Scottish Journal of Residential Child Care

Special Edition: 20 years of the SIRCC Conference

Scottish **Journal** of *Residential Child Care*

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Editorial

Graham Connelly

Welcome to the second issue in Volume 18 of the *SJRCC*, a special issue of shorter articles on the theme of reflection, planned to coincide with the 20th annual conference of the Scottish Institute of Residential Child Care, held in Glasgow on 4-5 June 2019. The issue includes the conference keynote address by Professor James Anglin.

The Institute – now an integral part of CELCIS - was established in 2000, although it originated in 1995 as the Centre for Residential Child Care (CRCC) within the University of Strathclyde. The Institute's other partners were Robert Gordon University, Langside College, Who Cares? Scotland and Save the Children.

The idea of a centre or institute dedicated specifically to the residential child care sector in Scotland, with emphasis on the voice of children, the broader education of staff, and a culture of research, came about in response to a highly influential report titled Another Kind of Home by the then chief social work inspector, Professor Angus Skinner (Skinner, 1992).

From the beginning, the Institute had an international outlook, its leadership aware of the importance of being open to influences from around the world, and of the value of showcasing innovative work in Scotland to make growing up in residential care the best it could be for children and young people.

More than 20 years on, a belief in the importance of developing youth and child care practice *and* creating space to think creatively about how the care children experience can be made better continues – exemplified by the SIRCC conference and in the pages of this Journal.

Charlie Gracie, social worker and poet, has written a poem especially to celebrate 20 years of the SIRCC conference. We hope you will enjoy it and be enlivened by reading the articles contained within this special celebratory issue.

Reference

Skinner, A. (1992). *Another kind of home: A review of residential child care*. Edinburgh: The Scottish Office.

Charlie Gracie

Three things about growing fruit

When a gooseberry bush suffers
poor soil
disease
weather-threat
young berries begin to waste
or tumble
to the hard earth.

When a young gooseberry
clings to a withered stalk
it too will shrivel
from lack of sustenance.

If a young gooseberry falls
the fall itself makes the flesh hurt:
rain pounds
beasties nibble
rots begin.

And we
we bring young berries in
place them in sunlight
on soft surfaces.
We give time for flesh to sweeten
give love for skin to heal.

And what to do for
poor soil
disease
weather-threat
so gooseberries can thrive?

About the poet

Charlie Gracie grew up in Baillieston, Glasgow. His first poetry collection, *Good Morning*, was published in 2010 by diehard, who will also publish his second collection in autumn 2019. His first novel, *To Live With What You Are*, was published in 2019 by Postbox Press. Charlie has been a social worker for over 30 years and is a CELCIS Associate. He now lives on the edge of the Trossachs. www.charliegracie.scot

'A Review Like No Other': Putting love at the heart of the care system

Key Note Address given at the 20th SIRCC Conference, Glasgow, 4-5 June 2019

James P. Anglin

Abstract

In this paper, the Scottish Independent Care Review is set in an historical and international context, presenting a typology of review characteristics and assessing the notion that this is 'a review like no other'. It is suggested that the evolution of child welfare tends to be cyclical rather than a linear and upward progression, meaning that discoveries or assumptions of one era tend to be lost or ignored, and then re-discovered, thus limiting the potential for ongoing system learning and steady practice improvement. Given the Scottish review goal to 'put love at the heart of the care system', the notion of love is examined in terms of its central role, multiple meanings and possible distortions. The article concludes that this review is indeed unique, and that the world will be watching and learning from this inspiring process.

Keywords

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When I first learned about the Scottish 'Independent Care Review', I discovered how jaded and cynical I have become over 45 years of government reports, investigations, reviews and efforts at 'transforming' child welfare, child protection and child care. In fact, the very word 'transformation' was virtually banned from workers' vocabularies in my own province as a result of a particularly unfortunate change process experience.

Some of the first phrases I heard and read in relation to the Scottish review were: 'a review like no other', 'putting love at the heart of the care system', and its purpose, 'to have the best care system in the world'. Well, doesn't every review want those things (even if they dare not say it)? Has any review ever come close to delivering on any of these? Not in my experience. And I have witnessed dozens of reports and reviews, likely well over a hundred across many countries. I have even participated, eagerly and with great hope, in a half dozen and even led one myself, only to end up disillusioned and disappointed every time.

The lowest point for me was after I personally completed an independent (one-person) review of the residential child care system in the Yukon Territory in northern Canada only to see none of my key recommendations acted upon. Governments can change very quickly, and along with them the intentions of the previous politicians, and new governments want to start fresh with their own agendas and experts. Ironically, a colleague of mine was asked to undertake a similar review in 2018, 17 years after mine, and he echoed some of the same themes and recommendations as I had.

Sometimes black humour brings forth a sardonic chuckle, and the ironies of life may cause us to smile ruefully, but if what I am saying is anywhere close to the truth about the vast majority of efforts to change and improve children's services, this must be considered nothing less than scandalous. After many years of puzzlement about why bureaucracies seem unable to change, or be changed, I wrote an article titled: *Transforming government services for children and families, or 'Why non-reductionist policy, research and practice are almost too difficult to be tackled but too important to be left alone'* (Anglin, 2008). My conclusions about the necessary conditions for true transformative change included the following:

- 'We must remain vitally concerned with the human experiences of the whole persons who become enveloped by the institutions in which we work, including fundamentally ourselves (p.76).

- 'We need to seek first to access and understand the lived experience of those we are there to serve. The most effective way to accomplish this is to participate together in joint ventures so that both parties can develop renewed and transformed understandings of each other and the nature of their mutual involvement. In such an interactive and mutual process, the language of the activity, traditionally quite technical and partial, is shifted in order to refer more accurately to real experiences, problems and aspirations. As Alfred North Whitehead has observed, "We think in generalities but we live in details" (p.76).

- 'We have to stop doing what we know doesn't work in order to create a space in which we can discover what can work (p.76).

- 'In brief, an essential element of a non-reductionist approach is to think, experience and act in full recognition of the integrity of persons and the wholeness of human life' (p.78).

When I first wrote those words about 20 years ago, while I believed in them deeply, I am not sure I thought I would live long enough to experience a process in human services that actually tried to function according to these principles.

To be and relate as whole persons, to access the lived experience of others, to participate in joint and mutual ventures with young people, to change our language away from the technical and partial, to stop doing what doesn't work, to create space for discovery, and to act in the recognition of the integrity of persons and the wholeness of human life – is all that just aspirational but unrealistic in practice, or could it be a reality in some form of system renewal process?

The Scottish Independent Care Review

Hope indeed springs eternal, and I am prepared to believe that this 'root and branch' Scottish care review might just be the fulfilment of my dreams of true transformation in child and family services. It is time to restore the credibility of

such concepts as 'transformation', 'the integrity of persons', 'the wholeness of life', and to add a concept championed by the Scottish review – 'a loving care system'.

But perhaps it would be helpful to take a moment to examine this review in the context of reviews historically and internationally. In Scotland alone, there have been 20 reports on the children's service system over a recent 15-year period (2001-2016), undertaken by the Scottish Executive, the Scottish Government or the Care Inspectorate (Children and Families Directorate, 2017). There have even been promising titles, such as 'It's Everyone's Job to Make Sure I'm Alright' (2002) and 'Getting it Right for Every Child' (2008). But we are now in 2019, and we certainly have not yet got it right, in Scotland or anywhere. This is indeed worrisome, given that we have had residential group care in the world for almost 1700 years, since at least the year 354 CE (Anglin & Brendtro, 2015). What will it take to get it right?

In order to understand better the potential of the current Scottish Independent Care Review, let us first look at the typical characteristics of other previous reviews, not just in Scotland but in a great many other countries as well. The following typology will allow for some comparison and discussion.

A typology of typical reviews

Auspices – reviews are almost always government initiated.

Review ethos – typically these include a belief in expert professional opinions and academic research.

System focus – usually one of: child welfare, child protection or children-in-care.

Purposes – modify the system, enhance practice, bring cost-efficiency, or make policy changes.

Precipitating factor(s) – regrettably, usually a death of a child, an abuse scandal, or a system/political crisis.

Reviewers – characteristically judges, lawyers, or senior (ex-) civil servants.

Design of review – single expert or team of professionals with some (often minimal) consultation.

Processes/Activities – select interviews, invited submissions, case record and policy analysis, literature reviews.

Outputs – a final report with findings and recommendations (often poorly implemented, if at all).

Even a quick scan of these characteristics reveals a strong bias towards professional, academic and government perspectives, and the placing of power in the hands of 'guardians of the system'.

Presumably, reviewers have been chosen to ensure impartiality, independence and rigorous investigatory and decision-making skills, because they often have little or no child care or child welfare practice experience. Reviews and investigations of child welfare and child care are almost invariably undertaken by judges, lawyers, or senior (ex-) civil servants.

How do you think the judiciary or legal profession would react to a child and youth care worker/social pedagogue or social worker undertaking a review of the judicial or legal system?

I am aware of one review in England that was undertaken jointly by a lawyer (Allan Levy, QC) and a social worker, a late colleague Barbara Kahan, who had been the Director of Children's Services in Oxfordshire, England (Levy & Kahan, 1991). It focussed on the use of isolation rooms, called 'pin down' rooms as a result of their purpose to pin down and isolate young people in care exhibiting unacceptable and difficult to control behaviour. I recall Barbara telling me once that a lawyer had criticised her for 'always taking the side of the child'. She did not see a problem with this, and took it as a compliment. Taking the side of a child does not mean they always get their way; it means someone is championing their experience, their voice, and their rights.

The Levy-Kahan report stated: 'Training is an essential element in the provision of a service for children in care. It can no longer be regarded as something for the few senior staff who oversee large numbers of untrained staff offer to the children' (Section 19.10).

And in section 19.12: 'We recommend that a strategy of training for the next five years is developed as a matter of urgency with a particular aim being to increase the number of trained and qualified staff in residential care without delay'.

Alas, my review of the history of child and family services demonstrates that their evolution tends to be cyclical (see Figure 1).
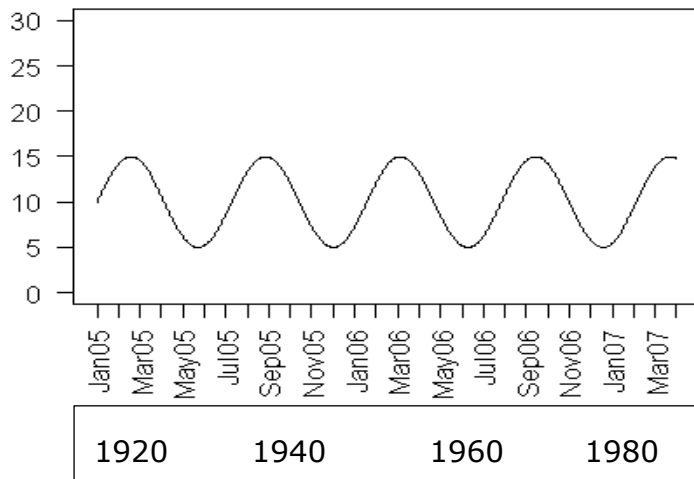
Figure 1 – Illustrating a cyclical pattern

It is not a linear and upward progression (see Figure 2), meaning that discoveries or assumptions of one era tend to be lost or ignored, and then re-discovered, thus limiting the potential for ongoing system learning and steady practice improvement.
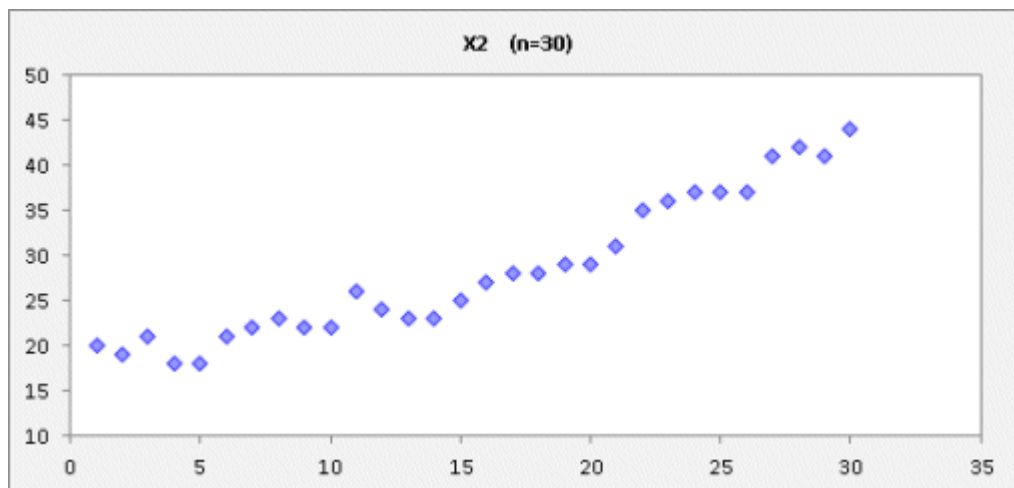
Figure 2 – Illustrating a linear and upward progression

To illustrate the cyclical nature of reports and reviews, let's jump ahead 26 years from the Levy-Kahan review (1990) to 2016, and the *Residential Care in England*

Report, often called the Narey Report (Department for Education, 2016). A programme director is quoted in Sir Martin Narey's report as saying:

> The low qualifications threshold and low pay… made it difficult to attract people with suitable experience, skills and insight. Other similarly low paid, entry level work, which required no previous qualifications commonly competed for the same candidates but were likely to be substantially easier and more compatible with having a home life and caring responsibilities (p. 60).

The response by Sir Martin Narey: 'I think that is defeatist...' Narey goes on to say:

> …work in children's homes is certainly demanding. But it's also fascinating and rewarding and offers much more variation and stimulation than the relative drudge of retail work for example. Many staff in children's homes wouldn't do anything else […]

> As the NCB TNS researchers discovered: 'Younger staff especially were said to be more likely to be ambitious and use children's homes as work experience and a stepping stone to other careers, typically [in] social work, teaching or psychology' (p.60).

As for training and qualifications, he says:

> We must have a competent and confident workforce, but I'm not at all sure that necessarily means a highly qualified workforce. Although the intention in Scotland is to require staff in children's homes to be graduates (from 2018), I urge Ministers not to follow that example in England. I'm not aware of evidence which suggests that an entirely graduate workforce would further improve the quality of homes (p.55).

Interestingly, in another section where Narey dismisses social pedagogy as not likely suitable to England (and while not supporting the development of *any* child and youth care education, as he notes Scotland is doing), he indicates that in Denmark, where such education is required:

> Outcomes for children living in residential care in Denmark are significantly better than outcomes in England with, in particular, better children's engagement in education. But it is impossible convincingly to assert that this is as a result of the use of pedagogy (p. 66).

To this I say: It must be their wonderful blue cheese that makes the difference. How sad it is to see the informed and forceful support for education and training clearly asserted by Levy and Kahan two decades earlier being dismissed out of hand.

How might the current Scottish Independent Care Review be untypical?

Let us revisit the review characteristics template introduced earlier, and consider how the Scottish review may be untypical, and in fact, may be 'a review like no other'.

Auspices – Instead of this review being initiated by a government department, it was initiated by Scotland's First Minister, Nicola Sturgeon, personally, and she made it very clear that she and this review would be accountable to young people in and from care. As far as I am aware, this is an absolutely unique situation in the history of reviews internationally.

Review ethos – Instead of some political agenda or ideology driving this review, it is values driven, and in particular by the First Minister's values of compassion, caring, sense of accountability and commitment to the well-being of the young people of Scotland. This too is a unique feature of this care review.

System – Interestingly, the Chair of the independent review, Fiona Duncan, is quite clear that the review is not focussing on the child care or child welfare system, but rather on the experiences and well-being of the children themselves. It is not about changing a system, but rather creating new and positive experiences for the young people living in foster or residential care.

Purposes – 'to have the best care system in the world', period! What else is there to say?

Precipitating factor(s) – In contrast to most other reviews that are initiated in response to a death or other tragedy involving young people, this review resulted from the First Minister of Scotland's authentic encounter with youth in and from care. She opened her heart and mind to the voices of young people, and was moved to respond with initiating this ambitious process. How refreshing!

Reviewers – As noted earlier, characteristically reviewers selected are judges, lawyers or (ex-) senior civil servants who have little or no experience with child care practice, or with the daily lives of young people in care. The Scottish Independent Care Review is being chaired by a woman with lived experience in care who also brings astute skills of analysis and a fierce sense of accountability to the young people of Scotland. She refers to her role as being a 'choreographer', and she is clear that this review must not take her name, and resists any such label. This is most unusual and reflects the ethos she is championing for this process.

Design of review – An emergent approach is being taken to this review, encompassing four stages (orientation, discovery, journey and destination) that will build on each other over three years. A unique feature is the provision of ongoing 'stop-go' feedback to those providing care services. The review is not waiting until the end of the process to initiate changes in practices. As well, there is an intention to try 'mini-tests' of new approaches to explore innovations while being aware that changes should be tried out and proven before being adopted on a broad scale. It seems these notions were suggested by young people themselves.

Processes – The most fundamental process adopted is to engage a virtual army of people in meaningful conversations (about 2,000 individuals) and in working groups over each stage of the process (involving over 150 people). More than half of those engaged have lived experience in care. In the journey stage, there is extensive communication and collaboration to link together the various working groups and themes being examined. This is certainly unprecedented involvement, and offers a prospect of ongoing change after the formal review process is completed. If hearts and minds are changed, behaviour is likely to

follow, and if an army is mobilised, many more people are likely to be inspired to join the cause.

Outputs – As indicated, the review is affecting attitudes and practices as it unfolds, engaging everyone in its purview as whole persons, challenging thinking and action from the perspectives of young people in care. Some 'stops' (red lights) have already been initiated (e.g. ending restraints), and some mini-innovations will be tested, meaning services are in the process of change before any final reporting and recommendations.

Some Reflections

Over the course of my life, I have learned that, from time to time, the stars just seem to align as if arranged by some higher power. For example, some of the events that led to the Inkatha Freedom Party joining at the very last moment in the first democratic South African elections in 1994 cannot be rationally explained, and these events averted certain bloodshed on a devastating scale (see Cassidy, 1995). In my personal experience, random events and the chance alignment of particular individuals have led to new opportunities and career directions that forever altered my life and work. Perhaps you can think of such moments and times in your life. This Scottish Independent Care Review, to my mind, carries an aura of such mystery and good fortune.

As I reflect on what I have learned to date about the initiation and unfolding of this unique review process, I cannot help but feel great hope that not only will the lives of Scottish children be transformed, but perhaps lessons will be learned that can be shared more broadly, across services and systems around the world. Virtually every country I know continues to struggle with the burden of inhumane, stigmatising and largely ineffective systems of care for young people. It is painful for all involved, but especially for the young people in care themselves, when the intention of the providers is to create nurturing, loving and healing places.

A note on the 'L' word: I think we need to approach the notion of love with some care and caution. For some young people in care, being loved has meant being manipulated and mistreated. For example:

- 'I beat you because I love you'.

- 'If you loved me, you would do what I tell you'.

- 'If you love me, you must keep this secret'.

As carers, we need to be careful about how we express our love, but we also need to help those with whom we work to think critically about what love means in the context of our child care systems.

A Canadian professor of child and youth care tells the story of talking with the head of a juvenile justice institution (youth corrections jail) as part of a residential care review in the province of Ontario a few years ago. When the professor mentioned the children's need for love, the director said: 'We don't want the staff to love the kids; then they will want to have sex with them' (K. Gharabaghi, August 23, 2016, personal communication). When leaders in our field think like this, we have a lot of work to do in clarifying what love has to do with out-of-home and professional care.

In another conversation, a Deputy Minister of Child Welfare in the Government of Ontario said to the former provincial Advocate for Children and Youth: 'We can't legislate love'. The Advocate replied: 'No, but you can legislate the conditions in which love can happen' (I. Elman, April 16, 2016, personal communication).

The Ancient Greeks had many words for love. Perhaps these are better thought of as dimensions of love, rather than pure types, as we may experience a mix of these with the same person. Four dimensions, or types, of love are perhaps most relevant to our work.

- *Agape* – selfless, spiritual love (e.g. God's love).

- *Philia* – love from shared experience (affiliation).

- *Storge* – friendship love, slowly developed.

- *Eros* – passionate physical love, attraction.

Those who work in a professional or volunteer capacity with young people in the care system need to engage in reflective conversations about these dimensions, or types, of love, and how these might manifest themselves in their day to day

practice. Often, those attracted to child and youth work are motivated by a sense of *agape*, a deep caring for people as persons, perhaps developed in their families or through a people-centred childhood. For example, they may have cared for younger siblings, or been part of an extended family, or close-knit neighbourhood or church community where they formed close relationships. However, even where that may not have been the case, over time through daily engagements with young people and colleagues, shared passions and interests may be discovered (*philia*) and meaningful friendships (*storge*) developed over time. Young people need to experience loving relationships between adults (including staff members) as part of learning how to engage themselves in loving relations with others.

While *eros* can be very problematic if not addressed properly, we cannot pretend that young people in care are never physically attracted to their caregivers. The reverse is also true, and how to respond to such attractions must be part of education, training, ongoing supervision and team discussions in our field.

The Associate Director of the South African Child and Youth Care Association (NACCW), Zeni Thumbadoo, has put it well. 'Love', she suggests, 'is present in powerful CYC moments with another, and must be present when real connections are made between self and other' (Thumbadoo, 2011, p.197). This is a form of *agape,* or love of another human being in the Ubuntu sense of: '*I am because you are*'; 'I am a person because of other persons'. She further asserts that 'caring and love intermingle in the encounters' between child and youth care practitioners and others (Thumbadoo, 2011, p.197).

A Canadian First Nations' author, the late Richard Wagamese, has written powerfully about the primal wound he suffered from being forcibly removed from his mother at a young age: 'It's being ripped from love that causes the wound in the first place and its only love in the end that heals it' (Wagamese, 2009, p. 13).

In a recent study involving conversations with 20 young adults from foster care undertaken by one of my students, Angela Scott, and myself, at the heart of the retrospective reflections shared by the young people was the sense of an elemental or primal loss. As one young woman so poignantly stated:

> …that's what we are missing out on as kids in care, *we don't feel*
> *that* love, that community, and family connection.

Ever since hearing that statement, the notion 'we don't feel *that* love' has been etched into my brain. It was this statement, encompassing not just an individual perspective but also a communal experience of youth in care, that revealed once again a deep and profound sense of what has too often been *missing* from the lives of those living in care.

How tragic. How wrong. How unnecessary. The Scottish Independent Care Review is the first such review I have seen with a working group focusing on the notion of *love.* Perhaps finally the primal pain of young people in and from the care system is being heard and responded to with care, compassion, and most importantly, action.

Conclusion

Governments and societies around the world must find ways to create loving, nurturing and healing spaces for all our young people, and especially those removed from their families of origin. I know I speak for the international child welfare community as a whole when I say that the world is watching, Scotland – we pray you succeed 'in putting love at the heart of the care system' so that you can not only help the young people of Scotland, but help the rest of the world learn how to do this as well.

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About the author

Professor James Anglin began his career as a child and youth care worker in a mental health centre in Vancouver after which he developed a six-bed group home for adolescents in Victoria, Canada. In 1979, he joined the faculty of the School of Child and Youth Care at the University of Victoria, later becoming Director. He also served as the university's Associate Vice President Academic and Director of International Affairs and was appointed Emeritus Professor.

Jim is currently researching the implementation and cultural adaptation of a principle-based approach to residential care (CARE) with colleagues from the

Bronfenbrenner Centre for Translational Research at Cornell University. He has published in North American and international journals and child welfare texts on a variety of child and youth care issues, most recently on understanding and responding to young people's pain and pain-based behaviour and the processes of healing from complex trauma.

Residential childcare in Ghana: Analysing current trends and drivers

Kwabena Frimpong-Manso, Antoine Deliege, Theresa Wilson and Yvonne Norman

Abstract

The paper describes the findings of a geographical mapping and analysis of residential care facilities in four regions of Ghana. The mapping exercise study identified 24 residential facilities with 944 children, amounting to 22% of residential facilities and 27% of children in residential facilities in Ghana. Most of the residential facilities were privately run with their budgets funded by international donors. Seventy-five percent of the residential facilities were unlicensed because they did not meet the national standards for residential care facilities. Most of the children in the 24 residential facilities were male and aged 11 to 17 years. Nine percent of the children in the residential facilities were 0-3 years, but 28% had been admitted aged 0 to three years. The average length of time the children spent in the residential facilities ranged between three and five years. In many of the residential facilities, the main reason for children's admission was poverty-related without involvement of social welfare officers. The implications for future service development emerging out of the study include ensuring that the residential facilities are licensed and have functional administrative systems to enumerate the children in their care, screen volunteers before they work in the facilities and reunify children in care because of poverty.

