating these into practice, not least the ways in which historically risk-averse practice cultures can accommodate a shift towards the more autonomous professional identity required to enable residential care workers to foreground relationships in their practice.

Keywords

Home, belonging, relationships, relational practice, professional identity, residential child care in Scotland

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> **This is my home.** When I come here on a Wednesday I come home. I've got my own home, but when I come here, I come home (26-year old woman speaking about the weekly visits she makes, along with her daughter, to the residential care home where she'd lived from ages 14-17).

Introduction

This paper explores ideas and concepts regarding how young people who have experienced living in residential child care in Scotland may be better supported to experience a sense of home and belonging in the care setting and when they move on. These reflections follow a series of workshops facilitated by the authors, involving a variety of professionals and care experienced adults from across the residential child care community in Scotland. Drawing on research that foregrounds the voice of those with care experience and professionals working in residential child care, contributions from workshop participants and current doctoral research of the first author (RDC), an exploration of key themes and issues that arise was undertaken. From this a more nuanced understanding of young people's constructions of home and belonging emerges. It is noted that young person–care worker relationships, grounded in everyday interactions, are central to the endeavour to engender a sense of home and belonging and that, in these moments, young people *experience* care.

More broadly, we aim to highlight the ameliorative potential of residential care for children who have experienced profound family and social breakdown, providing an intentional contrast to the often-negative discourses associated with the history of the sector (Smith, Fulcher & Doran, 2013).

This article comprises three sections. Firstly, we provide an overview of the workshop content — what home and belonging means to young people in residential child care. We then present a summary of workshop participant responses to these messages in diagrammatic form. We then conclude with a reflection on the possible implications of this for policy and practice in the residential child care sector.

The Workshops

From March through to June 2019, we facilitated four workshops, exploring the themes of home and belonging in residential child care. Two were run at the Scottish Care Leavers' Covenant conference in Glasgow in March, a third was conducted with a community of managers who work in residential child care and another at the Scottish Institute of Residential Child Care (SIRCC) conference in Glasgow in June. In total around 120 people from a range of roles and identities participated in these workshops, including practitioners, care experienced adults, care centre managers, field social workers, local authority workers, and academics. Individuals self-selected the three conference workshops, whilst the session ran with the community of residential care managers formed part of an organisational training day.

Our aims for the workshops were two-fold. Firstly, we hoped to shed some light on how young people — whose lives are more often characterised by disconnection from both people and place — *experience* connection and a sense of belonging and how these may contribute to the feelings of security associated with being at 'home'. Secondly, we planned to seek the views of workshop participants as to what this might imply for residential child care policy and practice.

Workshops were in two parts. In the first part, to 'set the scene', delegates were introduced to the testimony of young adults from the Why Not? Trust community of care experienced young adults*,* reflecting on their experiences related to the concepts 'home' and 'belonging', before moving to the second part, an exercise in group reflections. To complement and contextualise this, participants were given a brief overview of some of the research conducted with care experienced children and those that work with them, studies that address or touch on these and related themes (Clark, Cameron, & Kleipoedszus, 2014; Coady, 2014; Duncalf, 2010; Wilson & Milne, 2012).

Workshop part 1

A number of themes from the care experienced young adults and research literature converged and were presented to the delegates in the form of slides and a video of testimonies from member of the Why Not? Trust Community:

Young people's perceptions of home and belonging

Intriguingly, young people with experience of residential child care reported a sense of belonging to people and places not conventionally associated with home or family (Wilson & Milne, 2012). Bedrooms provide privacy, security and the opportunity to express identities through the selection of furnishings, decorations and the placing of significant items (Clark, Cameron, & Kleipoedszus, 2014). Personal items such as clocks, teddies and computers were transitional objects invested with significant meaning — a reminder of a special event or relationship, providing emotional connection and a continued sense of self across spaces (Emond, 2016; Gorenstein, 1996; Holligan, Hanson, Henderson & Adams, 2014). 'Secret' spaces within buildings provide young people with the security and comfort to work through difficult emotions. Home, as Milligan (2003, 2005) observes, 'is as much a social and emotional concept as a physical one' (Clark, Cameron, & Kleipoedszus, 2014).

Relationships in the everyday

The centrality of relationships for young people within and leaving care is well documented (Baker, 2017; Happer, McCreadie & Aldgate, 2006; The Care Enquiry, 2013; Independent Care Review Scotland, 2020; Stein, 2019) and emerges as the 'golden thread' (The Care Inquiry, 2013) within the testimony of the young people we worked with. However, the nature of these relationships is perhaps less considered. Here, we see that relationships, and relational moments are grounded in, and evolve through the everyday. Through hanging out together; eating together; kicking a football in the garden; in authentic exchanges where we give something of ourselves; through spontaneous hugs;

by 'going the extra mile', perhaps checking in outside of a shift — perceived as a demonstration of genuine care and of going beyond the job description (Coady, 2014; Cree & Davis, 2006; Doel & Best, 2008; Happer, McCreadie & Aldgate, 2006; Richmond, 2010). It is felt through rhythms and rituals — the high fives in the morning or the weekly pizza night. It is hanging in there with the relationship when things get tough (Garfat & Fulcher, 2012). These relationships provide not only vital connections within the residential care home but also anchors to places and their people when the time comes to leaving the care home. As one residential care worker observes: 'The house is just a house, the big thing is the relationship…people you know and trust, they are continuing care that you really need' (residential child care practitioner quoted in McGhee, 2017).

Going home is as much, and often more a reconnection with people as it is with a physical space. As Gharabaghi and Stuart (2013, p. 2) suggest, 'Relationships travel with young people as they move between physical dimensions of their life-space, and they serve to connect places….Relationships transcend not only place but time'.

> I was in secure with kids who were from the care system in England they were like, 'they still come and see you'? And I was like, yeah that's where I live, that's my home, they're responsible for me. They were like, 'wow as soon as we get kicked out there's no contact'… And I was like, 'wow, I couldn't imagine [her residential care home] would be just like, 'bye!' They wouldn't do that, ever (Janine, 27 – quoted from the doctoral research of the first author).

Other features reported about the nature of relationships between young people and workers included themes of consistency, fairness and that they offer predictability. Other than the moral imperative of these features, relationships may be conceived here as providing emotional and sometimes physical containment (Bion, 1962; Emond, Steckley, & Roesch-Marsh, 2016; Smith, Fulcher, & Doran, 2013; Ward, 1995). From the perspective of young people and their workers these are best couched in strong young person–worker

relationships, with particular respect afforded to those workers that demonstrate consistent care and commitment (Macleod, Fyfe, Nicol, Sangster, & Obeng, 2018).

Workshop part 2

Participants were asked to reflect on these themes in small groups of between four and six and make suggestions as to what must or should be done do to engender a sense of home, connection and belonging in children and young people living in, and moving on from, residential child care and what factors might detract from this aim. They recorded their responses on 'post-it' notes.

Although the delegates had eclectic roles and identities, common themes developed across all four workshops; details of the suggested must or should actions, and the must-not prohibitions, recurred throughout the engagement. Following the workshops, the authors collated participant responses and grouped them within three categories; a) carer/young person relationships, b) residential care management, c) policy and implementation.

Workshop Outputs

The following two diagrams capture this feedback. In each, the 'aim' at the top of the diagram sets out our shared aim, 'to support young people leaving care to develop a sense of belonging, a sense of being cared for'. In the first diagram, delegate responses can be read stemming from each of the above three categories (marked in yellow boxes). The second diagram collates comments about what we must not do to detract from this aim.

Reflection

While the majority of workshop participants agreed that the development of relational practice was a worthy pursuit, this was not universal. Some participants were reluctant to embrace the ideas of mutuality and reciprocity as components of practice in residential child care, for whom transactional, objective interactions were definitively professional. For some, keeping a safe distance to avoid emotional entanglements with the children they look after is essential to supporting role clarity, rational decision-making and behaviour.

It is important to honour the good intentions and acknowledge the systemic and cultural drivers that promote such an approach. However, the danger is that it valorises emotional neutrality and is likely to lead to a suppression of the inherent moral impulse to act with congruence in response to need (Steckley & Smith, 2011). This seems counter-productive both to the professional intent to care and to the young person's experience of feeling cared for.

This perspective may also be an implication of residential child care being subsumed within the professional realm of social work. Within this, the policy agenda and practice has been influenced by inquiry reports that followed high profile abuse scandals and invoked a move from child welfare to child protection (Coady, 2014, Smith, & Cree, 2012; Smith, 2003). The contention being that the pre-eminence of child protection has contributed to a risk averse culture within which the potential that exists to support the development of children and young people through relationships has largely been neglected. This, in itself, risks creating sterile cultures of care within which the pre-occupation about preventing abuse gives rise to defensive practice at the expense of a caring approach that supports development (Corby, Doig, & Roberts, 2001). Such an approach reduces the opportunities that exist for young people, living in residential child care, to construct meaning through their interactions with trusted adults to create their own identity (Parton, 2006; Smith, 2003).

The dominant discourse around residential child care often reflects a negative perspective and can focus on what it is regarded as failing to do in terms of the poor health, educational and employment outcomes associated with care experience. These narratives, developed from an outcome focused policy and research agenda that accentuates deficiencies, veil the broader social and economic issues surrounding a child's entrance into care and fail to address what could better benefit children (Smith, 2003). Rendering a like for like comparison with their peers outside of care is of little worth if we ignore the contribution that care can make to welfare across the life course (Duncalf, 2010). Rather than being the perpetuator, care can ameliorate the impact of profound social and family breakdown (Forrester, Goodman, Cocker, Binnie, & Jensch, 2009). Nevertheless, a negative narrative often prevails, conflating complex issues that can reduce opportunities for young people and imposes pressure to address

these on the professionals offering day to day care. The privileging of family care arrangements over residential child care has consolidated the perception of residential child care as the placement of last resort, despite high profile policy initiatives that have attempted to counter this (Connelly & Milligan, 2012; McPheat, Milligan, & Hunter, 2006; Smith, 2003). This diminutive status is extended to those who work in residential child care services, who are, or are perceived to be, less qualified and less expert (Smith & Carroll, 2015), thus creating confusion about the purpose of these services and the professional identity of practitioners.

One purpose that may lend clarity to the function of residential child care and its professional identity is to support young people to establish roots of belonging and a sense of security through enabling compassionate, trusting, caring relationships (Henderson, 2020). Relationships that are built around an emotional connection, that embrace complexity, developing reciprocity and power sharing (Li & Julian, 2012; Pekel, Roehlkepartain, Syvertsen, Scales, Sullivan, & Sethi, 2018). This requires emotionally intelligent people working in emotionally literate cultures, where interactions are informed by the disciplined intuition of those who find joy in the dance of attunement, who know how to contain, when to hold off, how to hold on, set limits, surface tensions and stretch expectations.

Some care experienced adults reported that plans and activities that focused on 'independent' living skills such as cooking, housekeeping and budgeting were experienced as tokenistic. For Why Not? Community members, the overt focus on preparing to leave care also served as a prompt to the impending losses they were about to incur in terms of relationships, familiarity and safety. Practising independent living skills was at least frustrating for them and compounded their fears about moving on. It may also be an indication of how professional interactions derived from policy, procedures and outcomes focused plans and tasks to address perceived deficits, can be experienced as uncaring. On the other-hand, one young person gave significance to the way a staff member mopped the kitchen floor as a revelation of the culture of care in his former home. The staff member quite simply explained what she was doing and how she did it, during an impromptu interaction. That he remembered something as

apparently trivial as this was a revelation in itself about the kind of experiences that young people hang onto. Other young people recounted similar stories of unguarded, unplanned and natural encounters in the context of mundane domestic routines, affecting moments of connection in the everyday and ordinary. If these are the memories, then this may be what matters.

It seems important to help young people to establish trust in a world where they can belong, a world not entirely benevolent but manageable within the range of their adaptive capacities, skills and resources nurtured through their relationships with caring adults. Rather than 'training for independence', those that had recently moved on from care issued a plea for the professionals in their lives to help them build resilience. Or in their words, to help them build 'the will to survive', an existential exhortation, perhaps another way of saying make sure I matter and that I know I matter, a riposte to any notion that resilience is a wholly inherent personal characteristic. Here, it is nested in relationships and contingent upon social, emotional, moral experiences and resources, within and out-with self.

It is the meaning created in these interactions, in the co-created spaces between individuals that register as the most significant and become the foundations of a relational approach (Garfat, Gharabaghi, & Fulcher, 2018). If relationships are founded on negotiated iterative exchanges, with the capacity to sustain and strengthen across the spectrum of shared lived experiences, then they can provide the optimal conditions for development and for engendering a sense of belonging. It is not surprising that young people desire at least the possibility that the feeling of being cared for will endure beyond their care experience.

If we are serious about foregrounding trusting, meaningful relationships in how we care for young people, it is absurd to expect that this can be achieved if we are planning to end the relationships necessary to develop this, before they are formed. The hope and possibility, if not the promise, of continued relationships beyond care experience (in the formal sense) is a necessity. These relationships extend the opportunities for reciprocation. Nothing says 'you matter' like an invitation to contribute to our lives. Some misapprehensions about this may relate to concerns about extending the burden of professional responsibilities

and obligations into personal lives. In practice, ongoing relationships may be less of a burden to the worker than unrequited compassion and the damage caused by insensitive disruptions to established relationships, with and between carers, young people, services and organisations. When we engage in continued relationships, our worlds interface, expand and enrich, and are interwoven into respective communities, forming part of a wider pattern of interdependences - a design for life.

Reason for hope?

In February 2020 the report of the 'root and branch' review of the care system for children in Scotland was published. The Independent Care Review was described as a 'review like no other' in that it privileged and amplified the voices of people with care experience. The primary message delivered in 'The Promise' (Independent Care Review, 2020), the report on the findings of the review, was that loving stable relationships, within care and beyond, should be central to policy and practice. Consequently, recommendations included a reassessment of what it means to be professional in a caring role and the development of guidelines to support this. Loving behaviour is to be established as the norm.

> The workforce must be supported to bring their whole selves to work so that their interaction with children is natural and relational (Independent Care Review, 2020, p.22).

> Too many times, notions of professionalism have got in the way of the development and maintenance of relationships (Independent Care Review, 2020, p.23).

These themes will resonate with many of the professional and care experienced participants in our workshops, and perhaps also received as vindication of some of the activities and practices already established. The report provides some hope for a broader consensus around these important enduring issues. There are of course many questions outstanding as to how these 'promises' can be kept and translated into practice, particularly how the cultural conditions will be created to enable professionals to act with disciplined intuition in response to need and the perceived risks this may entail. Though as the report concludes,

and others have said before, conceptions of risk must be broadened to incorporate the risk of children *not* having an experience of loving and stable relationships (Independent Care Review, 2020 p.104; Smith, Fulcher, & Doran, 2013).

Nonetheless the task of translating these promises, in creating a culture of care that enables professional autonomy to flourish within existing managerial structures, presents a huge challenge. This means in practice that reciprocal interactions need to be valued as integral to growth and development, in contrast with an approach where need is framed as deficiency rather than a universal human characteristic. This is not to say that some issues, the behavioural manifestations of social, emotional and psychological need, may not require remedial intervention, but rather that this should not be the basis upon which professional relationships are formed. Sensitive to the adversities our young people may have experienced, but not at the expense of valuing our common humanity – I am because we are (Ubuntu proverb).

Concluding comments

It seems obvious to state, but important to reiterate that systems cannot care, only people can. The contention here, and borne out through the workshops, is that the existing care system restricts residential care staff by prioritising compliance with policies and procedures to mitigate risk and obviate complexity (Stevens & Cox, 2008). This can diminish the potential that exists within residential child care for authentic, meaningful and meaning-making relational moments to take place.

The stories that we have heard from some young people about how they mattered and how they constructed meaning, in and through the relationships with professionals who went the extra mile, offers hope and a sense of direction. Within these relationships, they were able to develop a rootedness based on the feelings of security and connection these relationships engendered, evocative of a sense of home and belonging. For them, home is an emotional experience that is carried when they move on from care. This was particularly resonant for those that were able to continue relationships with their carers at least into early adulthood.

The maps to home and belonging, developed through the workshops are remarkable in their simplicity but we acknowledge the complexity of their applicability. This does not however diminish their importance. They give insight into a real-world perspective on how change may be implemented, in the everyday and ordinary, to ensure that the residential child care sector reveres and values relationships and is foregrounded in relational practice.

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Danny Henderson has worked with Care Visions since April 2002, and in a residential environment with children and young people since 1994, in various roles. He is also an enthusiastic member of The Why Not Trust community and an advocate of continuing relationships between young people who have moved on from care settings and former professional carers.

NB Nicki McLaughlin, Manager at the Why Not? Trust co-presented all workshops with the authors.

Mapping Diagrams

Aim: To support young people leaving care to develop a sense of belonging, a sense of being cared for.

What should we do?

What must we do?

Policy and policy implementation

- Problems in the system/culture in demonstrating love to a young person
- Local authorities need to get their interpretation of 'continuing care' right and all agree a set policy. Currently different interpretations of 'moving on'.
- Agenda should always be about building a sense of belonging from as young age as possible in care services
- Not needing to measure love. Use the word 'human' instead of love, building humanity
- Transitions must be improved
- Make sure staff are supported to stay involved with YP post care. Financial - should staff be paid for this? Staff time is tighter, often committed.
- Recognise the change from professional to friendship
- Stop unplanned moves
- Fund continuing care
- Establish consistency across local authorities
- Establish permanence in residential child care
- Professional rivalry needs to be put to one side (through-care staff not be annoyed children's house staff welcoming young people back)
- Provide 24-7 support
- Eradicate staff burnout
- Belonging and being cared for: what do young people say?
- Make changes to data/GDPR etc. to support relationships
- Engender a sense of belonging in your organisation
- Professional identity based on values and the foregrounding of relational approaches to working with children and young people.

(Residential) Care management

- Include young people in the life of the service community
- Young people making the decision to leave care rather than services. Conversations with young people about when they want to leave
- Put up pictures of your young people!
- Clear expectations on the role of the worker
- Creation of spaces to enable relationships, develop community
- Improve the recruitment process
- Ensure the wellbeing of staff
- Organisation needs to value 'connection'
- Children can decorate space and learn skills while at home
- Reduce staff turnover
- Consider the quality of relationships in the community young people are returning to
- Anticipate and plan for crisis
- Services and providers have a responsibility to maintain archives of photographs and memories for young people who have moved on, through a web-page that they can access: a lasting account of their story.
- Contact point to facilitate long term contacts
- Engage ex-residents as volunteers. Shows current residents that they want to be there
- Welcome your young people/ex-residents back to your services
- Celebrate key dates e.g. 21st birthdays, religious festivals, milestones etc.
- Keep connections with service open. Allow young people to return to the care placement

Carer/young person relationships

- Show affection - touch, hugs etc.
- Be committed
- Be consistent and honest
- Be creative
- Establish safe, authentic relationships
- Clarity. Can you keep relationships (beyond care)?
- Plan less, more informal approach
- Make memories
- Respect privacy
- Would this be right for my own child?
- Be person centred
- Be flexible - recognise shifts in relationships
- Provide boundaries
- Involve young people in considering who is important to them and how relationships could be improved.
- Continue relationships on their terms, not ours

Aim: To support young people leaving care to develop a sense of belonging, a sense of being cared for.

What must we **not** do?

- Make assumptions without checking with young people
- Use jargon
- Exclude e.g. cooks, handy folk (in RCC homes)
- Keep reminding young people that they will be moving on. May be intended to motivate but often felt as impending loss.
- Punish people for maintaining relationships
- Let money be taken into consideration (be the driving force)
- Change contact details of the RCC homes
- Dismiss view of young people
- Be pre-occupied with cost
- Make false promises
- Assume everything we are doing is right
- De-skill carers/practitioners

The Extraordinary ordinary

David Grimm

In the world, we find that life can be hard,

And it takes just a little to help us through the days.

On the nights when we struggled and cried ourselves to sleep,

You'd be there in the morning with a smile and a tea.

You were there at home time, with a smile and your cheers.

When we griped in your face for all that went wrong in life,

You stood and you waited for the anger to release.

When we are rude or aggressive, you would always ask why,

Never once did you even hint at attempts to push us aside.

In this world, we speak of flowers which wilt, and whether or not we should
change their place.

When I think of my past, my station and space, I see the warmth

And comfort of your compassionate face.

During night terrors, you'd sit by my side, you were supposed to say no.

Instead you let me sit in the comfort of your private work zone.

You didn't complain you just sat there, quiet, with me by your side.

You cared without saying, simply by being.

Moulding our comfort until we can dream.

You make us feel human, when our hope has all gone.

These small tiny things allow lives to thrive.

Your actions save lives, your words hold us tight.

We never forget and you stay in our Thoughts.

