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Editorial

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Welcome to the third issue in Volume 18, and our final issue of 2019. If you were looking out for us in September, I should explain that we delayed publication because the CELCIS team was very busy supporting the Global Implementation Conference in Glasgow. The delay has allowed the editorial group to reassess our publication schedule; we have altered the publication dates, and we have three issues planned for 2020 – in February, June and November.

I want to draw readers' attention to the *SJRCC* article archive in the CELCIS Knowledge Bank. Whether you are a student wrestling with an essay title, or a practitioner planning a new service, you may find we have published an article relevant to your area of interest. Our articles should pop up in database searches, but you can also scroll through the journal archive in our web pages.

It has been a busy autumn in policy terms in Scotland. The Scottish Government's Programme for Government in 2019-20 included a very large number of proposals and measures aimed at responding to the care and protection needs of children and young people, as well as upholding the rights of children and supporting families. I want to highlight just a few of these. The commitment to introduce legislation to establish a statutory redress scheme for anyone who has been a victim of historical child abuse whilst in care in Scotland is particularly welcome. There were two announcements that were undoubtedly influenced by campaigning by young care experienced adults. These are plans to extend the eligibility for free National Health Service dental care to care experienced people between the ages of 18 and 26, and the removal of the age limit (currently 26th birthday) for eligibility to receive a care experienced student bursary of £8,100 per year.

Meanwhile the Scottish Parliament passed into law the Children (Equal Protection from Assault) (Scotland) Bill which brings Scotland in line with the United Nations Convention on the Rights of the Child and with 57 other countries that have already given children legal protection from physical punishment. The Scottish Government abandoned plans to have a Named Person for every child in Scotland. Provisions for the scheme were contained in the Children and Young People (Scotland) Act 2014. The scheme was controversial and ran into legal difficulties in relation to transfer of information.

In July, the United Nations published a report by the independent expert leading the United Nations global study on children deprived of liberty. The study, led by the distinguished human rights lawyer, judge and academic, Professor Manfred Nowac, found that a staggering number of between 1.3 and 1.5 million children in the world are deprived of liberty every year. The report gives three main reasons for children being deprived of their liberty: 'lack of adequate support for families, caregivers and communities to provide appropriate care to children and encourage their development'; '"tough-on-crime" policies, including the criminalization of status offences, drug offences, petty crimes and low minimum ages of criminal responsibility'; and 'restrictive migration and asylum policies and extensive counter-terrorism practices'. The report includes many general and specific recommendations, several of which relate to institutional care of children. One of these recommendations particularly caught my attention:

> States are also urged to map all institutions within the country, whether private or public, whether presently registered or not, and regardless of how children arrived there, and conduct an independent review of each institution. States should operationalize a system of registration, licensing, regulation and inspection which ensures that providers of alternative care meet internationally recognized standards.

At first glance, this appeared to be a recommendation addressed to countries in turmoil because of armed conflict, or with limited resources, or with no developed system of children's services. And yet, BBC Newsnight has conducted an investigation, Britain's Hidden Homes, on the use of unregistered homes

affecting thousands of older adolescents in care in England and Wales. The films uncovered abuse of children, unsuitable accommodation, untrained staff, and lack of oversight by the responsible local authorities. The children's charity, Become, blamed increasing privatisation of children's services and called for an urgent review by government.

The UN independent expert, Professor Nowak, will give the next Kilbrandon Lecture in the University of Strathclyde in January 2020 and the full transcript of his lecture will be published in *SJRCC* in due course.

We have published several articles in *SJRCC* by researchers working at Udayan Care in India. In August 2019, Udayan published reports on youth leaving care, based on research conducted in five states of India (Delhi, Gujarat, Karnataka, Maharashtra and Rajastan), as well as an overall synthesis report. The research was supported by grants from UNICEF and Tata Trusts. The reports, detailed and very clearly presented, represent thorough analyses of the experiences of young people leaving care, including details of wellbeing, employment, financial independence and awareness of their rights.

In the current issue of SJRCC we publish four full-length original research articles, the transcript of the 2018 Kilbrandon Lecture and three shorter articles with accounts of current practice issues.