Keywords

Residential care, deinstitutionalisation, alternative care, Ghana

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Introduction

In Ghana, residential care is the main alternative for children without adequate parental care. A national survey conducted in 2006 revealed that between 1996 and 2006, residential care facilities for children (residential facilities) increased by 91%. There were about 4,500 children in care, 80% of them because of poverty (Csaky, 2009). Most residential facilities were not operating in line with the requirements set out by the Children's Act, 1998 (Act 560) because they did not have a licence from the Department of Social Welfare. In response to the situation, childcare reforms began under the Department of Social Welfare in 2007 to de-institutionalise the care of orphans and vulnerable children and shift towards family-based options such as kinship or foster care.

Since the reform started, however, there has been little information on its progress, including information on residential care and the characteristics of children living in the care option. The study describes a geographical mapping and analysis of residential facilities in Ghana to identify the 'hot spots' - high concentration of residential facilities - to develop an understanding of current trends, flows, and drivers of children in residential facilities in these areas. The study is relevant because it adds to the scant knowledge on the characteristics of children living in residential facilities especially in developing countries (Petrowski, Cappa, and Gross, 2017; Stark, Rubenstein, Pak and Kosal, 2017).

Method

Identification of residential facilities began in November 2016 through analysis of a national list of 98 residential facilities maintained by the Department of Social Welfare. Four 'hotspot' regions (Ashanti, Central, Greater Accra, and Volta), were identified, and 24 residential facilities in 10 Districts in these Regions, representing 22% of all residential facilities in Ghana, were selected for in-depth data collection. Development of regional level data collection tools for gathering information on mapping related to questions (e.g., trends and drivers; monitoring systems and tools) was done with the Department of Social Welfare and refined following pilot interviews in Greater Accra and site visits to residential facilities in one region. At the residential facilities level, we asked specific mapping related questions, followed by an in-depth assessment of

implementation of the Standards for Operation of Residential Care Settings in Ghana (GoG, MMYE and DSW, 2010). We developed four checklists for this assessment: manager, caregivers, premises and children. The mapping team included the staff of the Department of Social Welfare, a non-governmental organization, and two of the authors. Regional and district social welfare officers took part in site visits in the residential facilities and received a hands-on orientation to the assessment tools.

Data collection activities for the mapping exercise took place in the first quarter of 2017. Data collection involved multiple sources including interviews with social welfare officers, district assembly representatives and staff (social workers, managers, and caregivers) and children in the residential facilities. The authors also examined the facility records and conducted observations of the premises.

Drawing on information from registers and records of children, the authors captured data on children in the residential facilities in a standardised MS Excel format, which allowed for quantitative analysis. Individual data reports for each residential facility were prepared using a standardised template after which the data from the interviews were thematically collated. Findings from the interviews and individual data reports were triangulated and regional data reports were prepared. Key findings from these Regional data reports were synthesised and are presented in this report.

Findings

Status of residential facilities

Over half (58%) of the residential facilities were established before the care reform initiative, and 33% between 2008 and 2012, with no new home established since 2016. Apart from one facility run by the state, the rest were established by international and local nongovernmental or faith-based organizations (12); and Ghanaian individuals, either on their own or in partnership with foreigners (11). In terms of size, eight accommodated fewer than 30 children, 17 residential facilities had over 30 children (Figure 1) and five of them accommodated between 100-120 children. Thirty-eight percent of the

residential facilities provided dormitory-style accommodation. The 24 residential facilities had 1371 beds, but they were operating at 66% of their total capacity.
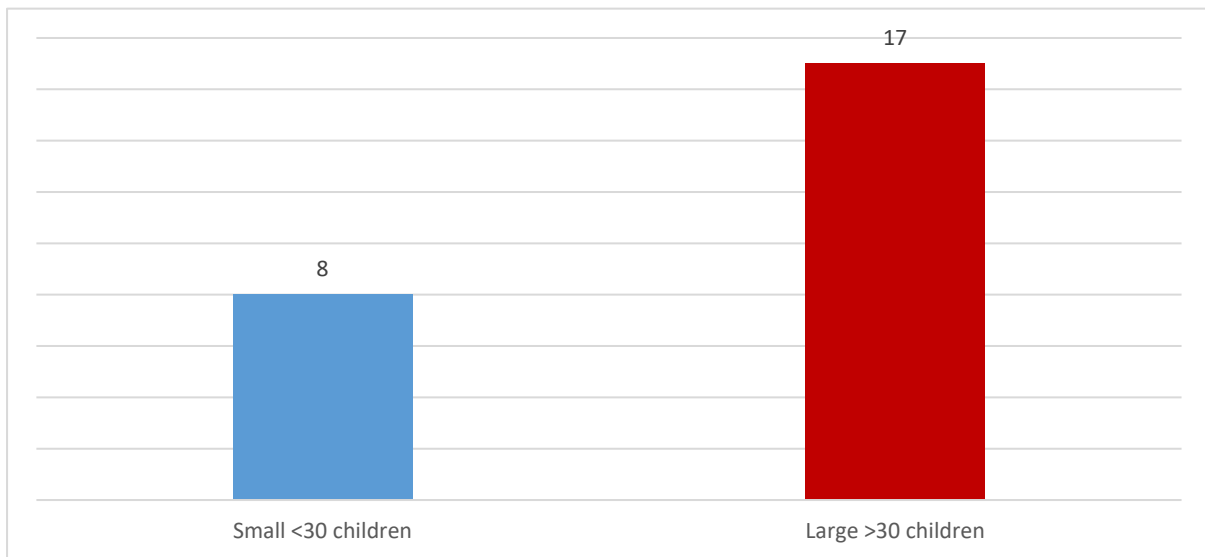

Figure 1: Size of residential facilities

Just under a quarter (seven) of the residential facilities had a licence to run at the time of the mapping. According to the regional social welfare officers, the residential facilities were unlicensed because they did not meet the 2010 Standards for Residential Homes for Children. The residential facilities reported that their funding came from a range of sources (e.g., volunteers, international donors) as displayed in Figure 2. However, the sources of funding varied in the size of their contributions in relation to the residential facility's budget. For instance, for 62% of residential facilities that accessed international donor funds, this was their primary source of income.

Local donors tended to provide more in-kind support (clothes, food) and were not a reliable source for meeting the costs of the facilities. Figure 2 does not include government funding because it is not government policy to fund private residential facilities. The one state-run residential facility in the Ashanti Region received government funding, although it was not regular and covered only about 30 percent of their funding needs with the remaining 70% of funds coming from local donors and income-generating activities.
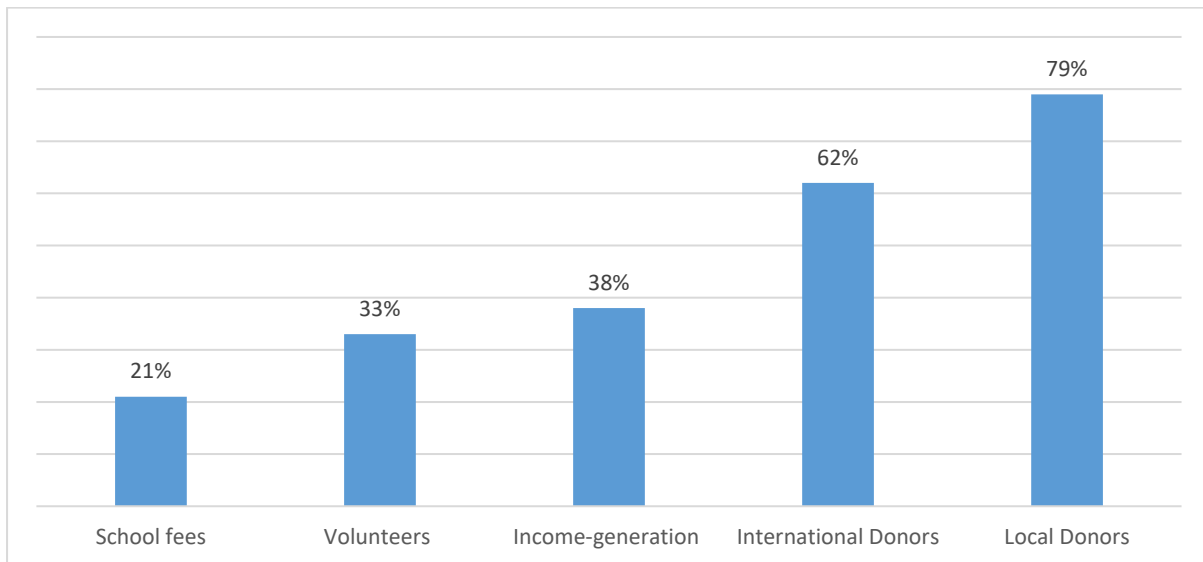
Figure 2: Range of funding sources accessed by the residential facilities

The residential facilities had an average caregiver to child ratio of 1:12, with the highest being 1:15, which is not aligned with the standards for operating residential care settings. Few residential facilities had any structured training programmes for their caregivers; many of whom were uneducated and employed because of their 'love of children'. Most of the caregivers were paid just above the minimum wage, did not have prescribed annual leave, and on duty 24 hours a day, seven days a week, for weeks on end. Children interviewed in many of the residential facilities reported the use of corporal punishment and, in one case, withholding of food as punishment.

Twelve residential facilities (50%) reported using international volunteers in their operations. Of these, five residential facilities used volunteers 25 years or older and had a professional qualification (e.g., teachers, doctors). Seven residential facilities used younger volunteers (18-20 years) who stayed for short periods (Figure 3). The residential facilities reported using volunteers sourced from volunteer placement organizations (e.g. Solution for Life Project Abroad) or the institution's international headquarters. Volunteers were not screened by social welfare officers and were used by residential facilities to supplement the low numbers of salaried caregivers.
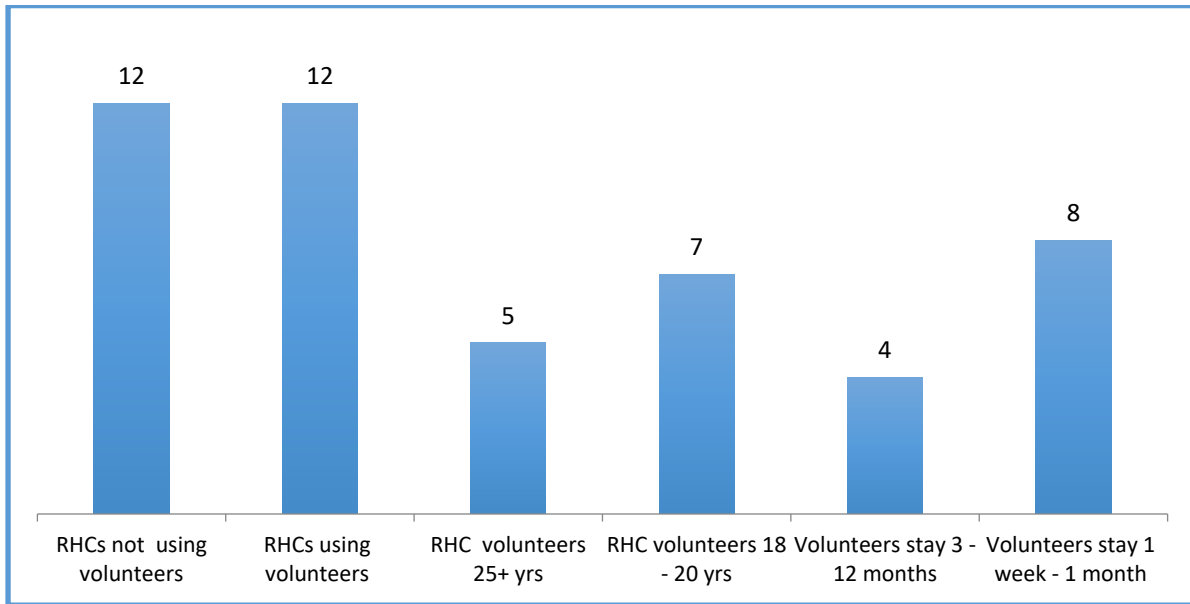
Figure 3: Trends in use of volunteers in residential facilities

Children in residential facilities: Trends, flows and drivers

At the time of the mapping exercise, there were 944 children in the 24 residential facilities. The majority of the children were male (57%), aged 11 to 17 years (66%), with an average age ranging between 10 and 14 years. Twenty-four percent of children were admitted when aged 0 to three years, but only nine percent of all children in the residential facilities at the time of the mapping exercise were aged 0 to three years (Table 1).

With the average length of stay ranging from 3.5 to five years, it is likely that many of the children admitted aged 0 to three years have spent at least one or more of their early years in residential care. While the average length of stay provides an overall picture of trends, it does not reflect the nuances of individual residential facilities. For instance, children in the government residential facility stayed for an average of three months, with the exception of children with special needs, while several private residential facilities had a policy of keeping children until they completed their education and children stayed on average for seven years in these facilities.

Region	Age Admitted to Residential Facility			
	0-3 years	4-10 years	11-17 years	Total (n=795)[1]
ASHANTI	37%	50%	13%	336
CENTRAL	12%	63%	25%	211
GREATER ACCRA	32%	43%	25%	223
VOLTA	8%	38%	54%	26

Table 1: Age of children when admitted into the residential facilities

Inconsistencies in record keeping by the residential facilities made it difficult to single out one main reason children were admitted to the facilities. There were often multiple factors at play that were exacerbated by poverty. Apart from the Greater Accra Region, the available information suggested that most children were not admitted to the residential facilities because of issues related to child protection. The category 'other' in Figure 4 below includes vulnerabilities related to financial constraints and parental ill-health.

Children were mainly referred and/or admitted to residential facilities by social welfare officers, the police or family members, with different Regional trends. For example, in Volta region social welfare officers referred most children while in Greater Accra region children were often referred by family or other people.

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[1] Information/records were only available on 795 children and not on the 944 children residing in the 24 residential facilities.
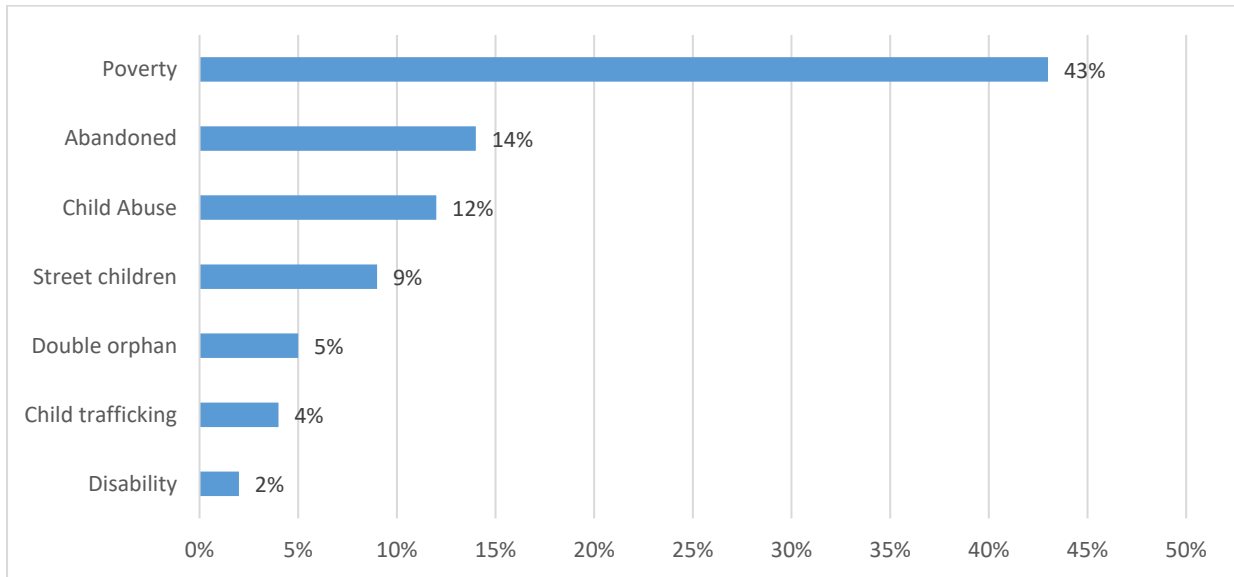
Figure 4: Reasons for admission to residential facilities

Even though the placement of children needs to be authorised by a judicial care order obtained by a social welfare officer, only 10 of the 24 residential facilities had some children with care orders. Reasons given for the lack of care orders included financial and capacity constraints. Information on districts and towns/villages where children were referred from was patchy and inconsistent. Available data shows that in many cases children are moved across Regions to be placed in a particular residential facility.

At the end of 2016, 925 children were in 23 of the 24 residential facilities[2]. During 2016, 200 children were admitted and 226 children were discharged (Figure 5). However, the discharge numbers are not reflective of the situation in most residential facilities as children were only discharged from nine residential facilities.

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[2]Complete information on admissions and discharge was only available for 2016 and only for 23 facilities
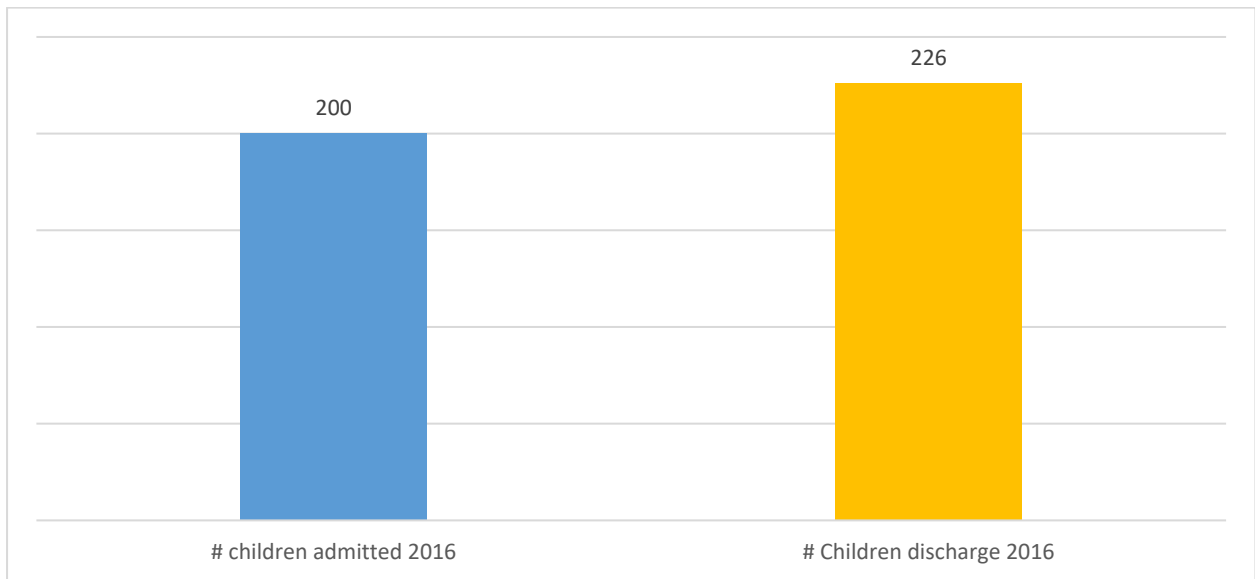
Figure 5: Flows of children into and out of 23 residential facilities

Discussion

While it was possible to collect some primary data from residential facilities, accurate numbers of children in the 24 residential facilities and the situation of these children were not always available indicating the lack of functional administrative systems for enumerating children. Allocation of adequate resources and investment in establishing and maintaining a standardized monitoring system is required. In spite of these limitations, the mapping study provides valuable insight into children in residential facilities in the country. The baseline data on the trends in the four regions can inform policy and practice and be a starting point for further mapping exercises in the remaining regions.

Private residential facilities continue to operate without the required government approval, licence or inspection despite this being a major requirement for the operation as stipulated by the Children's Act, 1998 (Act 560) and 2010 Standards for Residential Homes for Children in Ghana (UNICEF, DSW and MoGCSP, 2010). The Department of Social Welfare is currently not able to prevent these unlicensed residential facilities due to limited financial and human resources, leaving the children in these residential facilities at risk of abuse, neglect, and trafficking.

The mapping study found that most residential facilities in Ghana are established and funded by donors from the developed world, confirming findings from other studies (Ainsworth, 2014; Davidson, Milligan, Quinn, Cantwell, and Elsley, 2016). As in other developing countries in Africa, Asia and Latin America (Cantwell and Gillioz, 2017), residential facilities persist despite efforts to de-institutionalise because the state has outsourced alternative care provision to non-state actors, placing them in a powerful position to resist change and oversight. If the state can regulate and check residential care, it has to take more responsibility in its provision.

The mapping exercise confirmed the findings of other studies that volunteering in residential facilities is popular among tourists and travellers who come to Ghana Voelkl, 2012). However, in recent years, volunteering in residential facilities (orphanage volunteering) has been recognised as a serious international child protection issue (van Doore, 2015). Using volunteers affects children's psychological wellbeing and places them at risk of sexual abuse, especially when there is no screening of volunteers, and their engagement is short term (Carpenter; 2015; Guiney, 2017; Richter and Norman, 2010).

It is positive that only nine percent of children in the residential facilities are aged 0 to three years. Of concern though, is that 24% of children in care were admitted when they were aged 0 to three years, and many of them stayed in care for long periods because with a few exceptions, the policy of many of the residential facilities is to keep children in care until they completed secondary school. Children should only stay in these facilities on a temporary basis before reintegrating them with their families or a long-term family-based alternative. Residential facilities which fail to reintegrate children in care because of poverty should not be allowed to operate.

Years of research has shown the detrimental effects of residential care on children's physical growth, cognitive functioning, and socio-emotional development, especially in residential facilities with high child to caregiver ratios (Berens and Nelson, 2015; Fluke et al., 2012; McCall, 2013). The caregiver stress resulting from the high child to caregiver ratio could also be the reason many children mentioned experiencing corporal punishment and maltreatment.

The findings show that many children are in residential care for poverty-related reasons similar to findings from earlier studies (Herczog, 2017; Ruiz-Casares and Phommavong, 2016; Stark et al., 2017). However, poverty should never be the justification for separating children from their parents or prevent their reintegration with them, but a signal to support at-risk families. Since most family separations are poverty related, the State needs to ensure that at-risk families are prioritised and provided with cash transfers through the Livelihood Empowerment Against Poverty (LEAP) social protection programme.

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Adoption today: A consideration of adoption within the Scottish care and permanence system, and the challenges faced by children and families.

Fiona Aitken

Abstract

Adoption is the process where parental responsibilities and rights of a child are permanently transferred to another parent or parents. Legally introduced in Scotland in 1930, the process and legal context has changed and evolved over time, along with the nature and needs of children and families involved. This article establishes the unique position of adoption today with the Scottish care system, identifying the various needs that children and families can present with, and some of the challenges that they face in accessing support services. Taking into consideration Scottish adoption statistics and research relating to outcomes and needs of families and adopted children, it aims to raise awareness and understanding of adoption today in Scotland.

Keywords

Adoption, fostering, care experienced children

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Adoption and its position in the care system

The Scottish care and permanence system was designed to meet the needs of the children and families it was created to support, from those children requiring extra care within their family home to those no longer able to remain with their birth family. The care system, and care placements, can refer to a variety of settings from residential accommodation, foster or kinship care, to a family home under a supervision order. Children can leave the care system in one of

three ways: reaching adulthood and no longer considered to require corporate parenting or involvement; returning to their birth family with no further need for supervisory support; or permanent separation from their birth family by means of an adoption order that transfers all parental responsibilities and rights to adoptive parents.

In Scotland in 2017/18 there were 14,738 children deemed to be 'looked after children', with 90% of these being cared for in the community. Of this number, 34% of the children were in foster care with a further 28% in kinship care. In comparison, only 1% were with prospective adopters, waiting for their adoption order.

Perhaps because of the low numbers within collected statistics, adoption can often be omitted from conversations around the care system. Adopted children cease to be 'looked after' upon the granting of an adoption order, but this does not erase the fact that they once were. Adoption is unique in its permanent and irreversible nature and holds an important place in the permanence map for those children assessed to be appropriately suited for the process. Evidence has shown that family environments tend to provide children with opportunities to meet their best outcomes (Lloyd and Barth, 2011). Adoption offers a sense of permanence for children that other options do not – fostering, unless permanent, can lead to many moves and placement changes, and kinship placements are only permanently secured by adoption orders. Adoption tends to offer more stability for children (Triseliotis, 2002). In Scotland in 2017/18 there were 328 adoptions across all local authorities. While this number is a small percentage of the children who make up our varied care population, these adoptive families join many more in Scotland that represent a growing number of families living with similar, yet unique, needs.