About the poet

David is a care experienced consultant and a social work student, his background has been steeped in the world of care, being raised between foster, residential and kinship care. He has worked and volunteered with varying organisations across the sector to work for positive outcomes for his peers in care experiencing a similar upbringing to his own. Aswell as a student, David is also a poet and artist and occasional blogger.

Journeys to identity: Why care records matter

Laura Brown, David Grimm, Dr Gregor Clunie

Abstract

Care experienced people often find themselves applying for their care records in search of answers — to address gaps and inconsistencies in the knowledge they hold about their childhoods and personal development, which may in turn affect their broader senses of self. This article, written from our own lived experiences, provides a commentary on a system of writing, accessing and reading records which is not aligned to the circumstances and purposes of care experienced people and which indeed frequently disempowers and (re-)traumatises. We share our experiences of applying for and reading our records, as an adoptee and as a care experienced person. We also draw on the discussions and experiences of a Who Cares? Scotland care records campaign group. This commentary reveals the power imbalance at the heart of record keeping where the rights to memory, identity, and childhood are effectively questioned. It also makes suggestions for future practice. It asks for a complete rethinking of how care records are regarded by professionals and the sector, advocating for a shift in power as regards the production and control of information and a significant improvement in the care offered to those of us who choose to access it.

Keywords

Care experienced people, care records, Who Cares? Scotland, subject access requests, identity

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Introduction

Since late 2018, care experienced members of Who Cares? Scotland have been meeting regularly to discuss the meaning and significance of care records in our lives. This has entailed exploration of our experiences of accessing records, work alongside corporate parents to improve processes surrounding records access and visioning work to imagine radically different ways of supporting care experienced people to build — and where necessary to reconstruct — coherent narratives of childhood and personal development.

Individually and collectively, our group has identified our goals in accessing our records as being most broadly to find answers to profound existential questions, relating variously to our lives before care, our relationships with our birth families and the reasoning behind state intervention and decision making.

Many of us have identified the difficulty of recovering coherent narratives of childhood and early development amidst the 'fog of war' that can characterise care experience, the complexity of professional processes and the absence of appropriate support for personal meaning-making. This type of knowledge is the scaffolding for our sense of self, such that its absence can be confusing, disorientating and distressing.

Unfortunately, our group's experiences of accessing records has often been frustrating, alienating and re-traumatising, with record holders often being ill-prepared to respond to our specific purposes and circumstances. Members have discussed their subject access requests being met with suspicion or even hostility, cold bureaucratic responses and a lack of emotional support. It is common to receive papers describing the most traumatic moments in our lives through the post, without warning or signposting to relevant support services.

With regard to the substance and presentation of records themselves, members of our group have received files which are disordered, incomplete and fragmentary, which contain very significant, unexplained and often inconsistent redactions, which use unprofessional and stigmatising language, or which are illegible. Our experiences have led us to broader reflection on underlying dynamics of identity, memory, power, loss and shame.

In this article, we compare and contrast our experiences of accessing social work (David) and adoption (Laura) records and explore the meaning and significance of this process in our broader lives. Further, we examine the existing legislative framework around the right to access, before briefly considering potential improvements in view of the recent recommendations of the [Independent Care Review](#) in Scotland. In this connection, we want this article not merely to be an exploration of our own experiences, but rather also to function as an earnest call to action to all corporate parents in Scotland.

A corporate parent is a Scottish public body that has, by virtue of being named in the Children and Young People (Scotland) Act 2014, a set of legal duties which require them to uphold the rights and promote the wellbeing of care experienced people (see part 9 of the act). Wellbeing is defined in this context by reference to eight indicators, with the 'achieving' indicator relating specifically to children and young people 'being supported and guided in their learning and in the development of their skills, confidence and self-esteem at home, at school and in the community'([Statutory Guidance](#)). We know that a secure sense of self and the capacity for self-love and self-understanding, structured around coherent autobiographical memory, are crucial foundations for us all to thrive. Bearing in mind that many corporate parents are 'data controllers', we believe that these latter functions should, in respect of information relating to care experienced people, be understood in the broader context of their corporate parenting duties. Any good parent should support their children to understand who they are, where they've been and to have the pride and confidence needed to stand tall in a challenging social world.

A secure sense of self can be the difference between experiencing life as a painful series of threatening encounters or instead as an enriching adventure alive with opportunity and connection. We hope that for all those children and young people yet to enter care, self-knowledge and self-esteem can be developed in meaningful relationships with people who love them, with the therapeutic support of caring professionals as needed. However, for those of us who left care with heads full of fractured recollections and many more questions, we need honest, patient, caring support to help us understand.

The law in Scotland

Individuals can access their social work records by making a 'subject access request' under the Data Protection Act 2018, s.45 of which affords 'data subjects' the right to access their 'personal data', which public authorities must provide in writing 'without undue delay' and in any case within one month (s.54). In such cases as the local authority fails to produce the information within the timeframe, or at all, then there is a legal route to challenge and hold the agency to account in court or via the Information Commissioner's Office (ICO). Schedule 3 of the Act creates an exemption in the case of social work data whereby a local authority would not need to provide the information where doing so would be likely to cause 'serious harm' to the physical or mental health of the data subject or anyone else.

Significantly, 'personal data' is defined for the purposes of the Act as 'any information relating to an identified or identifiable living individual', with the meaning of the term 'relating to' crucially determining the scope of the accessible information. The ICO's guidance anticipates that this may include information which is 'biographically significant' or information used to 'make a decision about' that individual. However, it remains to be seen whether interpretation will be broad enough to effectively protect care experienced people's interests under Art. 8 of the European Convention on Human Rights in 'receiving the information necessary to know and to understand their childhood and early development' (Gaskin vs The United Kingdom, no 10454/83, ECHR 1989). Indeed, while much of the relevant information speaking to our childhoods is inextricably relational, it appears from the experiences of members of the campaign group that some local authorities are taking a very cautious approach to the provision of third-party information.

With regard specifically to information on adoption, adopted people aged 16 or over can access adoption court records from the Sheriff Court, Court of Session or from National Records Scotland. Additionally, information held by voluntary adoption agencies must be disclosed to an adopted person who has made a request to a local authority for adoption support services under s.9 of the Adoption and Children (Scotland) Act 2007 (relevant draft Statutory Instrument

available here). In relation to adoptees under 16, an adoption agency has discretion to provide the information where it thinks 'it appropriate to do so'(Part 2 S.3(2) of the instrument). Although no doubt well intentioned, it is unclear why access to agency records should be dependent upon requesting local authority support services. Further, given that there is no express time limit on agency responses nor seemingly any formal ICO oversight, this right of access appears weaker than that obtaining under the Data Protection Act 2018, from which adoption agency records are excluded.

Power

David and Laura consider that their experiences reveal crucial dynamics of power and control which underpin the creation, management and provision of access to records. With regard to access, Laura and David experienced polarising differences in treatment, which is considered to reveal how reliant applicants are on the goodwill of record holders. In David's case, he found that the people dealing with his subject access request went above and beyond to ensure the process was as welcoming and inclusive as possible. The parties involved in processing the records were clear and concise in their explanations and they made sure that David knew when, where and how he would receive his files. They offered support and multiple ways of receiving the files — within weeks he was in possession of his life records,which arrived in a single envelope, that had to be signed for.

In contrast to David's inclusive experience, Laura's experience has leaned towards controversy. In attempting to access information from a voluntary adoption agency, Laura was initially encouraged by telephone communication to arrange to meet a representative in person, who would 'have the records with her'. At this stage, Laura had been made to feel empowered — she had a sense of excitement and anticipation to read her history and find out more about where she came from.

However, on the day of the meeting and having travelled many miles from home, Laura met with intransigence, being told that she wouldn't be able to see the records until she discussed with the agency the past and present state of her

search and reunion and her life more generally. Whilst Laura was keen to access and view the records, she was also keen to have her own copy to read at her own pace, in private, at home. However, she was told that she had no legal right to obtain a copy of them and could only view them by appointment at the agency offices.

This felt to Laura like an individual, discretionary decision and she was astonished that on the whim of a stranger, she could be denied a copy of crucial information about her life. Laura felt betrayed, let down and unspeakably disappointed.

Fortunately, Laura has professional legal experience and was able to bring an action to the Sheriff Court. The agency began offering Laura copies of bits and pieces of the records, before eventually relenting and providing a copy of the whole file. The Sheriff (this is the judge presiding in the Sheriff Court in Scotland) helpfully recognised in his judgment 'the claimant would have been correct to recognise a reluctance, indeed resistance in the respondents providing a full copy of her file to her'. This is however not likely to be a practical course of action for many.

While David had a good experience of accessing his records, his experience of reading them has led him to reflect on the power of meaning-making deployed in their creation and processing. During his school years, David had taken to telling different people different things about his life — half-truths, curated stories with invented aspects — in order to protect himself from stigma and discrimination. When these unstable stories met with the cold, clinical written word of his records, written persuasively and possessing all the traits of truthfulness, everything began to unravel — he began to doubt himself and his own memories. David and Laura reflect that the position of the adult, the professional, who writes about the life of a child who, aside from the ordinary asymmetry of explanatory and descriptive power, may be living in a fog of war, is one of great power and responsibility.

Shame

While David had at different times felt shame on account of being care experienced, Laura had grown up feeling proud of being an adoptee, holding a pride of being picked for adoption. She had grown up hearing stories of how she had been chosen out of so many others and how she had lived with a foster family while waiting to live in her forever home. While Laura's experience of adoption and later life experience have led her to re-evaluate her memories of her upbringing and have raised pressing questions, she's adamant that she has never felt shame for her past, her adoption or how her life has been lived.

Laura did however feel shame on account of how she was treated in requesting her records, the response of the adoption agency implying that what she was doing was somehow wrong, improper or unwise. For her, this is one expression of an adoption model which is flawed insofar as it severs relationships with birth families and in many cases hands control over information surrounding adoptions and the adopted person's early life to adoptive parents. Laura believes that this implicitly prioritises the interests of parents and the state in establishing clean and clear legal rights and responsibilities over the interests of the adopted person in having access to and control over a complete and congruent life history.

David similarly reflects that his experience of engaging with record holders, while well supported, also generated a feeling of shame inasmuch as being asked pointedly what his purposes were in accessing the records communicated suspicion and a lack of trust. Similar experiences were had by several other campaign group members, who felt that record holders wrongly assumed or entirely misread their purposes. For David, this experience compounded an internalised sense of shame or guilt which made the decision to access his records difficult and one which took weeks — he questioned why he was requesting this information and why he should have a right to burden the local authority to satisfy his own curiosity. Further, David identifies a profound sense of shame as inhering in the very fact of not knowing who you are and having to apply to people you don't know, working in an office you've never seen, to understand your life story. David felt ashamed that strangers knew things about

his life which he did not, were empowered to take decisions about that information and were able to question his reasons for seeking to access it.

Identity and memory

While many of our campaign group sought to access their records in order to address existential deficits — pressing questions around their childhood, relationships with family and early development — often the content of the received records presented barriers to understanding and integration. A key recurring matter was that of redaction, which was applied very inconsistently and almost never explained or justified. In David's case, he received records without any redaction whatever, yet for others the paperwork had essentially been coloured in with permanent ink. This latter experience, of being 'handed files rendered virtually meaningless by the thick black lines of redaction, with no explanation of the deletions' has also been recorded in England (Williams, 2014). In group discussions, it emerged that three members had all submitted subject access requests to the same local authority yet had had markedly different experiences both in terms of interactions with employees and the approach to redaction which seemed to have been applied. This creates the impression that requests are being processed on an individual basis and without a uniform process grounded in relevant legislation and policy.

In Laura's case, the receipt of information from the adoption agency revealed a specific way in which information about her life had been curated — romanticised — which she believes speaks to the prioritisation of avoiding disappointment or distress, at the cost of authenticity and transparency, the latter having potentially longer-term impacts. Laura grew up with a handwritten letter from her mother, which contains several sombre soliloquies about why she could not keep Laura and had to give her away. This letter was extremely significant for Laura, both on account of its content and in view of the paucity of information she had about her life before care and adoption. However, when Laura received her agency information, she realised that there was a section at the head of the letter which had been removed in her copy. The section contained a prompt written by someone else — presumably a social worker — which read, 'Why I am giving my child up for adoption'.

Laura does not mind that her mother was encouraged to write the letter and was provided with a prompt to support the process — she is thankful to the kindly professional who recognised her mother may not have been able to write without help. Laura was however disappointed to learn that the unvarnished truth was kept from her — this had given the false impression that her mother had sat down to write a heartfelt letter to her daughter of her own volition. For Laura, this was inappropriate and did not accord her the respect she deserved. Laura and David both agree that adoptees and indeed all care experienced people should be provided with an honest and unedited account of their childhoods.

A further difficulty which members of the group, including Laura and David themselves, encountered relates to the language, tone and general accuracy of the presented information. Laura and David both encountered judgemental or pejorative remarks which seemed at best irrelevant and at worst unprofessional; David's records containing discussion of his being 'a goth' and Laura's files referring to her mother as 'plain' and 'unmarried' and to her as 'illegitimate'. Other members of the group have spoken to their parents and relatives being unhelpfully depicted as two-dimensional 'villains'. While it is understood that social work records are functional documents, with professionals often effectively writing to recommend or justify specific decisions, such material is not always conducive to reconstructing coherent narrative. Unfortunately, for those care experienced people who do not have strong relationships with family and who were not supported to reflect on and truly understand the course of their lives, this may be the only material with which to work.

Loss

Loss is a generational issue for care experienced people and many care experienced people dwell on losses in their life. Some of these are unavoidable and indeed are the result of vital state interventions, yet others are the result of failings in the care and protection system itself. Who Cares? Scotland members have complained of the infrequency and poor quality of contact with family, while there are examples of contact being suspended as punishment. Further, successful campaigning around the separation of brothers and sisters has led to

promised introduction of a legal duty for local authorities to place siblings together when looked after away from home, when it is in their best interests (Scottish Government, 2019).

For Laura, the adoption system compounds loss insofar as it gives discretion to adoptive parents about when and how much to tell children, while many continue to be alienated from their family heritage due to their names being changed. When a child is adopted, they cannot obtain a copy of their own birth certificate until they are 16 years old. Until then, they live effectively in a witness protection programme, hidden from their own family.

The loss of connection, knowledge and understanding ensuing from unnecessary decisions to separate (and limit or prevent meaningful relationships between) family members is redoubled when records are redacted in accordance with a narrow conception of 'personal data' which effectively atomises individuals and removes them from their family and social context. Further, for both David and Laura, the terms 'birth parents' and 'natural family' feel jarring and have caused significant embarrassment when used in discussion about their childhoods.

David and Laura are both keen to emphasise that loss is not confined to a specific moment in time, but continues to have a powerful impact in adult life. David often feels awkward and ashamed when building new relationships due to the fact that he struggles to define who he is and cannot recall key moments from his childhood — he experiences as loss his inability to pass along family stories or generational anecdotes. Laura similarly feels at a 'disadvantage' in being disconnected from her family history and heritage.

Vision of the future

Laura and David welcome the reports of the Independent Care Review in Scotland (2020, Chapter 2) inasmuch as they are ambitious and forward looking, speaking to fundamental questions of meaning-making power and information ownership and envisaging creative use of digital tools to enhance care experienced people's control over their own stories. Care records should be as far as possible co-produced, while the resulting information should be readily available throughout an individual's care journey, such that there is removed the

need to request access to information of which you have limited or no prior knowledge. This should be part of a broader process within which children and young people are supported to shape, reflect upon and understand their lives, alongside loving carers and supportive professionals.

The Independent Care Review reports are however disappointing on account of the relative lack of discussion or concrete proposals on how to improve experiences for very many people who have left care and whose records have already been written. There is a great deal to be done to ensure that care experienced people have an effective right to access the information necessary to understand their childhood and early personal development and that requests to do so are met with genuine care and understanding by a trauma-informed workforce equipped to provide (or to signpost to) a meaningful support offer. David and Laura, together with the other members of the Who Cares? Scotland care records group, are keen to work with any and all interested persons to achieve this.

Laura is further keen to emphasise that in her view, many of the deficits experienced by adoptees in relation to information, memory and identity are structured fundamentally by an adoption system which is not fit for purpose. Insofar as adoption severs legal ties with family members and hands significant control over narrative and life story to adoptive parents, adopted people are frequently alienated from elements of their childhood, disconnected from their family history and unable to challenge decisions preventing contact with relatives. For Laura, the framing of the Independent Care Review (2020) reports (see especially *The Promise*, p. 75) reinforce this dysfunction inasmuch as they explain that 'adoption *provides* children with a family'. Laura believes that permanence should be sought where possible without adoption, while even in the latter case adults should not be able to make for a child a decision with permanent and *irreversible* legal effects. Adoptees should be able to apply to discharge an adoption order where it is in their best interests, as is the case in other jurisdictions.

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About the authors

Laura is an adopted person and works as a paralegal for a Glasgow law firm. She is a keen runner and hopes to maintain a sub-30 minute 5km time whilst in lockdown. She has been through cycles of reunion with both sides of her family, and finds most peace and happiness at home with her husband and their two cats.

David is a care experienced member and a social work student. His background has been steeped in the world of care, being raised between foster, residential and kinship care. He has worked and volunteered with varying organisations across the sector to work for positive outcomes for his peers in care experiencing a similar upbringing to his own. As well as a student, David is also a poet, artist and occasional blogger.

Gregor is a National Development Coordinator at Who Cares? Scotland, where he facilitates participation and influencing work alongside care experienced members. Gregor holds a PhD in law and has interests in the fields of state theory, political economy and social reproduction theory.

Let love liberate our children to learn

Hazel G. Whitters

Abstract

This article is a short reflection on an example of practice within one early years' establishment which represents the journal's special issue theme, "The extraordinary ordinary: The power of everyday care." The practice focuses upon intervention for three generations of a family. The grandmother and mother experienced adversities in childhood, and similar circumstances exist for Holly who is three years old. The emotional and physical effects of toxic stress upon learning through play are presented from Holly's perspective. The practicality of daily living for her mother, in a context of addictions, is described as a potential barrier to participation. The long-term impact of trauma upon each generation is represented by the grandmother's negative attitude to change and her inability to provide a role model for the family. The article concludes by emphasising a key aspect in the complex process of transforming research into practice in the field of child protection: Sensitive and empathic responding by a practitioner which nurtures family love, and secure attachment.

Keywords

Parenting, early childhood, adversity, toxic stress

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Holly's story

Holly is vigilant. She crouches low to the ground, and strands of curly black hair sweep across her face, creating a transient shield against the world. Holly's toes are tight and poised, and one hand is positioned in readiness to support a quick exit. Felitti's adversities can be neatly tagged to the home circumstances of this three year old child: poverty, domestic violence, parent incarcerated, mental health, and more (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss & Marks, 1998). These issues remain applicable today, and they are recognised as having a residual effect upon children throughout the lifespan. Further inquiry into adverse childhood experiences is a prominent feature of current research and influential to daily practice. Trauma-informed practice underpins delivery of curricula and assessment of need in child protection (NHS Scotland, 2017).

Holly is in a warm, bright nurture room, surrounded by toys, and accompanied by two members of her family: mother and grandmother. A key worker sits on the periphery of this inter-generational group. A child can be removed from the external source of adverse childhood experiences, on a temporary basis, but toxic stress pervades the human body. A silent, and constant internal companion which affects the wellbeing of skin, of muscles, of organs, of heart, of brain, and encapsulates the inner working model – the unique core of every being which determines daily living. Toxic stress affects Holly's interpretation, understanding, and interaction with a learning environment.

Research explains how epigenetics influences the architecture of our brains (Champagne, 2015). The collegiate or ambivalent relationship between genetic disposition, and environmental influences, affects our ability and capacity to achieve high levels of wellbeing, and involvement with a learning environment. Holly's story is typical of the lives of many vulnerable families. Toxic stress is a family affair which research explains in a context of genetics, learned behaviour in specific circumstances, and survival strategies of fight, flight or freeze as responses to trauma or perceived threat (National Scientific Council on the Developing Child, 2017). These issues are demonstrated by the three generations of Holly's family as the intervention unfolds.

Holly's mum would not sit down, her arms were folded, coat fastened and she was shivering. Methadone collection was 8.45 am before the pharmacy was busy, excepting the passive line of adults with addictions who waited in silence, and anticipation. It is well-known that drop-off time for children in a service is the optimum engagement period for a family's participation in intervention; therefore during the first hour of the session this young mother was experiencing a physical, and emotional barrier to learning as her body assimilated the daily dose of methadone.

Gran was angry about child protection processes continuing to the next generation of her family. Social work, Children's Panel, action plans and projected outcomes were common examples in the vocabulary of this extended family. Parenting programmes were familiar territory for the matriarch but she attended the session, and listened carefully. Polite resignation is often witnessed in older adults in this context. Anger and resignation are not characteristics which feature positively within the theory of change.