Current framework of legislation and national policy

Since the introduction of the adoption process there has been a growing change in need and execution of it, driven by societal and demographic changes. The adoption landscape in Scotland looks very different in 2019 from its original state. Many years ago, it often involved very young infants and unmarried mothers, or orphaned children from children's care homes.

Adoption was legally introduced in Scotland in 1930, following the Adoption of Children (Scotland) Act 1930, shifting the process from the private sector to one managed by local authorities and charitable organisations. Around this time, it was common practice for young or unmarried mothers to 'relinquish', or give up, their babies at birth, from hospital. It was not unknown for these infants to be removed from their mothers very soon after birth, after a short period of caregiving. The Adoption Task Force, facilitated by the Centre of Excellence for Looked after Children in Scotland (CELCIS) has been involved with a variety of projects gathering information about adoption in Scotland. Their consideration of historical adoption and work with birth parents led to a paper that described the reasons leading to adoptions pre 1980. The majority were categorized as either 'coerced, pressured, consented in the context of time, consented but probably a difficult decision to make'.[3] This gives us an insight into the distress that the adoption process would have caused the mothers. Previously, there was no acknowledgement that there would be an impact on the infants who went on to be adopted, and many adoptions were hidden from the children involved. We now know that separation from birth mothers can cause lifelong trauma for children. This understanding leads to a better knowledge of the support needed to help both children and birth parents with this situation (Verrier, 1993).

The National Records of Scotland show us the pattern of the numbers of adoptions that have taken place in Scotland since tracking began in 1930. In that first year, only three adoptions were recorded. The number of adoptions grew year by year, peaking between 1966 and 1970 with 2,129 adoptions taking place. Since 1980 onwards the numbers have steadily dropped, with a yearly average of 488 adoptions recorded between 2011 -2015 – although these recorded adoptions include those securing parental rights for step-parents, rather than the process being a means of a child leaving the care system, of which this number is lower.

All adoptive parents in Scotland are subject to assessment within the legislative framework of the Adoption and Children (Scotland) Act 2007. The assessment process is deliberately designed to be comprehensive and stringent, to ensure

[3] https://www.celcis.org/files/6714/8551/3387/10_CELCIS_Continuum_of_possible_circumstances_of_birth_parents.pdf

that adequate safeguarding procedures are in place for the children waiting to be adopted from the care system. These children have often experienced abuse or neglect within their birth family environment. Thus a child who has been removed from their first family has already experienced significant emotional harm. The adoption assessment and matching process is designed to minimize the risk of further emotional harm which would result from the break down (disruption) of an adoptive family. Therefore extra care and preparation is required to ensure matches have the best chance of success.

There is a growing understanding of the importance of the system as a whole, from the initial assessment of the child and drafting their permanence plan, to the family finding and matching process, in the success of an adoptive placement. The Scottish Government established Scotland's Adoption Register in 2011, and it gained a statutory footing as part of the Children and Young People (Scotland) Act 2014 which requires all adoption agencies in Scotland to use it to register both children and adopters within three months of adoption order being issued, or approval to become adopters is obtained. Its existence is designed to both simplify and widen the process and opportunities for family finding in Scotland: it is a central register that can offer children and prospective parents the chance to find matches out with the boundary of their immediate area. There is some evidence that the family finding activities of the Register are succeeding in the placement of children typically deemed 'harder to place' such as older children and sibling groups. One of the methods used involves the opportunity for children to attend the Register's activity days in order to meet prospective adoptive parents. Since the establishment of the Adoption Register it has been responsible for 559 matches that have led to adoption orders.

The Adoption Support and Services Regulations (2009) states that every adoptive family living in Scotland is entitled to an assessment of support needs, and any adoption support plan or adoption allowance requirements that they have from this point are the responsibility of their placing agency for the first three years of their adoptive placement, and thereafter the local authority for the location where they live. This acknowledgement, in statute, of the need of families for support is fundamental in enabling them to access the help they may need to ensure the success of the placements - but in practice the appropriate

service delivery is often extremely variable. Different local authorities offer different levels of post adoption support, and there is currently very little in the way of specialist adoption services available in Scotland to support families. There can often be a battle for agencies to acknowledge the needs of children and families prior to support being put into place, despite these being varied, and in some cases, significant.

Needs of adopted children and adoptive families

There is a growing awareness that every adopted child or young person has experienced care, if they have been adopted from the care system. The term 'care experienced' is replacing 'looked after' in our terminology when referring to the group of young people who have been involved with the care system, and so this term applies to every child adopted from care in Scotland. This is significant, as it is one way in which adopted children can be identified as recipients of associated support requirements.

The changing landscape of adoption has led to a change in understanding of the needs of those within it. What we know today about the unique and permanent nature of adoption, and the varying background experiences and needs of adopted children, can help us to understand the very specific needs of adoptive families in Scotland.

Loss of first family

Children who can no longer live with their birth parents experience significant loss, no matter what their earliest experiences may have been. Those who go on to experience multiple moves or caregivers can be re-traumatised by further losses and separations with each move (Fahlberg, 1993). Understanding that this loss is experienced by all adopted children who are no longer living with their first family, can help us to better support these children and their families as they build strong attachment relationships with their adoptive parents.

Impact of in utero experiences

Our knowledge has also increased around the impact of *in utero* experiences that can have a long term effect on development. We understand more about the significant harm that illegal drugs and alcohol can have on infant brain

development, leaving infants suffering from painful withdrawal symptoms as a result of drug use, Neonatal Abstinence Syndrome (NAS) (Hepburn, 1993) or individuals living with lifelong brain damage and learning disabilities caused by the umbrella term of Fetal Alcohol Spectrum Disorder (FASD)[4]. Studies in relation to FASD show that prevention is vital, but early diagnosis can minimise the likelihood of secondary disabilities, or mental health issues, when met with specialist diagnosis and support services (Mukherjee, Wray, Curfs and Hollins, 2015). Healthcare Improvement Scotland SIGN (Scottish Intercollegiate Guideline Network) guidelines now state that FASD is likely to be three to four times more prevalent than Autism Spectrum Disorders, and identifies it as being a significant public health concern[5]. We know that for care experienced children, incidences of FASD are higher than in other populations; one 2015 UK based study showed nearly 75% of children waiting to be adopted had been exposed to alcohol during pregnancy. However, achieving a diagnosis can be challenging due to the lack of available information. (Gregory, Reddy and Young, 2015).

Early experiences

Today, we must also take into account the fact that children being placed for adoption are older, many with experience of adversity – neglect, trauma or abuse. In 2014 a study by the Department of Education found that over 70% of children who went on to be adopted in England and Wales had suffered trauma, abuse, and/or neglect. While similar studies have not been carried out in Scotland, it is not unreasonable to presume that children in Scotland who are adopted from the care system have experienced similar adverse childhood experiences, given the similarities between social demography and the reasons for entering care.

Impact of Adverse Childhood Experiences

We have an increased awareness of the impact of Adverse Childhood Experiences, and in particular can understand that physical, emotional, sexual abuse and neglect are evidenced to have robust association with specific

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[4] https://www.gov.scot/publications/fetal-alcohol-spectrum-disorder-awareness-toolkit/
[5] https://www.sign.ac.uk/sign-156-children-and-young-people-exposed-prenatally-to-alcohol.htm

childhood behavioural/conduct disorders and mental health difficulties including anxiety, depression and self harming behaviours (Couper and Mackie, 2016). Given the experience of many adopted children in their early childhoods, we can predict that some will go on to experience difficulties associated with these.

Implications for attachment relationships

The concept of primary attachment relationships explains how children make sense of their world – before language, communication is formed through response to pre verbal communication, and these responses from others contribute to the inner working model of the child. They allow constructions of the child's self and relationships, to be formed. Relationship patterns formed in infancy impact on the child's response to adults and caregivers later in life – which can mean that adopted children with multiple early caregivers (birth parents, foster carers, adoptive parents) can struggle with secure attachment, even if these changes happened in the early stages of infancy (Howe, 2005).

For adopted children, they may have learnt that connection is not permanent and therefore attachment seeking behaviour can be more pronounced, including separation anxiety and fear of abandonment, or indiscriminate affection which can require heightened safeguarding.

Education challenges

It is not uncommon to hear of difficulties with education, especially in the school environment, as for children who have experienced trauma, or loss, or with an insecure attachment base, school can be challenging. Small changes that occur daily in a classroom can cause anxiety – and this can result in either internalised anxiety or 'acting out' (Bombér, 2013, p.113). If attachment is insecure, or experiences *in utero*, or as an infant have impacted brain development, there is likely to be a negative impact on a child's ability to settle, and thus to learn.

The needs of adopted children are part of the complexities facing adoptive families that can lead to support requirements. This is not to say that all children who are adopted will have significant support needs, but it does identify them as being a potentially vulnerable group. In addition, adoptive families must be aware of the wider context of needs that adoption brings; identity issues, life story telling, birth family contact and family tracing. These are issues that are

specific to adoption, and the majority of adopted individuals will require help with them (Triseliotis, Feast and Kyle, 2005).

Current context, and barriers to support

A recent mapping survey of support services for adoption in Scotland, carried out by Adoption and Fostering Alliance (AFA) Scotland and Adoption UK Scotland described one of the barriers to support for families as being the sheer scope and variety of need that families have (Grant and Critchley, 2019). The study concluded that over 50% of respondents indicated that support would have been helpful, but was unavailable in areas such as behaviour management, support with education needs and improving family life.

According to statistics compiled by the Care Inspectorate, in 2017, 328 children were legally adopted across 27 local authority services. In the same year, 16 adoptions broke down (disrupted) across 10 local authority services before the adoption order was granted. Four adoptions were disrupted in local authority adoptive households after the adoption order was granted. This shows us that a relatively small number of adoptions disrupt in comparison to matches made – however, as previously discussed, any placement disruption is hugely damaging to those involved, and in particular when the move was designed to be a final and permanent one.

It is possible for some people to lose sight of the impact of early life experiences, and the trauma of separation from first families, when adoption offers children stable and loving environments. In adoption circles the concept that 'love is not enough' is often stated to make clear that loving your children does not replace the need to understand and support their needs. However, for children, the loving family environment that adoption can provide makes it one of the most positive outcomes for a child leaving the care system. In order to ensure this remains the case, adoptive families require understanding, and support, fit to meet their children's needs.

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Adoption UK Scotland: Who are we?

We are a voluntary and membership organisation that offers information, advice and support. We work with adoptive families from across Scotland. The advice and information that we give to families regarding their rights encourage knowledge of local council or agency policy guidelines, but sits within the Adoption Support Services and Allowances (Scotland) Regulations 2009, the Looked After Children (Scotland) Regulations 2009 and the Adoption and Children (Scotland) Act 2007.

The services that we offer include a frontline helpline service that parents can use to seek support for their adopted children, emotional support for parents, peer groups run by experienced adoptive parent volunteers, and training workshops and resources.

Studying 'deinstitutionalisation' outcomes in Cape Town: How it all happened

Juliane Petersen

Abstract

In line with her academic background in the field of international relations and political science, the author studied the international 'deinstitutionalisation' movement as an example of a global norm change. In her recently finalised PhD study, she assessed in how far this norm change has actually reached the ground in the particular case of Cape Town's children's home sector and how local practitioners perceive and evaluate this change from their perspective. This article tells the story of how the motivation for her research developed in the context of her previous studies and work in Cape Town and how she went about conducting her study.

Keywords

Deinstitutionalisation, practitioner perspective, norm diffusion, South Africa

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How it all began

Reflecting on the overall research process of my recently finalised PhD study takes me back to where it all started. It was about a decade ago that I learned about the 'deinstitutionalisation' (DI) movement, just before the 'UN Guidelines for the Alternative Care of Children' were celebrated as a break-through in the field and substantiated this as a fundamental change of best practice norms.

At that time, I was a young and eager German MA student of political science who had fallen in love with living in the vibrant and controversial city of Cape Town. I had studied at the University of Cape Town for two years and got involved in different social projects in the city's township communities. These projects focused on women empowerment and income generation, protecting and counselling women, youth and children at risk, and providing afternoon programmes for children from the community. I was the typical German volunteer and intern, idealistic, dedicated, and still having so much to learn.

One day, my supervisor introduced me to the nearby children's home. Thinking of it now, I would describe what I saw as one of the proto-type scenarios of what the DI movement has been up against. It was not that many children, but seeing about 15 approximately three-year-olds sitting on the floor quietly, seemingly anxious or just apathetic in a smelly, unaired room was heart-breaking. These kids had never taken part in the community programmes.

The situation left a deep impression on me. I started coming by quite frequently to help out a bit, but much more importantly, I decided to dedicate my MA thesis to gaining close insights into the realities of children's homes in Cape Town, as well as the international debates surrounding 'best practice' on this matter. I really wanted to understand how children in this situation could best be cared for and thus, how children's homes should best be run. This was the beginning of the story of my PhD research, as the MA study I conducted back then became the baseline of my PhD research design eight years later.

The MA baseline

My literature review [6] taught me about the vicious circle of caring for children in institutions and the crucial importance of deinstitutionalising care systems and promoting family-and community based alternatives. At the same time, many scholars explained how an adherence to certain standards could at least help to reduce the harms and risks of residential care. For example, they called for ensuring the appropriate training and supervision of care staff, favourable staff-child ratios, and keeping children integrated in the community and in touch with their families. Drawing from this literature, I developed a multi-dimensional questionnaire to interview the leaders of Cape Town based children's homes in order to find out where they were at in terms of these principles and standards.

According to an official government list, there were 30 registered children's homes in Cape Town in 2009. However, only 23 of these were found to be up and running and I conducted interviews at 22 of these homes. In addition, I included two examples of unregistered children's homes into the sample.
I highly appreciated that everyone was generally very helpful and seemed rather open to be visited and interviewed for the purpose of the study.
It showed that many children's home leaders were quite aware of modern approaches and quite a few stressed their efforts in getting children back into the community. Yet, they pointed out some typical dilemmas, such as an overburdened and inefficient social work system, high numbers of failed foster care arrangements, and the challenges of working with traumatised families in dysfunctional communities. In this context, one of the most striking findings was that 75% of the respondents agreed – mostly strongly - with the statement that 'international actors promoting DI do not understand the reality in our country' and that 'children's homes are not an ideal place for children, but right now they are the only realistic option'. It was here, that I started realising that most practitioners would support DI as an ideal, but that making this work on the ground was a much more complicated topic.

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[6] For example, this included Dunn, Jareg and Webb, 2007; Powell, 2006, 2004 and 2002; Tolfree, 2003 and 1995; Meintjes, Moses, Berry and Mampane, 2007; Meiring, 2005; Desmond and Gow, 2002; several UNICEF publications.

From researcher to practitioner - and back to researcher

During the time of conducting my study, I got closer to the new management of the children's home I mentioned earlier. The management had been taken over by a local church group which had organised a complete home make-over and had certainly instilled a new sense of love and care at the place. I presented my research to them and it turned out that the topic of DI and modern best practice standards was also still new to them. One could say that this confirmed common concerns in the context of DI. However, we were all eager to learn from one another, so after completing my study I became part of the management team. This was the beginning of my five years of working in the field, first at this organisation and later at a much larger child protection NGO which runs programmes across the continuum of care. I also attended different local and international conferences (i.e. the FICE Congress 2010 happened to take place at our doorstep) and kept learning more about the debates and challenges in the field. Among many things, my work on the ground taught me that the practice of protecting children at risk is a particularly complex task where clear-cut answers and solutions are scarce – everything depends on so many factors.

In light of my experiences, I became intrigued by the idea to – once again - look at our sector from an academic, meta-level perspective. Doing my PhD had always been a dream of mine but I wanted to maintain a strong practice focus. I realised that the data I collected in 2009 offered a unique opportunity for a diachronic comparison of how the sector had developed in the context of the DI movement. The year 2009 even happened to coincide with the year in which the UN Guidelines were endorsed at the global level and, in 2010, a set of highly progressive updates to the South African Children's Act (2005) had come into effect. Beyond an analysis of developments, I wanted to assess which factors and conditions had driven the practitioners on the ground to adjust or not adjust their practices and how they perceived and evaluated the DI norm from their perspective.

In early 2016 all decisions were made. I had enrolled as a PhD student at my home University (Hamburg) where I had also done my MA studies. My favourite professor of International Relations had agreed to supervise my research and I had secured a three-year scholarship for the conduction of the project.

Research design and research process

In terms of a theoretical framework, my study fitted in with a broader scholarly debate on so-called international norm diffusion processes in the discipline of International Relations and Political Science. Khagram, Riker and Sikkink (2002, p. 14) describe (international) norms as severely powerful institutions as 'they determine the expectations or standards of appropriate behavior accepted by states and intergovernmental organisations that can be applied to states, intergovernmental organisations, and/or non-state actors of various kinds'. Diffusion is understood as the process in which ideas or norms spread within or across national or cultural borders as a consequence of interdependence (see e.g. Gilardi 2013). One prominent example in this regard is the general institutionalisation of children's rights norms and their diffusion across the globe.

However, norm diffusion scholars emphasize the remaining gaps in understanding the actual outcomes of and reactions to norm-diffusion processes at the implementation level of target localities (see e.g. Risse, 2017; Zimmermann, 2017; Gilardi, 2013). In this context, the main research question for this study was derived and formulated as: *Which empirical-analytical insights can be gathered on the ground to further differentiate the outcomes of norm diffusion processes and what shapes them - beyond the established factors, such as transnational influences, domestic filters and diffusion mechanisms?*

In the given study, the international DI movement became the case example of an international norm diffusion process and the micro-cosmos of Cape Town's children's home sector became the target locality for observing outcomes and practitioner responses on the ground.

To understand the matter at hand in its full context, the study included elaborations on the global, the national and the local dimension. The aim was to explore how this very specific new norm has developed in the global child protection field, how it has been adopted and translated in the national context of South Africa, and in how far it has been translated into practice in the specific case of Cape Town. Thereafter, the main focus was to gain further insights into what had determined the responses of the practitioners in charge on the ground.

Methods and data collection

The study was designed as an empirical-analytical and micro-level case study. This overall approach was selected to allow for a holistic and meaningful insight into a complex social phenomenon based on real-life events and actors (Yin, 2003). A mixed-method approach was applied and data were collected from a variety of sources.

To start off, the analysis at the global dimension was based on a review of the available academic and grey literature on the DI topic, which had developed a lot since 2009. [7] This was complemented by two expert interviews, as well as observations and background talks at two major topic-specific international conferences which both took place in Europe in 2016.

For the analysis at the national dimension the review included international and local South African literature [8] as well as some legal documents and updates. In addition, volumes of the field-specific local journal published by the longstanding national umbrella organisation, the National Association of Child and Youth Care Workers (NACCW), were reviewed. Overall, it can be said that South Africa is often perceived as a very progressive case, but various implementation challenges are commonly highlighted.

Eventually, the assessment at the local level took place in two subsequent steps using two different methods. At first, a diachronic comparison of indicators showed the developments which had taken place in Cape Town's children's home sector since 2009. Thereafter the reasons for the changes or non-changes were assessed in Grounded-Theory-guided interviews with children's home leaders.

The diachronic comparison

The adaptation of programme approaches and care models was assessed in a comparison of the data collected in 2009 and a new set of data collected in 2017. The set of indicators was carefully selected to allow for the collection of a

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[7] For recent literature reviews see e.g. Dozier, Zeanah, Wallin and Shauffer, 2012; Babington, 2015, or Williamson and Greenberg, 2010. See also Cantwell, Davidson, Elsley, and Milligan and Quinn, 2013; LUMOS, 2017; Costa, 2016; Csáky, 2009; Browne, 2009; Anglin and Knorth, 2004; Garcia Quiroga and Hamilton-Giachritsis, 2014; Islam and Fulcher, 2016; Embleton et al., 2014.

[8] E.g. Patel and Hochfeld, 2013; Jamieson, 2014; Meintjes et al., 2007; Abdullah, 2007.

comparable set of data without the need to conduct renewed interviews at each of the children's homes. Instead, the indicators were observed on publicly available information on websites and documents (e.g. closures, transitions, changes in programmatic approaches or statements in terms of DI principles).

Some obvious changes had taken place over the time period of eight years. For example, in line with the updates to the South Africa's Children's Act (2005) from 2010, the categories and terminology for the registration of children's homes had been redefined. The new category of 'child and youth care centres' had replaced 'children's homes' and was much more inclusive. After careful consideration of the new situation as well as some lessons learned in the MA study, the target group for the new round of data collection included 25 organisations. Nineteen of these had also been part of the 2009 study and could be directly compared.

To give a very brief impression of the findings, it can be summarised that about half of the children's homes in Cape Town showed some adjustments to the new norm. The other half did not seem to have changed their approach in any significant way. Overall, this demonstrates that both is true at the same time: classic residential care is still a far spread norm and the new norm has also been diffusing. In fact, the study reveals a diversity of co-existing and sometimes ambivalent outcomes. While a small number of homes has closed or fully transitioned, several homes maintain a 'both-and' approach. For example, some organisations care for 80 to 140 children in their residential programmes. Yet, at the same time, they have added a strong programmatic focus on providing family strengthening and family reunification services and/or other critical community support. This outcome exemplifies an ambivalent sub-type of compliance and resistance in terms of the DI norm.

Interviewing children's home leaders

In the second step, the reasons for the adaptation, non-adaptation or resistance to the new norm were explored in Grounded-Theory-guided interviews (see e.g. Bryant and Charmaz, 2011). The manageable sample and the familiarity with the field presented a situation where the use of such interviews seemed to be particularly feasible and meaningful. Considering the highly heterogeneous field,

the children's homes which were approached for interviews were selected with the aim to include a variety of different examples in terms of settings, contexts, and outcomes. Eventually, 15 formal interviews were conducted at selected homes, usually with the directors or – in three cases - with other leading staff.

The Grounded-Theory-style approach guided the way in which the interviews were conducted. Open questions regarding the respondent's general approach, challenges, background and motivations served as a basic frame and brought up several key themes. As the interviews progressed, the DI topic and related issues were brought in to assess the respondent's awareness of, reactions to and perspectives on the topic. The interviews were recorded and transcribed and the data was analysed and evaluated in accordance with respective coding systems.

In general, the approached individuals were open and interested in being part of the study. However, the nature of the interviews differed depending on the context and the availability, interest and knowledge of the interviewee. While some were very aware of - or even involved in - wider local, national or international advocacy work, others were solely influenced by their micro-level local context and completely unaware of the broader debates.

To make a very brief statement in terms of the findings, it can be said that – as expected - the interviews revealed a variety of factors, which often confirmed existing theory. However, it was striking that the study found less confirmation of international and donor influence than assumed. Instead, changes of programme approaches seemed to depend to a large extent on the personal experiences, convictions, capabilities and self-perceptions of leading staff.

Conclusion

This study developed in the light of my (the author's) background in the field and my conduction of a previous empirical study on Cape Town's children's home sector in line with my MA thesis in 2009. This offered a special opportunity for learning from the given case in the context of a current debate on the outcomes of international norm diffusion processes. The DI movement offered a great example to demonstrate the immense complexity and multi-dimensional nature inherent in norm diffusion realities. In the residential care field – as likely in many other fields - we are dealing with a variety of co-existing and competing

norms and interests, parallel efforts and pockets of actors, donor-recipient dynamics and other controversies and ambivalences.

In this study, a strong effort was made to present multiple different perspectives on the topic at hand. At the same time, the potential role conflict between my being a previous practitioner in the field and my task of being an unbiased researcher was openly addressed by clearly stating the motivations and aims of the study in this respect: to contribute to the DI debate the perspectives and realities of Cape Town's children's home leaders. For example, it showed that some of these leaders resist the DI norm based on an informed and moral-based judgement in the light of the realities they experience in the context of their specific local challenges and opportunities. This is an outcome which does hardly seem to be considered in DI discourse - nor necessarily in norm diffusion theory.