Seven potential steps are highlighted by Horwath and Morrison (2001) in the assessment of a carer's capacity to change: pre-contemplation, contemplation, determination, action, maintenance, lapse or re-lapse. Anger is an emotive reaction to circumstances, and an immediate obstruction which tempers a readiness to learn. Resignation could be placed within one of the four responses to change which the previous authors describe as *compliance.* This reaction includes high effort but low commitment. Time is an essential partner in the creation of a context for change to occur; however vulnerable families often operate within a status quo of minutes, or hours, or days, and many parents and carers find it challenging to engage with long-term processes.

Human beings respond to conditions which can support learning or divert the pathway of development. Responses can overcome adverse influences, or be enveloped by negativity. Research has found that the brain has the property of plasticity; therefore the architectural structure can be changed (Van der Kolk, 2003). Internal characteristics of an individual, and external factors which support positivity or disseminate negativity throughout the inner working model, are driving forces in neural development. Emphasis is given to intervention

within the first 1000 days of life in which plasticity has the greatest potential (Allen, 2011); however neural re-connections can take place throughout a life-span (Moore, Arefadib, Deery & West, 2017). Behaviour in adulthood encompasses attitudes and values which may have been formed within childhood, or adulthood, for example the experiences of Holly's mother and grandmother. Historical influences can produce an inter-generational effect: grandparent to parent to child (Heckman, 2011). Every practitioner will agree that the context of child protection is cyclical. Optimal value, and sustainability of outcomes, are gained by supporting several generations of a family (Education Scotland, 2019).

The rationale of parenting intervention is the development of secure attachment between child and primary carers: Holly, her mother, and maternal grandmother. Gaining longevity of outcomes for vulnerable children involves identifying, and capitalising upon the strength of an extended family unit. If secure attachment is created then the child's inherent motivation and capacity to seek out learning is activated, executive functioning increases, and developmental milestones are achieved (Whitters, 2020). Holly needs to recognise that she is in a safe environment. Holly's representation of home is a source of toxic stress which has been transferred to the nurture room, prompted by the presence of mother and grandmother; therefore consideration is given to external and internal influences which affect the structure, and operational capacity of her brain. These considerations form an essential preliminary to the delivery of any intervention.

Sensory interaction supports secure attachment

At birth, babies experience many forms of tactile interactions with their parents, and secondary carers as family members. The senses of a baby are primed for learning and a lifelong emotional bond can rapidly be established, for the majority of families, through consistent and predictable nurturing of an infant.

Secure attachment supports a child's social and emotional wellbeing, and development of the sense of self (Fonagy, Gergely & Target, 2007). Campbell-Barr, Georgeson and Nagy Varga (2016) discuss links between the biology of

attachment and motivation for learning. Achieving the autobiographical self involves the ability and capacity to regulate your own impact upon the world.

The sense of self continues to mature throughout adulthood. Parents or grandparents who have experienced adversities in the past, and continue to be affected by current stress responses, may not be able to demonstrate a positive relationship to a child, or to each other. Early relational experience is quickly adopted as a blueprint which guides future ties. Negative relationships are the role models often witnessed by children within a home in which the adult's behaviour is affected by environmental and social challenges. This description matches the home circumstances of Holly.

Sensory interactions provide a necessary foundation for re-establishment of this integral relationship; however intervention has to be achievable and desired. Living in a context of abuse creates fear, anxiety, and antipathy to touch by parents, and children. Iterative and responsive practice strategies are essential to overcome instinctive reaction, and to re-configure the inner working models of the three generations of Holly's family. For example, non-tactile actions in the initial stages of the intervention. The adults were encouraged to promote acceptance and encouragement, communicating Holly's self-worth by a nod, thumbs up, or a beaming smile. Over time Holly's mother was shown how to use the back of her hand to gently acknowledge the little girl's interactions, and to demonstrate care and affection. Eventually the grandmother was confident to apply a finger-tip touch in order to communicate love to her granddaughter. Basic human responses are easy to achieve in a safe context but reactions to adversities are integral to survival in an unsafe environment, and it took time, and patience to support these adults to ignite natural inherent nurturing behaviours. A family's ability to transmit love and secure attachment to a child is invaluable.

The parent-practitioner relationship in services is used initially for information-sharing, and collation of facts, but over time the relationship develops into multi-layers of knowledge and understanding. This relationship matures into a therapeutic alliance. Emotive memories shape and consolidate this alliance. The collaboration of two people, service-provider and service-user, is created for a

purpose: to instigate, and to support change in parent and family. Implicit memories of a parent are founded on childhood experiences, good or bad, and explicit memories informed by reaction and interaction with the learning environment of life. New memories are formed, and complex processes configure and re-configure the inner working model (Bowlby, 1979) which affects perceptions, values, attitudes, and operational skills.

The family members were encouraged to recognise their power and influence upon each other, and to use it wisely. The practitioner communicated belief in the family's ability and capacity to succeed. Belief from a professional, which is shared effectively, is an intangible powerful aspect of the therapeutic alliance.

This alliance is a medium to present activities which the child can achieve – a quick return for Holly, and multiple opportunities for her mother and grandmother to recognise attainment, to feel pride and to share this positivity with the little girl. Activities were presented which related to Holly's interests in order to capture learning potential. Ideas were implemented which supported reciprocity and represented secure attachment in practice. The high level of learning which occurs within a serve and return interaction was demonstrated in video feedback, and promoted understanding to each generation (National Scientific Council on the Developing Child, 2016).

Conclusion: Research to Practice

Discovery and explanation is the goal of researchers. Attainment of families is the goal of practitioners. Reading a thesis or research brief is easy, and enjoyable as academic knowledge empowers the individual, and fulfilment is based upon an increase in comprehension; however the true value of research for society is harder to achieve, and resides in practice. Practice is the application of academia. Practice is transferring veracity from findings to fieldwork. Practice is the professional's demonstration of worth – not regarded as personal achievement but a desired outcome which represents the work of researchers, funders, political strategists, and families. Knowledge of human development, child protection policies, and common adversities, can be learned

but it is challenging to understand the world from the perspective of a vulnerable family.

External adversities do not dissipate because of a family learning session but intervention can support internal change, and influence behaviour of adults and children. Subsequently the effects of toxic stress can be reduced.

This reflection on practice concludes by highlighting the potential, and potency of family love to increase resilience and development throughout an extended family unit. The practitioner's role has immense value, alongside interventions. A different interpretation of the world was presented to three generations of Holly's family which was perceived, and comprehended from a lifestyle founded upon secure attachment. We all need love, and consistent predictable relationships, regardless of our stage within life's journey. Let love liberate our children to learn.

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The value placed on everyday professionalism

David C. Lane and Robert Shaw

Abstract

This special issue is focusing on the 'extraordinary ordinary' of everyday life in residential care. This is appropriate as daily life is not only the bread and butter but also the meat of the work. It is its main strength but also its main weakness. The residential care profession does not have its own distinct body of knowledge, and its status in the UK, unlike much of continental Europe, is low. The key to successful care lies primarily with the values and motivation of the workers.

Keywords

Residential childcare, daily life, professionalism, care environment

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Daily life and professional care

It is through sharing the living situation with children and young people that close relationships are built, and it is the trust in those relationships that enables confidence and self-confidence to grow and problems to be faced. It should be acknowledged that the same thing applies to foster care. Both foster carers and residential child care workers spend long hours with their children and young people, sharing activities, providing personal care and conversing.

This contrasts with virtually every other professional group whom the children and young people meet. Social workers, psychologists and psychiatrists tend to see children sessionally, for an hour or so, and in that time they usually have to address the reason for the session directly — to administer a test, or to discuss a care plan, for example. In short, they have to focus on problems.

In residential care, it is the daily task which is the focus and provides the milieu in which the individual child or young person may choose, if they feel comfortable, to raise the problems which they are facing. They can choose from the staff team the person whom they most trust — who may or may not be their keyworker — and they can open up and disclose as much as they wish to share. There is not the pressure to focus on the problems that led to admission that exists in sessional contact.

What is more, the aim is to make daily living enjoyable, stimulating and rewarding, if at all possible, and to build on the child or young person's strengths and positive interests. This contrasts with the pathological concern of other professions.

Millham, Bullock and Cherrett (1975) showed that young offenders in residential care respected the instructors who taught them trades most, as they needed to learn the skills which the instructors taught if they were to get jobs. Next, they respected the teachers who helped them to read and write. The least respected were the care staff, as they appeared to do no more than domestic tasks around the house units.

These differences were played out in the 1960s when Clare Winnicott (1971) sought, as Director of Studies at the Home Office Central Training Council, to

develop a framework for lifelong training for those working in residential care. Following the transfer of these functions to the newly extended Central Council for the Education and Training in Social Work, a working party developed proposals for a new form of training which Hudson (1973) criticised because they did not take account of the non-verbal interactions which are central to residential care.

There had been notable attempts before then to bridge the gap between the continuous nature of residential care and the sessional nature of professional interactions, two of which were described twenty years later by Bettelheim (1974) and forty years later by Silverman (1992). The former describes the design of an environment within which professional interactions can take place; the latter describes the use of a sessional approach, the 'life-space interview,' to support the aims of a residential care setting. In the UK Lenhoff (1960) and Balbernie (1966) had both described institutions intended to cross this boundary. In 1981 Ainsworth and Fulcher were to attempt a synthesis using the term 'group care' but it is fair to say that this concept never took off in the UK.

Smith (2009) helpfully covers recent developments and notes that the UK has never been touched by the European concept of social pedagogy (Petrie, Boddy, Cameron, Heptinstall, McQuail, Simon & Wigfall, 2005) which had informed the training of residential care staff in continental Europe so that, whereas the care staff in an English approved school were less well trained than the teachers, in continental Europe the care staff would be better trained than the teachers in an equivalent institution.

The evidence

At a time when there has been so much emphasis on abuse within the care system and, in particular, residential care, it is difficult for people to conceive of residential care as being beneficial. Yet there is overwhelming evidence that residential, foster and adoptive care can bring benefits to people's lives when the relationships are positive and are allowed to develop.

Kadushin (1970) found that severely damaged children who had been considered unsuitable for adoption but had then been adopted had lost all

evidence of prior harm five years later; Koluchová (1972) reported that two severely abused twins had fully recovered after four years of stable foster care; Tizard (1977) found that adoption and care by foster parents who ignored instructions to be 'professional' was the most effective; Wiener and Wiener (1990) found that adoption was the most successful and stable residential care the second most successful placement for children. In particular, they found that stability measured as no more than five changes of placement in 14 years was significant for success.

There are echoes in these findings of the National Child Development Study (Fogelman, 1976) that only long-term changes in a child's situation have any effect and of Bronfenbrenner (1974 a, b) that short-term interventions only have a short-term effect; real change only happens if there is a long-term positive change in a child's life.

Both Tizard and Wiener and Wiener make the point that adoptive parents are prepared to give so much more time to the children than natural parents; in other words, for the typical child in care, not just quality but also quantity is needed to make up for all the lost time. On the sheer arithmetic of contact hours, a foster parent is available for 168 hours per week, and a residential child care worker for five working days per week, whereas the other professionals may have one-off sessions, or a series of sessions for treatment or an occasional visit to fulfil statutory requirements. Teachers fall somewhere between the sessional professionals and the carers, as they may have substantial daily contact, but it is within the framework of educational requirements.

Foster carers and residential child care workers can therefore have a fundamental and substantial impact on the lives of those for whom they care. This is not inevitable, as there can be failure for all sorts of reasons, but the opportunity is there. The important point is that the development of relationships permitting change and growth are in the context of the everyday. There is no operating theatre full of expensive equipment; there is no solemn court room with lawyers and other officials all playing their roles. Instead, there are cups of coffee to be made, washing to be done, and discussions about food or family contact. These provide the milieu for therapy.

How might these everyday tasks become professional?

Hudson (1974) has argued that professionalism can be defined by values, by a body of knowledge or by being paid to exercise skills. Since the 19th century, professionalism in the UK and Europe has increasingly been seen to be associated with a body of knowledge and, apart from social pedagogy, there is no discrete body of knowledge which might be used to define the professionalism of residential care workers. Yet many of those who work in caring environments, whether hospitals, social care facilities or foster homes, do not rely on a discrete body of knowledge; rather they are defined by the values they hold and the skills they exercise. While we may respect an airline pilot who lands a large plane safely, a lawyer who knows their way round the law and the surgeon who can deal with tricky operations skilfully, in the end we are reliant on their values, that they will not drive the plane into a mountain, that they will represent you to the best of their ability and that they will not use you as a playground for their fantasies.

Wolins (1969), in a cross-cultural study found that successful residential child care was associated with an ideology, expectations around that ideology, long term aims, integration into the local community, support from peers and socially constructive work. These all rely on the values and skills of the staff, not on a body of knowledge. More broadly Ladd (2005), reviewing a century of psychological research, found that successful childrearing depended on children having access to positive attachments while, from the opposite perspective, Rodriguez-Srednicki and Twaite (2006) found that emotional abuse, not sexual abuse as is commonly believed, has the greatest adverse impact on children and young people.

In other words, the success of adoptive parents, foster parents and residential child care staff is founded on their values and the skills they employ to put those values into practice. Their particular advantage over natural parents is that, in the case of adoptive and foster carers, they often give a much greater commitment to those in their care and, in the case of residential child care workers, they can offer collective support when dealing with children and young

people with profound difficulties, support which would not be available to most natural parents.

However, natural parents have a key role in maintaining their commitment when foster parents and residential child care workers care for children and young people over a short period; in this case, the success of the short term placement is dependent on the level of contact with natural parents (Taylor & Alpert, 1973; Fanshel & Shinn, 1978). In other words, commitment to a positive relationship, whether provided over a short period by natural parents or over a longer period by adoptive or foster carers or residential child care workers, is essential for children and young people's well-being.

Demonstrating success

Unlike the airline pilot who lands the plane safely, the lawyer who wins the case and the surgeon whose patient becomes well again, a foster carer or residential care worker can only demonstrate their success many years later when the children and young people are themselves successful, for which, quite properly, the credit is seen to go to the adults who, as children and young people, were in care. Those involved may be aware of the impact of the caring adults, but it is hard to demonstrate to outsiders.

However, two studies illustrate this, Wiener and Wiener mentioned above and Skeels's (1966) follow-up study of the adult lives of children who had experienced contrasting experiences of residential care; all of those who had had the positive experience were self-supporting in their adult lives; only one of those who had experienced the less satisfactory experience was not dependent on benefits and he had, interestingly, spent some time in a more positive environment after leaving the less satisfactory one.

The world is full of people who have been children and remember what it was like being brought up, and of parents who have brought up their own children and remember what worked for them. Too often politicians and others in positions of influence see child care as something pretty basic, which almost anyone can do, and they do not appreciate that care workers, unlike parents, are doing this for someone else's children, who often bring with them the

baggage of poor parenting, histories of abuse suffered, low educational attainments and a bleak view of life, and need to bring to this task an extra commitment. What is asked of them is no ordinary parenting, but that is not how the public at large often see it.

It is helpful for child care workers to understand how children develop, how things can go wrong and how to deal with difficult behaviour and with ordinary upbringing. It is helpful if they understand family life and the social context of the families of the children and young people. It is helpful if they can share activities with children and young people. It is helpful if they know something about the physical and mental illnesses to which children and young people may be subject. Residential child care workers may not have a body of knowledge which is peculiar to their profession, but there is a very wide range of skills and knowledge which has a bearing on their work.

However, to be successful carers, it is in the everyday nature of residential care that such professional knowledge and skills have to be worn lightly, and even if the workers are thinking hard about the best way to tackle a crisis it should not be apparent to those they are caring for. The key is that they need the right values and the skills to put those values into practice. Putting values into practice is not simple and straightforward; it demands careful thought and planning, sometimes hard physical work, and constant reflection on the attitudes, values and motivation which they bring to their work (Smith, 2009), something well explored by Terry O'Neill (1981) who had been in care and then became a residential child care worker.

Professional development

Because quality care work is underpinned by values and skill development rather than by a body of knowledge, it requires the lifelong professional development envisaged by Clare Winnicott in the 1960s both because care workers need to revisit and explore the values which underpin their work and because skill development can only take place over time and in the light of experience. Vander Ven (1981) and Anglin (1992) have described some of the dimensions of such professional development and, while reflective practice was originally

developed for professionals who rely on a body of knowledge (Schön, 1983), it is eminently suited to care workers who can develop their skills by reflecting on how they have used them in the past and becoming more focused and creative in how they use them in the future.

The wider context

Conventional professions in part gain their status from the standing and wealth of their clients whereas social workers, community workers and care workers are identified with the underclasses whom they serve, and by association and limited rewards their status is similarly low. Sadly, this can affect the caring professions in a number of ways. They are often paid less, trained less, or given poorer support and supervision. In much of continental Europe the profession of social educators or social pedagogues is well established, with thorough training, appropriate salaries and a stable and skilled workforce. Too often in the UK the workers have not had these benefits.

Conclusion

Over the last 60 years many people have fought to improve understanding of the residential task, of its scope, of the skills involved, of the training needed, and in the process to improve the status of residential child care professionals, but it has been an uphill task, not least because people have tried to conceive of care work in terms of a body of knowledge rather than in terms of the values and skills that underpin its professional status. If anything, standards have slipped, not least because its potential contribution and its support needs have not been understood, but also because those who have relied on a body of knowledge to define the profession, not least the many abusers who have held social work or similar qualifications, have lacked the values that are essential for quality care work.

We need to take up this battle, because losing it has and will affect the lives of children and young people for whom it is worth fighting.

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David Lane is now well into retirement. In the course of his career he worked in the residential assessment of children's needs for eight years, three years at Central Council for the Education and Training in Social Work as a social work education adviser, senior management of social services for 18 years, consultancy and expert witness work for 20 years, concluding with five years as a panel member of the Northern Ireland Historical Institutional Abuse Inquiry. He played significant roles in a number of charities and professional organisations. He was awarded the CBE for services to child care and social work in 2016.

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Crossing the paradigm of 'Including the "Self"': Toward an understanding of comprehensive reflexivity and a systemic epistemology as useful concepts for social care professionals.

Niall Reynolds

Abstract

Sometimes the most important relationships in a young person's life are those with the social care professionals who are charged with their care. Often these relationships develop and evolve within complex systems with an increasing move toward a culture of monetisation of care which is driven by the structures of advanced capitalism. These broader economic processes present a challenge for social care professionals in how they position themselves within often competing narratives about the delivery of care. In this paper I will discuss the concepts of adopting a systemic epistemology that encourages social care professionals to engage with themselves within the broader frame of what is called comprehensive reflexivity. Ideas will be discussed that focus on making connections between the social constructive paradigms and front line practice. It is often said of systemic psychotherapists that their area of expertise is in being non expert. They often deploy this idea deliberately in order to assess and dilute the power dynamics within relationships and employ collaborative practice techniques as a means of building meaningful relationships. The transferability of these ideas is hugely relevant to social care professionals interested in developing ethical and reflexive practice.

Keywords

Comprehensive reflexivity, systemic, ethical practice, social care

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Introduction

It is in the relational spaces between intricate social structures, individual experiences, conscious and unconscious processes and the delivery of care, that the disposition of systemic epistemologies can be useful in developing ethical and reflexive practice, which aims to maximise the development of agency, empowerment and mental health. We are relational beings and as such seek connections with others through relational modes of communication. Systemic practice offers a way in which to understand and navigate complex human systems. Thus, systemic practice supports recognition of the centrality of our everyday 'extraordinary ordinary' interactions with others as paramount. If as professionals we can begin the discussion of understanding ourselves more comprehensively we can be better placed to meaningfully understand the young people we care for. By becoming aware of and discussing these concepts, social care professionals can develop moral practices which stimulate a progressive understanding of comprehensive reflexivity. Krause offers a definition of comprehensive reflexivity and advocates against 'promoting an idea of subjectivity as empty' or 'just like us' to a more inclusive position which embraces 'recursiveness between different aspects of meaning, interpretation and experience held or expressed by others' (2012, p.8). A systemic epistemological position is a position which acknowledges the recursive involvement of different aspects of systems and organisations including the role and outlook of professionals. I argue that adopting such a position offers a way for social care professionals to perform ethical practices that cultivate an understanding of their own positioning as a continuous relational process. To discuss these ideas further I will examine a case example to highlight their usefulness to everyday care and advance the concept of 'extraordinary ordinary' practice.

Solipsism Unravelled

In his book, *A view from nowhere*, Thomas Nagle grapples with the philosophical contemplations of 'the perspective of a particular person inside the world with an

objective view of that same world, the person and his viewpoint included' (1986, p.3). This is a way of conceptualising a mode of 'being' in our everyday lives. It illuminates a complex space that exists within the interchange of socially constructed entities and that of a constructivist disposition of persons with love, greed, jealousy and prejudices in the ordinary everyday. For example, social care professionals work within and influence systems of care that are often bureaucratic, over-managerial and beholding to political expectations. These influences on the 'professional self' can both challenge and position persons in being complicit in systems of institutional oppression. Jemmot and Krause refer to the 'everyday' as the space which highlights the relational aspects of 'self' with being 'persons with identities, languages and notions of specific cultural and professional meanings — some within and others outside our own awareness' (2019, p.2). In this way we can move away from descriptions of self as solipsistic and toward a position of comprehensive reflexivity also referred to by others as 'radical reflexivity' (Ahmed, 2004; D'Arcangelis, 2017), 'operational perspectivity' (Rabinow & Stavrianakis, 2013) or 'methodological reflexivity' (Pillow, 2015). These ideas present an invitation to social care professionals to examine the ways in which they see themselves as part of a complex set of relationships in which they practice. I have worked in the Irish social care system for many years across a number of diverse settings. Through these many work contexts I have observed a system that is closely immersed in the western ideologies of individualism and the liberal market economy. This continued paradoxical relationship between care and advanced capitalism has led to a cultural industry of social care provision in which we all play a part. It is within these structures and when describing what we do that I suggest we are more comfortable at looking toward what is 'out there', 'over there', as 'different to us' and as being an objective reality which we are not part of. This is an easy, convenient and unethical way forward and social care workers should be challenged to think about positioning themselves in different ways.

In his 1929 book, *Process and Reality*, Alfred Whitehead, whose thinking influenced Gregory Bateson, put forward the concept he described as the fallacy of misplaced concreteness. Whilst this book now belongs to an historical epoch,

the concepts discussed are still hugely relevant to positioning and reflexivity in social care provision. (For reference, Gregory Bateson's work has greatly influenced the development of systemic theory and practice; in his 1972 book *Steps to an Ecology of Mind* he writes about the influences of Alfred Whitehead's work and the concept of 'misplaced concreteness' [p.64]). Whitehead highlighted the mistakes we can make in assuming abstract concepts for accurate descriptions of reality. We do this all the time when having case conferences, access visits, team meetings, writing and reading court reports, and in our direct work with families. We also do it when we are describing the more ornery aspects of the families and systems to which we contribute. Regardless of selectivity on how we position ourselves differently and in different contexts — our basic belief systems, world view, research ideas, biases, prejudices and approaches to working with families are all connected at some level. Trying to understand all these things and their connectedness helps guide us toward a better understanding of ontological and epistemological positioning vis-à-vis our relationship with the social care we provide.

These philosophical musings can guide social care professionals to a more practical application. Whitehead's use of the word 'misplaced' is hugely helpful in creating a healthy doubt in thought processes and actions. In my own experience the idea of applying doubt has become a positive and central feature in acting somewhat as a perpetual consideration when thinking about my ethics in practice and my positioning. The emphasis here is on creating a healthy doubt which is productive within a professional's application of reflexivity and should not be confused with professionals who display doubt in their decision making or competence. It is no longer OK to rely on that old chestnut of engaging in 'reflective practice' as a panacea for progressive social care professionals.

> Reflective practice involves thinking about and critically analysing one's actions with the goal of improving one's professional practice. Engaging in reflective practice requires individuals to assume the perspective of an external observer in order to identify the assumptions and feelings underlying their practice

and then to speculate about how these assumptions and feelings affect practice. (Imel, 1992)

Whilst this has some value it can easily just become about us and create 'blind spots' to a multitude of other relational processes that are central to outcomes. This is a distinguishing feature in the difference between reflective practice and comprehensive reflexivity and is an engagement that is well suited to the complications of working within social care systems.

An ode to a Greek legend – what we can learn from the fable of Narcissus

The fable of the Greek legend Narcissus has inspired poets, playwrights and literature for at least two thousand years and is the basis for volumes of modern popular psychology. So, what can we as social care professionals learn from it? In his poem Personal Helicon, Seamus Heaney writes: 'to stare big-eyed Narcissus into some spring is beneath all adult dignity'. There have been many critical analyses of Heaney's work and his use of Narcissus as depicting his autobiographical self as a child and the universality of transitioning from this self-obsessed stage to adulthood. The Nazar Bazmi (2019) literature blog offers a useful interpretation of Heaney's poem in explaining the 'poet's own reflection from the well is like the Narcissus in Greek mythology and the deep echo from the well is like Echo in Greek legends who was a maiden who loved Narcissus but he [was] wrapped in himself'. It means the poet is ignorant to the world around him. As the story goes, Narcissus was a young man in love with his own reflection so much so that he could not move away from it, ultimately resulting in his death. There are similarities here for the development of social care practice. I think that social care professionals also need to transition from a narcissistic fidelity with self-reflecting and aspire to a more comprehensive understanding and participation of and in our own and others' orientations. We do not pay enough, or sometimes any, attention to the representations of 'Echo' as depicted in the story and are often so focused on our own preservation, working in chaotic systems, that we are blinded to looking outward.

In their work with refugees in the UK, Jemmott and Krause focus on the underdevelopment of thinking by systemic psychotherapists in not emphasising 'background understanding: the structure and organisation and meanings which constitute the background and history to the personal, social and political history of themselves and their clients' (2019, p.6). These 'recursive loops' give voice to professionals in trying to understand the continuity between past events, social relationships and the meanings as experienced by them and their clients in the present or what Das (1998) describes as the 'image of turning back' or a 'turn towards and then away from the self (D'Arcangelis, 2017).

This represents an all too familiar struggle by social care professionals when working with families, as though families are unconnected to or distinct from the context of the working relationship. Professionals fail to see their own identities, histories, politics, personal and professional stories as being connected to the families with whom they work and somewhat symptomatic of the families' indifference or perceived 'otherness'. In what follows I describe and discuss an example from my own work as a social care leader in Ireland's largest children's secure care facility.

Practice example

This example is taken from my time working in Irelands largest secure care facility for troubled children. I worked at the facility for eight years and at the time the team was comprised of mainly white Irish middle class professionals of mixed gender, with a range of experience and background disciplines e.g. social care, social work, psychology, nursing and others. At one period there was an unusually high number of admissions to the unit of male children from the Irish Travelling community. While it was not unusual to have traveller children at the units it was unprecedented to have such a high number being placed at the same time. Irish travellers are one of the most discriminated against communities in Irish society (O'Connell, 1997; Cihan Koca-Helvaci, 2016). This unusual pattern of admissions created a certain anxiety among the staff teams who worked at the unit. My own observations at the time and in retrospect are that the staff team were unnerved and in some ways developed a 'risk anxiety'

regarding the disproportionality of young travellers in the units. It was perceived as a threat to the stability of the units and was voiced as such at team and management meetings. I was also trying to understand my own positioning within the team and in relation to these dynamics. I am a white male who strongly identifies as working class and was raised in what others would describe as a significantly disadvantaged geographical area. There were a significant amount of children who had been through the secure care unit from the same postal address as I and many of my family, Dublin's north inner city. Whilst there were lots of differences between me and the young male travellers we did share a background of experience in discrimination, particularly through our communities being disenfranchised or stereotypes ascribed by others with little room for understanding the complexities and differences within communities.

Soon there were a number of violent incidents at the unit with some staff members being badly hurt. In the debriefing and safety management responses, it was observed that the young travellers were communicating with each other in their native language known as De Gammon. This was construed by many on the staff team as enabling violence as it was deemed the travellers were using the language to plan violent acts against the team. Many members proposed responses that included 'total lockdown' of the units and separation of the travelling young people. To a degree this was understandable as the responses were given through fear and having seen some of our colleagues being badly hurt. In one instance a female staff member had her nose broken. The units were constantly on high alert and a hyper vigilant divide was evident between the staff team and the traveller young people. There were differences expressed among team members of how best to respond, however, an overwhelming majority favoured a zero tolerance approach. As the crisis rumbled on there was a distinct omission from much of the dialogue of how we had arrived at a position of 'us and them'. In some ways I was also experiencing a sense of the 'odd one in' among my colleagues as I did not share in the majority view of responding with a zero tolerance approach. In my view this was a notional concept of a zero tolerance to violence, however, it was masking intolerance to the young travellers' use of their language and cultural expressions.

The punctuation of discussions within the team was important as it began with the violence displayed by the young travellers and not as I had seen it, in the changing dynamics and risk anxiety within the teams, that led to the breakdown in relationships between staff and young people. Similar to Narcissus's failure to relate to Echo, the staff team's preoccupation with our own safety, while understandable, took precedence over relating to the young travellers. What was behind that? What were the historical, societal and political influences that created an anxiety among the team prior to the violence? What were the invisible or unvoiced socially produced differences that existed and played out maybe unconsciously among the team? What were the ideas held or expressed or the single stories held by team members about young males from the travelling community? These were issues that nobody wanted to talk about, in this lack of talk ignoring the ethical deficits of a system focused on itself as separate to the traveller young people within that same system.

In describing the work of Pierre Bourdieu, Krause (2019) refers to the concept of 'symbolic violence' as being enacted through the structures and values of systems of care that are refined within neoliberal ideologies. Here we were in the country's largest and most advanced secure care unit caring for the most vulnerable young people in society and many staff were resistant to exploring 'what lay behind' the violence, or even to thinking about how their relational arrears may have been a contributing factor in maintaining it. There was a visionless uneasiness about their expert positioning held so tightly which blinded us to seeing ourselves as being part of the challenge whilst simultaneously holding the key to the solution.

For example I suggested at team meetings that the use of the De Gammon by the travellers may be seen in a different way, as respecting it as a cultural symbol of the travelling community and that maybe we could release a number of staff to be trained and learn the language. This was met with sighs of disapproval and gazes of amazement. Huge swathes of suspicion descended when I made another suggestion of engaging traveller advocacy groups to advise on up skilling our team regarding cultural competence and trying to understand more in ways that we could connect with 'them over there'. I am in

no way suggesting that De Gammon was not used to plan potential attacks on the staff team and I was often injured during physical restraints at the unit in preventing these, however, the nuances and cultural expressions required were lost in a system so focused on preserving itself it forgot to look outward. It was clear that there was both overt and hidden institutionalised discrimination against the young male travellers, and they felt it, and they reacted. Gradually, there was an easing of the 'bellicose' no-tolerance approach and over time some tokenistic concessions, for example, the introduction of culture nights at the units. The introduction of books and other materials regarding traveller culture and the De Gammon were introduced as tools which staff could use to engage conversations and build relationships. However, not due to some 'ah ha' moment was the necessity for cultural overtures realised, more so through the depletion of the staff team numbers, through sick leave and injury as a result of the violence. Even in the end, when the system expressed tokenistic flexibly, in my view, it done so only to survive itself with a continuing contempt for the complexities of ethical cross-cultural work.

Toward a systemic epistemology

In describing the work of Gregory Bateson and his influence on the development of 'epistemology' and theories of knowledge, Carr highlights an 'eco-systemic epistemology' as a world view or 'belief system which entailed the idea that the universe – including non-material mind and material substance is a single ecological system made up of an infinite number of constituent subsystems' (2012, p. 114). Bateson's ideas have hugely influenced the development of systemic theories and practice over the past 60 years and were partly influenced by Ludwig von Bertalanfy's development of general systems theory which was designed to try address the question: How is it that the whole is more than the sum of its parts? These ideas can be useful in pushing social care professionals to think about the production and theories of knowledge in making those connect with our positioning and practice. The challenge here is to bring forth a systemic epistemology and seek ways in which it may have a practical usefulness for social care professionals. Although it may be argued that the

function of 'thought' is a conceptual one; I also take the position it has a practical application. If social care professionals can begin to conceptualise how they relate to and think about themselves and others in their work – whilst also seeking practical applications of thought, they are engaging in a more ethical practice.

One way in which a systemic epistemology can offer a practical application is what Dallos and Draper describe as a shift from a first order cybernetic position to a second order position. Cybernetics is a discipline that has long influenced systemic thinkers and in this shift they describe the changing position of the therapist from 'expert scientist who was able to accurately diagnose and intervene in the problems of the family' to a second order position were the therapist is 'less expert and more of a collaborative explorer who works alongside the family to co create some new and hopefully more productive ways of the family seeing themselves' (2000, p. 66). The key change in this position was that the therapist was no longer seen to be outside of the system looking in as an expert but more connected to and influencing the system from a co constructionist perspective. This has a real application to the thinking that was applied to the example provided of the team's responses to the young male travellers. If a second order position as described here was accepted the team would have seen our own influences and connectedness to the travellers as being within the same system of care albeit having different positions. To do this social care professionals must embrace patterns of thought that allow primacy to ideas of what Bradotti (2019) describes as the 'mind-body' and 'nature-culture' continuums and to do this in ways that promote variations in approach to 'thought' or as elusive thinkers that are experimental and 'committed to a conception of movement in thought' (Patton, 2010, p. 219). It is that idea of movement in thought that I believe will allow social care professionals to shift from hierarchical to network systems of power and openness to intergenerational transmissions of cultural shared behaviours, meaning, symbols and values that are understood (Caffery, 2019).

Concluding remarks

I began the article by seeking to highlight the intersections in which social care professionals may challenge themselves to think about their positioning within complex systems of care, which are mostly influenced by western ideologies of individualism. The framework of adopting a systemic epistemology and engaging a comprehensive reflexivity are co-operative processes that demonstrate a way to understand power formations and the space between institutional oppressive practices and individuals constrained by them. This provides grounding for the emergence of new ways of being for social care professionals in adopting systemic approaches in thought to a range of differences and challenges. We must begin to embrace these concepts as a new charter toward understanding the fragmented temporality of the present in our everyday 'extraordinary ordinary' interactions with others. I did not myself ever condone the violence displayed by the male travellers in the example described but could also not prevent myself from turning back to my own experiences of feeling marginalised or discrimination. In ways this process of turning back makes way for a continuum in which the background influences and formations of identity are fluid and present in how we relate to others. It is this perpetual relationship with who we are and what we do and who we care for; that I think holds much hope for the future development of social care professionals and practice.

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Home is where the art is: Creating healing environments

Kerri Rasmaidh

Abstract

Residential care facilities are both institutional and domestic; they are homes but also places of work. Why is it that residential care homes for children are so generic and soulless, lacking warmth and love? We examine the nature of the individuals who live within residential homes to find an answer to this conundrum and then the resulting solutions, with some suggestion on how to create a nurturing and healing environment for all; a space that feeds the body, mind and soul of those within.

Keywords

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Home is where the art is

Residential care facilities have the seemingly impossible task of creating a 'home', whilst simultaneously being an institutional environment regulated by policies, procedures and legal guidelines. Both children and workers reside in them. Therefore, it is both a home and a workplace, with the added challenge of a transitional population, as residents and workers come and go within the walls of these liminal spaces.

In my work I have visited and worked within many residential care facilities across Scotland. It astounds me, that even though the individuals are different within them, the care purports to provide different care options or care provision, the workers may come from varying backgrounds and philosophical perspectives, ultimately the homes remain formulaic, consistently cold, plain, institutional, unfriendly, drab and clinical. It is as if the walls are only skin deep and the disembodied objects within the rooms, merely floating upon the surface without any depth, connection or solid foundation. The objects that furnish these cut-out spaces may very well be brand new and shiny, but are usually mass produced, made in factories by machines, mostly with human made materials and of ill-construction; flimsy, easily broken, easily discarded and replaced.

What are these spaces telling us about the people who live within them? What are they silently, symbolically expressing about the experiences of those within? Are they speaking of value, worth, care and love?

The inhabitants

The children who live in residential care facilities usually have experience of complex and severe childhood trauma. The trauma overwhelms their beings and senses; the traumatic experiences are indigestible and freeze the developmental progress of the child. As a result, the child cannot regulate their emotions or states of mind, and this leads the child to remain in a hyper-aroused and hyper vigilant state, perceiving all around them and including their environment as potentially hostile and dangerous (Diamond, 2015, p. 301; Carr, 2017, p. 10).

> The children have never made a real bond with another human
> being, they have little or no inner world, they use their
> environment instead; they are in no position to establish
> communications because they have no inner equipment with
> which to do so (Docker-Drysdale, 1968, p. 36).

Barbara Drysdale-Docker explains that the child who has experienced childhood abuse is pre-neurotic, pre-object relations, that is, they have not developed enough ego strength to create defences, therefore exist in a more primitive state of being (Drysdale-Docker, 1968, p. 101).

Psychoanalytic theory describes the ego or soul as the sense of self, the part of the self that is known and can be defined as me. It is through this ego or soul that we make sense of ourselves and the world around us. Trauma inflicted upon children has been referred to as 'soul murder' by Shengold (1989, p. 20), that the child's very sense of self and identity is mortally threatened. Those who have not developed sufficient ego function have also been described as having a wounded or sick soul and the work of the carer is to repair or create a suitable environment enabling the wounded soul to heal or come into full formation.

> Shamanic cultures throughout the world describe illness as a loss
> of soul. The shaman's task is to journey in search of the
> abducted or lost soul and return it to the sick… The soul cannot
> be lost in a literal sense because it is always present with us.
> However, we do lose contact with it's movements within our daily
> lives, and the loss of this relationship results in bodily and mental
> illness, rigidification, the absence of passion, and the
> estrangement of nature (McNiff, 1992, p. 21).

McNiff also offers art and artistic processes as being the most effective way of regaining the lost soul and healing the sickness associated with this. This resonates with what has been written about the power of 'creative psychotherapies', (art psychotherapy, music psychotherapy, dance movement psychotherapy and drama psychotherapy) working specifically effectively with those who have experienced childhood trauma and resulting PTSD (Post

Traumatic Stress Disorder), (Chong, 2015). Chong notes that trauma is not in the past for those who are suffering from it, it is in their here and now; their feelings, emotions, body sensations, the relationships with others and including their environments (Chong, 2015, p. 117; Rothschild, 2000, p. 7).

Rothschild (2000) describes the somatic nature of trauma and its physiological and neurological effects pointing towards a somatic approach for its recovery, as does Chong when she writes that art is a somatic and sensory healing experience including its capacity to regulate emotion and body experiences through art making, whilst simultaneously working within the area of the brain where the trauma is located (Chong, 2015, p. 121).

The environment

The space we live in is a reflection of the self; the home is an expression of the individuals who live in it; this is a reciprocal relationship. The environment has a large part to play in the healing process of those who have been soul wounded by childhood trauma (Clark, Cameron & Kleipoedszus, 2014, p. 3). 'The salvation of the soul comes when people engage in their environment. Depth is in textures, colors, and movements of actual things' (Mcniff, 1992, p. 21).

Rudolph Steiner the prolific and revolutionary educator offered very specific directions and advice regarding the use of environment for the guidance, well-being and healing of those who live and work within Steiner viewed the space we live in as alive, stimulating thinking and shaping the possibilities of those within; that space consisted of matter and spirit (Uhrmacher, 2004, p. 98).

Moving deeper with this concept, the very objects within the space are also imbued with life and meaning; art itself is not only for decoration but is a living, communicating, physical manifestation of higher natural laws. The act of art making and the finished object allows individuals to participate and experience elements of the divine that are not possible to know through any other way. Art and its expression bring spirit and/or soul into the earthly world (Uhrmacher, 2004, p. 101).

In this way, forms within space stimulate thoughts and so it is important to examine or think deeply about environments and what is in them, as this

intrinsically affects the thoughts of those who live within. This correlates with the idea of environment as a reflection of how the inhabitants feel and think about themselves. If the environment is creative, wholesome and nurturing then this will make the individuals living in it feel creative, wholesome and well cared for.

Steiner went a step further, proposing that this very careful and thoughtful attention to the environment could create true healing and eliminate wrong doing, transform evil into good in a way that no institution or system of correction or care would ever be capable of (Uhrmacher, 2004, p. 103). This is a powerful thought and one we must earnestly consider when designing, living and working within spaces that care for others.

How to build a healing environment

So how then do we transform the residential care environment into a space of healing and growth? Firstly, we must hold in mind we are not only nourishing the body and mind, but also the soul of the individual; the sense of self that has been wounded through childhood trauma.

> The soul is the bearer of our thoughts and feelings, our moods,
> and artistic inclinations and with its mobility and flexibility we
> make friends, learn and express ourselves. What feeds the soul
> is art and beauty, and imagination (Van Duin, 2000, p. 70).

Objects that are made by a person are imbued with the being who made them, the essence of the soul of the maker is transferred into them and they therefore become ensouled objects – emanating soul. This is something mass produced objects do not have or do. In art psychotherapeutic theory there is a concept of an embodied object or image, it holds a feeling state that cannot be communicated in any other way, it is symbolic and has meaning beyond linear thought or expression (Schavarien, 2000, p. 59.) This is the essence of why institutional spaces are soul-less, void of soul, because there is nothing in them that is ensouled and therefore can heal the souls of those within.