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Life story approaches and relationships within residential child care: A practice reflection

Elaine Hamilton

Abstract

Residential child care creates a world of opportunity. It is unique and dynamic and often helps shape and direct the future for many children and young people. Relationships are key, they are multi-layered and adaptable, moulding to the children/young people and their individual needs. The use of daily life events, the rhythms, rituals and routines of the house help to create a safe space where the journey of therapeutically exploring the life story can evolve. In this article the author uses a case study to provide the reader with experiential examples, highlighting the importance of these every day interactions and life events to build and sustain authentic relationships within the residential child care environment, demonstrating the impact of such relationships in supporting a young person's exploration of their life story. The recognition that life story work is often a process and not a specific task allows the residential practitioner to consider their role in this journey as adaptable and helps to identify greater opportunities for relationships to be enhanced.

Keywords

Relationships, life space, life story work, residential child care

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Introduction

Getting to the end of a 1000-piece jigsaw puzzle and discovering that there are pieces missing is gut wrenching. Hours, maybe even days have been spent carefully selecting the pieces, turning them around to make sure they fit, moving those that feel wrong to create space for the correct piece. A long and often concentrated effort is required, where we try to make sense of the shapes, colours and sizes in front of us. Where do we start? Which piece are we drawn to most? These questions are fundamental in the world of a child/young person who has suffered trauma. Parts of their life they don't even know happened, yet have impacted their journey, pieces of the puzzle that are unclear but live in their memories, stories they have heard but can't place and suggestions of events that have taken place but hold no meaning. Life story work helps to put all these pieces together, helps the child/young person to make meaning from their journey, understand the context of decisions and the impact of these and helps them to form an identify of themselves in the past, now and for the future (Ryan and Walker, 2018).

In my 14 years' experience within the field of residential child care in Scotland it has become clear that relationships are the key ingredient to supporting children and young people with experience of trauma to recover, grow and develop and to hold meaning and understanding to their lives and their journey. These relationships must hold substance, be demonstrative of an emotional attachment, they must be reciprocal, and they must evidence mutual respect and understanding (Li and Julian, 2012). In order to be successful in carrying out programmed work with children and young people as a form of intervention, developmental relationships require to be present. The presence of such relationships is deemed to '…have lasting influence on long term outcomes, including social skills, emotion regulation, conscience development, trust in others, and general psychological well-being' (Li and Julian, 2012, pg. 158). Life story work is often used as a therapeutic intervention to support the child's development and understanding of their inner world and how this relates to their perceptions of their reality (Rose and Philpot, 2010). It requires a relational approach where the relationship between practitioner and child/young person is significant (NICE, 2010; Buchanan, 2014).

As a residential child care practitioner, I place a great deal of value and importance upon relationships. My experience has led me to develop an understanding of the power of relationships in terms of connections and the level of influence this can have when supporting and encouraging others: '…a relational approach offers hope for a different future… one in which the relationship is considered central to growth and development' (Garfat, 2003, p. 5). Using life story work is helpful as one of the tools that can be used for relationship building.

Delivery is vitally important. Garfat (2003) notes that when involved in an activity or intervention with a young person, the process by which you deliver and engage has lasting implications for the outcome. Not just in that moment, but over time, it can assist in the forming of developmental relationships between residential child care practitioners and children/young people. Sharing a moment, an experience together helps to create social connections and helps us understand one another and our thinking. Children who have suffered trauma and adversity have often built protective barriers around themselves, meaning that they are less open to relationships and more cautious of the intentions of adults. Their ability to form attachments can be hindered and they often struggle to emotionally self-regulate. Every interaction a practitioner has with them helps to break down these barriers. If those interactions can be carried out in a way that feels safe and holds meaning for the young person, that process can help reframe their view of the world and allow for them to enter the process of healing (Rose, 2012). Life story work can create many opportunities for meaningful interaction.

Theories of relationships are long withstanding in the world of residential child care. Vygotsky's social interaction theory supports the argument that interactions with others and being involved in mutual activities with those who have a greater knowledge or skill set can help the development of cognitive skills and enhance the child's social development and growth. Vygotsky referred to this as scaffolding (Daniel, Wassell and Gilligan, 2010). The importance of having a more experienced other holds close links with life story work in the sense that the relationship and shared experience influences the outcome and the cognitive understanding experienced by the child/young person. Life story

work is activity based and involves participating together (Ryan and Walker, 2018). It requires to be tailored to the needs and abilities of the individual; therefore, the practitioner must have a coherent understanding of the child, their history and how they currently make sense of this (Baynes, 2008). With this in mind, it could be argued that residential child care practitioners are often ideally placed to carry out these therapeutic interventions.

Residential child care settings offer opportunities for workers to get alongside the young person. This allows them to engage in everyday events and experiences, opening the relationship up to effective use of therapeutic interventions such as life story work. Residential child care practitioners should consider and explore ways in which they can enhance the opportunity for such interventions that will support the development and growth of the young person (Smith, 2015).

The social pedagogy approach does just this. It has evolved across many European countries as a holistic profession concerned with social education in its broadest sense. It can be suggested that the very essence of social pedagogy is about being with others, building relationships, being present, being genuine, empowering, initiating learning, skill development and ultimately about using oneself to influence and simply be (Smith, Fulcher and Doran, 2013; Bird and Eichsteller, 2011). Social pedagogy is about 'how' things are done not 'what' is actually done.

'This perspective of social pedagogy means that it is dynamic, creative and process-orientated rather than mechanical, procedural, and automated. It demands from social pedagogues to be a whole person, not just a pair of hands' (Bird & Eichsteller, 2011, p. 9).

This type of approach to care lends itself well to working within the lifespace. Creating an environment within residential child care that is filled with safe and authentic relationships where life story work can evolve.

As a practitioner in Scotland, I have many experiences of working with children/young people who have been identified as being suitable or appropriate to begin life story work. I have watched it unfold successfully for some, but for others, I suspect it may only be a distant memory that holds little meaning. In

the following section, I describe one of those experiences and provide some reflections on the meaning it held and why.

The story of C

It is July 2011, and I am supporting a young girl aged 11 (C) to get ready for her Social Worker visiting. I have been working with this young girl for three months and this is her second worker throughout this time. She tells me that she has had so many, that she can't remember them all but often recounts stories of her favourite. It's clear from her stories that she doesn't really understand why he can no longer work with her as she has previously seen him visit other young people in the house. This was therefore yet another experience that contributed to her thoughts and feelings of rejection and abandonment. The intention of the visit was to begin working on her life story book. This was a decision made at a recent meeting by a team of adults involved in supporting her care. It was envisaged that the social worker would speak with the child's mother to ascertain key pieces of information, photographs and stories that C can place within a workbook as a way of helping her understand her story and form her identity.

As we made breakfast together in the kitchen, I found myself working hard to encourage a bit of a smile and some excitement from C to take part in this activity. She loves arts and crafts and we had just bought some new materials that I suggested she could use. I felt excited for her, but I could see in her eyes and by the way she was picking at her favourite cereal that she wasn't sharing my excitement. She is a young girl who, by nature, wishes to please people and will do anything to avoid disappointing those around her. So, when the new social worker arrived for their third meeting C went off to the lounge, where everything was set up and spent the next hour working away on her book.

At the end of the session, I excitedly asked her if I could see what she had done. She passed the book to me and talked through each of the completed pages, explaining the reasons for those which had been skipped. I told her it looked great and she smiled, happy at my acknowledgement of her work. I spoke with the social worker who felt that the session went well and advised that they had arranged to meet the same time the following week. However, my stomach was

in knots. Something just didn't feel right. I knew deep down that getting the answers to some of the questions that C had would help her process and understand her journey, but I also knew that this wasn't the way to do it. The rest of the day goes by without any further mention of the book and as C went to bed that night, she asked me to keep it for her in the office as she was worried about spilling something on it. As she headed off to bed, I knew that the worry wasn't because she felt it was precious or valuable but more about upsetting the adults who had decided that this was a good plan for her.

Three months isn't a long time to get to know someone who you work with, well at least not when you are a busy social worker who sees a child once, maybe twice a month. However, as a residential child care worker, you spend five days per week with that person, in their house, making them breakfast, running them baths, washing and ironing their clothes, playing board games, watching TV, baking, going to the shops for groceries and generally living life alongside them; those three months can feel like you have always known each other. Residential child care can be just that. Not just for the children and young people but also for the practitioner. The setting brings a whole different dynamic to what we understand about a workplace. The rhythms, rituals and routines that are found within the house help set the culture and create structure to the way in which day to day interactions occur. The predictability of this creates a sense of security that allows for the children/young people to begin to feel safe in the development of relationships (Smith, Fulcher and Doran 2013).

Knowing where to begin, which questions to seek the answers to first, how to plan the process and when to improvise stems from relationships. In C's case, it was about knowing her, knowing how she thinks about things, how she processes, what upsets her, what makes her smile, what she needed to know and what purpose she thought it would serve. Just as important for me though, is knowing yourself – how does the young person see you? What do you bring to their life? How can you support their meaning making? What influence do you have in assisting their processing? How can you shape this journey for them in a way that helps them manage the difficult parts and utilise the growth elements? As a residential child care practitioner, working in the life space you do this every day. However, on a life story journey I needed to be open to the impact

this therapeutic journey may have on my relationship and also about how to use the relationship to enhance the outcome for C.

C needed some creativity and thought put into her life story book. She needed to be supported in this journey by those who knew and cared for her and would be there day after day helping her process the information she was learning and the feelings and emotions she was experiencing. She needed relationships to be the focus of this experience. Recognising that the process of creating a life story book as conceptualised during the review meeting wasn't adding anything to C's experience, myself and her case team decided we needed to do better. The ideology of life story work was developed. We set about looking at how we, as her direct care team, could create the opportunity to embrace this, supporting C to consider what she wanted/needed from it. What were the questions she needed answers to? What were the memories she couldn't quite recall? And most importantly how was discovering all this going to help her move forward? The focus of our approach was helping C to lead the way in uncovering her journey and supporting her to attribute context to her meaning of this (Baynes, 2008).

The Common Third is central to social pedagogic practice. It describes the use of activity to enhance relationships between the practitioner and the child (Bird & Eichsteller, 2011). In order to support C to benefit from her life story work we adopted this concept and encouraged exploration of her past world throughout her present. We purposefully used the life space as a means to share experiences such as games, puzzles and mealtimes to create opportunities to identify the questions that C sought answers to for her life story book. We then incorporated the revelation of these into daily life (Smith et al, 2013; Garfat, 2016).

C had mixed memories about her various placements. She often questioned what age she was when she lived in previous foster placements. With support from C's social worker we established a timeline. Our knowledge of C and her enjoyment for adventure and surprise gave us the idea that we could take her on a mystery tour, uncovering the journey of her placements and creating a photographic trail of this. C loved it – the journey and visits to all her previous houses and local communities reignited memories, some of these were happy

and some were difficult to process but they gave us the next step. More questions arose and C was beginning to make sense of her story in her own way. She often revisited parts of it after some contemplation and as she grew older, she began to attribute new meaning to the events and memories that she determined to be key.

C required support to cognitively process the information she was obtaining. The adults around her understood C's level of cognitive functioning and therefore could tailor the supports required. By scaffolding this learning in a way that C could process cognitively, secure attachments began to develop. As practitioners we needed to demonstrate an understanding of C's zone of proximal development in order to ensure we created opportunity for her to grow and develop her own understanding (Daniel et al, 2010). This required skill in terms of our knowledge of self and our ability to make use of our reflexive selves (Gardner, 2014). The opportunity to enhance everyday experiences and rituals into meaningful moments is what places residential child care in a novel position to therapeutically engage a child/young person in life story work.

C was 18 years old when she left our care. The young girl who initially felt abandoned and unloved had embraced her story. The impact of her early life experiences remain to this day as she enters new relationships, but her resilience and cognitive understanding is much greater, offering her the ability to embrace and respond to these challenges. In our view, the meaningful life story work she did with us contributed to this. C's life story work continued throughout her time with us. C was fortunate; all the key members of her case team remained in the house and the stability and continuity of that experience, sharing memories and the meaning making of these grew and developed supported by adults with whom she shared real meaningful relationships (Rose, 2012; Ryan and Walker, 2018).

Conclusion

Residential child care in 2019 is an evolving practice. The profession in Scotland is growing and developing with greater knowledge and understanding about the impact of experiences within this setting on the future outcomes for the children/young people. Skills are being developed and enhanced and workers are

expected to take on a more therapeutic approach to their role than ever before. Residential child care is becoming more about nurture, hope, opportunity and experience than its historical platform of the traditional care home; a place where basic day to day needs were met by the adults working in the home and any notions of 'treatment' was considered beyond the scope of their role (Smith, 2015).

Relationships impact our lives on so many different levels. Every day they influence our decisions, create opportunities, impact our emotions and support us through life. Young people living in residential child care experience a variety of relationships that are often inconsistent, making it difficult for them to develop a secure base from which to build positive attachments (Buchanan, 2010; Rose, 2012). However, as a residential child care practitioner it is important that we acknowledge the influence we have in helping to shape those fundamental developmental relationships for our children and young people. It is our task to create environments in which they can explore themselves, their stories, their relationships and question their understanding and development. Life story work can be used as a therapeutic tool to support a child/young person to make meaning from and share their story with others and it can be incorporated into daily life. It is both demanding and rewarding, for practitioner and the child/young person. You can use your very being to embrace the relationships and create key opportunities for exploring each life story. 'Don't wait for the perfect moment, take the moment and make it perfect' (Anonymous). Residential child care offers an opportunity for practitioners to get alongside children/young people on every level. Make sure you make the most of these situations. Be creative & aspirational in your approach. Look for moments and then seize them. Everyone will reap the benefits.

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About the author

A graduate of the University of Glasgow, with an MPhil in psychology, Elaine Hamilton has 14 years' experience working at all levels within the field of residential child care, with further experience in field social work and educational psychology. Currently service manager at Nether Johnstone House residential child care services, Elaine is completing the MSc Advanced Residential Child Care

course at the University of Strathclyde and is working on her dissertation on life story work within the residential setting.

Why we decided to transition from residential to family-based care

Laura Horvath, Mohamed Nabieu and Melody Curtiss

Abstract

The Child Rescue Centre became the first orphanage in Sierra Leone to fully transition from residential to family-based care. The decision to transition was made for many reasons, but the most unique reason is found in the story of Child Rescue Centre Director, Mohamed Nabieu. Nabieu, brought to the orphanage in 2000, and spent the majority of his childhood in the facility before returning as its Director. Following a 2016 directive from the Sierra Leonean government working with UNICEF for all orphanages to develop plans for de-institutionalization, Nabieu and Dr. Laura Horvath of Helping Children Worldwide began discussing research on the care of orphans and vulnerable children. The global research in support of de-institutionalisation was borne out by anecdotal evidence collected over 16 years at the orphanage, including Nabieu's own experiences. That ultimately led the Child Rescue Centre and Helping Children Worldwide to collaborate on a plan to close the residential centre and shift focus to family support. By the summer of 2018, they had successfully reintegrated the children into biological, kinship or foster care, closing the residential programme.

Keywords

Orphans, vulnerable children, residential care, family-based care

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Global Standards, the United Nations Convention on the Rights of the Child, and the Guidelines for the Alternative Care of Children

The ratification of the Convention on the Rights of the Child (2004) served as a catalyst for a global movement to de-institutionalise programmes that support orphans and vulnerable children. Progress has been stymied by continually arising crises and a historic preference for orphanages as a response.

A major tenet of the United Nations Guidelines on the Alternative Care of Children is the principle that 'the family being the… natural environment for growth, well-being and protection of children, efforts should be primarily directed to enabling the child to remain in or return to the care of his/her parents, or when appropriate, other close family members' (2010 p.3). Cantwell, Davidson, Elsley, Milligan and Quinn state that in cases where a family is truly unable to care for a child, the Guidelines advise that the state should be responsible for securing an alternative placement that best meets the needs of the child, including a child's need to grow up in a family (2012).

Child Rescue Centre History and Statistics

The Child Rescue Centre was established in the waning years of a brutal 11-year civil war in Sierra Leone that separated vast numbers of children from their families. Surviving family members were scattered, and the social infrastructure supporting them was fractured. Tracing families of separated children during and immediately following the war was rendered impossible.

As with many orphanages in the developing world, the Child Rescue Centre was established by a global church in response to a moment of crisis and emergency. Efforts were focused on ensuring the health, security and well-being of a specific group of children separated from care. A solution crafted to address the immediate need of a finite beneficiary pool rapidly became defined as the organization's mission focus, and thus its identity. The solution then expanded to include access to education for the 40 beneficiaries, and the organisation's vision to 'prepare future leaders of Sierra Leone'. This focus became the metric of success even after the pool of beneficiaries grew. Were the children healthy,

well-nourished and educated? If 'yes', then housing the children in an institution solved the problem. Ironically, within six months of the orphanage opening, the programme expanded to include children served in family homes. Those children were never institutionalised, but the identity of the organization was based on those who were, and a comparison between the efficacies of the two programmes was never attempted.

The war ended in 2002, and rebuilding began, but the road was long and arduous. By the time UNICEF completed its Report on Children's Homes in Sierra Leone (2008), the Ministry of Social Welfare, Gender and Children's Affairs lacked capacity to consistently communicate, supervise or regulate institutions to national standards. Lack of capacity in state structures often leads to isolationism in organizations desiring quick, efficient solutions. Lack of government oversight can enable organisational agility and autonomy but avoiding bureaucratic intervention in programme operations also disconnects the organization from local and national context of child welfare issues, to available resources and potential local solutions that are vital for sustainable development.

The UNICEF report (2008), did lead to a national commitment to increasing the government's capacity. In 2009, the Child Rescue Centre complied with a government directive requiring reunification of all residential children over the age of 16 and committed to trying to reunify children earlier if possible. Before that work could gain traction, an Ebola outbreak caused a two-year halt while the country dealt with the crisis and its aftermath. Being a global religion-backed organisation provided the Child Rescue Centre with the stability and impetus to survive the dual catastrophes of civil war, the subsequent Ebola outbreak, and the attendant damage to social infrastructures. Still, Ebola interrupted the program's focus on reunification, and without Ministry enforcement, the interest in expanded efforts subsided. So, what changed? Two things; increased attention by the organisation to the cause of internal problems in the orphanage, and renewed pressure by the global development community for Sierra Leone to recognize the reoccurrence of these same problems wherever orphanages are found.

In 2013 and again in 2014, incidents of negative behaviours concerning children in the residential programme were reported and handled as isolated events, and measures were taken to reunify the children in question and enhance supervision on the campus. Horvath and Nabieu began extensive research into behavioural issues of traumatised children in institutional settings and discovered that such children are at high risk of trauma-induced behaviours and actions that can include physical abuse, and which persist even after reintegration. Brown contends that 'while…placement in a supportive family can result in the formation of close attachments…many institutionally raised children will still have problems interacting with peers and adults outside the family' (2009, p.17). Many of the children reunified out of the residential program have continued to exhibit negative behaviours including truancy, pregnancy, and substance abuse.

In early 2017, the Ministry and UNICEF met with leaders of all registered orphanages in Sierra Leone to encourage these organisations to develop plans for transitioning their residential care programmes to family-based care within a five-year period. At the Child Rescue Centre, a change of leadership provided unique opportunities for self-reflection, in that one of the original street children, Mohamed Nabieu, raised in the orphanage, had graduated college and been hired as its Director in 2016. Almost immediately, Nabieu began working with Helping Children Worldwide's Dr. Laura Horvath, to examine the residential programming, and study the global research on residential children's homes. Nabieu's experience as a child mirrored global stories and the research supported his opinion about the negative impacts of institutional life on child development. In his words, 'the Child Rescue Centre was one of the best orphanages, but it was still an orphanage and the way we were living was very different from the average Sierra Leonean. We had strict supervision and schedules and were unable to visit with family members'. While he credits his education and rise as a leader to the excellence of his upbringing in the institution, he shares: 'though we had access to good schools, tutoring, and even trips to new places within Sierra Leone, it was not the same as a normal home. Many of my residential brothers and sisters still struggle to feel connected to our families'. Nabieu and Horvath became convinced that the answer was to

adopt a transition plan to move from residential to family-based care as rapidly as reasonably possible.

Reunification, however, is much more complex than simply placing a child in a family, even his own, if the family lacks the support it needs to be successful, and particularly when a child has been institutionalised and separated from family for a long period of time. In an interview, Lamin acknowledged that 'transition is often difficult for children and families. Reunifications have failed and children have tried to run back to the institution' (2018). As Nabieu notes, 'even when children get reunified, it is hard for many of them to fit back into the culture. They don't know much about community life, they don't know their family, and the community sees them as different'. It is far easier to begin to address needs in a crisis with formal alternative care such as orphanages, and far more difficult and complicated to switch from crisis mode back to a family-based focus, particularly when resources to support families are lacking or difficult to access. Even when supports are available, Lamin argues, 'it takes a skilled social worker to assess and judge when to intervene and how to best support parents to be successful' (2018).

Unlike many orphanages throughout the developing world, the Child Rescue Centre was uniquely prepared to execute the de-institutionalisation of their residential programme because they already had a spectrum of family-based care options in place. These helped provide avenues for reintegration with kinship or foster families. Having had an established, family-based care program already in place since 2001 made reunification of children in the residential program a smoother transition.

In early 2017, the Child Rescue Centre redoubled its efforts to trace family of all children in the orphanage, ascertain their needs and prepare them for reunification with their children. Believing that intentional work on attachment with families and children would alleviate some of the negative post-reunification behaviours, Nabieu created a plan for the reintegration of the remaining residential children that could be accomplished within 12-18 months without sacrificing the quality of preparation provided to help families form healthy attachments and strengthen the bonds of relationship before, during and after reintegration.

Being the director allowed Nabieu to tap into his own experiences as a child of the residential programme to initiate changes, such as encouraging families of children in the residential program to visit the children. 'We also encouraged the children to visit family in the community and do "normal" things. Many had been in the residence for almost 10 years, and they didn't know much about community life. Strengthening the relationship between children and families was very important to me', Nabieu said. The last 20 remaining children in the residential programme were transitioned into family-based care in July of 2018, where they will continue to receive material and other supports through a case management system.

Access to healthcare, education, tutors, computers, security and safety made the residential programme appear to staff, donors and families, as the best possible situation for these children. Analysis conducted in 2017 on all the children who ever lived in the residence revealed that 98% of them had had a living relative who could care for them with adequate support. This post-mortem also revealed that after a year or two of living with the advantages and routines of the orphanage, families felt or were actively discouraged from removing their children and risk them losing access to resources that the family could not provide. 'People living in desperate situations are looking for opportunities for their children', Nabieu says. 'An orphanage is perceived as a way to guarantee them a good life'. However, research indicates that children institutionalized for years are at greater risk for long-term negative impacts on social, emotional and cognitive development. Wolkind reports: 'significantly more indiscriminate friendliness, over-friendliness and/or disinhibited behavior for children in institutions, suggesting "disorganized attachment disorder" has a greater prevalence among these children compared with children in families' (1974).

By all accounts, the Child Rescue Centre had always been a residential programme of the highest quality. Helping Children Worldwide's and the Child Rescue Centre's drive to meet and exceed standards in the care of children eventually required the organisations to embrace the research indicating that family-based care is best for children, and this in turn led them to confront, head on, the decision to de-institutionalise. Fearless introspection and extensive research in the field of orphan care, combined with the personal experiences of

Nabieu and other graduates of the orphanage, allowed Nabieu and Horvath to share hard truths and opportunities for change with others in the organisational leadership, and for them to hear and respond.

Still, stakeholders on both sides of the ocean struggled with the transition. The shift from residential to family-based care meant a loss of deep personal connections for those working in the orphanage. The decision to release long-term personnel in making the transition from a residential to a case management model proved to be especially painful. Staff and children became attached to one another, and donors too became attached to children and staff they saw on repeat mission trips to support the orphanage. The Child Rescue Centre experienced significant resistance in its efforts to shift to family-centred programming. These very real losses were balanced by significant gains. The change is leading the programme to introduce local solutions that are contextually appropriate, with a greater sense of local autonomy and sustainability. While the orphanage had long been recognized in the country as a premiere model of formal alternative care, and many of the children raised in its institutional care model had succeed in becoming 'leaders of the future', the research was incontrovertible that such care was counter to the best interest of children, and the leadership on both sides were forced to confront and address the ethical challenge that conflict presented and to adopt a different model.

Transitioning to meet global standards

For more than 18 years, the Child Rescue Centre had taken a programme management approach that seemed to work well enough. However, it created a situation in which children and families were considered collectively as clients served by a specific programme with the focus on the total number of children in the programme at any given point in time, rather than as individual cases to be served, monitored, and evaluated based on specific needs. In 2018, Nabieu identified a case management team of nine staff. Out of necessity borne of budget constraints, this has resulted in caseload ratios of approximately 1:65 which makes meeting the global standard of monthly site visits a challenge. Recognising that this ratio exceeds the global standard for caseload ratios of

1:25, the Child Rescue Centre has established a plan to increase staffing within three years to achieve the global standard.

Another gap in the capacity of the Child Rescue Centre in making this crucial shift in programme delivery was in expertise and knowledge of best practices in case management. A step in the right direction was the assignment of specific children to specific staff, which is helping children and families establish relationships with their assigned case manager. Plans for building capacity in case management include training provided by a team of social workers from America traveling to Bo in the summer 2019. Child Rescue Centre staff will be coached in the creation and maintenance of individualised case files using a collaboratively developed database system, review case files for discussions around best practices, and be coached in the conduction of successful site visits and maintenance of case files. Representatives from other children's organizations across Sierra Leone as well as the Ministry will be included to strengthen collaboration so that they can support one another in the development of robust case management across organisations.

The Child Rescue Centre has and continues to lead in the care of orphans and vulnerable children since the moment it opened its doors. Lamin reflects that he was not surprised to learn that the organization is leading the de-institutionalisation efforts in Sierra Leone. 'The Child Rescue Centre has always set and met high standards in the care of vulnerable children', he said, 'of course they are the first in Sierra Leone to de-institutionalize their residential program' (2018). Bo Ministry Representative Patrick Banguara shares that the Child Rescue Centre is the first organisation in the country to submit and completely execute a plan for de-institutionalisation. The organization continues to work closely with the Ministry as it moves forward in developing and building capacity in its case management programme.

Despite a lengthy history of promoting orphan care and marked success in providing care to vulnerable children through the institutional model, when the Child Rescue Centre and Helping Children Worldwide recognised the need to change, they had the structure, the resources and the community confidence to introduce a better programming model and to lead child welfare reform in practical, demonstrative ways.

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About the author(s)

Prior to joining the Helping Children Worldwide (HCW) staff in November 2014, Laura Horvath, Ed.D. was a professor of graduate education at George Washington University and George Mason University, simultaneously serving HCW's programs in Sierra Leone as a volunteer for over a decade. Laura has an in-depth knowledge of education, and a deep passion for global child welfare, the care of orphans and vulnerable children, public health, ethical missions, and sustainable community-led development programs. Laura has served HCW as its Education Specialist, African Programs Director, and currently as the Director of Program Development and Community Engagement.

Mohamed Nabieu ("Nabs") was one of the first children brought into the Child Rescue Centre (CRC) after the Sierra Leone civil war. The CRC sponsored him through University. Upon graduation, he served the CRC in Sierra Leone for five years, first as the Sponsor-A-Child Coordinator, and later as the Programs Director. Under his leadership, the Child Rescue Centre successfully transitioned from orphanage to family-based care in collaboration with Helping Children Worldwide, the United Methodist Church, child protection agencies, the Sierra Leone Child Care Government, local staff, parents and children. With his wide range of experience and background in Development, Business and Organizational Psychology, Child Protection issues, leadership development, organizational change management, and team building, he finds great pleasure in serving vulnerable populations, building people up and empowering the next generation of leaders.

Melody Curtiss has worked in child welfare and juvenile justice reform for over 30 years, as an attorney-advocate, an advisory member of the Board of Directors of the US National Foster Parents Association, and as a nonprofit CEO. She currently serves as the Executive Director for Helping Children Worldwide in the greater D.C. area, whose mission is to serve the most vulnerable children in the world and lift them from poverty and despair.

Reaching beyond or beyond reach: Challenges influencing access to higher education for care-experienced learners in Scotland

Peter Tormey

Abstract

Children in Scotland who spend time in the care of a local authority report lower educational attainment and are less likely to complete their secondary education than their non-care-experienced peers. Recent legislative changes designed to promote greater access to positive destinations for care-experienced people aims to enhance support into adulthood, promotes greater collaboration between public bodies, and increases non-repayable funding for care-experienced learners to study at college and university. This article will address the changes, unintended consequences and barriers that still persist from the period 2014 to the present. Education can be a catalyst for change and the rate of progress made to date to support care-experienced people into higher education must continue if Scotland is to achieve the ambition of a society where those with experience of care have the same equity of opportunities as the population at large.

Keywords

Higher education, corporate parenting, widening access, participation

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Background

The introduction of the Children and Young People (Scotland) Act 2014 set out the legal duty for public bodies, including colleges and universities, to provide

care-experienced people with the support and guidance to promote access and participation (Scottish Government, 2014). As a corporate parent, public bodies must seek to support the wellbeing of care-experienced people in a holistic fashion, including in the case of educational institutions through the publication and reporting of a Corporate Parenting Plan to government ministers. This legislative intervention, in addition to the recommendations of the Commission on Widening Access Report, A Blueprint for Fairness, in 2016, has provided a new impetus to the pre-existing work undertaken by Scottish universities to widen access to higher education (HE) study. Until this point, access initiatives centred on lower or 'contextualised' access thresholds and named contact support established in achieving Frank Buttle Trust accreditation in the early to mid-2000s (Buttle, 2019).

Scotland's care-experienced young people report the lowest secondary education attainment in comparison to non-care-experienced peers, with the gap widening through the years of secondary education (Scottish Government, 2019). Children who are in the care of a local authority or 'looked after' consistently rank the lowest in terms of qualifications achieved compared to their contemporaries. Only 6% of care leavers who leave school go directly to university study, unsurprising when 75% leave school at the earliest possibility aged 16 or younger (Scottish Government, 2019). However, as with other widening participation to university groups, percentage figures mask significant issues in ascribing a definition to all from a similar background in a homogeneous fashion. A combination of archaic, imperfect or inadequate data capturing systems and inconsistent use of definitions mask a much more mosaic, complex access to university data for care-experienced people in Scotland. This article seeks to add clarity to the conversation of access to HE, provide practical guidance to those who wish to support individuals into HE and to promote post-compulsory education as a vehicle of change for care-experienced people who, without targeted and informed guidance at key life stages, may not have the opportunity to achieve their academic potential.

Beware of differing definitions

From this point, the term care-experienced will be used to describe an individual who experienced any form of formal care, at any point in their life, and for any

duration including those adopted shortly after birth, those looked after in early childhood and those who are commonly referred to as care leavers (leaving care after their 14th or 16th birthday). In this regard, the term care-experienced not only refers to a time when an individual was cared for or looked after, or the time when they became a care leaver when this formal care ended (aged between 14-16 years) but also the individual's sense of their experiences. In this sense the term care-experienced represents a life of experiences centred on an individual whereas the terms looked after, looked after and accommodated or 'LAC', and care leaver are often ascribed to an individual at a particular period of time or to signify eligibility to access services or support and are commonly used within a social work or secondary education setting. Within the context of tertiary education, the term care-experienced has become increasing accepted by the majority in recent years including by student unions, funding bodies, universities and colleges, and by the Scottish Funding Council. However, respective university institutions may have their own definition of care-experience, which can add an additional layer of complexity.

As a consequence of the differing definitions published, and the respective scope of each definition, data pertaining to care-experienced student access to university is advised to be treated with caution, as direct comparison conclusions are not possible at present. For example, the annual school leaver destination survey recently reported 7% progression to university for care leavers, up from 4% in 2015/16 (Scottish Government 2019; 2017). This figure, though still significantly lower than broader peer group (40%), demonstrates progress is being made. However this a one dimensional data which excludes the care-experienced learners studying at university who:

• Leave care before care leaver age (circa 16) and progress to university;

• Progress to university through other routes;

• Study at higher education level at college, not university.

In Scotland, unlike the other nations of the United Kingdom, the majority of students studying at HE level do so by studying Higher National qualifications at a college and not at a university (Scottish Funding Council, 2019). The Scottish Credit and Qualifications Framework (SCQF) allows for parallel provision of levels

of study with colleges commonly offering level 7 certificate (HNC) and level 8 diploma (HND) with universities offering undergraduate (levels 7-10) and postgraduate degrees (levels 11 and 12). College students can, where routes are available, 'articulate' onto a university degree programme gaining full credit for their HN qualifications, in essence direct-entry to progress to the next year of study and an honours degree (level 10). For example a student with a HND qualification joins at year 3 in a related degree programme, subject to meeting the admissions eligibility criteria, and achieving the same university in the same four year timeframe. In the context of care-experienced learners accessing HE, those studying HN programmes at college are missing from the national school leaver data introduced earlier (Scottish Government 2019; 2017). It is correct to note at this point that widening access initiatives aim to increase the numbers of care-experienced students, amongst other under-represented groups, to first year of a university degree programme, and that the aim to reach parity between peers irrespective of background is an important one within Scottish society.

Care-experienced learners in Scotland applying to Scottish universities do so under a capped places system where, although the cost of tuition is paid by the government, competition amongst applicants increases demand compared to English students applying to English universities who operate student fee paying, uncapped systems. Scottish universities under the guidance from the Scottish Funding Council 'Outcome Agreement' process encourage universities to broaden access and participation within universities, as a response universities set admissions policies with 'minimum access thresholds' (commonly referred to as contextualised) whereby entry requirements are adjusted down to take into account of disruption to secondary education. Additionally, universities may also offer summer schools or bridging programmes pre-entry as a condition of a minimum access threshold offer.

Recent research investigating participation rates amongst care-experienced learners within countries who operate similar child protection care systems such as England (Harrison, 2019), Ireland (Brady, Gilligan and Nic Fhlannchadha, 2019), Australia (McNamara, Harvey and Andrewarthan, 2019) and the USA (Dworskey, 2018; Gypien *et al.*, 2017) report similar underrepresentation of

care-experienced in HE. The Irish HE system, similar to the Scottish equivalent, is faced with many of the same challenges in recording, monitoring and tracking care-experienced learner participation within HE, namely an over-reliance on incomplete, imperfect and limited access and participation data (Brady, Gilligan and Nic Fhlannchadha, 2019). As a consequence, under reporting of care-experienced learners due to a paucity of accurate data is likely to exist at present. Similar findings within an English context have been found whereby, although care-experienced learners are less likely than their peers to participate in HE, and although official statistics of access rates appeared to have stalled, more care-experienced learners than expected are studying towards a degree were found (Harrison, 2019).

If there is no parity of participation within HE in Scotland, England, Ireland nor Australia and USA for that matter, what can be done to improve access and retention? One overarching and important finding (McNamara, Harvey and Andrewarthan, 2019; Harrison, 2019; Dworskey, 2018) centres on stability of accommodation within a care placement. In the context of corporate parenting responsibilities held by all Scottish universities and colleges this is key. Scottish Government statistics clearly illustrate the importance of stability with regards to optimising educational attainment. However to solely focus on in-care accommodation to increase educational attainment wound be too narrow a focus and a one-dimensional response to counter the complexity of the issue. A broader conversation around providing stability to include those looked after (in care) and those without a statutory care order is recommended. Similarly colleges and universities need to work closer with local authorities, as corporate parents, to ensure those who are qualified and wish to progress to tertiary education have the information to make informed decisions, and have access to continuing care accommodation (fee waived or substantial financial contribution). Stability through the key stages of transition, for example leaving care (Gypien *et al*., 2017), or indeed starting university, is crucial for genuine participation when establishing a foothold in education.

In Scotland, 75% of care leavers (the larger care-experienced figure is unknown) leave secondary education aged 16 years of age or younger, at the earliest possible time (Scottish Government, 2019). On all measures, including

qualification level achieved, number of qualifications achieved and post-secondary school destination, care leavers in Scotland underperform compared to their peers (Scottish Government, 2019). Strikingly, there is a linear negative correlation between an increased number of accommodation placements and lower levels of educational attainment. It is therefore unsurprising that care leavers, and indeed more broadly the care-experienced population of learners in Scottish universities, accounts for approximately 0.5%, or 334, of the student body (Scottish Funding Council, 2018).

Achieving university entry requirements, particularly for high tariff degree programmes such as medicine, law and dentistry especially at prestigious institutions, can be out of reach before a care-experienced student reaches their sixteenth birthday. Similarly, Harrison (2019) identified that care-experienced learners in England typically enter university with less prestigious qualifications and attend less prestigious institutions. Parallels to these findings exist in Scotland with data highlighting similar challenges in accessing prestigious universities and an over-representation in college sector studying at sub-degree or Higher National level (Scottish Funding Council, 2018). However as discussed briefly within the introduction, due to the SCQF and articulation agreements between colleges and universities the over 4,000 self-declared care-experienced learners in college (unpublished ahead of print) (Scottish Funding Council, 2019) in Scotland can continue to degree level study, although access to high tariff programmes is typically precluded.

Although care-experienced learners who may have experienced significant disruption to their education due to accommodation moves amongst many other challenges, a community or local college setting may be an ideal and nurturing environment to gain a qualification prior to entering the labour market or as a bridge to university degree study (Dworskey, 2018). Importantly, decisions on post-compulsory education routes should be completed in an open and informed manner to best tailor information for the individual, and ideally publically-funded organisations with corporate parenting responsibilities in Scotland should consult one another to extend the reach of HE access.

Care-experienced, like other widening participation under-represented groups in HE, commonly face multiple, often concurrent, barriers (Mowat, 2019) in areas

such as student finances, isolation, lacking social capital, weak social networks, and in respect of care-experienced learners in particular, lack of family support (Jackson and Cameron, 2012). The findings of a recent publication (conducted in Scotland) found that there is no lack of aspiration from widening participation or students from under-represented backgrounds debunking the 'aspiration myth'. Rather, from the over 4,000 individual responses, the level of aspiration from a child was linked to that of the parent or guardian (Treanor, 2018), with similar findings linking care-experienced and their carers' aspirations to the educational attainment (O'Higgins, Sebba and Gardiner, 2018). For care-experienced young people, therefore, aspiration to achieve one's potential must be perpetually reinforced and rooted in accurate information concerning options. Universities, colleges, schools and all corporate parents, and indeed society as a whole, must do more to build aspiration, help develop self-confidence and self-efficacy for people of all ages to access opportunities. Indeed, a steady mentor is key to improving post care outcomes (Gypien *et al*., 2017) and has demonstrated to improve academic attainment levels for care-experienced learners in a Scottish secondary school setting when integrated into the teaching environment (MCR Pathways, 2018).

In addition to practical barriers, such as accessing secure financial and accommodation support, limited care-experienced learners to reach for HE study, having to overcome emotional barriers such as isolation or living without stable caring relationships, personal barriers such as disabilities and mental health occur at increased rates. Recent data published by the Scottish Funding Council pertaining to disability and mental health data from the near 320,000 students studying in the Scottish college sector show 10.6% of the approximately 4,000 care-experienced learners report multiple disabilities (compared to 3.2% for non-care-experienced), 8.1% report dyslexia (compared to 4.2%) and 6.9% had a mental health difficulty (compared to 2.6% of total student population) (Scottish Funding Council, 2019). Issues concerning mental health and access to professional timely support affect many tertiary education learners, and indeed wider society, however with respect to care-experienced young people research suggests that 60% of those that have access to services before leaving care ceased to do so within the first month of leaving care (Piel,

2018). Without cognisant support, from family, through a mentor and by professionals, to aid care-experienced learners to successfully overcome the multiple challenges presented at each stage of their primary, secondary and college education journey then the disadvantage of opportunities may continue into the labour market (Jackson and Cameron, 2012).

A systematic review of the literature conducted by O'Higgins, Sebba and Gardiner (2017) found that with respect to care-experienced people who were in foster or kinship care placements, there are multiple contributory factors which influence educational attainment. However those with additional educational needs, minority ethnic, and males were consistent predictors of poor educational attainment. Similar gender imbalance findings have been reported in Scotland (Scottish Funding Council, 2018) and at my own university (Edinburgh Napier University, 2018) where approximately two-thirds of self-declared care-experienced learners were female.

Corporate parenting and continued education: An opportunity for effective, efficient person-centric working

Thus far this article has outlined the challenges that may commonly face care-experienced people to access, and stay in, tertiary education. In addition to these multifaceted and often complex barriers, recently a group of researchers from Australia (McNamara, Harvey and Andrewarthan, 2019) summarised some of the less homogeneous, more common, disadvantages as being linked to poverty, namely: lack of financial support; insufficient student funding; paying student tuition fees; and accommodation costs.

With respect to the current Scottish HE environment, recent policy changes afford support in all the areas listed, though in some cases access to support is based on one's care-experience background. For example, all care-experienced learners in Scotland studying at HE level in college or university have access to specific student funding. At university this comes in the form of the SAAS Care Experienced Student Bursary, a full £8,100 (non-repayable) grant for students aged 26 year or younger when starting their degree programme and summer accommodation grant (SAAS, 2019) (nursing-related programme access a different bursary). Additionally, many universities offer additional funding to

supplement student income through their own bursaries and scholarships, the Propel website (https://propel.org.uk/UK/) provides funding, course information and contacts at the majority of universities and colleges in the United Kingdom. The majority of universities offer 52 week student accommodation tenancy options, and in some cases offer student accommodation scholarships either independently or as part of a partnership with third parties. Unlike in other nations of the United Kingdom, tuition fees are paid for by the Scottish Government through a student funding agency.

There is still progress to be made in harmonising the levels of support with funding accommodation. Care-experienced students who do not have access to statutory aftercare or continuing care support from their local authority due to leaving care before becoming categorised as a 'care leaver' aged 14-16 years commonly cannot access financial support under Section 30 of the Children (Scotland) Act 1995 to fund accommodation during their studies, even if they are under 26 years of age and in receipt of the SAAS Care Experienced Bursary. Consequently, anecdotal evidence suggests care-experienced students who self-fund their own student accommodation cost must work more hours of paid employment and may struggle to access or fully participate in HE in the first instance. Furthermore, those who do not have access to local authority or third sector aftercare services may not have access to the same level of information on post-compulsory education options or the relevant support services. For example, the approximately 25% of care-experienced people who come from a 'looked after at home' background, a placement type unique to Scotland, display the lowest positive destinations and educational attainment of all care-experienced backgrounds and typically do not have access to the same continuing or aftercare services augmenting disadvantages (Barnardo's, 2015).

For corporate parenting to truly work as intended, corporate parents must continue to construct systems which work for the individual to promote their wellbeing, abilities and interests, moving away from an institutional systems based approach. The work done to develop these ideals to date has been primarily conducted at an individual or service level, however greater integration is required. For example, the university sector is built on a number of cycles which follow a distinct pattern linked to milestones or the academic calendar

which, in the context of being open to individuals who through no fault of their own, may restrict access and openness. Care-experienced people who wish to attend university are dependent on third parties to receive in a timely manner the various documentation to support applications for funding, student accommodation and to study. Whereas non care-experienced students can complete prerequisites at a time of their convenience. Similarly, local authorities may not possess the expertise, contacts or resources (time, financial) to support transitions to university or college study, and have processes of their own to contend with which may not complement education providers' work practices. This disconnect between universities and local authorities can add to the feelings of uncertainty affecting the confidence of young people to access HE (Krongeter, Schroer and Zeller, 2016; Lewis *et al*., 2015). Archaic systems, wherever found, must be re-established by corporate parents to take a more person-centric holistic approach to limit the effect of multiple accumulative barriers preventing care-experienced people accessing HE and the associated lifelong benefits of gaining a degree.

Access to HE, either from secondary school to university or college or from college to university, has never been more accessible for care-experienced people of all ages in Scotland. However, despite many enhancements in access and funding, care-experienced people still face multiple barriers to overcome to participate in HE. Corporate parents must work ever closer to preserve and expand opportunities, including in areas of funding, accommodation, pastoral and mental support, to remove barriers where possible especially in a challenging public services funding environment. Practitioners who support care-experienced people must work ever closer together to share and disseminate accurate information and to build aspiration for positive futures where it is missing. Participation of formal or informal education can be a vehicle of change not only for one's career but also for one's sense of self and personal development. For education to act as a catalyst for greater social mobility for care-experienced people, the rate of progress made to date must continue if Scotland is to achieve the ambition of a society where care-experienced people have the same equity of opportunities as the population at large.

Care-experienced students studying in HE are talented, resilient, magnanimous and have the ability to achieve their goals and aspirations, however the journey into tertiary education can stall before it begins if timely guidance or a lack of aspiration by practitioners is the standard approach taken. As practitioners and corporate parents, we must exchange knowledge to ensure care-experienced people can reach beyond to access higher education.

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About the author

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estranged students, contributing to the development of policy documents. Access, transitioning and participation within higher education are areas of interest which intersect the widening participation backgrounds of these cohorts.

MCR Pathways' relationship based practice at scale: Revolutionising educational outcomes for care-experienced young people

Iain MacRitchie

Abstract

Scottish mentoring charity MCR Pathways' founder reflects on the transformational impact relationships and mentoring is having on Scottish care-experienced young people, mentors and organisations in Glasgow and other local authorities in Scotland. Using pioneering embedded partnerships with local authorities and schools, the MCR model is aiming for long term system and culture change to the education system. While focused on the Scottish system, the author took his original motivation from five years of working in the residential care system in England and increasingly from witnessing the same issues in other western countries. The article explores the challenges preventing policy makers from creating a consistent impact on the educational outcome of Scotland's most disadvantaged young people relative to their peers. With young people leading the debate, it proposes simple changes to Scottish corporate parenting and widening access policies and practices, based on statistical evidence and 12 years of powerful stories.

Keywords

Care-experienced young people, looked after children, mentoring, education

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Introduction

When I first committed to tackling the staggering education outcome and life-chance disparity between Scottish care-experienced young people and their peers, I was told one thing: The plan would not work. The problem was too big and too complex to fix. On this fact, the doubters were correct - for decades the injustice was and still is substantial. I had seen the same issues at first hand while working in the English care system and believe it is mirrored in many western countries.

The harsh reality of being disadvantaged from birth

According to government reports, in 2017 only 28%, or just over one in four, care-experienced pupils (students) (Scottish Government (2018a) stayed on in school beyond the age 16 compared to the 88.4% universal rate for pupils in Scotland (Scottish Government, 2018b). Between 2015-2018, nationally only 35% of S5[9] care-experienced pupils achieved three or more qualification at SCQF Level 5[10] or above, compared to the 80% three year average universal rate for Scottish pupils. Poverty, instability, and family crises scars for a lifetime (SQA, 2016, 2017, 2018).

The term 'care-experience' refers to children or young people who have spent any time in the care of their local authority. The terms 'care-leaver', 'care-experienced' and 'looked after' are often used interchangeably, with care-experienced increasingly being the preferred terminology.

In 2007, when we first set out, the gap between these groups was even starker. Fewer than half of care-experienced young people were in sustainable destinations after leaving school, compared to the 81.8% universal rate for Scottish pupils. Forty per cent of these young people were unemployed and not in education after leaving secondary school (Scottish Government, 2007).

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[9] S5 is Secondary 5 (equivalent to junior year of high school, or age 16-17)

[10] Basic high school leaving certificate level. See:
https://www.sqa.org.uk/sqa/71377.html

Unlike most of their peers, who on average leave home at 25, few care-experienced young people have family to fall back on (CELCIS, 2019). Unstable post-school destinations combined with lack of family support leave many of our most disadvantaged in dire circumstances. The Scottish Government estimates that nearly 20% of care-experienced young people experience homelessness after leaving care (Scottish Government, 2013). This number may be an underestimation, masking the true severity of the situation, as a significant number of looked after young people are listed by their local authority as being 'lost contact' (Scottish Government, 2013).

From the statistics and personal stories, it's clear the human cost of failure is a gross injustice. These are young people without choice and disadvantaged through no fault of their own.

This was the state of care when we began formulating the transformative plan that became MCR Pathways. From the beginning, as now, I passionately believe that there is not only a will, but there is a way to make change happen. MCR Pathways now supports over 2,000 care-experienced young people each week - giving them a voice and influence and showing us how they can flourish. These are individuals who are inspired to engage, achieve, and positively progress through the education system and onto a lifetime of value and contribution. The impact of MCR Pathways has transformed educational outcomes and life chances for care-experienced young people.

So what is so revolutionary? What is having such a profound impact not only on young people, but also everyone else involved: individuals, employers, schools and communities? It is born from complexity, but is breathtakingly simple.

A system of contradictions - where success can equally be failure

Professionals agree, the outcomes for care-experienced young people need fundamental change. This change is needed in systems, culture and in the aspirations we have for the young people. However, our systems are resistant to change through a series of inherent contradictions and vested interest. Research shows that relationships matter deeply to young people's development (Center

on the Developing Child, 2015), but process, budget and time constraints reduces or eliminates the ability for professionals to form meaningful relationships.