If we view the workers as home-makers, they must involve the home community in the task of creating the home. In this way, the home becomes an expression of those who live within it, reflecting and mirroring back so that one

can learn about and know oneself (Van Duin, 2000, p. 82; Bettelheim, 1960, p. 70). Whilst holding in mind the transitory/liminal nature of the house community, the home effectively becomes an identity in its own, a culture of its own; those passing through it can partake in, be nourished by, and contribute to it.

The home-maker becomes a filter for those who live there, thinking about their senses and how they may be affected by the things in the house, such as lighting, sound, smells, touch and taste, as a mother does for a baby; this also includes the aesthetics of the space, how it flows, the colours used and what materials the objects are made of. Furniture and furnishing that are made of natural materials such as wood, pure cotton, pure wool and clay. These emanate honesty and integrity; they are sturdy and solid, resonating with the simple truth of nature and the intrinsically healing power of natural things.

Food, and our relationship with it, is also intrinsically important:

> For children who have never had enough food, love or attention from adults, a plentiful amount of good food on the table in the same place, at the same time, and with the same care each day begins to offer the experience of a world which will sustain them. Well prepared, well presented food adds layers to this experience of being truly considered (Carter, 2003, p. 138).

Simple acts of care and attention include holding in mind the preferences and individual needs of each person in the home. This is not a tick-box sheet to remind staff of who likes what, or from a care plan file, but actually held in mind and thought of by someone – this act of holding an individual in mind is an extremely powerful way of communicating esteem and value.

Most homes share a meal together but how is this meal set-up? Eat from beautiful crockery, use linen napkins, light a beeswax candle in an attractive candle holder, place a small vase of flower in the centre. This is feeding the hungry souls as well as their stomachs.

> In order to create beauty in the home one enters into a relationship with the inner quality of things… most homes, like all

workshops, have their mechanical aids, which can be compared to the craftsman's (sic) basic tools of the trade. They perform the hard and rough groundwork, but they cannot replace the sensitive touch of the human hand. In the home, housework may have become like a poor Cinderella, but it can be transformed into its true value as the Princess of all gestures of love (Van Duin, 2000, p. 82).

Examine how media is used in the home, how much screen time is used. Although information technologies can be helpful in moderation, they dull the imagination, stultify human communication and are often not a productive use of time. '…Such tools and their messages lead children towards materialism, consumerism, competition, and addictions in a variety of forms' (Uhrmacher, 2004, p. 113).

Provide a space for creative expression such as a studio or corner of a room with free access to art and crafting materials and a variety of paper and notebooks; always buy the best quality materials available. Creative tasks help children to overcome feelings of helplessness and passivity and begin to establish a sense of safety in their bodies and their environment (Carr & Hancock, 2017, p. 10). One can consider learning new skills such as gardening, knitting, woodwork, pottery, anything that involves natural materials, the hands and imagination.

We can read a chapter book aloud for others to hear at a regular time of the day, perhaps children can take turns with this, or it might be that a staff member reads aloud as an act of love for the children. Fairy tales have a particularly powerfully positive effect on the healing child.

> While it entertains the child, the fairy tale enlightens him about himself, and fosters his (sic) personality development. It offers meaning on so many different levels, and enriches the child's existence in so many ways, that no one book can do justice to the multitude and diversity of the contributions such tales make to a child's life (Bettelheim, 1991, p. 12).

Working with our hands nourishes the soul and can be applied in a variety of creative tasks for the home including cleaning, cooking, mending, making and baking. We can think more deeply about these tasks in relation to the soul. We can use organic natural cleaning products and cloths made from 100% cotton, wooden sweeping brushes with metal pans; we can cook with organic vegetables, fruits and grains; we can mix our food with wooden spoons in ceramic hand-made bowls; we can serve our food on beautiful serving plates with wooden serving spoons all can help themselves to.

Furniture should be made of unpainted solid wood, be sturdy and strong. This demonstrates to children that their environment can hold them, that the home/container can support and withstand the force of their fledgling beings. This is an essential symbolic communication that needs to be made in order that the individuals living in the home feel safe; the environment and psyche of the workers can withstand the children's inevitable attacks and full force of their wrath and rage that result from their loss and betrayal, by those they have a human right to be loved and cared by and for (Carter, 2003, p. 146).

Referring back to the individual who has experienced childhood trauma and the way the environment becomes an extension of the self, the child needs to be able to damage the environment and then seek reparation and healing through this cycle of destruction and creation/repairing (Docker-Drysdale, 1968, p. 12). The environment must be strong enough to withstand these attacks and at the same time be made of a material that *can* be repaired rather than discarded and replaced.

If we are taking seriously the psychological importance of the symbolic nature of the child's relationship with their environment, then to discard things and replace them is not communicating value or worth; it is not demonstrating to the child that they can have suffered damage but can indeed be repaired and in doing so the repaired objects often, just as the child does, exhibit the scars of this damage but are still needed and part of life.

To conclude…

The list of ways to create healing environments is inexhaustible, but I hope I have provided a sense of what is required to begin to establish a healing environment. A way of engaging with and entering into the nature of the environment in such a way that provides a deeper sense of holding and nourishing, delving deeper than just the surface façade of a space, and reflecting upon the way the environment is used by the individuals within it. Often we are providing an environment that was not there for these children within the mother/child dyad; a kind of 'intensive care' is being provided that can be a critical issue of life or death for these children (Lanyado, 2003, p. 67).

Every physical element of a home is an opportunity to communicate care, value, and a sense of belonging to the children, that 'they are worth caring for and deserve good things' (Carter, 2003, p. 146).

We can walk into a space and experience it on a more profound and meaningful level. The children and staff who transit through these spaces deserve this level of care and attention; let us never forget the work happening within them is truly profound and potentially life changing.

> Children are spiritual gifts from heaven… every single child
> becomes for us a sacred riddle, for every single child embodies
> this great question – not, how is he (sic) to be educated so that
> he approaches some 'ideal' that has been thought out – but how
> shall we foster what the gods have sent down to us into this
> earthly world (Uhrmacher, 2004, p. 105).

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Kerri Ramsaidh is an Art Psychotherapist, Chair for BAAT Scotland, Director of Somerville Enterprises CIC. This organisation has been established to create therapeutic residential schools for care experienced children. Kerri has worked in Community service creation and provision for over twenty-five years. Kerri is working towards revolutionising the care system and the way we provide care for those who have experienced childhood trauma; so that there is equality of opportunity for care experienced individuals.

The Extraordinary Role of Case Management in Daily Care

Laura Horvath

Abstract

The Child Reintegration Centre (CRC) in Sierra Leone fully transitioned its residential programme to family-based care in 2018. The reintegration of all the children from the residential programme into families necessitated the inclusion of a robust case management system to ensure permanence for every child. Case Management is critical to provide support and ensure success. Good case management includes gatekeeping, discreet record-keeping, inclusion of the child and of the caregivers in the development of care plans, clear exit strategies and family support plans to ensure the health and safety of the child and to strengthen and empower parents. The CRC Case Team conducts traditional assessments and home visits, but also teaches parents and caregivers how to parent well, build financial independence, and become empowered to care for their own children. Families are encouraged to attend workshops, social and sports events at the CRC to strengthen parenting and relationship skills, and engage with other families on the programme, building strong community relationships as well. By creating a community of care consisting of assigned case workers, the CRC case team, and other families in the programme, families are learning to care for their own children, each other, and their community.

Keywords

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Global movements to deinstitutionalise must lead to robust case management systems

Decades of research have shown that children develop best in families, compared to institutions. Additionally, an estimated 80% of children living in institutional care have a living parent who could care for them if they had the means and support to do so, and those who do not almost always have a living relative who could.

In October of 2019, on the 30th anniversary of the United Nations Convention on the Rights of the Child, a Resolution on the Rights of the Child was presented, adopted and ratified. For the first time, it urges governments to transition away from orphanages and invest in family strengthening efforts to keep families intact and ensure permanence for children. Focused on the child's right to a family, it underscores a global movement to transition from residential to family care, and to close orphanages and children's homes all over the world.

The movement to close these homes came in response to the boom in the unnecessary institutionalisation of children, accounts of abuse and neglect at orphanages, and the growing research on the effects of institutionalisation on children. The evidence is clear; most children in orphanages have living families, who have placed their children in these homes due to poverty or by coercion from corrupt actors. This, paired with the well-meaning support of Westerners to build more homes, has led to more orphans or vulnerable children placed in homes. While pressure is mounting to transition from orphanage to family care, it is important to note that it is not a simple matter of just closing orphanages. Without appropriate case management support, children's homes that simply place children into families without providing transition support and ongoing case care are ironically at even higher risk of separation. 'The deinstitutionalization movement['s] (closing down orphanages) desire is to place kids from orphanages into family settings, through reunification, foster care, adoption, or into smaller group homes, but often does not have an exit plan for the children in the homes they close' (McGinley & Runyon, 2020).

When children are cared for in an institutional setting, the primary driver of programming is more often the needs of the institution than the needs of an individual child. Conversely, a systems approach such as case management, requires a conceptual shift from the traditional, stand-alone programming focus on children in groups, to the achievement of more sustainable, comprehensive and long-term responses geared to the needs of each child. According to World Vision (2012), such an approach encompasses addressing a case holistically, strengthening critical roles and key actors responsible for the wellbeing of a child. Additionally, child welfare programmes can help establish linkages between children and families, government and community systems in ways that ensure that children thrive.

Vulnerable children and families are entitled to efficient, comprehensive and respectful assistance on multiple fronts set out in national and global policies, but are often faced with piecemeal, inadequate and intrusive services, or are neglected altogether. Services designed to protect children's rights often function on their own, disconnected from other services that may also be needed if these rights are to be protected and their needs met holistically. The results are often overlaps and gaps in services, negatively impacting those in need of services. From the child and family view, and from the perspective of those at the grassroots level involved in assisting them, the service structure can often seem an unnavigable maze full of unknown challenges, and many give up (Integrating Case Management, 2017).

A growing movement to pursue more sustainable, empowering responses to children in crisis focuses on family strengthening.

> Family strengthening is building on the capacity of biological parents, relatives, or local families to keep, adopt or foster children in their own communities. It seeks to strengthen local communities, systems and individuals to ensure children have the resources needed to thrive within families in their home countries (Oswald, 2020).

New approaches in development practices are also shifting the model from providing handout support such as cash transfers, to more relationship models that utilize social work and case management that 'focuses on client needs through strength-based lens, and involves regular meetings with social workers for activities such as counseling and life skills training' (Jindra & Jindra, 2015). Shifting from a transactional to a transformational model focuses interventions on moving people out of poverty to self-empowerment long-term, but requires a trusting and ongoing relationship.

Case management

Case management can be a critical factor in ensuring that closing an orphanage and reintegration of children does not result in greater numbers of children winding up separated from family and living on the streets. The use of quality case management practices has been demonstrated to improve decision-making and service delivery in child welfare practice that reduces family separation and improves family permanence.

Within the context of programmes for orphans and vulnerable children (OVC),

> case management can be understood as the process of
> identifying vulnerable children and families, assessing their needs
> and resources, working together to achieve objectives and goals,
> implementing plans through specific actions and receiving
> service, monitoring both the completion of actions and progress
> toward achievement of objectives and goals (USAID, PEPFAR,
> 4Children, 2017).

However, it is important to bear in mind that 'case management is a principle, not an event', cautions Mick Pease, co-author of *Children Belong in Families: A Remarkable Journey Towards Global Change*. It is not just about taking a child home: 'It encompasses a series of processes that covers everything in that child's life whilst they are living away from their family' (Pease, personal interview, 2019). When done well, it is also a collaborative effort. 'Case management involves significant collaboration with the client unit - generally a family or household, including a child or children and their caregiver(s) - and

utilizes problem-solving and empowering approaches aimed at increasing resilience of the child and family' (USAID, PEPFAR, 4Children, 2017).

Pease points out that a parent knows his child's needs, his strengths, her potential, their particular weaknesses and challenges, and carries all of that knowledge in their heads, barely conscious that it is there, but intuitively stepping in to guide and intervene to make things happen for the best interest of the child (2020). Children who grow up in family settings benefit not just from the obvious love and support of caregivers, siblings and connections to extended family, but also benefit from knowing their own and their family's stories. Research from The Family Narratives Lab shows that 'children and adolescents who know more of their family stories show higher wellbeing on multiple measures, including higher self-esteem, higher academic competence, and fewer behavioral problems' (Fivush, 2016). Case management systems must stand in that gap and provide this to children as surrogate parents, while children live separated from their families in alternative care. As children are reintegrated back into families, case management has to help transfer all of that to the parent or caregiver. The relationship that the case manager builds with the entire family is critical to the handing over of this responsibility. This relationship is a partnership, where the caregiver leads and the case manager provides support.

The Child Reintegration Centre

The Child Reintegration Centre (CRC) in Bo, Sierra Leone, completed its transition from residential to family-based care over a period of two years, from 2016 to 2018. In addition to providing family and individual counselling designed to help children institutionalised for years to re-establish healthy bonds with their parents or caregivers and the other members of their 'forever families,' staff were retrained and prepared for a different role - as case managers serving these children and their families to build capacity and ensure permanence.

Across the developing world, case management often 'includes a range of providers and actors, paid and unpaid, both informal and traditional such as family and kinship networks, community volunteers as well as formal, employed

professional and paraprofessional workers' (Strengthening Child Protection Systems in Sub-Saharan Africa, 2012). The case management team of 10 is comprised of five staff with social work degrees, and five paraprofessionals. Two of these paraprofessionals are former house mothers who lived in the CRC residential programme, providing 24-hour care for 10 children each living family style in the programme. As the CRC transitioned its model and reintegrated children into their forever families, the staff were able to build on trust already established in their relationships with these children before, during and after reintegration, and to deepen relationships with the caregivers of these children as well to ensure a successful and smooth transition for the entire family. In a similar fashion, the other members of the case team establish and maintain strong connections not only with the children on their caseloads, but with their parents and caregivers as well. Caregivers of children in the CRC programme observe that case managers spend time not only checking on the welfare of the children assigned to them but have ample opportunity to build up the skills of those who care for them daily in order to ensure that children thrive. This relational practice represents a shift 'from services *for* the poor, to services *with* the poor' (Jindra & Jindra, 2015), and is critical to ensure that the entire family not only survives but thrives.

'A family is a system', explains Beth Ratchford, licensed clinical social worker (personal interview, 2020). If you hit one toy on a baby mobile, all the others swing and bounce as well. Families work the same way - a shock to one aspect of a child's life can set off a chain reaction in all other aspects of that child's life. When a family is vulnerable because of poverty or other crisis, even minor shocks can become catastrophic. Case managers do not focus solely on the child whose name is on the top of the case file, because they understand that they are a part of the family system. In this way, the case manager guides a family through reintegration to permanence, 'walk[s] with [the family]... hearing how they want to change their lives, and helping them to do that' (Jindra & Jindra, 2015).

Management of case information also plays a critical role. Case managers do not make unilateral decisions regarding interventions in cases, but work closely in

partnership with caregivers, pulling in children as well, in age appropriate ways. Case managers, caregivers and children work together to develop case plans, beginning with initial assessments of a family's stability using the Child Status Index (CSI). The CSI measures attainment of goals in six domains of care: food and nutrition; shelter and care; protection; health; psychosocial; and education and skills. The index includes a four-point scale for each goal so that the child's wellbeing can be assessed as good, fair, bad, or very bad. Using the CSI as a starting point, case managers work with families to identify goals and interventions that will help families to raise scores in specific domains, set benchmarks along the path forward, and help the families move toward graduation from case care and independence. CSI measurements are taken at regular intervals to chart progress toward achievement of goals (USAID Assist Project, 2009). Through the case management process, case workers - working on partnership with families - record progress and determine when the child and household have met their case management objectives.

> Ideally, case management should work closely with the [family] and build on existing resources and strengths to help inform decisions about what the [family] can complete independently as well as what additional interventions may be required (USAID, PEPFAR and 4Children, 2017).

A trusting relationship between family members and case manager is critical to empowering a family to learn to care for their own, on their own.

Site visits are another essential component of casework. CRC case managers conduct monthly site visits, alternating between home and school. Site visits at home allow case managers to observe the home environment, spend time with caregivers reviewing progress, addressing any areas of concern, and collecting photos and data to continue to build the case file. These visits may provide the opportunity for private conversations with the caregiver, or with the child, as well as the chance to observe interactions between the child and caregivers, siblings or other family members, and often members of the community. School visits allow case managers to observe the child with peers at school, and to check in with the headmaster and teachers to see how the child is faring at

school. The CRC has also identified school liaisons at the school where CRC programme children attend. These volunteer personnel keep an eye out for issues or concerns, and reach back to the case manager to alert them to any issues that need to be addressed.

It can be difficult to conduct case management in such a way as to empower parents and caregivers rather than make them feel as if they are being spied upon or 'checked up on'. It is critical that caregivers perceive case managers as allies and members of a team designed to help a child and family to thrive, and not as a 'cop' looking for flaws in a caregiver's parenting. By focusing on the entire family versus an individual child, a CRC case manager's goal is to strengthen and empower the entire system. Building a relationship with the family as a member of 'the team' is a large part of the case manager's job.

CRC family strengthening and community building activities

Recognising the need to observe family interactions through a variety of means, the CRC facility is also utilized to bring families on-site for family strengthening training. The training curriculum includes courses especially designed for the predominately non-literate parents and caregivers whose children are supported in the CRC programme. Culturally relevant workshops on positive discipline, trauma-informed attachment, basic economic and microfinance training are provided on a regular basis. Cohorts of approximately 25 caregivers participate in workshops while their children are engaged using the CRC's library, playground, computer lab, and other activities. Parents engage not only with CRC staff providing training, but with each other as well, sharing joys and challenges of parenting with one another and often learning from each other. CRC staff can observe parents' interactions with one another, and build relational bonds with their own 'clients' in a more relaxed atmosphere. This deepens trust within the team of case managers and families.

Family fun days are another opportunity for families to engage with the CRC staff and the community in much less formal ways. With 600 cases currently on the CRC's case load, it is impossible to bring all of the families together at once,

so family fun days are offered frequently to a different group of families each time. Families enjoy a meal together, and then engage in games, football and volleyball matches with each other and with the children. Families and children are able to interact with one another informally and socially, building relationships with each other, with other families in the community and with the staff, who provide support and are able to observe these families in a relaxed setting.

An African proverb states that 'it takes a village to raise a child'. Case management teams can play an important role as a part of that village, supporting and building capacity that helps to bridge child to caregiver, family to family, and families to community. As the world shifts to ensure that every child grows up in family and not in institutions, relational case management plays a critical role in becoming a part of a child's 'village' by allowing case managers to develop and build on relationships with the entire family that ultimately strengthen and empower parents to care for well for their children.

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Swinging Between Lines of Fear and Blame

Beverley Graham

Abstract

As a leader, getting team dynamics right has always been a difficult job. If you add in the mechanics of fear and blame, you have an increasingly difficult, almost impossible barrier to break through. In these environments making the child the problem can be easy for our staff members but what about asking staff and leaders to consider their contribution to incidents. Our children and young people are the central focus of everything we do. How can our children and young people thrive and experience love in environments where fear and blame are predominant? This paper explores the author's journey within their leadership role, explores how unconscious drivers like fear and blame can lead to toxic cultures, and reflects on some helpful tools which can help to develop better awareness both at an individual and an organisational level.

Keywords

Self-awareness, team culture, growth

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Working in Residential Childcare can be one of the most challenging and also rewarding careers. As a leader within this sector, the role can be isolating, alongside a great deal of pressure and expectation. The sector demands a level of self-awareness, however, in my experience not all of us are self-aware or willing to step into consciousness. At times, we take the route of swinging between the lines of fear and blame.

Burn-out is a very real problem that threatens our staffing levels and the service we provide to our children and young people. Many organisations pay careful attention to this for the staff teams, introducing tools such as balanced rotas and increased support from their manager. In my experience I have not always felt this level of understanding from staff teams. As a leader, my management style is embedded in the relational/parental style; however, when faced with expectations from my staff, which at times feel harsh and relentless, I admit that I found the state of empathy hard for me to access.

I have experienced burn-out numerous times in different roles in my career within Residential Childcare; experiencing it as a leader had the most impact on my emotional wellbeing. I have always been passionate about providing high quality care to vulnerable children and young people. When I stepped into leadership, I transferred this value onto the service my staff received from me. I have always seen management as a service role. I am a giver. Reflecting on this, I have realised that the problem with givers is that we need to be aware of the underlying reasons for this in order to set limits. When I stepped into the leadership role, I did not know this, and I had little self-awareness. Within three years I hit burnout, and I hit hard.

A leader in the state of burnout is disastrous for team dynamics. In my journey, I felt that I could not inspire my staff team to care for the children whose behaviour challenged the service. I had sat in numerous team meetings asking my team to love this child, but my feeling was that none wanted to. I ran numerous team building and development exercises, but I made no progress. As time went on, I

expressed my frustrations to my line manager, and I felt more isolated and frustrated. On reflection, I felt lost in the swamp of shame and blame.