People are inspired by stories. The experiences of those in care charges our emotions to act, to right the wrong. However, policy is driven by statistics and economics. How do we inspire and sustain change when we remove the human catalyst and source of insight and solutions?

In building a track record for reviving businesses across the world, I have long since learned that all change is about human nature. As a leader, I can initiate change, but it is the collective which sustains it. The Glaswegian 'never say die' attitude has served me well and often determined success or failure. I continue to be told 'not possible' 10 times more often than 'yes, let's do it'. I now accept that this is the default institutional response. To see change through means being relentlessly positive, persuasive and staying true to the MCR values of motivation, commitment and resilience.

This cause has become a life's work and passion. It started in the early 2000s when I accepted a job to lead the turnaround of three failing care organisations across England with 90 homes, five schools and a foster agency. Despite losing a combined £500,000 a month, within three years a dedicated team got the organisation back into surplus, with a care and quality led transformation. It was an experience fraught with complexity, constant challenge, failure, and ultimately, an inability to help the young people to the extent required. This is an experience that stays with you.

I was shocked and could not come to terms with the fact that the outcomes for young people had not improved. In fact, in part, they had worsened. Helping the young people to engage, trust, and rebuild their confidence and self-belief often led to them being 'moved on' to new homes. Budgets and the need to reduce costs determined decisions. The cruel reality for the young people was often literally a black bag and effectively another change of parents. Instabilities layered on instabilities. It made no sense.

From experience, I knew additional expenditure was never going to be the way to sustainable and transformational change. Through trial and error and carefully listening to the young people, it was clear education was the only way out of poverty, crime and homelessness that so commonly followed these young people. Education outcomes dictate job choices and life chances. My focus was to find the way to ensure our most disadvantaged young people got the qualifications and confidence they needed from the education system.

But there lies the challenge. When adults have personal problems we naturally struggle to concentrate. How then can we expect young people experiencing uncertainty and instability at home to then concentrate and engage in school? These are environments fuelled with peer pressure, performance demands and now the immediacy of social media to highlight all differences. I understand why these young people disengage or become disruptive and leave school at the first opportunity.

The goal was to provide individual support, but on an industrial scale as part of the system. I wanted to create a programme that offers time and space for each young person to talk, be heard and understood and to believe their circumstances can be overcome. This would be a way to bridge every young person's talent and potential with opportunity. And would be a method where every participant, whether young person, adult, employer, institution and community, are immediate beneficiaries. I believe we have found it.

MCR Pathways' most powerful tool is mentoring: matching care-experienced and disadvantaged young people with a 1:1 volunteer. This is someone who cares and commits their time to meet weekly for an hour in school. Mentors are trained, but not to be social workers, teachers or experts in child psychology. They are simply people, freely giving their time for no other reason than they care. I was told this wouldn't work at scale. But what started as a pilot in one East End Glasgow secondary school has developed, relationship by relationship, into a programme supporting nearly 2,000 young people each week.

MCR Pathways now operates across Glasgow and in a number of schools throughout Scotland, in Aberdeen, Aberdeenshire, Edinburgh, North Ayrshire,

South Lanarkshire and West Dunbartonshire, with many other local authorities committed to joining. With government support to expand nationally, MCR has a goal to become 'business as usual' within the Scottish education system. Discussions are already underway for the MCR model to be adopted in England and internationally, from Norway to Australia.

The impact of MCR mentoring is profound. In 2014, pre MCR mentoring, the first 15 Glasgow schools that were involved in the programme saw just 53% of care-experienced young people progressing to a positive destination. Just four years later, 86% of MCR mentored care-experienced young people in the same schools left school to college, university or a full-time job. Of the 180 mentored care-experienced young people who left between academic years 2016-18, 150 (83%) went on to college, university or a job and 167 (93%) went on to a 'positive destination' (Skills Development Scotland, 2016, 2017, 2018).

The MCR story brings us to the central question: Why does good policy fail so many of the individuals it is intended to help? Why hasn't policy, created by passionate individuals dedicated to change, empowered and improved outcomes for care-experienced young people?

As a lifelong student of systems and culture change, I know the process can be mastered. MCR is disruptive, but, purposely, very respectfully so. Every idea and system was once a good one. Time naturally decays effectiveness and human nature becomes defensive. MCR does nothing in isolation and would fail spectacularly without partnerships and collaborations. We have had many false starts in some key areas of need and slow rates of progress. This happens when relationships with professionals are not strong enough. Our partnerships with educational authorities and school are pioneering and designed to go much deeper. They are integrated with shared staff, facilities and a working plan to share and transfer knowledge and practice. This is the philosophy and DNA of the MCR model. We will not need to exist in 10 years' time because the MCR model and mentoring will be embedded as a right in Scottish education. MCR has no vested interest.

The MCR model is transformational because it prioritises individual relationships and leads with a clear and ambitious statistical definition of impact. We believe that it is essential that this practice needs to be backed by policy to ensure young people are always determined by their talent and potential, and never their circumstances.

Creating a 'one good adult' system - Benefitting all involved

MCR Pathways was founded in one school, St Andrew's Secondary School in the east end of Glasgow, and developed over five years through trial and error. Most of the targeted young people did not have a consistent and supportive adult at home and teachers did not have the time to fill the void. But when these young people had someone they could trust and rely on, everything changed.

1:1 relationship-based support, critically part of a complete system

The MCR programme's core elements combine into a complete system. It includes support in the transition from primary to secondary school, group work in 1st and 2nd year (of high school), 1:1 relationship focused mentoring from the critical 3rd year and a bite-size programme of Talent Tasters work experiences. The system places relationships as the common denominator.

MCR recruits, trains and matches volunteer mentors from all walks of life to mentor, listen to and support a young person for one hour a week. Developed with partners in the public and private sectors and higher and further education, Talent Tasters then provide young people with varied, hands-on introductions into the world of work. Half days in length, they are also rewarding and sustainable for the organisation and staff delivering them.

In 'mature' schools, MCR supports approximately 80% of each school's care-experienced young people with a mentor. This leaves 20%, made up of young people experiencing such severity in their circumstances that they struggle to attend school consistently or not at all, or young people who feel the programme is not for them. These young people often join later when their school is more

mature and higher numbers are being mentored. For the MCR programme, every care-experienced young person is included.

MCR Pathways has developed targeted re-engagement programmes designed for these harder to reach pupils, with dedicated staff working with disengaged S3[11] pupils. Supported case by case, the goal of re-engagement is a return to school or progression to a supported college place. Re-engagement is entirely dependent on relationships being established with the young people and their families and carers. Success is possible, but consistency of their engagement continues to be a challenge.

Nine of nine young people in the Glasgow North East S3 re-engagement programme last year improved attendance, sustained their participation in S4[12] education and are continuing in college post school. Yet a similar 2019 programme working again with S3 pupils, covering two areas of Glasgow, has seen 12 in 18 engaging and currently planning their next steps for S4.

The issues the young people face are varied and considerable. Identifying and working with schools and specialist partners regarding solutions for those not engaging is continuing on a weekly basis. All care-experienced young people are monitored and offered opportunities, whether mentored or not. We are confident that the relationship based approach, with continuous programme learning, will provide us with the ability to reach every young person, irrespective of their circumstances.

While MCR Pathways developed its high impact model through practice, academic literature has emphasised the importance of stable adults in young people's development. A study by Harvard University's Center on the Developing Child (2015) found that the single most important factor that determines if young people and children can overcome adverse early experiences is their ability to develop and show resilience. In the landmark study, what the Center found was: 'the single most common factor for children who develop resilience is

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[11] S3 = Secondary 3, equivalent to freshman year of high school, or age 14-15

[12] S4 = Secondary 4

at least one stable and committed relationship with a supportive parent, caregiver, or other adult'. This study perfectly encapsulates why MCR mentoring makes such a powerful impact on young people.

Prioritising partnerships

Each school has a full-time MCR staff working as part of the overall school team. Mentors provide the scale and depth of individual relationships for each young person.

MCR mentoring takes place during the school day, meaning the vast majority of mentors are taking time out of their working day to volunteer - over 80% of MCR's volunteers are employed. Rather than seeing this as a cost, mentoring is in fact an enormous benefit to staff and employers alike. Staff who mentor report that it makes them more motivated and engaged at work. A Gallup meta-analysis (Harter, Schmidt, Agrawal and Plowman, 2013) which reviewed 263 studies covering 192 organizations, in 49 industries, and across 34 countries, showed that high employee engagement brings an uplift of every business performance number. They found it improved profitability by 22%, productivity by 21%, customer ratings by 10% and quality by 41%. A mentoring culture is a highly effective one. I have lost count of the number of mentors in senior positions who say it is the best part of their working week.

The MCR model purposely does not inform mentors about a young person's past as we refuse to accept it has anything to do with their future. This takes the adult out of their comfort zone and away from their default judgement and desire for solutions. Listening and relationship building come first and for as long as it takes. There is an array of ongoing online and offline training, allowing working mentors to grow their skills and bring them back to the benefit of their organisation.

Research from the University of Strathclyde have found that MCR mentoring builds skills essential to leadership and effective management, including active listening, empathy and relationship building. There is now a course launched by the university, Leadership through MCR Mentoring, designed specifically to build on these skills (Strathclyde, 2018).

The MCR model has a body of evidence to show the deep and lasting benefits for all participants, in the schools, organisations, mentors, communities and most importantly for the young people. It is measurable and tangible in social, economic and commercial terms.

Impacting a generation

The power of mentoring, partnerships and 'One Good Adult' for each young person is profound. MCR use individual extrapolations from independent, published data on attainment levels and post school destinations to evaluate programme efficacy.

Behind these statistics are young people, who now have the support and confidence they need to achieve their goals. Billy McMillan is one example of a young person who benefited immensely from the programme. Now a second year student at the University of the West of Scotland, an activist for young people in care, and an aspiring future politician, Billy barely resembles the reclusive boy he was just five years ago. He shared his story with *The Herald* newspaper (Smith, 2018).

Coming from Lochend Community High School in Glasgow's Easterhouse, an area that has consistently ranked in the bottom 5% for poverty in Scotland (SIMD 2016a), and prior to being matched with his mentor Billy did not think he would amount to much.

> Going to school felt like a pointless activity, because I couldn't do the work. I'm dyslexic and I couldn't read for most of primary and a bit of secondary and going there was simply an action to go and sit and do nothing.

For Billy, 'the concept of going to university when you come from Easterhouse sounds impossible'.

But this changed when he was matched with his mentor, Mary, in S3. He described her impact,

It could have easily gone the other way. But Mary looked at everything I'd done and marked out where the issues are. She didn't tell me where to go, but where I could go. My father was a heroin addict. I've seen it so much – it would have been too easy to go down that route… The programme gave me something to strive for. It gave me the ability to actually achieve those goals.

Time to let young people lead policy development

Over the last 12 years of MCR Pathways, what we have found is that the failure of policy is not about desire, intent or ambition. Creating effective policies should be about building on successful precedents. Through combining stats and stories, collaborations and partnerships - we can create the foundation for effective and successful policy.

MCR systematically brings together ideas and groups from across our communities to find solutions. When young people lead, and professionals, organisations, schools and policy makers work together, anything is possible.

We feel confident to make these policy recommendations - knowing where we are and where we want to be - and recommend the steps that need to be taken. Our young people tell us to get on with two policy areas in particular.

Corporate parenting

The current definition of corporate parenting 'places parenting duties on a range of publicly funded organisations in respect of looked after children and care leavers' [with the intention to] 'increase the breadth and depth of support available to those groups of children and young people' (Children and Young People (Scotland) Act 2014. (2016b).

While the 2014 Act provided much needed legislature to better support care-experienced young people, practical corporate parenting at scale still remains elusive. The current legislation results in organisations creating plans that could impact some young people, but not yet a significant number. We believe that the 2014 legislation can be made effective, with some simple additions.

The best way for corporate parent to directly support a young person is to help them get the best education. It is what parents do. The MCR mentoring model does just that.

A corporate parenting expectation that focuses on supporting all care-experienced young people individually to get the best from the education system is a natural step. By implementing MCR mentoring, organisations benefit further by adopting a tried and tested system that impacts all participants and the organisation on a social and economic basis.

Widening access

In 2014/2015, the Scottish Government (2016c) published legislation and new recommendations in the report, *A Blueprint for Fairness: The Final Report on the Commission for Widening Access* which set an ambition to close the educational gap between the nation's most disadvantaged young people and their peers. The report found that young people from the 20% least deprived communities are more than four times more likely to enter university compared to those from the 20% most deprived communities.

To redress this imbalance, the report called on universities to make a number of changes. Many of these recommendations focused on creating quotas for young people from deprived backgrounds and using contextualise admission policies to maximise applicants from these backgrounds.

We believe the best way to support disadvantaged young people is by higher and further education institutions working directly in schools and building relationships with a younger cohort. As a past Sutton Trust Fellow, I was shocked, but not surprised, to see the data (Jerrim, 2017) showing that disadvantaged young people entering secondary school can be between two and four years behind their peers in literacy and numeracy levels. By applying the MCR mentoring model in the critical 13 to 18 years old age group, they will support more young people into university and college and establish the relationships to sustain it.

With university and college staff as MCR mentors, young people become more familiar and feel more welcome. Retention rates improve. In addition to adjusting the entrance requirements, the focus should also be on ensuring young people can meet the rigours and requirements of continuing education. We know they are just as talented as their peers, its support and social networks they lack.

There is a will across Scotland to ensure all our young people are determined by their talents and potential and never their circumstances. There is a way for this to happen through education where the individual flourishes and everyone is a beneficiary. Partnerships and collaboration drive profound benefits for all participants and can transform a generation. I've taken five years out of my business life as a full time volunteer to help make it happen. There is nothing more important and it is possible. In Glasgow, the impact of mentoring has been nothing short of transformational and these benefits are being replicated across Scotland. By embedding individual one to one support, and making simple policy changes we will have righted a long standing wrong.

About the author

Scottish entrepreneur and philanthropist, Iain MacRitchie has transformed 18 organisations - from 50 to 5000 employees - and has acted as trusted adviser to over 100 others. An expert in leading large scale organisational change, Iain has a track record in helping develop teams and individuals to realise their full potential.

After setting up MCR Pathways in 2007, Iain now volunteers full-time to lead the revolutionary mentoring and talent development programme. His goal is to establish MCR as a national education model to ensure that all care-experienced and disadvantaged young people are defined by the talents and potential, never their circumstances.

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Learning from lived experience in government care: Sharing gains in knowledge and practice in youth participation with key care stakeholders

Jade Purtell, Luke Westwick, Brittany Witnish, Jarrad Butcher, Annie [Withheld], Ralph Salera and Jenna Bollinger

Abstract

Increasingly progressive organisations are changing how they see and work with young people. Such organisations as well as government are acknowledging the invaluable skills and insights young people with lived experiences can contribute as youth leaders, and genuine co-design partners shaping policy with key decision makers. This paper presents three care experienced perspectives on the benefits and challenges of capturing the voices of young people to inform policy and organisational decision-making in youth services. Sharing models of effective youth participation in policy development may lead to improved policy making and greater efficiency in child welfare service delivery. Encouraging young people's participation and empowerment involves a range of 'soft skills' that can be resource and time intensive. Sharing learning and knowledge from and about this work can be difficult as a result. The authors work on many innovative and important youth participation projects and seek to share young people's suggestions for how to facilitate meaningful participation for young people. Strategies for avoiding tokenism and increasing shared decision-making are discussed.

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A number or organisations around the world work with children and young people with experiences of government care such as foster care, group homes or residential care and extended family and kin placements. Many children and young people growing up in care do not have the same access to opportunities as others in the community and often experience adverse outcomes (Mendes, Johnson and Moslehuddin, 2011). There is however, great commitment amongst care experienced children and young people to affect policy changes that can improve outcomes for people with care experiences. The authors have met with and learned from key organisations and policy actors supporting care experienced young people's participation in care policy improvements around the world. We have identified needs to support greater information sharing about local initiatives and efforts with world-wide audiences. The United Kingdom (UK) in particular has advanced collaborative efforts with #CareDay19 in February this year. The first author's meetings with Who Cares? Scotland and the Drive Forward Foundation in 2018 have been instructive in thinking about opportunities for Australia to learn from leaders in the field. In Victoria, Australia, there is significant youth-informed policy development work taking place. As a result, momentum is building for further work in this field. Building an evidence base regarding the impact of youth participation requires greater attention to be paid to the evaluation of discrete initiatives taking place across the community sector. With an improved evidence base, more and more organisations can have access to information about how to embed youth participation in their own policies and practice.

The growth of children's rights recognition and youth participation

In Australia, the national consumer body representing children and young people with a care experience, the CREATE Foundation, is celebrating 20 years of learning from lived experience in government care (CREATE Foundation, 2019).

The organisation has contributed to significant improvements in the out-of-home care (OOHC) system in Australia including the establishment of a National Children's Commissioner and the National Standards for Out-of-Home Care (CREATE Foundation, 2019). The rights of children and young people to have their voices heard by key policy and decision makers are becoming more widely supported (see Crofts, Beadle, Cahill, & Romei, 2017; Oliver, 2016). Increasing numbers of youth advisory groups are being set up in organisations providing services to children and young people in the state of Victoria in Australia. Around the world, many organisations exist to support young people's participation in services that support them. Many organisations work specifically with children and young people who have been in the care of the government to advocate for the improvement of such services.

This year, organisations from the UK, Ireland, New Zealand and Australia, collaborated on a campaign for Care Day to raise awareness of this work internationally, social media campaigns were collated on a dedicated website (https://careday.ie/) to celebrate and acknowledge those who had been in government care. These organisations are specialised in supportive youth participation work with care experienced children and young people. There are a number of other organisations initiating their own care experienced youth participation policy and advocacy groups with different approaches and objectives.

Youth participation and empowerment has been included in state regulations for services to children and young people through the Child Safe Standards in Victoria, which were developed to ensure that community groups and youth services are safe places for children and young people (Department of Health and Human Services, 2018). There is little direction within these guidelines about how different organisations should enact youth empowerment and participation in practice. Despite taking the position of empowering youth to participate, when new groups are developed, they may encounter barriers to providing opportunities for young people's advocacy due to the lack of specificity in the guidelines as to how to enact these opportunities. Though support for youth participation is growing, barriers to participation exist and can slow or limit progress in young peoples' voices being heard. Greater information sharing

between organisations supporting youth participation could allow young people's voices to be heard by key decision makers and inform policy-making improvements more quickly.

This paper is designed to offer greater specificity in how young people's voices can be heard, as told by the care experienced young people who are involved in various youth participation initiatives.

Sharing participation practice wisdom

Over many years in Melbourne, Victoria, numerous youth advisory groups have developed in relation to OOHC and youth services. The CREATE Foundation has been showcasing some of this work in Victoria through bi-annual youth-led forums that invite Young Consultants (who are care experienced youth, or currently in OOHC) from CREATE and youth advocates from other organisations to present their recommendations for service improvements directly to government ministers and Child Safety and Child Protection leadership. This unique forum, called the Hour of Power (HOP), attracts commentary on Twitter from key decision makers and has been credited with influencing key political decisions around care policy and child safety inquiries (see CREATE Foundation, 2018).

Favourable conditions for youth participation from care experienced perspectives

To develop this reflective paper the authors sought contributions from various youth leadership groups. Youth advocacy groups and organisations that support these groups, are typically very busy, however. Ralph Salera was able to support Jarrad Butcher and Annie, representatives from the Salvation Army's former Westcare service's The Youth Group Advocates (TYGA), to share about their experiences working as Youth Participation Champions.

The following section provides the words of care experienced young people on issues around youth participation and empowerment. For the purposes of this article, these excerpts are provided interview-style, rather than grouped as themes with the intent that the young people speak for themselves, rather than interpretations being made as to what they are saying.

Why are you passionate about youth participation and empowerment?

I am passionate about youth having the ability to have self-determination and participate in their community in order to enable them to represent their interests in a responsible way, acting on their own authority. This will enable youth to become stronger and more confident, especially in controlling one's life and claiming one's right[s] (Jarrad).

I have spent some of my teenage years in government care and now reflecting on this experience, I can see the importance of having a system that intends to provide for young people that has had these same young people aid the development. Youth-led decision-making practices are crucial to ensure that power is given back to those who are accessing services to provide a more balanced service delivery. As someone who has lived part of their life in government care, I can recognise how much power and decision making was taken away from me. My passions lie in ensuring that this power is returned to all young people (Annie).

What has been your journey and your organisation's journey with youth participation and empowerment?

The Youth Group Advocates (TYGA) began small with the simple idea of exceeding tokenistic participation. Salvation Army and TYGA worked hard to be recognised and demonstrate a more meaningful way to engage young people in service delivery. We aided in the hiring of new staff members, the TYGA team sat with a different perspective of what qualities were desired in a candidate and worked together with [staff] Ralph and Alyce to reach a final decision (Annie).

I have been involved with Salvation Army (former service) Westcare in The Youth Group Advocates (TYGA) advocating for young people in care by attending conferences and sharing my

out of home care experiences. Along the way I have learnt to be self-confident and learnt to have self-determination. Myself and everyone in this group have been a positive influence for change for young people in out-of-home care (Jarrad).

Where do you see youth participation and youth empowerment efforts heading in the future?

Young people who have had a care experience have the chance to give back through the TYGA program when they transition from care after the age of 18 into independency. They will be able to advocate with other like-minded young people who have also had an out-of-home care experience to move into the future where all young people feel empowered and can have the best care system and also be heard (Jarrad).

Ideally, I would love to see all organisations having dedicated youth advocacy groups that they can turn to, to aid in the development of policies and procedures, hiring new staff, being a part of representing the organisation, being given opportunities to reach state and national decision makers, that can engage with other young people in the service (mentoring) and any all other forms of inclusive practices (Annie).

What are the benefits you've seen and experienced for your organization, staff and young people involved?

The most significant advantages and benefits have been the valuable opinions of young people who have experienced living in the industry alongside the professional expertise of managers and support workers at (the former service) Westcare. The recognition of TYGA's objectives and methods as being a great form of empowerment and participation that can be duplicated within other organisations. TYGA have been very proactive and have met with the National commissioner for young people to put forth our suggestions, knowledge and recommendations (Annie).

What learnings and advice do you have for others in creating more youth participation and empowerment opportunities?

> The first step would be to determine the specific need for youth participation, in other words: What do you envision being the ultimate outcome and benefit to practice/service delivery? Next, make the active commitment to having face to face contact with young people to get guidance on what needs to be done and how to get it done. I think most organisations engage young people on what needs to change but the crucial difference is devising creative and practical solutions to promote change (Annie).

What needs to change in current youth participation practice?

Tokenistic participation: young people need to be given the opportunity to actively engage within the organisation.

> There are many things within the Social industry that could use improvement. Every industry, service and organisation will have different strengths and weaknesses. It is impossible to give a comprehensive description of everything that needs to change but I believe the first step of identifying what needs to change in any specific context is to get the opinions of the young people who have experienced the service and to continue to create this space for participation constantly. One-off forms of participation give little to no accountability or power to the organisation or the young people involved (Annie).

Victorian Centre for Excellence in Child and Family Welfare (CFECFW) Young Leader, Brittany Witnish, also contributed some thoughts on providing supportive environments for young people's participation. Brittany has experience conducting her own youth consultation with the Youth Affairs Council Victoria (YACVic) as a 'Young thinker in residence' conducting a project on young people transitioning from care in Victoria, Australia (Witnish, 2017). Ms Witnish works currently with the CFECFW as a care experienced Young Leader on policy,

advocacy, and campaigning projects (CFECFW, 2019). Ms Witnish has been involved in doing similar work for many organisations in a range of settings and shared some perspectives on how organisations can work with young people in these arenas. The following is an edited excerpt of Ms Witnish's perspective regarding good practice in supporting youth participation and empowerment.

Recognition of care experienced young people's capabilities

Care experienced young people who are experienced in leadership and advocacy have detailed subject knowledge of youth and care services, usually with a range of well-informed opinions on the topic of youth participation and youth engagement. Young people therefore appreciate it when they are treated as capable and knowledgeable people that practitioners can learn many good practice tips from. Young people with a care experience have often had many decisions made for them in life, so when these young people are now engaged for youth participation projects and work, they expect to be treated with the same respect and regard as professionals. Directive, highly structured activities that stifle open discussion and information sharing between young people, who may be working together for the first time, can be perceived as condescending. When working together in forums and similar events with youth services practitioners and management, young people behave in a professional manner and expect the same of others. Often young people will be grouped together as the 'youth' voice, for example, which can make young people feel their contributions are being regarded as 'less than' than the contributions of those practitioners and professionals present.