Reaching burnout as leader forced me into a journey of self-discovery and consciousness. It forced me into the situation where I had to consider my ego and how my own trauma and abandonment history played out in my behaviour or expectations (Anderson, 2000). This never-ending journey of healing and consciousness started as the most difficult journey I have ever embarked upon. I have felt rage, disappointment and great sorrow as I faced my fears. I have had days where I have had to wrap myself up with a blanket as the waves of sorrow and shame washed over me while I considered that I am the problem. I had to open my heart to self-love and understanding. As a result of my journey, I made a lifelong commitment to unlearn behaviours that do not serve a helpful purpose for me. One tool that allows me to do this is the R.A.I.N meditation (Brach, 2019).

Brach evolved four steps in this meditation:

R – Recognise. Taking a moment to recognise how your feel.

Using this I noticed I was annoyed with my staff team at times, because I felt some of them did not care about the children in our service. I felt I poured myself into team development and now as I felt unheard, I had isolated myself. I believed my staff team were attending work because of the good pay and did not recognise the privilege they held. I recognised anger and despair in me and also saw how I tried to push these difficult feelings down.

A- Allow. Take a moment to allow yourself to feel your feeling.

When I first named these feelings and expressed my anger, guilt crept in. I tried to push it all down, resist the difficulty and carry on as normal. I believed that in feeling this way I was not being the compassionate leader I strived to be. I felt my self-worth was depleting. By allowing them the space to be, this also allowed the feelings and the energy attached to flow through me. I visualised that the negative energy attached to these feelings was no longer trapped in my body waiting to

come out in passive aggressive ways or physical illness. The concept of *Chakras* (Butler, 2016) or 'energy centres' within the body was helpful for me in this visualisation. When Chakras are open, life energy runs through them freely, and harmony exists between the physical body, mind, and spirit. This helped me to allow the feelings.

I-Investigate. Looking within to investigate your feeling further.

Stepping into consciousness and adapting this way of being to leadership opened wounds I thought I had healed. These wounds related to events in my childhood, particularly my sense of abandonment. In these moments I saw that I had been mirroring my experience as a child in relation to the adults around me. I had been acting out my trauma cycle, demanding the high standards that had been expected of me in childhood. By investigating these feelings, I saw that I had spent years pushing down these feelings, meaning that at any opportunity they sprung to life needing to free.

N-Nurture. Allow self-compassion.

Self-compassion can be very difficult for a continuous self-betrayer. I noticed that for me as recovering perfectionist it was extremely difficult. Taking that step into self-compassion is a brave one, especially in a culture where fear and blame are ever present. Stepping into consciousness and completing this meditation allowed me to recognise my tendency to be a 'people pleaser' as another tool of self-betrayal and another act in trapping myself between the lines of fear and blame.

I found wholeness in my journey to consciousness. I admit I will never be that perfect compassionate leader all the time. I am human, and that is fine. In healing myself, I have noticed that a number of staff and leaders are also exhibiting behaviours that are caused by earlier psychological wounds, doing their own dance between the lines of fear and blame, unconscious of it all. This can have a negative impact on practice. At some point we all face trauma in our workplace. Our staff teams can often be involved in serious incidents. At times our children or young people can be required to be held safely. Holding another human safely while they

are in extreme distress or listening to disclosures of abuse or even helping a distressed child clean wounds caused by self-injury, is traumatic. These traumatic events can become normalised in time. Unless the trauma is truly addressed, I believe the residue of trauma remains with us, and we can simply become numb to the effects. Therefore as staff and leaders, we need to be open to self exploration and seek positive healing strategies that work for each individual.

In addition, as trauma shapes behaviour, I believe this can shape the culture of our organisations. Without attention paid to our behaviour and without stepping into consciousness, we create a breeding ground for fear and shame. This can be a major influence on any organisation from staff retention to service output. A safe culture is not just about how an organisation survives, but it is what is needed to thrive.

Through my journey of healing I noticed how many times during my career in I had been deep in a toxic culture. On reflection, it seemed like some of the organisations had almost developed a 'personality' that cried out for love and compassion in all the most self-destructive ways, just like the traumatised children we pledge to care for. Bion (1980) argued that in every organisation, two groups are actually present: the work group, and the basic assumption group. The work group is the primary task group; the residential child care team. The basic assumption group describes the unconscious drivers on which the behaviour of the group is based. The basic assumptions are fight/flight and dependency. I cannot count how many times meetings had become a game of 'you' and 'me'. Looking back, it seems like many of us had lost sight of our humanity as part of the group struggle to get the basic assumptions met. Unless we work to understand and deal with the basic assumptions as part of team development and care, our practice can never be as good as it might be.

Now I have committed to be a conscious leader, I strive to use my position as a positive influence. In the book, *Atomic Habits*, Clear (2018) describes, ' "the aggregation of marginal gains" '(p.1). This is the idea of breaking down a task,

looking at everything that is involved to complete the task and then improving each part by 1%.

To heal within the organisation, each task can be broken down into the following components.

- Support

It important to give the supervisee/ staff team the responsibility of defining support. Not only does it create accountability it allows connection. We can never know what someone really needs unless they communicate it to us. In a group setting I asked the staff team what they expected of their manager, and what their manager can expect of them, in terms of support.

- Accountability

Individual development plans introduce accountability. It is vital that the supervisee has overall responsibility of this. A manager can suggest areas of development, but the staff member must take ownership and agree or there will be no progress. With the team I asked them to agree a house ethos and then created an opportunity to discuss progress at each team meeting.

- Development

Tracking development is important. It has always been important to celebrate successes and sit together when things are hard, and progress is slow. It is vital that communication is always compassionate, that it you and me against the problem, not you against me.

The components all interlink, with similar points. They form an everlasting cycle that requires a conscious leader with compassionate communication to fuel it. Like the mind, body and soul, all three interlink and influence the other. On reflection, I think this is true for all journeys to healing and consciousness. In my own case, I experienced a resistance from ego, both mine and others. It is still difficult when faced with such challenges and restless resistance, yet with compassion and love I continue my work.

Like the human mind, Residential Childcare is a complex system; change is inevitable and with that comes chaos and crisis. Because of this we will continue to face many challenges. Our organisations will develop their personalities and cultures will be born. Even with a commitment from the leaders to live consciously, we are all human. This means at times we may once again take to swinging between the lines of fear and blame. One of the ways to make a difference is to develop conscious leadership which can, in turn, implement the correct support, accountability and development components within the group so that unconscious drivers like fear and blame will not lead to toxic cultures.

For those organisations ready to embrace healing and embark on this journey, I send my love. I wish you all the best as you step lightly into your fears and please never forget, we are all just doing our best. As Brown (2018) said 'dare greatly, rise strong and brave the wilderness' (p27).

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The author has built up a career within Residential Childcare now currently holds the post of Registered Manager, she is extremely passionate about providing quality care to our most vulnerable children and young people. The author is a certified NLP practitioner and also provides coaching to those whom have experienced discrimination within the workplace.

'The theory doesn't work here': the teenage bedroom in a residential special school

Nick Pike

Abstract

Drawing on non-participant ethnographic observation, this paper explores some of the challenges for residential child care staff of operationalising an 'ordinary living' policy in a residential special school for children with complex learning difficulties and challenging behaviour. In particular, it explores the complex and multi-faceted uses made of teenage residents' bedrooms and describes a critical role for child care practitioners in making sense of competing priorities and constructing a workable practice framework.

Keywords

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Introduction

This article draws on an ethnographic study of a residential special school for young people with complex learning difficulties and challenging behaviour (Pike, 2013). At the time of the research the school had 42 pupils residing in a rural area on the borders of England and Wales. The study involved 75 hours of non – participant observation carried out in the autumn term of 2010, in one of the school's residential units, a 7 – bedded unit which I call 'The Hawthorns'.

Ethical clearance for the research and for subsequent publication was given both by the research site and by the Social Science Research Ethics Committee of Cardiff University. Unless otherwise indicated, all observations are taken from contemporaneously recorded ethnographic field notes. All names of residents and staff have been changed to preserve anonymity.

Social institutions that cater for people whose impairments or behaviour have led them to be excluded from the community mainstream can be thought of as 'liminal spaces'. 'Liminal' in this context means something which sits on the borders of mainstream society and instead of following expected social conventions is characterised by multiple anomalies (Murphy, Scheer, Murphy & Mack, 1988; Willett & Deegan, 2001). It is often argued that participants in such liminal spaces seek to reduce the anomalies by the creation of what Fox calls 'a social micro-climate' defined as a 'social environment' 'with behaviour patterns, norms and values that may be different from the cultural mainstream' (2005 p. 89; also: Spencer, Hersch, Aldridge, Anderson & Ulbrich, 2001).

Residential child care settings, including special schools are good examples of this process. Ironically, however, as in most child care settings, the 'social micro-climate' of a residential special school is based upon replicating as closely as possible, the routines and rhythms of what Ward (2004) calls 'ordinary living'. In the residential setting, though, such 'ordinary living' is simulated, rather than replicated (Ward, 2006).

Ordinary Living Philosophy

This article is concerned with just one aspect of the operationalising of simulated 'ordinary life': namely the way in which residents' bedrooms are conceptualised, used, decorated and furnished.

Research in the sociology and social anthropology of family life has identified what Morgan(1996; 2011) calls 'family' practices , the everyday taken-for-granted ways in which family members live their lives and develop their relationships (Smart, 2007). Central to these ideas are the possession and display of what Miller (2008) simply calls 'things' .

In this article, I discuss the school's attempt to replicate one aspect of those family practices: those pertaining to the individually decorated and furnished teenage bedroom equipped with appropriate furniture, clothing and electronic media, and suggest that the 'ordinary life' policy becomes distorted by the complex purposes and meanings that surround the part played by the bedroom in a resident's life in a residential special school.

In respect of accommodation, at the time of the research, the school adhered strongly to the 'ordinary living' approach, as the 2010 prospectus makes clear:

> Our students live in small group residential bungalows built around a central courtyard. We create homely environments that provide life skills training as well as having all the home comforts you would expect.

Even though 'ordinary living' in the residential child care setting is simulated, rather than replicated (Ward, 2006):

> the apparently simple concept of the ordinary, in fact turns out to be potentially problematic... For example, children who have lived for any length of time in families or other settings in which other people's behaviour is persistently confused, violent, bizarre, neglectful, abusive or otherwise distorted have learned that **that** [emphasis original] is the norm with the result that what we might call 'ordinary' or 'common sense' may be

experienced by them as confusing, bizarre or provocative (Ward, 2004 p.213).

And if this is true of families where children do not have significant cognitive and developmental impairments, it is even more likely to be true where they do.

Bedroom Design and Equipment

Something of the complexity involved in the design, decoration and occupation of residents' bedrooms is revealed by initial observations on the decorations and furnishing of individual bedrooms. Each resident's bedroom had been decorated and furnished to suit their individual needs and interests, although this was mitigated where furnishings had not been provided because of the possibility that a resident might use them to harm herself or others. All wardrobes were built in.

> Amarjit's room had been painted pink and white, with representations of 'Rosie and Jim' on her wardrobe, pink and white bedding on the bed, and plenty of soft toys in the room. Colin's interests in 'space' and rockets had result in an imaginative painting of the solar system on a black background on one wall and a rocket shaped pyjama case on his bed.

However:

> Some bedrooms were much bleaker, though, with little on the walls and only a bed base and a mattress in the room. Some young people destroyed mattresses (one, Bryn, liked to open his up and climb inside it!) and The Hawthorns had recently invested in some specialised mattresses with a blue thick polythene exterior – these lasted for several months rather than the hours and days of conventional mattresses.

and

> the last room had bare walls except for a large painting of Disney's 'Peter Pan' on one wall, secured under Perspex and the

room was empty except for a blue mattress on the floor. At home Callum slept on the floor in a completely bare room. Staff had tried putting a bed base and mattress in the room, but this had been destroyed and Callum had slept curled in a ball on the floor. Recently, they had succeeded in getting Callum to accept a mattress in the room, and he now slept (still curled up in a ball) on the mattress. The painting of Peter Pan was also an experiment as Callum liked Disney films but had not until recently accepted decoration on the wall.

Multiple Meanings of Bedrooms

The basic philosophy is clear. Teenagers in their home environment would expect to have control over their bedrooms, to exercise a degree of choice over their decorations and furnishings, and for their rooms to be equipped with a range of personal electronic goods, and the school sought to replicate this. But this is a situation where replicating ordinary 'family practices' does not easily apply.

The first reason is that in the residential special school environment, the bedroom serves more functions than the equivalent room in a family home.

It is:

- a place of socialisation between child and key worker;

- a place of quiet self – occupation;

- a place for assisted dressing and undressing;

- an enforced time- out facility when residents become distressed or aggressive, where their behaviour is seriously anti-social;

- as a last resort, it can become for the briefest periods, a place of restraint.

The following examples show the different range of meanings that can be attached to a bedroom in a residential unit. We start with the obvious. A bedroom is a place to sleep, rest and relax:

> Very quiet on arrival – Bryn had been up for a bath but had then
> gone back to bed; Amarjit was in her bedroom; Ryan had been
> up for breakfast and had then gone back to bed. Sandy was still
> getting up.

Secondly, a bedroom is a place for getting dressed and undressed – although unlike conventional teenagers, the residents in the Hawthorns all needed significant assistance with dressing and undressing. Here's Bryn again, after lunch:

> It was time to return to school. Casimir told Bryn that he was
> going on a trip. He took Bryn to his bedroom to get ready –
> which involved putting socks and shoes on and an old plastic
> anorak.

A bedroom is also a place of retreat, a place to get away from other people; in fact, in the Hawthorns, it was the only place to get away from others. One member of staff commented:

> 'the space available to young people is very limited and if one
> young person wants to get away from another, the only option is
> to retire to their bedroom'.

But as well as being a place of retreat, it is also a place to entertain and to build relationships. There were numerous examples of individual work between residents and key workers in the young people's bedrooms. One weekday, after school, the following was observed:

> Iona was supporting Amarjit in her bedroom and Nigel was
> drawing with Colin in his bedroom. Callum and Ryan were largely
> to left to their own devices, watching Disney DVDs in their room.

These latter activities were not untypical for any teenager making use of their bedroom as a centre of their personal and social life, albeit, these tended to be based on relationships with staff rather than with peers.

However, this is not the whole story:

> Amarjit entered the dining room, removed her tights, pants and
> incontinence pad and began to masturbate. Two staff intervened
> telling her 'you do that in your room'.

They then physically manoeuvred Amarjit along the corridor to her bedroom. Here the bedroom is being used, against Amarjit's own wishes, to enforce a view of what is socially appropriate behaviour, and the bedroom is therefore, at least temporarily, being used as form of behavioural control. This process is common in an establishment where there are no alternative facilities:

> Whilst pupils and staff were milling around, Amadi became very
> agitated and he began scratching, pinching and biting. Four
> members of staff encircled him, so that he couldn't run out of the
> lounge. Then two firmly held him by the upper arms and
> escorted him away to his bedroom.

What these examples show is that the concept of the resident's bedroom as being a private space, under the resident's control, subject to the resident's choice does not do justice to the complexity of the actual way in which bedrooms are used.

The bedroom that would be a 'private' space in contemporary Western family homes, and increasingly so as a young person enters teenage years, is here a public-private space. Willcocks and her colleagues, in a critical review of older persons homes, pointed to the disorientation caused to residents by finding themselves carrying out essentially private life practices in the public space of the care home and argued for the development of residential care practices that made a clear distinction between public and private with a choice as to how much of the resident's private life was lived in public (Willcocks, Peace & Kelleher, 1987).

The vulnerability and dependence of the resident group in the Hawthorns makes this challenge much greater. However, there is more to the complexity of bedroom utilisation than the question of bedroom usage, and this too reflects the gap between philosophy and reality when it comes to resident self-determination in their bedrooms.

Complexity of Choice and Control

In the Hawthorns, there was a genuine expectation that residents would exercise choice in the decoration and equipping of their bedrooms. What happens, then, if a young person cannot or chooses not to exercise choice over their bedroom's design and equipment? Or, if a young person's choice is radically counter-cultural to the extent that their preference is for four bare walls and a bare floor? Which takes precedence, the culturally normal bedroom even if that causes distress, or respecting a young person's 'choice' even though the reasons for that choice may arise as a consequence of their particular cognitive impairment?

A very good example of this followed a decision of the school, in the wake of an OFSTED report, to comprehensively redecorate The Hawthorns. The manager asked for a list of each resident's choices for his or her bedroom:

The principle of encouraging choice and control was clear; in practice it was much more difficult:

> Diane said 'Amarjit was very clear – she wanted her room pink and you know how keen she is to follow Sikh tradition; well she has asked for the sort of headboard with curtains that are common in Sikh rooms'.

> Tony described his attempt to engage Bryn more ruefully: 'I kept patting the wall and asking what colour, but all he kept replying was 'mini roll' so I'm putting it down as brown and beige!'.

In practice, then, however committed to the principles of choice and control, given the severity of impairment of some young people, staff had to improvise and at times decide for themselves how rooms were to be furnished and decorated. In doing so, they could easily find themselves in situations of conflict.

For example, staff discussed the possibility of experimenting with unlocked drawers in Sandy's room, so that she could have access to more of her own things. Sandy's mother was very concerned about this proposal when she came to visit:

> Sandy's mother spoke to her keyworker about the renovation of
> The Hawthorns. She was happy with the plans for redecorating
> Sandy's bedroom, but very concerned about the plan to leave
> Sandy's drawers unlocked and accessible. They had done this at
> home, and the result had been broken and flying furniture. She
> strongly recommended keeping all storage areas locked.

Staff must take note of parental opinion, which can be based on long experience of caring for the young person. The complexity of following parental advice was, however, not always straightforward:

> Halina said that it was good to get Amarjit out of the house as
> she had been very angry this morning and had thrown her
> television on to the floor and destroyed it. She talked of the
> dilemma of allowing Amarjit access to her TV, even though she
> destroys it. Halina told me of Amarjit's mother's request that
> Amarjit have access to her computer – apparently, she has one
> at home that she has never attempted to destroy. 'Perhaps the
> thing is to allow access and let the items be destroyed'.

Here we have advice from one parent that runs in complete contradiction to that offered by the parent of another resident; here choice and control is fundamental even if the outcome is distress and possible injury to the child, and inconvenience for staff. But Hawthorns' staff didn't just have to deal with parental input. In respect of the same incident:

> A new TV had been delivered but had not yet been installed.
> Halina was saying that she understood that staff had been
> instructed to allow young people full access to their TV's, DVD
> players etc. on the understanding that all breakages would be
> swiftly replaced.

So, we have here a complex set of conflicting ideas, principles and instructions from a variety of different sources. We have a starting point of trying to create a homely environment, broadly aimed at cultural normality for adolescents, which is now to be reinforced by instruction from within the school's management

chain; this approach can sometimes be alarming and distressing for some residents who can react to it by destroying the fixtures and fittings that they do not want; often perceived as slightly impractical by staff, it is supported by some, but not all parents, and as a consequence, staff members will need to negotiate in respect of each child, each family and each bedroom a compromise solution acceptable to everyone.

Conclusion: Conflict and Creativity

In practice, then, however committed to the principles of ordinary living, of choice and control, given the severity of impairment of some young people, staff had to improvise and at times decide for themselves how rooms were to be furnished and decorated. Rather than a unit wide child care philosophy, individual staff teams developed local solutions for specific rooms, specific residents and specific staff. In doing so, they could easily find themselves in situations of conflict, requiring creativity and improvisation amongst child care staff as they sought to operationalise the whole philosophy of 'ordinary living'. One shift leader summed it up:

'The theory doesn't work here'.

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About the author

Nick Pike has recently retired after 25 years as a practitioner and manager in childhood disability services (including a residential special school), mostly in the voluntary and independent sectors, and extended periods teaching disability studies and social work at Winchester, Gloucester and Oxford Brookes Universities. The research underpinning this article formed part of a professional doctorate in social work at Cardiff University's School of Social Sciences.

The limitations of vicarious trauma prevention strategies when applied to residential child care

Marianne Macfarlane

Abstract

Vicarious trauma is recognised as a potential consequence of supporting clients with trauma. Research into vicarious trauma, its impact on professionals and the consequences for clients has been limited to date, however, strategies have been developed to assist in identifying, preventing and managing symptoms. To date these strategies are not easily applicable to the residential child care setting, despite residential care staff working alongside young people with complex trauma.

Keywords

Vicarious trauma, trauma prevention, residential child care, care staff

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As the coronavirus pandemic took hold, and unprecedented procedures for managing it were put in place, we learned that care staff are essential workers. Care work is not well paid, or even understood by the broader public. Residential child care work seems simple; provide care for young people who cannot remain within the family home. There are few more ordinary tasks than raising children. However, these essential workers have a far more extra-ordinary task. They offer relationships, every day, for days on end, to young people so traumatised by past relationships that their rejection of new relationships is forceful and fearful in equal measure. Residential child care workers understand that the young people need them, and need the offered relationship, to begin healing from their trauma, and yet they must withstand everything in each young person's arsenal of challenging behaviour.

Pearlman and Saakvitne (1995) define vicarious trauma as an individual's internal response to hearing about the trauma experienced by others. Vicarious trauma can affect therapists, social workers, foster and residential carers and other professionals involved with traumatised people, as well as in personal relationships. In professionals, vicarious trauma can occur following exposure to a single traumatic event or can occur cumulatively through hearing different trauma stories from a multitude of clients. Izzo and Miller (2010) believe the issue of vicarious trauma among helping professionals is underestimated and underreported. To extend this opinion, research into vicarious trauma prevention strategies shows that few can be meaningfully applied to residential child care, particularly in extended shift patters of 24 or 48-hours. Residential child care is often isolating for those working in it; due to confidentiality they cannot share much of their job with their loved ones, and due to widespread prejudice against young people in care, the realities of caring for these young people is neither valued nor understood by wider society. At the least care staff can expect those designing strategies to support them to understand and cater for the realities of their working life.

The terms vicarious trauma, compassion fatigue and burnout are often used interchangeably by service providers, however, one can occur without either of the others, or the three can occur at the same time and exacerbate the impact

of each. The staff turnover rate in residential child care is high (Colton & Roberts, 2007) and undoubtedly impacts upon the young people involved, as they must reconcile themselves with yet another adult choosing to leave. There are many advantages to using a 24 or 48-hour shift pattern when looking after children and young people, however, it could serve to make staff turnover feel more personal; the adults lived alongside the young people in a shared home environment, and still wanted to leave. The focus on creating as much of a family atmosphere as possible in care may further compound the loss of staff, as young people feel rejected by some of the pseudo-family paid to care for them following their separation from their biological family. Staff leave residential care for diverse and complex reasons must seldom be directly related to a single young person, but adult justifications mean little to children who feel abandoned.

All of those working with traumatised people are at risk of vicarious trauma, however, if it is recognised as an issue in those seeing their clients in set, time-limited appointments, we must recognise the potential impact on those living alongside young people for two days in a row. Therapists are required to undergo some form of therapy as part of their training, and those who are registered with a regulatory body are required to have an external supervisor, and often have further supervision within their workplace. Many therapists hear about their client's trauma in extensive detail and carry the burden of helping the client heal. Residential child care workers also hear about trauma, often with little or no notice and additionally, may be present at the time of re-traumatisation or new traumas. For example, a young person may be rejected by their parent; the therapist will assist them in unpicking this in their next session, but the residential child care worker is there at the time of the rejection, and responsible for the young person's wellbeing as their distress plays out over the following days.

The purpose of this paper is not to explore which job is harder, as both of these professions come with their own unique challenges, similar challenges and multitude rewards. However, in the case of vicarious trauma, the limited information and strategies available are often written by and for therapists. Attachment theory teaches us that nurturing relationships with caring adults

provides potential for young people to heal from their attachment-related trauma. Secure, consistent relationships are required to support young people through the difficult process of trauma-integration therapy. The staff team's main task is to offer these relationships, remain steadfast through countless, and often literally painful, rejections; they sit beside the child at their highest peak and their lowest trough, the target of their rage, their anxiety, their endless fear. Often, they work in houses with two or three equally complex young people; their deceptively simple job descriptive of offering relationships belies the reality.

The foremost measure to guard against vicarious trauma is awareness of the concept; without this, practitioners cannot translate the signs they may be experiencing. It has been noted that the individual can often misdiagnose the symptoms of vicarious trauma, as many of the primary symptoms are similar to those of ordinary stress (Trippany, Whitckress & Wilcoxon 2004). Therefore, education on both vicarious trauma itself and its manifestations is the first and most important measure to guard against its occurrence. In order to have an awareness of emerging symptoms of vicarious trauma, practitioners need to have established solid self-awareness and familiarity with their internal environment; this will allow them to notice changes in thoughts and feelings as early as possible. Shapiro (2012) believes mindfulness practice may be a protective factor against vicarious trauma, through improving the psychological health of practitioners. Young people with disrupted attachment can find time alone, self-soothing and independence challenging, and many of them experience impulsivity and lack of safety awareness to the extent that they need supervised throughout their waking hours. Staff must remain as alert and vigilant as their traumatised young people if they want to keep them safe and to read subtle emotional cues well enough to intervene quickly on the behaviour escalation curve. This precludes them from using mindfulness during hours when the young people are with them. An abundance of paperwork, phone calls, meetings, and organising a busy household can quickly take over those times where the young people are sleeping or occupied, meaning mindfulness practice may be hard to fit it then either. It is all too easy for authors to say that time will only be found when mindfulness is prioritised by staff; unfortunately,

prioritisation is also often demanded by line managers, social workers and family members and there are only so many hours in a shift.

It seems that mindfulness practice may only fit in during time off as it is an important measure in self-care, it may be that staff should choose this option. As Izzo and Miller (2010) point out, this implies the individual has responsibility for fixing any issues that arise. Organisations hold responsibility for creating a culture among their staff where vicarious trauma is part of the daily language and opportunities are created to assess for it and address it when it occurs. It is becoming popular for employers to educate their staff on vicarious trauma and self-care, and this is an important first step. Organisations can cement this first step by providing formal training for all staff on mindfulness practice and other forms of self-care, and then embedding this learning through mandatory, protected time for self-care breaks built into each shift.

Following on from self-care as a measure against vicarious trauma, staff are advised to talk about their feelings. Client confidentiality prevents staff from relying on their friends and family for emotional support, as they are bound by policy to only share general feelings around their work, rather than specific events or information about individuals involved. However, sharing even vague information from their work life may prove problematic. Bell, Kuskorni and Dalton (2003) note that working with trauma survivors can challenge our societally shaped perceptions on the nature of the world around us, and our fellow human's capacity for cruelty. Staff experiencing an acknowledgement of the darker side of society may be reluctant to share even general feelings with friends and family, due to not wanting to change their loved ones' perceptions of the world. Within certain parameters, staff are allowed to share information within their organisation, such as through single or group supervision. During times of low staffing, holidays or increased stress in an organisation supervision is often one of the first practices to be pared back or dropped altogether when arguably it is more important than ever in crisis. As with self-care, supervision should be mandatory and protected for all employees, and when performed well, it provides not only a space for staff to unpack their feelings separately from their persona as selfless caregiver, a therapeutic supervisor can spot signs of

vicarious trauma early before the individual themselves can see them. Just like intervening early on the behaviour escalation curve to prevent an incident, intervening at the first signs of vicarious trauma can prevent it from taking hold.

Current literature allows residential care staff to educate themselves on vicarious trauma but falls short of representing them in the many strategies given to limit its impact. Care workers cannot follow advice to take five minutes out when they feel themselves becoming overwhelmed. It is more difficult for them to set boundaries around challenging behaviour. If the young person becomes distressed and makes verbal threats against their social worker, they may be asked to leave until they have calmed down. The care worker is required to leave the room with the child and assist them in calming down. If the young person throws a chair at their therapist during a session, the therapist can leave the room to maintain boundaries. The care staff need to walk into the room, withstand assaults and find the right words, at the right time, to calm the child down. At the end of a long and fraught Looked After and Accommodated Child Review it is only the care worker who needs to consider how to help the child recover from what they have heard, how to get them safely to the car, get them both back to their house without incident, and sit up with the child and comfort them for as long as it takes the child to fall asleep. There is no doubt that all the adults around a young person with disrupted attachment and complex trauma have difficult jobs, and that none of their challenges compare to the ones the child faces. However, most of their professions are valued, and their challenges are spoken about, even published, and this cannot be said for care workers. Too often they are overlooked, underappreciated, not asked for their opinion of the child they spend so much time with. It is not difficult to imagine that this atmosphere of under-recognition allows issues like vicarious traumatisation to grip tighter. Rather than waiting for the recent recognition of their roles as essential to lead to meaningful change in the way residential child care is perceived and supported, care staff should find their voice and lead that change from within. By recognising their own extra-ordinary practice, they can begin their own research into the issues entangling that practice; they can open up necessary discussions with their colleagues, their employers and the wider industry on what strategies have worked for them and where more research is

needed. In short, care staff should discover the expert within themselves and fill the gaps in literature and understanding from a place of unique insider knowledge.

Care-experienced children and young people are not readily accepted by British society. That is clearly and loudly evidenced by the abundance of petitions that are formed in response to residential child care homes being opened. Houses which are rural and secluded can still be subjects of community gossip long after they have been established. The message is clear; care experienced young people are 'other', out with the safe and the norm, and as such are to be rejected and feared. The staff who choose to spend their lives looking after these young people are 'other' by association. It can be difficult for staff working 24 or 48-hours shifts to find relatable conversation as so much of our society and our social repertoire is geared towards the traditional nine to five job. Residential care staff can be bitten, spat upon, sexually assaulted and must shift between dozens of roles per day with little warning. The positives are as hard to relate to as the negatives; that tiny moment of success when a child makes eye contact for the first time, or the note of apology after an all-night incident. Yet their roles are not valued, or understood, or supported, by the society they live in. The very least these staff can expect, as they navigate their extra-ordinary jobs, is for the literature designed to support them, the strategies devised for their emotional well-being, to be written inclusively and with understanding. Young people in residential care have long and painful trauma histories, which in some cases begin at birth and carry on to the present day, and it is their care staff who sit with that trauma and the defensive behaviours used to guard it and continue to offer nurture and praise and role-modelling, for as long as it takes; extra-ordinary adults helping to raise extra-ordinary young people, in an essential role.

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About the author

Marianne Macfarlane is the Therapeutic Services Co-ordinator for Common Thread, a residential child care provider with houses and schools across Scotland. Marianne has worked for Common Thread since 2011 and is particularly interested in complex trauma, and its impact upon young people. The following article represents the author's own view.

Turning Ordinary Love Into Extraordinary Outcomes at East Park

Liam Feeney

Abstract

This article describes East Park School's journey in conceptualising agape and what it means to provide a care experience that demonstrates love in a meaningful way:

- Explaining why young people need to feel loved and not just cared for.

- Describing how we explored the difficulties of maintaining professional boundaries in practice, while managing risk in situations where we looked for more loving ways to intervene.

- Showing how we build on trust and existing relationships to create more opportunities for our young people to experience love.

- Defining what love means to young people with complex and multiple diagnoses and witnessing extraordinary outcomes.

- Explaining how we entrench the expectation of love into recruitment and induction conversations for new staff.

Keywords

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Why do our young people need to feel loved and not just cared for?

East Park is a registered charity based in the Maryhill area of Glasgow since 1874. It provides education and supported accommodation services to children and young people with additional support needs, including autism.

This article focusses on the journey of the Skye and Lewis intensive support units, which provide care and support to young people who require additional positive behavioural support intervention. Their complex and multiple diagnoses can present barriers to interpreting communication, imagination and social and emotional interaction. This requires us to be creative and innovative when developing and sustaining the experience of love in our residential environment.

On page one of 'The Promise', published by The Independent Care Review of Scotland's care system[1], the commitment to children and young people is expressed as the ambition that they can say, 'We grow up loved, safe, and respected so that we realise our full potential'.

Our staff at East Park are committed to this promise and hope that all the young people we care for and support not only believe that they are loved; but achieve better outcomes by taking that sentiment for granted.

When we first formally asked our staff teams in the Skye and Lewis intensive support units in February 2019 if our young people at East Park felt love from us as practitioners, they consensually affirmed that this was the case.

Our support workers agreed that they felt unconditional love for our young people and that their empathy, commitment and resilience when presented with multiple behaviours of concern on each shift were only possible as a direct result of that love. They saw this as an assumed part of their role, an ordinary expectation. Our organisational goal was to develop a reliable cultural approach that turned ordinary, everyday love into extraordinary outcomes for our young people.

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[1] See https://www.carereview.scot

The workers had a refreshingly free and open approach to discussions about conceptualising love in residential child care. They understood that love meant different things to different members of staff and that relationships were complex and amorphous.

I felt that we should engage all of our staff in different departments in a questionnaire about love, in order that we could assess our organisational understanding before workshops or training. I asked them five questions:

Do you believe our staff at East Park should show our young people love?

1.   What should this look like?

2.   How would they know they are loved?

3.   Does their diagnosis have an impact on their perception of love?

4.   How do we manage to preserve professional boundaries when showing love?

5.   Are there situations that arise where showing or responding with love can increase risk?

A sample of their answers below give an indication about our wider organisational understanding of the requirement for love in residential child care:

> Many of our pupils are highly affected by attachment issues and trauma related behaviours and by showing love we can rebuild strong and secure attachments. (Principal Teacher)

> I believe it would be impossible and harmful working in a care environment without showing love to them. Children need love to help them grow and develop and to understand roles, boundaries and feelings in relationships, a child who knows or feels they are loved has the freedom to express themselves without fear and has the freedom to dream. (Care Services Manager)

> Some of our young people come to us with a history of significant trauma. All come from previous placements which have broken

down. Many are looked after away from home. All of this along
with communication disorders including Autism can make
forming trusting, safe relationships a real challenge for them. I
think it's our responsibility to make them feel safe, important and
loved. (Educational CALM Associate)

Expanding our preconceived ideas of what love is, and deciding what kind of love
is appropriate to share with our young people, was a little more difficult.

How we explored the difficulties of maintaining professional boundaries

The ancient Greeks described *agape* as 'the highest form of love, charity' (Liddell
& Scott, 2010, p. 4). It was important for the team to understand that when we
speak about love, we were not focused on the kind of love that we might feel for
a partner, our own children, friends, family or colleagues. We used *agape* as an
explanation of how we can feel love that is selfless and without condition for
people who require our support.

We arranged one to one conversations with staff to recognise and appreciate
current practice and look at how we could improve the group culture to ensure
that we had standardisation in our approach to love. Love as a concept proved
challenging for our staff to define in relation to looked after young people, and
there were natural reservations for people who qualified or trained at a time
when the importance of professional boundaries between themselves and those
they supported were emphasised by trainers and lecturers.

> Of course we love our young people, we might not all say it when
> we speak to them but we show them every day that they are
> loved. It is more difficult if there are bank workers or agency
> workers who don't know them, that's why it is important that
> they have consistency with regular staff. (Support Worker)
>
> I think it depends on your own experiences, some people might
> be more comfortable being tactile and others might have
> personal reasons for not wanting to cuddle or get close to

> someone. I would always respond if a young person reached out for a cuddle, but I wouldn't judge a colleague if they felt they couldn't. (Support Worker)

> I'm not sure about the word 'love', I've seen some of the work key workers have done with pictures on the wall and questioned whether it was a word we should be using with young people. (Support Worker)

> If it gets too much you can always remind the young person about personal space, but still show in other ways that you care for and love them. (Support Worker)

The word 'love' is mentioned 85 times in the seven reports of the Independent Care Review, however, a deputy team leader explains that:

> Love is hard to define – it is much more than just a word that is said - in fact it can often be said without meaning, a throw away remark, regurgitated over and over, that if not meant, over time devalues and feels meaningless. It's something that is felt, a two-way connection between individuals - a bond of trust. There is no template for how to show love - it is an individual experience between two people formed on a mutual understanding of each other's needs, interests, and values and responding to these in way that feels unique to you both. It is much more important for a child to feel love.

As a team, we explored many literary interpretations and contemporary articles on love in order that we could discern an appropriate definition and shared expectation. Barth (1958, p. 745) described *agape* as being 'in utter independence of the question of . . . attractiveness' and with no expectation of reciprocity. This kind of charitable, selfless love was a definition our staff were able to take pride in aspiring towards. Our next mission was to explore how to manage the inevitable risk that developing this ethos further would present.

Managing risk in situations where we looked for more loving ways to intervene

In our intensive support units, our young people are supported with primary, secondary and tertiary interventions to de-escalate when experiencing anxiety, distress or an escalation in behaviours which may harm themselves or others. As a last resort, when all therapeutic strategies have failed, physical intervention can be required to keep them safe. Physical restraint itself can be harmful and regardless of reassurance and loving care in the aftermath, our young people are left with lasting memories of being held against their will. As a team we recognise the importance of exploring ways to avoid physical restraint as a key priority in our development plan. To this end, we have built on our existing ethos of 'absolute last resort', to deliver training and implementation of a new style of positive behavioural support plan. These changes are intended to facilitate a more creative therapeutic approach to de-escalation using evidenced based strategies to inform practice.

We use the principle of least restrictive intervention first and identify in each plan what that means for the child. Our primary, secondary and tertiary interventions are person specific. If a young person has complex and multiple diagnoses of, for example, Autism Spectrum Diagnosis, ADHD, Acquired Brain Injury and Pathological Demand Avoidance, their plan will detail the appropriate intervention according to each environmental, emotional or physical trigger or response. We understand that the interplay of each diagnosis will be unique for this young person and that evidenced based autism strategies alone will not be sufficient. Staff must be proficient in evidenced based strategies for Acquired Brain Injury, Pathological Demand Avoidance and ADHD and know which approach to use at the right time. This can only be done through relationship building and understanding of each young person.

The successes and areas for improvement are continually reviewed and each accident or incident is viewed through the prism of how the young person felt with a view to create more positive and loving relationships. We recognise that our young people experience significant trauma and anxiety, and physical interventions have a lasting effect.

> I don't like it, when it [physical intervention] happens it makes
> me want to punch staff. (Young Person, reflecting on how it
> makes him even angrier and sustains his escalation.)

Emotion Works[2] is an educational programme designed by teacher, curriculum designer and educational consultant Claire Murray, that puts learning at the heart of emotional health and well-being. We initially used the programme to help young people understand and express their feelings, behaviours and responses, however we now include it as part of our debriefs for staff to put the young person at the centre of the incident and focus on their perception and how it was resolved for them.

> The Emotion Works debrief makes you reflect on your feelings as
> a practitioner. It goes further than the incident report which just
> analyses behaviours, antecedents and areas of improvement.
> This debrief supports you to calm down, makes allowances for
> you so you feel ok about negative feelings and forces you to
> move forward positively in respect of your own feelings and the
> young person's. The focus is on everyone's feelings and it makes
> you a more empathetic practitioner, mentor and support worker.
> Young people feel the benefit of a staff team who look for a
> positive relationship-based outcome because we understand their
> emotions which builds trust and the experience is shaped by
> forgiveness and unconditional love (Support Worker).
>
> We recognise that the importance of building up relationships is
> to do with trust and reciprocity. When we understand where a
> behaviour is coming from, when we know the young person, we
> can assess and plan alternative interventions. When a child
> understands that our behaviour is based on love for them and
> not power, they can trust our motivation and in turn staff can

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[2] https://www.emotionworks.org.uk

take calculated risks to explore more creative interventions (CALM Instructor).

Building on trust and existing relationships to create more opportunities for our young people to experience love

In June 2019, I asked our staff at a team meeting if they believed that our journey so far had resulted in the young people of our Skye and Lewis units feeling more loved.

> Of course they do, we show them love every day in our actions and words. We might not use the actual word 'love' but it should be obvious in every interaction. (Support Worker)

We wanted to ensure that our journey continued with a critical eye in order that we could further improve the quality of our commitment to providing a loving service. After exploring love as a practice expectation for five months in team meetings, staff surveys and projects we were beginning to more freely and critically assess our journey.

By July we were beginning to self-monitor and challenge each other to find more loving ways of communicating and reduce missed opportunities to engage positively with our young people, however avoiding complacency and self-congratulatory acceptance of the status quo would require further assessment and development.

On a Monday in September, during the young people's morning routine, I had observed:

- One young person diagnosed with Attention Deficit Disorder, an Autism Spectrum Diagnosis and an Acquired Brain Injury struggled to get the attention of a staff member who was finishing a handover conversation with a colleague. They repeated their allocated staff members name four times at increasing volume before a response which indicated that the staff member would be 'with him in a minute.'

- One young person who elects not to verbally communicate reached out for a staff members hand twice as they were passing with laundry but was not seen.

- Two support workers were having a conversation about a young person's presentation and behaviours from the previous night in the vicinity of two other young people in the communal living room.

When the young people went to school we explored these notes and I asked how each person might have felt or interpreted those exchanges.

> If they are ignored or don't feel listened to, they will feel unimportant and unloved. They might believe that the tasks we have to complete, or our conversations with each other take precedence over them and it could damage their self-esteem. (Support Worker)

> It is essential that for our young people to feel loved, that they first of all trust us. If they think that we talk about them publicly and share information about other young people when they are not there, that we will do the same for them. This can cause them to become guarded and put up emotional walls, or barriers to communication that make it impossible for us to build meaningful relationships which lead to the experience of love. (Support Worker)

As a result of this discussion, I revisited the questionnaire I had sent out and followed up some answers with one-to-one discussions to identify how we could define love in a child centred way that was specific to each young person and the barriers they may face in communicating their needs.