Safe spaces for consultation

Many organisations attempting to improve their youth participation processes will try to establish and maintain a youth-friendly and 'safe' space for young people. This is important with care experienced young people who may have been engaged to share aspects of traumatic life experiences for others to learn from. It is important that young people feel comfortable to speak and contribute. For young people who are experienced in advocacy and policy work, they may already feel comfortable in a forum environment working collaboratively with

youth services professionals. Attempts to make them feel 'extra' comfortable by having different roles for 'young people' and professionals may be seen as again, not valuing young people's contributions as highly as those of 'professionals'. It is helpful in these situations to learn about young people's capabilities and experiences in advocacy and policy work to ensure a young person's skill sets and expertise can be best utilised. When young people are recruited for policy and advocacy work through organisations already working in this space, it is likely they have been supported and prepared to do this work, and indeed they may have been doing it for years already.

Conclusion

Just as young people with a care experience are a heterogeneous group, approaches to youth participation can take many forms. The young people here, who are a particularly articulate group of care-experienced youth, have highlighted a number of important elements to youth empowerment and participation. They include: needing to provide a genuine forum that allows for accountability by the organisation to implement perspectives of young people, providing opportunities for young people to participate in a manner that is seen as equal to that of professionals that gives an authentic and genuine sense that young people's participation and perspectives matter, and allowing the voices of young people to be heard on many levels of the organisation from hiring to policy development.

Growing opportunities for care experienced young people to use their skills and knowledge to help inform key decision makers' thinking and policy action, appears to be developing. Young people have much to contribute in identifying ways for care systems to improve. Developing further information sharing avenues for discussion about youth participation and advocacy in practice, as well as more networking opportunities for those young people and community sector staff engaged in this work, is likely to assist with capacity building for organisations with less experience in the field of youth participation and empowerment.

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Representations of 'family' in residential care: Perspectives from residential care staff in Zimbabwe.

Getrude Dadirai Gwenzi

Abstract

There has been an increasing emphasis on the provision of family-style residential care for children in alternative care globally, the aim of which is to create a family environment for children without parental care. Few studies have explored the dynamics within family-style institutions, particularly the relationships between children and residential care staff. Additionally, family-style settings mimic 'real' families, but few studies have explored how the family in residential care is conceptualised. Using empirical evidence from residential caregivers (n=23) in family-style institutions in Zimbabwe, the article discusses how 'family' is represented in residential care, including the challenges associated with this type of paid, non-biological and temporal 'family' form. Study findings suggest that residential caregivers and children live within a physical space that allows them to enact 'family practices', such as eating together and sharing cultural values. However, the behaviour of the children and the rules of child discipline and child rights affect the extent to which residential caregivers can 'parent' in residential care. This brings into question the 'family' nature of residential care. The study makes recommendations for policy and practice related to child welfare practice in residential care.

Keywords

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Introduction

Residential care for children is a form of alternative care for children who can no longer be cared for by their biological families. In most countries, it is supposed to be the last resort, after exploring community-based interventions (Browne, 2017). However, the reality is that a large number of children are still being placed in residential care, particularly in less developed countries where there are higher rates of family instability and poverty (Lumos, 2017). Additionally, institutions are more attractive to international donors and the increase in the number of orphanages in some parts of Africa has been due to this need to attract overseas donors (ACCI Relief, 2016).

The demand for alternative care persists in Zimbabwe and there has been a steady increase in the number of residential care facilities over the years from 31 registered institutions in 1994, to 56 in 2004, and an estimated 122 institutions by 2014 (Ministry of Public Service, Labour, and Social Welfare, 2014). There are three major types of residential care facilities: centres for abused, abandoned, neglected and orphaned children and youths; centres for juvenile youths; and centres for disabled children. This paper focuses on the first type. Two models of residential care exist, that is, family-style and dormitory-style. Family-style consist of smaller family units resulting from the St. Petersburg USA Orphanage Intervention Project (2008). By design, they imitate a 'family' home, often meaning smaller numbers of children (UNICEF, 2016). In contrast, the dormitory-style facilities consist of large numbers of children living in dormitories 'segregated by sex and age, and deprived of maternal care, privacy and freedom to be spontaneous' (Gutman, 2004, p. 583).

The National Residential Child Care Standards (Government of Zimbabwe, 2010b) and the *Minimum Quality Standards for OVC Programming* of 2008 provide guidelines regarding the quality of care in institutions and the minimum standards for how care should be provided (Government of Zimbabwe, 2010b; UNICEF Zimbabwe, 2011). Additionally, the *Caregivers Manual* (UNICEF Zimbabwe, 2011) acts as a handbook on child rights and child care for residential care staff. The *Manual* states that caregivers must be given titles of known family figures such as 'aunt', 'mother', 'uncle', 'grandmother', etc. and

the expectation is that children are cared for in the same way biological family figures would have cared for them. (Government of Zimbabwe, 2010b). However, this family spirit, although ideal, has been described as problematic because children often distrust their caregivers, doubting their genuineness (UNICEF Zimbabwe, 2011). Due to the limited studies on residential care in Zimbabwe, very little is known about family-style residential facilities in the country.

The 'family' concept

The study of families in sociology has included analyses of various living arrangements and explorations of whether the relationships therein could be described as 'family'. Scholars have studied single-parent families, separated households, adoptive families and same-sex families (Powell, Hamilton, Manago and Cheng, 2016). The new sociology of 'family' pays less attention to the structure of the family and more on the quality of relationships and practices that constitute 'family practices' (Morgan, 2011). 'Family' is now being understood based on affective characteristics, care, and support, rather than blood relationships (Erlingsson and Brysiewicz, 2015; Finch, 2011; Pahl and Spencer, 2010; Smart, 2007). Ribbens McCarthy, Doolittle and Sclater (2012) describe 'family' as an idea that forms a key construct through which people develop meanings in a variety of social settings.

There, however, remains a gap in our knowledge of family life in the non-normative setting of a residential care facility. This paper argues that if co-residence, affective qualities, and family practices are factors that can be taken into consideration when conceptualising 'family', then family-style residential care is an additional space where 'family' can be examined. This contributes to the literature on the conceptualisation of 'family'. The following research questions guided this research:

a) How is 'family' represented and maintained in residential care?

b) What challenges do residential caregivers face in creating a 'family' environment in residential care?

Residential care and the 'family' concept

In residential care, caregivers play a central role in the lives of young people (Sulimani-Aidan, 2016). They take on a variety of roles, which scholars have summarised as the provision of 'basic care' to children and young people in residential care (Connelly and Milligan, 2012; Smith, 2009). Basic care includes ensuring that young people receive adequate food, are clean and healthy, attend educational establishments and get access to positive, appropriate relationships (Connelly and Milligan, 2012). Residential care workers are typically involved in tasks such as setting routines, preparing meals, liaising with key social workers, chaperoning children on activities and assisting with other daily living tasks (Winsor and McLean, 2016).

The task of residential care has always evoked powerful echoes of family and debates as to whether the task is better represented as 'family-substitute, family-alternative or family-supplement' (Ward, 2004, p. 212). According to Smith (2009), residential care staff find it difficult to be both professional and play the caring role. A large portion of the time spent in caregiving is devoted to building relationships with young people in care. Scholars argue that care staff within residential care are not biological parents, they are *in loco parentis*; that is, they function in a way that approximates the role of parents for the children they look after (Cox et al. 2015). However, Fowler (2016) found that whilst some residential care staff identified as a substitute 'parents', others were clear that they could not replace biological parents. Caregivers struggled to find a balance between their 'parenting' role and their worker role, particularly when they had to perform certain duties that disrupted the feel of the 'family' home, such as completing children's care plans and conducting safety checks.

This suggests, as Kendrick (2013, p.79) states, a blurring of 'the boundary between familial and non-familial relationships' in residential care. Kendrick (2013), shows evidence of children describing their residential care experience as being like a 'family' and referring to staff using kin names such as 'dad' or 'sister'. Similarly, Neimetz (2010) found that a family-like environment was created through the use and identification of family roles played by institutional caregivers in China. From a developing country perspective, children in

residential care in Ghana refer to their caregivers as 'mother' or 'aunty' (Darkwah, Daniel and Asumeng, 2016). Törrönen (2006) analysed the 'community' in a children's home and found the presence of a home-like sense of belonging, with some children viewing it as their home. The study highlights, however, that the meaning of 'home' may be more complex for the children in residential care. Some scholars have examined practices that fit within the concept of 'doing family' in residential care. For instance, McIntosh, Dorrer, Punch and Emond (2011) showed how food practices can be strongly linked with social representations of the family, with meal times described as settings for family interaction within residential care (McIntosh, Dorrer, Punch and Emond 2011).

Meaningful relationships have been acknowledged as significant for young people in residential child care (Brown, Winter and Carr, 2018). However, caregivers are usually low-paid, work long shifts away from their own families, and often lack the training to deal with children's difficult behaviours (Colton and Roberts, 2007). A number of stressors have been found to affect caregivers, including the children in residence, interpersonal relationships at work and child rights regulations (Darkwah, Asumeng and Daniel, 2017). These issues underlie caregivers' approaches to their caregiving work and may affect how they relate to the children. It is evident from these studies that residential care relationships may be complex, however, less is known about the construction of 'family' in these settings.

Methodology

A qualitative exploratory research design using an interpretivist epistemology was utilised in the study. A purposive sample of caregivers was drawn as part of a larger doctoral study on the social construction of 'family' in residential care. Ethical approval and access to residential care facilities were granted by the Department of Social Services in the Ministry of Labour and Social Services in Zimbabwe in August 2017. Data were collected between July-December 2017. Residential caregivers gave consent to participate in the study and permission to record interviews. A total of 23 caregivers from five family-style residential facilities agreed to participate. The caregivers were aged between 25-60 years

with a range of one to 25 years of experience as caregivers. The selected residential facilities accommodated children aged 12-18 and each unit had at least 12 children, with a maximum of 14 children per household.

A semi-structured interview guide was used, which focused on caregivers' daily lives with the children, their perceptions of their relationships with the children and their perceptions of 'family' in the context of residential care. Interviews were conducted at the residential facilities and lasted approximately one hour each. After full transcription of interview recordings, a thematic analysis was conducted which brought out the main themes from the data. The analysis involved line by line coding using NVIVO software, drawing from theoretical concepts of 'family display' and 'family practices' and relevant literature. This paper will discuss two broad themes that came out from the data.

Representations of family in residential care
Family practices and display in residential care

Caregivers reported that they lived as a 'family'. The facilities were structured in a way that each 'housemother' lived with up to 10 children in one cottage-style house. All the caregivers reported that the children called them 'mother' and in the case where the caregiver lived with her husband, he was called 'father' by the children. In turn, caregivers called the children [*vanangu*], the Shona term for 'my children'. As one of the caregivers stated:

> We have a system that promotes the building of caring and
> loving relationships; relationships that are like family. Children
> call me and the housemothers 'mum'.

Children are also encouraged to view each other as brothers and sister in the home to discourage sexual relationships among them, particularly as children grow older. The parental role and responsibility of the caregiver were as clear and in the course of everyday life, children engaged in cooking, cleaning, gardening and life-skills. Each home consisted of a mix of girls and boys co-residing together. There was no reported gender division of labour, both boys

and girls are being taught to do household chores. One housemother expressed her parenting role below:

> I encourage them to do well in school, that is their future.
> Everything to do with their lives I am responsible.

Another caregiver described how sending older children on errands, just as she would send her own children. Another aspect of the caregivers parenting role was to teach children cultural values. This was particularly important for girls when they grow older and face cultural expectations such as marriage:

> I am like their mother, I tell them everything and guide them.
> Some will need to get married, they will need to know how to do
> certain things, such as house chores and taking care of the
> family.

Participants expressed that they attempt to create a family environment and instilling a sense of 'normal' in the home. This includes joint meal times and family meetings when there is an issue to be addressed. Such routines such as going to church together, sitting and watching television, allowing the children to play at the neighbour's cottage within the same gated community makes the staff and children feel like they are living as a 'family'. Children go to school and come back to do their homework with help from either their older siblings (housemates) or from the housemother. There are children of different age groups from infants to adolescents. One of the caregivers said:

> It is just like a family home, we even have babies. The children
> do gardening, rear poultry, they go to school and church.

Residential Care Practice Issues

It is evident from the above that 'family' is being practised and displayed in some way in the residential care facilities. However, this is not without its challenges. Caregivers reported that although they are living as a 'family' and playing their parental role, there is a limit on what they can do as 'parents'. Particularly, they expressed frustration with issues of disciplining the children. The majority of the caregivers expressed feeling disrespected by the children

and a general perception that children in care were being spoiled by the child rights framework. For instance, 50-year-old Maria who has been a housemother for 10 years said:

> I think they see that we are not actually their real parents, that's the way I see it. The children know it, you find that a child can tell you, when you tell them to do something, that they are not going to do it, that they know their rights; so, they can refuse to listen to you because you cannot discipline them in the way you would discipline your own child.

The child rights framework allows children to know their rights to speak out against any form of abuse or maltreatment. However, caregivers reported that some children are abusing this knowledge of their rights and use it as a challenge to authority. Caregivers reported that the discipline plan is made by the social worker or manager, which limits the powers of the housemothers who live with the children daily and the children use this knowledge to disrespect them. For example, 49-year-old Rozaria said:

> From what I observed, due to the guidelines of our own work we just leave other things for example when a child does something, we are advised [by social worker or manager]to leave them as they are, unlike at home, as a parent you can enforce what you want the child to do. Here we are constrained by the guidelines so we just leave it.

Caregivers reported that the emphasis on children's rights without teaching them to grow to become responsible adults may be the reason why some care leavers struggle to make the transition to independent living. As one of them stated:

> I have seen that in an institution there are rules that focus mostly on children's rights. So, the children hold on to the rights more and fail to do what they are supposed to do to better their lives. They do not focus on their responsibilities which makes life harder for them when they are outside of the institutions.

Linked to this, the study found that some caregivers lack the knowledge about the children's backgrounds and this is privileged information that only the case manager knows. As 38-year-old Marita stated:

> Us caregivers do not have information about the children, we are not given access to the files or information about their background. Only a child who feels free to share can share. Later as we live together, children feel free to disclose their past.

Caregivers reported difficulties in building relationships with limited background information Caregivers from two out of the five residential care facilities stated that this is done to protect the children. For instance, 47-year-old Sarah said:

> We are not told why the children are here, children's records are in the office. We do not have conversations about the children's birth circumstances, we just take care of their physical needs.

Lastly, the study also found that the children's knowledge that caregivers are paid workers affects their relationship, especially adolescents. The account from 42-year-old caregiver, Vimbai below illustrates this:

> I have adjusted as a mother to them, but they know I am a worker. They expect me to do certain things for them because I work for them, sometimes a child will not flush the toilet expecting me to come and do it.

Similarly, a caregiver from another residential facility mentioned how some of the children often tell her 'you are not my mother' when she tries to reprimand their negative behaviour.

Discussion

It is evident that 'family' is being practised and displayed in family-style residential facilities through interactions and activities that validate the caregivers and the children as being a 'family'. The analysis of the language of 'family' (Ribbens-McCarthy, 2012) and caregiver accounts of how they play their parental role brought out some positive insights of the caregiver-child

relationship. Caregivers' parenting role extends to instilling cultural values and teaching basic life-skills. However, challenges are inherent in the relationship as the evidence shows. As children in residential care grow older they often begin to challenge caregivers' authority and the knowledge that caregivers are being paid to 'parent' them further complicates their relationship.

The quality of relationships in residential care forms the backbone of social work with children and families (Leeson, 2010). The findings somehow suggest a more practical than emotional relationship, despite the familial terms they call each other. Caregivers provide the training and physical duty of care, but the lack of respect from older children affects the relationship. The perception of children in residential care as spoilt is similar to findings in Ghana (Darkwah, Daniel, and Asumeng, 2016) where the child rights framework was also to blame. With Zimbabwean caregivers, this affected their capacity to discipline the children.

The functional definition of family involves both instrumental and affective roles being played by certain members of the family, usually the parents or guardians. In this definition, even a biological parent who cannot fulfil one of their roles would be excluded from the family definition (Ooms and Preister, 1988). This paper argues that the inability of caregivers to discipline the children they care for undermines their ability to parent effectively, and in turn, being a 'family'. Children in residential care were reported to be using the child rights framework as a means to challenge caregivers' authority and they would report any reprimanding of their behaviour as abuse. Darkwah et al., (2016) argue that caregivers interpret children's rights laws as threatening to their job. The child rights versus 'proper parenting' debate has shown evidence, including bonding challenges which result from the non-blood relationship between caregivers and children in institutions, which hints at a complex situation for caregivers in their work (Brown, 2009; Bullock, Courtney, Parker and Thoburn, 2006). However, some scholars believe that good quality relationships can exist despite organizational and structural constraints (Winter, 2009), but this has not been fully explored with caregivers.

Hannon, Wood and Bazalgette (2010) state, using evidence from the United Kingdom, that some of the children come into care at an older age and have

more entrenched behavioural and emotional problems that are difficult to contain. This is worsened by some caregivers' lack of knowledge about the children's backgrounds and the supremacy of social workers over them, which further undermine the caregivers' authority.

Conclusion

As Zimbabwe slowly moves towards de-institutionalisation and family-based settings are becoming the most preferred model of alternative care, practitioners may benefit from an understanding of how 'family' in these settings is represented and played out in everyday life. In this paper, the expectation on caregivers to care for children in the same way that family-care would is juxtaposed with evidence of the meaning and representation of 'family' in the residential facility. Caregivers are attempting to provide a family-environment for children in residential facilities in Zimbabwe, evidenced through 'family practices' and forms of 'family display' described above. However, the formal care procedures and emphasis on the child rights perspective pose a challenge to the capacity of caregivers to discipline and be respected by the children in care. This has implications for relationship-based practice with a focus on residential caregivers.

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National Confidential Forum: Reflections on participant experiences

Martin J. McKee

Abstract

The National Confidential Forum is an acknowledgement forum established to capture and communicate the experiences of people in residential/institutional care in Scotland. People provide the Forum with accounts of their childhood experience of care and its longer term impact on their lives. We have heard from more than 150 people of all ages so far and with an analysis of 52 recent testimonies now complete, emerging findings are being prepared for Scottish Government. In practice, testimonies provided to the Forum encapsulate people's personal histories and all stages of care: before, during and after - sometimes long after, allowing us to investigate the legacy effects of care. In this early paper, the role and function of the Forum is explained in union with an exploration of participants' reasons for attending a hearing, and their experiences and benefits of speaking with us.

Keywords

Care experience, residential settings, institutional settings, acknowledgement

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The National Confidential Forum

The National Confidential Forum is an acknowledgement forum, established to capture and communicate the experiences of people in residential and institutional care in Scotland. People provide us with accounts of their childhood experience of care and its longer term impact on their lives.

More than 150 people of all ages have now spoken with our expert staff who provide support and guidance throughout the process. Some testimonies have been written and sent to us but the vast majority have been told to us confidentially, in person in a quiet room at our offices, but also in other settings such as prison, safe community spaces, or elsewhere. People sit with us for two hours to share their journey through the care system and often their full personal histories; all stages of care; before, during and after – sometimes long after.

The Forum is a place where people can come and describe their experiences and the effects of those experiences, in their own words and at their own pace – it is a fundamental and crucial element of the Forum model. Testament to the model is that participants in the Forum tell us that they feel able to describe even the most difficult experiences to the extent that suits them. We do not ask direct questions but participants have described the good and bad of care they experienced as children with many speaking of neglect, maltreatment, physical, emotional, or sexual abuse that they experienced while they were meant to be protected, supported and nurtured in care.

Personal accounts and testimonies are powerful and relevant in a way that other information is not and the Forum is particularly significant in providing a space for those voices. It is a fairly unique opportunity for care experienced individuals to come and speak to us about anything they wish to share or convey. It is our role to then use those accounts to identify key issues within the care system and around the lifelong impact of childhood experiences.

To establish a full and proper picture of those experiences and accounts of care, we recently completed an analysis of 52 testimonies to identify themes, patterns

and trends in order to write a findings report for the Scottish Government. The ages of participants who have spoken to the Forum so far mean the experiences on which our findings are based cover accounts of care from the 1940s to the early 2000s. While participants discussed in excess of 100 institutional or residential settings, it is more accurate to describe these as placement moves since some participants reported staying in the same setting more than once.

Participants speak of diverse and mixed experiences and reflect at length about their time in care and long after. Sadly, we hear many accounts of intense loss; loss of relationships, loss of education, loss of childhood, in short, a loss of opportunity which often has a profound effect on participants many years after their time in care. While people regularly share accounts of strict regimes, neglect, indifference, abuse and brutality, they also highlight – though in fewer numbers - experiences of warmth, compassion, kindness and empathy from family, friends or those associated with homes and other settings; valued relationships that had a positive impact on their childhood or in their subsequent adult life. Crucially, we hear a great deal about the lifelong impact of care; the legacy effects of lives shaped by those childhood experiences that encompassed their identity in the many years after care, their personal achievements, adult mental and physical health, employment, education, housing, finances, and relationships with parents, siblings, wider family as well as friendships, romantic partners, children and grandchildren. Many also comment on the changing care experienced landscape over the years.

People come to the Forum for a range of reasons but they usually expect that what they share with us will be used to improve the care system and the mechanisms that govern, support and surround it. By understanding people's experiences and the lifelong impact of care, suggested improvements will be based on real experiences and clear recommendations can be provided to Government.

It is well established and now widely recognised that care experienced individuals face disadvantaged everyday realities compared to their non-care experienced peers. A significant common variable is their encounter with the

care system. If you want to know how to fix or improve a system or service, you must ask the people who have experienced it – they are the experts, and everyone who spoke with us had something important to say.

Participant experiences
Why come to the Forum?

It is an important aspect of the person-centred Forum model to ensure that the participant guides the focus of the hearing. Even if those who have attended a hearing at the Forum have been in contact with other agencies, organisations or support, it is very unlikely that any participant will ever have had the chance to speak for two hours about their experiences, and certainly not to guide that discussion, free from challenge.

There is a very strong sense from all the testimonies that participants were relieved to finally have ownership and control of their own biographical account. For most, agency and the idea of ownership was typically lacking when they were younger and in care or soon after. A significant development over the past year is that we are now able to provide participants in the Forum with a written copy of their testimony, should they wish one. There has been a high uptake from participants and our impression is that the provision of written testimonies reinforces the sense of being heard and enhances the acknowledgement function of the Forum.

Most who attended a hearing explained that the process of providing a testimony in this format was cathartic. Motivations for coming to the Forum were varied, ranging from a desire to offload, to be heard and acknowledged, a demand for greater transparency and openness in the system, a need for justice and closure, and above all, a sense of obligation and responsibility to ensure that their experiences could be a source of protection for others, and instrumental learning for Scotland.

Until recently, some were unaware that there are mechanisms to formally provide their experiences of care. Many realised it was time to share their

experiences and while they were finally ready, they remained apprehensive about their attendance. We understand that depending on people's experiences, it can be a difficult prospect to contemplate and some participants found it challenging to agree to come along and even cross our threshold to speak with us.

> It's been a lot for me to make that phone call

> As [a supporter] said I've taken a big step to even step in this building today and speak to youse guys. That's the first step of a whole process. It's not going to be resolved today it's going to be months down the line, it's years down the line...

> In fact it's been far more emotional than I thought it would be than just actually come and read a bit of paper, I just compartmentalise and that would be that … I think it's been very valuable for me to come

> I never spoke a single word it tae anybody till well late in ma thirties probably even forty … and like I say even now I find it really hard … I can barely thinking about it, never actually getting the words to …

Reflecting on their time with us, some were very clear in their own mind about the impact of their narrative; attending a hearing was a way to formulate and make sense of their history.

It's good to talk

It is common to hear participants describe the benefits of providing a testimony; as a release, a relief, a chance to offload, easier than they expected, satisfying, therapeutic, and quite liberating to finally have the chance to share their accounts of care. That was an unintended benefit for many.

> … a relief, a godsend, really enjoyed speaking with you – didn't think I would.

Forum Member: So, did anything come up for you in the break that you feel you'd like to add or reflect on or?

I guess I'm just feeling the benefit of having this conversation, you've both got a really nice approach so thank you

Forum Member: That's really nice so thank you

I'm really pleased I've done this, pleased I've talked about it. It feels better.

It's good. It's like, what do you call it? It's like you go down memory lane and two attentive people listening to you.

It has been a kinda release for me in many ways as well.

But it was lovely talking to youse both. I suppose the only thing I'd like to say is it's actually given me a great deal more, not only satisfaction, but value having had the opportunity to even look at it evaluate it and talk about it. No like it's taken anything off my shoulders that's no what I meant at all, what I mean is it's actually given me a…it's put into context what actually happened and it's actually made me feel even more eh comfortable, positive, happy about it

It's been therapeutic writing this testimony so thank you for giving us the opportunity.

Well, I shouldn't say this but I think, I quite enjoyed speaking to youse.

Forum Member: Thank you

I didn't think I would, but I did. As I say, I'm quite wary of who I talk to, you know what I mean? Difficult to trust. It always has been, it always has been. I did have a big mouth at one time, you know?

Reflecting on their hearing at the Forum, it did not go unnoticed by some of our participants that while they recognised the opportunity to share their experiences and unburden themselves, they remained cautious of opening up old wounds and reliving past difficulties.

> It shouldn't be hidden; it should be spoken about because it's part of me. It's a healing process for me to move on because em I think em I don't think em me just putting it on the back burner is the best way forward 'cause I think em like discussing it to people like yourselves it's kinda, it's opening a can of worms but at the same time it's release. It's getting something off my chest or something that was on my mind for a long time and it has held me up I mean obviously for all those years as in jobs and that stuff like that 'cause I am quite a... I know I'm talking to you now but 'cause of my medication I have… I am a very kinda quiet, person.

It was interesting for us to learn just how powerful the act of simply being listened to and acknowledged can be for people, particularly for those that may have been denied that opportunity in the past, or previously had their voices minimised.

> I believe I want to leave some kind of record to show I existed

> I do feel a sense of relief … that somebody's actually listen sat and listened to me

> Yeah listened to that's big … yeah that's what you want, people to listen to you and not judge you

> I've probably said more today … than I have in the last thirty five years … it's been in my mind for years, it's always at the back of my mind … it's a weight off ma mind. It's something I've always

wanted to do. I just wanted somebody to listen. That's all I ever wanted

Participants were also keen to impress upon our listeners, the need for a culture of openness in the care system; an innate sense of transparency. That and the acknowledgement function of the accounts of care can help towards closure for some.

> Very much, shh, shh, under the carpet and getting told try here or go here it's like everybody wants to pass the buck. Naebody want's tae come tae the realisation that eh, what's really happening to vulnerable bairns … well that's good, it's good that it is getting spoken about and I'm glad that I've been here to share the tiniest wee bit of information that hopefully youse'll find somewhere some good to do somebody some good.

> That's basically, that's basically my kinda what I want to get out of this whole situation what is, how do I get... I need some kinda closure on it because I think I've just carried the guilt for too long. It's a guilt that's not my guilt, it's somebody else's guilt but I've carried it … it's not my guilt and it's taken a long time. It's taken a lot of kinda prodding from [partner] to say move yerself just go and dae it, you know what I mean? If [partner] wasn't there I probably wouldn't have done this. I wouldn't have had the confidence to do it and em and I think em plus yer diggin up parts of your life which are not nice

> I decided then to come myself really because I am hoping some closure, some acknowledgement, the [residential] school experience I had wasn't healthy

> It's kinda, instead of kinda guidance and support to maybe to kinda point you in the right direction, kinda support you to get to

where you want to be or ... that's what kinda, that's what
hopefully that's what I want to get out of this whole exercise to
get kinda closure on that part

Improvements in care

However much personal value was gained from speak at the Forum, the aspect
that far outweighed any other benefit for participants was the knowledge that
providing their account would go some way to improving the situations for, and
treatment of, others. While some accounts of care were positive, many were not
and participants reported an exceptionally strong sense of responsibility to
provide their account in the hopes of protecting children currently in care; that
their experiences should not be replicated in the current or future experiences of
Scotland's children. Almost all participants referenced this in some way.

> That's what I want to do. I just want – I don't want it to happen
> to other people. I think the world's hard enough and I think if
> you are neglected, abused, bereaved or any of reason for you to
> be in a care home, there is a reason for you to be there. Nobody
> wakes up in the world and goes 'I want to go into a care home
> the day'. There is reasons you're there. If you're in there, you're
> in there to be supported. I just want them to be supported the
> best way possible … and if I can come and tell my story to help
> that person then that's all I can do.

> Yeah, I just hope that you can find something in my story. I
> don't know if I've told you enough but - that could help someone
> … that would be wonderful.

> I'd love to help them any way I could, anyway I could.

> Honestly, anything to help these kids these days in care, I will go
> and work voluntary with these kids because I love it.

I think this has just been maybe a long time coming for me and I'm so glad that I've done it. If I can help just one person, I'm glad I've done it.

Protect other children, that's my priority, you know

Ah'll be a voice for people that's no able, ma sister especially, you know?

As far as the children's home goes do all that you can because I don't want children today going through these sorts of things.

If I've brought anything here today that would protect one child that's worth it … anything today that helps to stop social workers making the same mess it is worth it.

I think the biggest motivation for me was to try and give my information out that would help others … the biggest thing for me would be to do that.

So, the only reason I'm doing this is partly to make sure it doesn't still happen.

I just think it just gets swept under the carpet too much and if it's no spoken aboot, if there's nae communication then nothing's ever gonae to get done aboot it

Anecdotally, it appears a relatively high number of participants were motivated by their own care experiences to actively pursue fields of employment in their later adult lives that support young people and advocate change for those experiencing care. A range of occupations in the health and social care professions were mentioned; social work, advocacy, youth services, mentoring, and support work. It is important to note however, that this is an emerging finding so we must exercise caution. While there are strong indicators this is the case, further analysis is needed to explore and fully validate this assertion.

In an attempt to challenge stigma and negative stereotyping of care and care experience, some participants came forward to highlight the positives aspects of their care. They wanted their attendance to demonstrate that care experienced people can achieve as much as their non-care experienced peers despite a less advantaged start in life.

> …nothing really bad happened to me
>
> She said no, just talk about everything
>
> I said I'm up for that
>
> Forum Member: And actually it's really valuable to us
>
> Yeah, it's really good
>
> Forum Member: It is, it's very valuable to hear all experiences, good and bad
>
> You don't hardly hear a lot of good in care
>
> I can't mind if it was the telly or facebook and then when I read through and I thought "oh, I could put something on that, 'cause mine was more, I would say mine was positive than – ken, bad – not anything bad.

Despite hearing about some positive aspects of care, some of the positives could only be regarded as relative.

> The homes have made me who I am today … I love them for that, but its social work I have a grievance with. The homes obviously, the physical abuse I think shouldn't have went on. I don't understand why they did do it.
>
> Forum Member: The restraint?

Yeah that's what we called it … so, I know it's still abuse but, you know, I hope these days that does not go on in children's homes now

That's good, thank you. I want to think that children are so innocent they must be protected, especially ones who already, for no fault of their own, are already vulnerable … I think that there was a lot of people who were there and genuinely trying to care for me and look after me but weren't even aware and I think that some of these people must know that and there's some of these people that are in these positions that need to start looking at more for the signs you know.

And I thought, yeah I've been in care. And it's a mixture of good care and bad care. Maybe I could point out the good bits and they can get copied and the bad bits ye can do something about.

Forum reporting activities

With the Forum having received Scottish Government confirmation of a funding extension to March 2021, we are accelerating our reporting and engagement activities to amplify the voices of institutional and residential care experienced individuals to better learn about and understand their diverse range of experiences in care and the impact of that care.

Within the year, the Forum expects to produce a range of main and supplementary outputs, including; an upcoming Summary Report highlighting the emerging findings from analysis of 52 testimonies provided to The Forum building on the findings from our *What We Have Heard So Far Report* covering the first 18 months of the Forum.

A range of supplementary reporting outputs will follow that will likely include: participant experiences of coming to the Forum; a methods paper detailing how our analysis was achieved; hearing reflections highlighting learning and improvements at the Forum; participant messages to Scotland; and a

comprehensive series of thematic outputs variously focussing on education, health, relationships, criminalisation, employment, social networks, stigma, sibling separation, accessing records, instant adulthood, relationships in adult life, post care instant adulthood and so on. Lastly, policy and practice recommendations will be synthesised and prepared following stakeholder consultation of findings, to integrate findings into identified policy and practice implications for Scotland.

These reporting activities and the supporting engagement work will add to the current evidence and develop a body of learning and insight, helping to ensure the Forum's activities have the most sustainable and positive impact. It is the Forum's role to use people's experiences to make a difference, identifying key issues around the lifelong impact of childhood experiences, and ultimately improve lives of care experienced individuals.

If you want to find out more about the Forum – who we are and what we do, contact us free on 0800 121 4773, email information@nationalconfidentialforum.org.uk or visit our website at nationalconfidentialforum.org.uk.

About the author

Martin McKee joined the National Confidential Forum as Research Associate in July 2018. He is an experienced social and public health researcher and fieldwork manager who has worked in both public and third sectors for nearly 10 years in areas as diverse as health and wellbeing, social care, education, housing and regeneration, criminal justice, employability, and culture. His work to date has included a range of evaluations and social impact studies focusing to what extent complex interventions, programmes, and services are successful, often in relation to socially disadvantaged and marginalised groups. He is currently leading the Forum's research programme analysing the testimonies received to date to amplify the messages from those with care experience in Scotland. This in turn will promote policy and practice recommendations to the Scottish Government.

Closer to children and families: Benefits and costs of improvements to children's residential care in Slovakia

Lucia Hargašová

Abstract

The purpose of the paper is to describe the transformation of the Slovak residential care system over the last two to three decades. The goal is to analyse the benefits and costs of the most important changes in light of the political, theoretical and ideological shifts. The residential care system for children in Slovakia has improved significantly in many respects. Children's homes have been transformed from large facilities into smaller units; and children under the age of six can only be placed in foster families or family care. Children's rights have been implemented through care policies, and there has been gradual recognition of the need to address the difficulties faced by birth families. Many decisions in policy and practice have been underpinned by a pro-family orientation and concepts such as attachment theory. Nonetheless, the process of pursuing better quality care and of building a system that meets international quality criteria has been followed by collateral shifts. Re-education, diagnostic and specialist facilities have not been the primary focus. The labelling of children in care as problematic and a derogatory discourse about Roma children has persisted to a significant extent. With the facilities no longer being under the direct control of the state administration and the education and health ministries, some of their psychological and pedagogical experience and knowledge has been lost.

Keywords

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Introduction

Slovakia is a young post-communist country located in Central Europe, which was founded in 1993. Thirty years ago, in 1989, the Velvet Revolution started in former Czechoslovakia. It gave people hope, especially regarding their struggle to transform the country into a democratic state. Crucial changes occurred in political, social and private life and this was also the case in children's residential care.

Nowadays, Slovakia, a country with approximately 5.5 million inhabitants, has over one million children under the age of 18, and 1.3% of them live outside their biological families (Central Office of Ministry of Labour, Social Affairs and Family Statistics, 2015). Placements are either residential or non-residential in nature. Children who are not in residential care are either placed with kin, foster carers or adoptive carers. Residential care is mainly provided in children's homes and, to a lesser extent, in specialist educational units such as re-education centres, diagnostic centres, and therapeutic and educational sanatoriums (Family Act 36/2005).

In the article, we will highlight the main changes aimed at improving the residential care system for children over the last two to three decades in Slovakia and describe the benefits and costs.

Our past - children in collective state care

It would be difficult to describe the advantages and disadvantages of the improvements to children's residential care without explaining the past. By looking at previous decades we can convey some idea of the residential care legacy that constituted the starting point of transformation.

Politically, Czechoslovakia was transformed from a totalitarian communist regime to a state with a democratic system of government. And later, in 1993 when the country was peacefully divided, Slovakia continued its own transition. In the communist era, large numbers of children were institutionalised (Kriglerová, 2015). This did not just mean that children were taken away from their families due to inadequate parental care, but that parents were also

encouraged, if not required, to send children with disabilities to residential schools and specialist units. It was both politically and ideologically unacceptable for children and people who were 'different' to be seen in public. For only then could the ruling party promote its image of a healthy, strong country. Children's homes were called 'internats', and usually consisted of a large building containing shared bedrooms, bathrooms, a canteen and staffed by carers working shifts who looked after the children. There were specialist internat schools for children with other health and mental disabilities. Another type of children's residential care was the so-called 'reformatories' for children who, colloquially put, misbehaved. Professor Matějček was an important figure in the theory and practice of institutional care[13]. The research he and his colleagues did on psychological deprivation and child development contributed substantially to the understanding of children's mental needs, especially in residential settings. Their findings, along with a political ideological shift in the 1960s that reinvented the principles of humanity and allowed inspiration to be gleaned from western knowledge, contributed to the reintroduction of foster care in 1973 (Kusá, 2009). In 1974 Zlatovce Children's Village was founded, inspired by the 'Kinderdorf Pestalozzi' SOS Villages in Switzerland (Škoviera, 2007). In its day Zlatovce Children's Village was a unique project, which, apart from providing high quality care to the children living there, served as a showcase care facility for foreign visitors. The idea was that the care should emulate family conditions. The village, equipped with its own education, sport, culture and leisure facilities, consisted of 17 households with capacity for approximately 200 children. It was located on the outskirts of the town and the units were relatively independent – a practice later criticized as not meeting the new standards of inclusion (Škoviera, 2007).

In the socialist era children's residential care was exclusively state-run, collective care in which the promotion of communist propaganda was central. Institutionalization and collectivization were prioritised over individual needs,

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[13] See for example: Langmeier, J., and Z. Matejcek. (1975) Psychological Deprivation in Childhood. New York: Halsted Press.

leading to the isolation of large numbers of children for the sake of the socialist community and depriving children of contact with their biological families.

This description of the care system setting paints a terrible picture of the care provided in the past, but it would be incomplete if we did not also highlight the positives. Scholars and those variously involved in care have provided testimonies of good experiences of care, including the nurture and development of positive relationships between children, peers as well as carers. They valued the stability of the placements and the strong collective identity they developed as 'children from children's homes' (Škoviera, 2007; see for example Ladický, 2013).

Following the collapse of the communist regime in 1989 the children's care system joined the list of items requiring reform and alignment with the newly redefined democratic values.

Transformation and deinstitutionalisation

The state monopoly in the provision of substitute care ended after the Velvet Revolution. The state abandoned its role as executor of collective care in institutions and become an enabler, guaranteeing and supervising the child's right to adequate care. Care was no longer restricted to 'traditional' approaches, but embraced more liberal and foreign ideas. It is easier to look back to the start of the transformation process, right after the founding of the Slovak Republic in 1993, than it is to estimate when the process will finally be completed. Endeavours are continuing and the most recent strategy sets out the priorities for 2016–2020.

'The key changes [transformation] occurred in 1993 to 2005, although the laws enacted at that time are still being adjusted and amended' (Návrat, 2012, p. 8).

The transformation and deinstitutionalisation of alternative care was mainly triggered by nongovernmental and charitable organisations. They played a crucial role in prompting changes to residential (and substitute) care in Slovakia by pursuing children's rights and promoting the idea that placements should

closely resemble family conditions and prevention strengthened to reduce the number of children taken into care (Návrat, 2012).

The transformation has gradually led to the predominance of the kind of care provision that prioritises family conditions. The first Family-type Children's Home was set out in the 1998 Social Assistance Act. In the communist era, especially in the 1950s, family-type foster care was almost abolished, while during the transformation the goal was to ensure that the majority of looked-after children were brought up in family-style conditions. Children's homes were transformed, where possible, from large facilities (big buildings) into smaller houses or household-like units within these buildings. Special attention was paid to children under the age of three, who could only be placed with carers under home conditions – foster carers or professional parents. This rule now applies to children up to the age of six (Legal Protection of Children Act, 2005). In 1993 a special profession was introduced – 'professional parents' – (Búšová, 2009). These are employed by children's homes and care for children throughout the day under home conditions, whether in a house or flat.

In 1996 and 1997 responsibility for regulating children's care facilities was transferred from the various ministries (Ministry of Health for pre-school homes, and Ministry of Education for children's homes) to the Ministry of Labour, Social Affairs and the Family. The aim was to provide continuity and a unified approach to children's care.

The 2005 Legal Protection of Children Act and the Family Act placed the child's best interests at the centre of social work and defined the family as the primary place of child care. The alternative care principles were no longer intended to serve and satisfy the system, a communist-era legacy, but were designed to satisfy the needs of the child.

In 2011 the Slovak government approved its Strategy for the Deinstitutionalisation of the Social Services System and Foster Care in the Slovak Republic. The principles it lays out reflect the efforts to ensure implementation of the United Nations Convention on the Rights of the Child, and

the transition from institutional to community-based care (Strategy, 2011). The Strategy recognised both the need to minimize the number of children in the care system and to address the difficulties facing birth families before children enter the system. It also promoted a strong preference for community-based care and professional parenting. In the past, it was believed that children should be prevented from developing relationships (including good or beneficial ones) if they were intended to end in the future (Návrat, 2012). In the transformational years pro-family attitudes were promoted and bonding has come to be seen as beneficial in alternative care. Theories such as attachment theory became gradually more accepted in the theory and practice of care. Findings associated with attachment theory and related concepts have underpinned many decisions regarding the law and practice.

Elements lost and neglected in residential care

The transformation was supposed to be conducted in four different areas – infrastructure, finances, staffing, and conceptual approach. Critics rightly pointed out that many facilities had undergone financial and infrastructural transformation including changes to the physical setting, whereas there has either been no change or only minimal change to staffing and conceptual approaches within the care system, and this is still true today (Kriglerová, 2015).

Following legislative change in 1996, a group of professionals and practitioners criticised the fact that alternative children's care was being moved out of the education sphere. They did not see themselves as 'social workers'; instead they felt the pedagogical knowledge and experience was being lost with the uncritical importing of western ideas. For example, after the transformation carers had less opportunity to engage in psychotherapeutic training (Škoviera, 2015). They thought it necessary to maintain and further develop the educational and pedagogical approach rather than adopting a dominant 'care approach'. They argued that the care approach merely focused on meeting the child's basic needs and neglected the holistic side of developing the child's personality.

Pro-family organisations that claimed family conditions were key and best for children and the efforts to eliminate all that was old in the care system meant that residential care came to be perceived as the least preferred setting for children's care, sometimes regardless of the child's unique circumstances. The strong emphasis on family-type care does not mean that it is the best kind of placement for all children. There will always be some children for whom residential care is the best option possible. The risk that the potential offered by residential forms of care for certain groups of children is overlooked remains one of the challenges.

The effort put into transforming children's homes was accompanied by a shift in focus away from other types of residential unit. Re-education centres, diagnostic centres and specialist facilities have remained under the administration of the Ministry of Education and their formal set-up remains more or less institutionalised. These units partially escaped transformational attention, despite being designed to accommodate clients similar to those in children's homes[14].

Labelling and essentialising – discourse about children in care

Although the rights of the child are guaranteed under Slovak law, practices still have some room for improvement, especially regarding the inclusion of children in decisions about their care (Council of Europe, 2012). The axiom 'caring for children, but without children' also reflects the way children are discussed. In the care discourse, in academia and practice, children are often described in terms of their behavioural and emotional problems and are seen as problematic or difficult to handle. It may be that the theoretical concepts in traditional developmental psychology still exert an influence on the way children are

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[14] The general population tends to think children who have no parents are placed in children's homes whereas reformatories are for children with behavioural difficulties. In fact, the majority of children in both groups have living parents, experience similar adversities and it is very common for many of the children in the re-education centres to have come from children's homes where carers were no longer able to cope with their behaviour.

understood. They contain normative ideas about child development and suggest
it follows a predictable path of change. It is believed that children sometimes
progress through the developmental stages more slowly and exhibiting individual
differences, but any major deviation from the norm is considered pathological
(Lukšík and Lemešová, 2013). In the substitute-care literature published in
Slovakia the population of children in residential care is described in terms of
their problematic family background and is suggestive of the reasons why
children are removed (e.g. 'unwanted' children, 'abandoned' children). Often a
considerable section is dedicated to listing the 'typical' characteristics of children
in care, such as disabilities (cognitive, physical), adaptational, emotional and
behavioural problems, learning outcomes below that of the normal population,
attachment disorders, emotional deprivation and trauma (see e.g. Bizová, 2015;
Škoviera, 2007). Some children in care are labelled as 'unadoptable' or 'difficult
to adopt'. They tend to be older children, of Roma[15] origin, have health issues or
are siblings.

The percentage of children of Roma ethnicity in children's homes (60%) is
significantly higher than among the general population (Mikloško, 2013).
Perceptions of Roma children in care are shaped by stereotypes and prejudice.
Views of personality traits among Roma children are still derived from
essentialist ideas about their Indian roots. They are often described in scholarly
articles and book publications as being lively, disobedient, fidgety, of a different
temperament, sometimes of different (lower) intelligence and as being musically
talented; their different lifestyle is seen as being 'in their blood' (Gallová-
Krieglerová, 2015; Lukšík and Lemešová, 2013).

The focus in the discourse about children in care on special characteristics,
names and labels can be explained by a desire to better understand their specific
needs, life situations and features. It is therefore driven by an aspiration to

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[15] Roma or Romani people, sometimes referred to as Gypsies, are an ethnic group living
predominantly in Europe (e.g. in Central European and Balkan states, Russia, Spain,
France, Ireland). People of Roma origin are the second largest ethnic minority in
Slovakia (estimated to account for up to 7.5% of the population), and they often face
discrimination and prejudice.

improve care and services. However, we might question whether maintaining such a strong focus on the child as the subject of expert attention and the framing of children in terms of their specific needs and characteristics does not divert attention away from the child's positive personal traits and potential, and away from attempts to understand care within the broader context of the child's relationships with carers, siblings, peers and the community.

Conclusion

The Slovak system of care has undergone many changes intended to improve care for children living outside their birth families. Undeniably, many mistakes have occurred in the process and some question the conceptual direction, the overwhelming number of legislative changes, and insufficient level of personal support. It is customary in the last paragraph to conclude and make suggestions. Instead, I would like to express my gratitude. I am too young to have experienced or to have been involved in all that I have written about. My motivation to study residential care issues came out of my scientific curiosity and workshop experiences with practitioners. As a citizen of a democratic country and as a researcher I am grateful for the freedom to share our views with people from another country. I am happy that I can freely and openly discuss the advantages and all the imperfections of the system. I always enjoy talking about the need to provide training and professional support to practitioners, or asking questions about how conditions in marginal residential units can be improved, or discussing the necessity of engaging children in decisions made about their lives outside their families. This could not have happened thirty years ago, or at least only under very restricted circumstances. It is not something I take for granted. The most significant change (in residential care) I would like to highlight is the freedom to express our ideas and to be inspired by different ideas and opinions.

Acknowledgement

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Resource Review

Healing environments for children who have experienced trauma: an IRISS Evidence Search and Summary Service outline. https://www.iriss.org.uk/resources/esss-outlines/healing-environ-children

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This evidence summary attempts to answer the question, 'What are some of the elements of a healing environment for children who have experienced trauma'? The question is a worthy and important one. While the environment that children live in has often been considered it has rarely been from this perspective.

The summary includes evidence from a range of literature, including mental health and architecture and states that the importance of the built environment should not be underestimated. Five themes of healing environments are suggested:

1. Nature: access to and / or views of green and blue space.

2. Connectedness: creation of social opportunities and interactions which can in turn increase inclusion and connection within a group of people. This can include ensuring continued contact with the outside community and creating spaces for group therapeutic activities.

3. Comfort and Safety: the need for felt physical and psychological safety is emphasised. A potential tension between balancing security and comfort or homeliness is acknowledged.

4. Personalisation: the freedom for children to personalise a space to give feelings of control and ownership which can support both well-being and respect of the environment.

5. Stakeholder involvement in planning and design: a collaborative design process based on integrating evidence along with the views of children and staff.

The review is brief and practical and should be accessible to many. This is a real strength and hopefully the summary can add some structure to the design of children's environments. This includes both existing services who wish to adapt existing homes or spaces or those who are designing from scratch.

A weakness of the review is the evidence available; often this is from healthcare and wider well-being research and not specifically children who have experienced trauma. The review therefore should also act as a call for researchers to look into this area more specifically and add some more robust answers to this question.

About the author

Dan is a forensic psychologist who has worked in residential and secure care for over ten years. He has completed research including that which seeks young people's views on their experiences of care. He is currently working to increase trauma informed care in residential and education services.