Defining what love means to young people with complex and multiple diagnoses

> Love is built into our understanding of what is necessary for young people to become well rounded, fully functioning adults. We learn about Maslow's hierarchy of need as part of our vocational training and how without the sense of love and belonging, our young people won't be able to reach their potential. Some of our young people don't verbally communicate and to this end, our actions, facial expressions, gestures and tone of voice are more important in helping our young people grow in confidence so that they can develop skills in a place that they feel like they belong in and experience love from us as their carers. (Bank Support Worker)

> Love means different things to each young person. One of our young people affected by an autism spectrum diagnosis will feel loved if people are tactile with him on his terms, if they reassure him when he's anxious, if they make him feel safe when he is overwhelmed and spend time with him without overstimulating him or being invasive. For another young person trying to understand the world with global developmental delay, you have to be pro-active and use humour as an intervention or offer him a cuddle if he is upset so that he feels love, so staff have to have knowledge of what love means to that individual (Support Worker).

Our journey continued by working together to identify what love meant to our young people and how we could share this with new inductees, family members, visitors and stakeholders external to our organisation. We agreed that we would create a visible collage on our walls with photographs which captured loving moments between our young people and their families, friends and staff. Alongside this we captured in speech bubbles what love meant to each young person and by doing this hoped to create a visual and immediate

conceptualisation of how to make sure our young people felt loved by all people who may potentially engage with them on entry to the service.

Witnessing Extra-Ordinary Outcomes

One of the most effective motivators for staff being asked to re-evaluate current practice, is witnessing the positive impact on the lives of the young people they care about. Two powerful examples of this were:

The young people were so familiar with Emotion Works and staff had been so deliberately relaxed in their use of love in conversation, that unprompted a young man finished a FaceTime conversation with his mother by responding with 'love you' at the end. This brought his mother to tears as she had never heard these words before. He felt love for her, but articulating it meant the world to her. She called and text staff repeatedly to thank them for their input as she didn't believe it would have been possible for him to say those words. His communication is complicated by ADHD and demand avoidant impulses so coaching him or requesting him to say it would have been impossible, but a natural introduction to his vocabulary and staff using it in a meaningful context supported him to say what he felt at the time.

A young girl who chooses to communicate primarily using Makaton and digital technology now prompts staff to tell her that they love her when their relationship has developed into a trusting one. She says the words in a complete sentence first, then says their name before pointing to her to indicate that she wishes staff to finish the sentence (staff member) . . . loves . . . (young person). When the staff member completes the sentence, she expresses joy and laughs heartily. This exchange would have been unthinkable at the beginning of our journey. The staff who have worked towards demonstrating love in everyday practice were rewarded in every interaction that resembled these two examples. We wanted to continue our momentum and ensure that we did not stagnate when new staff joined our team.

Entrenching the expectation of love into recruitment and induction conversations for new staff

In order to ensure that support staff who have recently joined our teams are able to buy into our ethos of demonstrating love in practice, our care services manager and I agreed that we should describe our values during the interview process and ask our candidates how they could practice in a way that ensured our young people felt love, as part of their competency based interview. Surprisingly, some candidates were able to articulate how they could contribute to this by referencing not only how they believed they could make a difference, but by using frames of reference personal to them; they were able to describe what they would hope for their loved ones should they be recipients of care services.

> My brother has been diagnosed with an autistic spectrum disorder and I love him, I wouldn't want anything less for him if he was being supported in a place like this. I know how to love and would care for the young people here with the same kindness and compassion I have for him and would expect for him from others. (Interviewee for support worker post)

> Being loving comes naturally to me, I am family orientated, I believe that by building trust, being open and being genuine, that young people would feel loved. (Interviewee for support worker post)

These two candidates were successful, in part because of their ability to describe in practice, how they could ensure the young people they would be supporting would feel loved.

Our aim in including love themed questions is to develop the expectancy of love at the outset and then enhance insight, personalised care and the loving capabilities of staff as they develop in their role.

In addition to the integration of love as an expectation at the recruitment phase, we designed an additional introductory session as part of induction for new recruits. This involves our head of care, care services manager and service co-

ordinator describing the organisation's values, objectives and four priorities, one of which is love.

> East Park recognises the importance of loving, nurturing caregiving for young people living in residential care. We believe that loving interactions and relationships between caregivers and young people, can minimize adverse outcomes, leading to happier and more resilient young people. Our aim is that young people receive care and support from warm, responsive professional staff who are able to play, converse, hug and respond with genuine affection and empathy when young people display behaviours of distress.

> We want the children and young people who live at East Park to know that we are not just 'caring for' them, we really do 'care about' them. (Head Of Care)

As we look to spread our message beyond the organisation we are looking to inform, enable and spread our message to family members, donors, healthcare partners, regulatory bodies and members the wider community. We felt that we were able to engage with the readership our free magazine, *East Park Patter*.[3] Our front page feature in the March 2020 issue outlined our ethos, commitment and aspiration of embracing love in our care environment.

We hope that by developing our teams systems we can maintain a golden thread of understanding in how to demonstrate love in practice by:

- Encouraging loving, trusting and meaningful relationships with our young people

- Identifying what love means to each young person we support

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[3] http://eastpark.org.uk/wp-content/uploads/2020/01/epp_online_edition_19_2020-03.pdf

- Assessing, planning and practicing in a way that is cognisant of each young person's interpretation of love

- Testing capacity of love in potential staff in our new approach to recruitment

- Embedding the principles of love through staff induction

- Assessing our successes and areas of improvement in love themed supervision,

- Critical peer assessment in daily observation and coaching improvement

- Including Love as an agenda item at every team meeting.

We are on a continuing journey in understanding ordinary love that will, hopefully organically, develop a cultural norm with the extra-ordinary end result that all children who leave East Park Services can reflect on their lived experience in the knowledge that they were loved by those who supported them.

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About the author

Liam Feeney has worked in social care for 20 years in Glasgow, Edinburgh and Aberdeen in a variety of roles with Children, Young People and Adults.

The conflict between theory and practice in caring for children: Field narrative of a Social Worker

Shivangi Goenka and Kiran Modi

Abstract

Every child is vulnerable just by virtue of being so, but upon entering the juvenile justice system, this vulnerability is aggravated due to a myriad of reasons such as violence, abuse and neglect, amongst others. This is the plight of 5% of the total population of children in India as per government statistics from 2018. With this in mind, where do we stand at protecting these children, giving them the needed care, support, resources and guidance and ensuring their protection and development once they are declared as children in need of the system's care and protection and sent to live in a child care institution? This paper attempts to bring to light, through the experiences of a social worker in India, the present day conditions of the children and the staff in these homes, focusing on the gap between what exists in theory in the law, the increase in the intensity of the trauma that the children experience in a place that is solely built with the purpose of taking care of them, the practical gaps in implementing laws and policies and hopes to provide suggestions to improve these conditions. The author works as a training coordinator with a leading child and youth care organisation based in Delhi and is currently implementing a state level project to support transitions from care and aftercare to care leavers.

Keywords

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> Hume raat ko daraawne sapne aate hai ki hume yaha se nikaal
> ke Aftercare home mein bhej diya gaya hai

'I get nightmares that I have been sent from here to the aftercare home', said Shalini* (* all names have been changed to protect the privacy of the children and young adults), a 17-year-old girl in a child care institution, to a social worker during a life skills workshop about the transition phase from the child home to the aftercare facility, provided by State government.

India's National Policy for Children (Ministry of Women and Child Development, 2013) seeks to address the issues pertaining to children in need of care and protection. One of its main objectives is expressed as follows:

> To secure the rights of children temporarily or permanently
> deprived of parental care, the State shall endeavor to ensure
> family and community-based care arrangements including
> sponsorship, kinship, foster care and adoption, with
> institutionalization as a measure of last resort, with due regard to
> the best interests of the child and guaranteeing quality standards
> of care and protection.

The Juvenile Justice (Care and Protection of Children) Act, 2015 provides the meaning for 'child care institution' as a:

> Children Home, open shelter, observation home, special home,
> place of safety, Specialized Adoption Agency and a fit facility
> recognized under this Act for providing care and protection to
> children, who are in need of such services.

When Shalini shared her fears, the other girls agreed with her, expressing how they would love to work and study and undergo any training necessary, if it would result in them getting a job once they turn 18 and not move to the aftercare home. The huge walls, the small dingy rooms, the constant smell of something rotten and the sense of fear, all of it reflects the narrative of the children, feeling like being in institutional care is similar to being imprisoned.

This mutual feeling across child homes defines the normal or the ordinary for them.

Reena*, a 19-year-old girl living in an aftercare home, bursting into tears, expressed her fear of never finding a way to leave the home because she does not have a family who could take her away from there. She says this is what the other girls have told her, too, when there were fights and arguments amongst the girls.

The children of a child care institution expressed a desperate need to get out of the home. Their idea remains that while they lack a home that they call their own, they cannot make something of their lives. Their mental health being in shambles, there is a constant threat of self harm. A 19-year-old boy, Prabhat*, was found with blade cuts across his throat and arms as a result of having false promises made to him about his time in the children's home and how soon his parents would take him from there. This boy was rescued from child labour when he was brought in and then he had lived with a foster family that he had gotten attached to. Having gone through the phase of being taken away from a family twice had taken a heavy emotional toll on his sense of security and the idea of attachment. Lack of a counsellor in the home and the insensitivity of the staff to his situation drove him to act in this manner and when spoken to, the only thing the boy kept asking for was to go home, to his family.

As in the case of Prabhat*, institutions can fail to provide the care and support that a child needs. The standards of individualised care may be compromised because they cannot devote attention to the specific and varying needs of each child in the institution as the ratio of children to staff is usually higher. Research has shown that children who live in institutions from an early age, especially those between the ages of (0-3), experience developmental delays that adversely affect their physical, psychological and cognitive growth with long lasting consequences at times (Better Care Network, 2009).One of the most neglected groups of children in these homes are the children with special needs. With the provisions mentioned in the Juvenile Justice Act 2015 for the children with special needs, there is hardly any in the field. Special educators, counsellors, psychiatric help, tools designed for their help and development;

even if attempts are made to made to makes these available, the quality of the service provided is inadequate. For example, an untrained special educator lacks the sensitivity and the skills required to work with children with special needs.

The children constantly also ask: 'why me'? They seem to want to understand their faults and in the process, when they don't get the professional help that is needed, they end up finding themselves to be the culprit within their own life. They start justifying the abuse and neglect that they have been through. Similar experiences of everyone around them solidify their idea of this being their normal. Ansh*, a seven-year-old child, asked his care givers in the home to somehow bring his mother there to speak to him so that he can apologise for not being a good child and not listening to her, and promise her that he would be good so that she can take her back home. A 19-year-old girl in an aftercare home said that she would listen to her mother when she asks her to please a man so that she would get her out of the institution and take her back home. She has now internalised the thought that she is being punished for not listening to her mother and she should have because the mother would know the right thing to do.

The trust issues that these children have developed come from deep root causes. The abuse and neglect that they had suffered, which made them reach the institution in the first place, was never actually dealt with; instead the abuse within the institution, lack of an enabling environment, unavailability of trained counsellors, and the false promises by staff, make it absolutely impossible for them to see hope.

Asha Bajpai (2017) explains that many children who have both parents are sent to institutional care because the parents, coming from a background of deprivation, see these institutes as hostels for children to get education, food and learn discipline. The ground reality in some of the homes is different. As per the observation from the homes visited, it was found that the children are not being sent to schools due to so-called safety issues, and there is a common teacher for all, to teach the children of all ages and capabilities. Sometimes there are sunshine stories, too. Raj, a 16-year-old boy in one of the homes, aspires to be an engineer and has recently applied to take his class tenth exams,

by open school. He shared about the efforts the authorities and care givers had put in to make sure his documents could be managed and was allowed to sit for the exams because they believed that the child had a bright future.

An example of utter insensitivity: a couple had visited a home to celebrate the birthday of their child with the children of the home. The children were made to sit on a dirty mat, while the cake was being cut. Once the cake was cut, the attendant served the cake to the children, picking out lumps with his hand and dropping it on the dirt covered hands of the children, who had not taken a bath for days. One reason this jumped out at me was for children's regular complaints of stomach aches and headaches, and other infections; of course, these could also be a sign of mental and emotional trauma in physiological forms. The girls from one home shared that on their hospital visits, the staff at the hospital treated them 'like they [were] as dirty as beggars from the street'.

> A long history of institutionalization also produces problems for young adults when they leave institutional care and try to reintegrate into society, leading to much higher rates of homelessness, aggression, difficulties finding employment, criminal activity, and depression resulting in high rates of suicide. The aftercare system in the country is in the doldrums. So a child in need of care and protection may turn into a child in conflict with law (Bajpai, 2017, p. 203).

The idea of safety and protection of children who are living in child homes runs deeper than any other rights. The right to protection has overshadowed the right to development and participation almost entirely. The constant refrain, 'it is for the safety of the children', from the authorities and care givers sounds like a lame excuse for getting away scot free for not providing opportunities for development. The children are not being sent to school because they will be unsafe. The children are not allowed to go the market because they will be unsafe there. The children cannot go to a playground because they will be unsafe. And this idea is even more entrenched through gender discrimination. A girl shared a story of her employment offer letter being ripped into pieces in an Aftercare home because the authorities and care givers would not know what to

do if she got raped and ended up becoming pregnant, so 'for her own safety' it was better if she stayed within the confines of the home.

India's Centre for Human Rights and Law, in a short movie, 'Ek Tha Bachpan', very poignantly brings the reality of how the children who once enter the juvenile system suffer at the hands of the institution, due to various reasons. Some of them, due to lack of sensitivity and training for authorities and care givers and overcrowding in these institutions, lead to lack of attention to the children's individual needs.

Institutional care fails to provide holistic development to children due to various factors. Some of the common factors impacting the lives of children under institutional care include basic necessities like proper and nutritious food, health and shelter, shortage of staff and lack of adequate furniture, physical abuse and sexual abuse. The need of the hour is to improve the quality of institutionalised care and to revolutionise family care (Williamson & Greenberg, 2010).

> The UN Study on Violence against Children (2006) identified care institutions as one of the five settings where violence against children occurs. It mentions that children in institutions 'are at risk of violence from staff and officials responsible for their well-being'. Inappropriate institutionalization can compound the effects of abuse and neglect, and contribute to the suffering of children and the harm done to them (Bajpai, 2017, p. 203).

With the recent global and national thrust on de-institutionalisation and movement towards family-based and family-like care, there also needs to be an understanding that institutions are necessary for the children for whom family alternatives are not available. Data released in a Government of India Report titled *The Situation of Children in India* (2018), published by Ministry of Statistics and Program Implementation, indicates that 5% of the total child population is orphaned. That is almost 23.6 million. Child homes are needed as the number of 'children without parental care' are humongous, as well as, these options are still at a nascent stage, and need a lot more in-depth understanding, trainings, on the part of authorities and care givers, and society at large. In the meantime,

there is an urgent need to develop debates, discussions and attempts on sensitisation, training, and follow-up and regulating the staff, authorities and care givers, to enable them to follow the provisions of the juvenile justice policies.

The staff need to be trained in treating children as individuals not as inmates; the interactions need to be in a response-contingent manner and the children should be encouraged to take the lead wherever possible. Structural changes of reducing the number of children in each home should be handled at an urgent basis. This would help in multiple ways. It would help the authorities and care givers be able to maintain relationships with the children, not feel a constant burn-out and overlooking care would become more practically possible. The same is needed for social workers; they need to be assigned less cases in order to maintain focus.

There is a need to understand the plight of each individual that works in a children's home. The mental health facilities that are required for children are equally required for the authorities and care givers, staff and social workers in order to cope with the trauma that they constantly soak in. More recruitment is required for these roles in order to lessen the burden. It is high time that focused efforts be made towards drastically improving the plight of these children and young adults and change the notion of this being their ordinary. These extraordinary yet crucial steps will eventually be beneficial for the children living in care while to exercise the children's right to a family life, the process of moving from institutionalisation to family based and family like care can continues. As one of the young girls reflected: 'I sometimes feel special and happy to be part of these ordinary interactions that engage us through workshops and leave us with positive experiences'.

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About the author

Shivangi is a trained social worker currently working with Udayan Care in its project to support careleavers in India and is mentored by its managing trustee, Dr Kiran Modi.

Book Review

Lowborn: Growing Up, Getting Away and Returning to Britain's Poorest Towns by Kerry Hudson

IBSN: 978-1-784-74245-4, Chatto & Windus, Vintage

My Name is Why by Lemn Sissay

IBSN: 978-1-78689-234-8, Canongate

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In this review of two powerful memoirs, Samantha Fiander wonders how reflecting on the past might help us to address the challenges we face now.

> "Family is a set of disputed memories between one group of people over a lifetime. I sort of realised that at eighteen I had nobody to dispute the memory of me." (Lemn Sissay).

I am writing this in the middle of April. It feels important to give this frame of reference: none of us will know what our communities and world will look like when this issue of the Journal is published. I am quietly socially-distancing, living through 'COVID-19 coronavirus lockdown' in Scotland, while so much that so many people have taken for granted, is now turned on its head. A time when, perhaps, like me, you are looking to discover something new to read in the quieter moments.

I am not someone who tends to re-read books – fiction or non – but that doesn't mean what I read does not stay with me. And so in thought at least, with what feels like new resonance, I have returned to two memoirs that particularly affected me last summer, resulting in this: less of a book review and more of a book reflection. For *Lowborn* by Kerry Hudson, and *My Name is Why* by Lemn Sissay, are stories of communities, of relationships, of values.

Each of the writers exposes so honestly not only so much of their life to date but how they now look at those experiences. These works are an exploration in understanding what happened in their childhoods, in ways which feel like these are being committed to paper selflessly for our learning. These are stories that they have been encouraged to tell, voices of experience that often go unheard. Hudson and Sissay are – to coin a very modern phrase - telling their truth, and in doing so both open up deep, multi-layered truths about the power, dynamics and destructive forces of the relationships we have as we grow up. That we are defined by these relationships is a myth. Rather, what we see through these works so clearly is that who we become can be shaped by relationships. The parent, the social worker, the friend.

Both contrast their own memories with a comparator – for Hudson it is returning to people she knew and places she lived, now decades on; for Sissay it is the files and records made by social workers that he fought to access and make sense of.

Lowborn is Hudson's first non-fiction book. Preceded by fiction – the old adage of write about what you know is so strikingly evident in the acclaimed Tony Hogan *Bought Me An Ice Cream Float Before He Stole My Ma – Lowborn* began as an online column and takes us on a journey in every sense, retracing the moments of her childhood that took her back and forth, across England and Scotland, through many turbulent upheavals, with her mother and sister in a constant search for a better, happier life. With her novelist skill the writing is so descriptive of the communities she returns to. There is no hiding from the realities of the difficulties of her upbringing, but her respect for the communities she now revisits is salutary. Hudson rebuffs any suggestion that she is anything but lucky to live a different life now.

Having followed his writing, and through my professional work, I had known quite a bit of Sissay's story – his poetry, his childhood, his legal victory against Wigan Council, the local authority responsible for his care. But this does not really prepare you for *My Name is Why*.

We read for ourselves the destructive impact of the actions of those supposed to care most for him: his adoptive family's rejection after raising him from infancy,

separated from all he knew, only to discover when he could finally access all his records, that his mother's wishes to be reunited with him were ignored.

That Sissay is a natural storyteller makes the disputed memories comment he often repeated while promoting his memoir last summer all the more poignant. It is all there in that phrase and I was left feeling that *My Name is Why* is part closure, part a need to bring the whole story together in one place. Sissay writes 'good people did bad things'. With this simplicity he leaves the reader to sit with their own feelings and judgements. Given what is laid before you, it is remarkable that what comes through from him as the stronger force is understanding, not blame. No child should ever experience what he did. There will always be something so prophetic about the name Sissay's mother gave to him. Why indeed.

Together these memoirs tell us so much about the needs and experiences of children, the role and impact of the very people who were supposed to help and support them, and how our circumstances can shape how we see ourselves. And the new resonance for me? The pain and despair of the impact of the pandemic has brought to the fore fundamental questions of how we treat and value each other, how we live, of poverty, of inequality, of community and fairness. It is how we prevent and respond to social injustices that matters most. While we may not know or be able to see what the future holds in these uncertain times, reflecting on these memoirs makes me wonder whether if we can understand the past better, perhaps there can be better times ahead.

About the author

Samantha Fiander is the Communications and Engagement Lead for CELCIS, the Centre for Excellence for Children's Care and Protection.

Samantha was reviewing her own copies of both these books.