The issue opens with a paper on the association between traumatic event exposure, post-traumatic stress disorder and aggression in looked after young people by Rachel Webb and Dan Johnson. They say that their results 'make a strong case for implementing sensitive and validated assessment processes that can be used with all looked after young people'.

Adrian Graham and Campbell Killick report on their Northern Ireland-based study of team resilience to prevent burnout in residential care, based on interviews with managers. They conclude that: 'There is a very strong correlation between teams and their influence in creating positive change within the lives of young people in residential care. The make-up, nurturing and looking after of teams is a complex and challenging experience that requires time, patience, and dedication'.

The third research paper is provided by a PhD candidate, Amira Abdel-Aziz, who has researched the assessment of alternative families in Egypt. The paper highlights several challenges, including: 'the inability to track some of the children, the lack of competent and sufficient workforce, the negative stereotypes and stigma towards abandoned children who are one of the main target groups of the programme, and the inability of mothers to register their children in case of not having a marriage certificate'.

Alicia Brown, Raymond Chadwick, Lisa Caygill and Joyce Powell have contributed a paper on their research which used an interpretative phenomenological approach to explore the experiences of residential carers in relation to self-harm. They found that: 'Managing self-harm was reported to be an emotionally demanding experience for care staff and they had learnt to manage using a variety of coping mechanisms. In the short term these were effective but had potential to incur longer-term damage to both themselves and the young people'.

Dame Elish Angiolini's Kilbrandon Lecture posed the question, what has been learned (by interested parties in Scotland) about youth justice and welfare in the 50 years that have passed since the Social Work (Scotland) Act 1968 which established the Children's Hearing System.

Our commentaries and reflections section includes articles contributed by: Cath Lowther, Jo Dunn and Juila Powell (about educational psychology support for staff in a children's home following a critical incident); Norifumi Senga (on changes being made to the social foster care system in Japan); and Caroline Anderson (explaining how one Scottish local authority aims to meet the information rights of care experienced adults seeking access to their care records).

I hope you enjoy this rich compendium of analysis and reflection. The *SJRCC* will return in February 2020 with a special issue of articles by leading authors we asked to think creatively about residential care in the future.

The Association between Aggression, Traumatic Event Exposure and Post-traumatic Stress Disorder of Looked After Young People.

Rachel Eleanor Webb and Dan Johnson

Abstract

This study identified an association between symptoms of post-traumatic stress disorder (PTSD) and aggression in a sample of looked after young people. Observational data on PTSD symptoms and the frequency of aggressive behaviours was obtained for a sample of 36 boys and 13 girls in residential and secure care over a retrospective 28 day period. The study identified high rates of traumatic event exposure and PTSD symptoms, with 51% meeting the criteria for a likely diagnosis of PTSD. The severity of PTSD symptoms was also found to be associated with verbal and physical aggression towards members of staff and peers within the care environment.

Keywords

Trauma, PTSD, aggression, residential and secure care

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Introduction

Aggression and Violent Behaviour of Looked After Young People

Violence and aggression occur disproportionately in residential care and out of home care settings (Darker, Ward & Caulfield, 2008). There are many factors involved in this including the context of care environments themselves (Hayden, 2010). There are also factors at the individual level and in recent years there has been a focus on the wider literature on the association between childhood experiences of adverse events and later concerning behaviour such as violence. For example, Bellis, Ashton, Hughes, Ford, Bishop and Paranjothy (2016) examined the impact of adverse experiences with a sample of over 2,000 adults in Wales. It was found that those who had experienced more than 4 different types of adverse childhood experiences were 15 times more likely to have committed violence against others over the last 12 months. Furthermore, a study by Duke, Pettingell, McMorris and Borowsky (2010) found that of a sample of 136,549 students more than one in four reported experiencing an adverse childhood experience and each type of adverse experience examined was found to be significantly associated with interpersonal and self-directed violence.

The Adverse Experiences of Looked after Young People

Children who are in the care of the local authority (often termed Looked After Children) have often experienced high rates of adversity including physical, emotional and sexual abuse, neglect, domestic violence and removal from the birth family itself (Rahilly & Hendry, 2014; Simkiss, 2012). A study of 52 looked after children found that 69% had experienced neglect, 48% physical abuse, 37% emotional abuse and 23% sexual abuse (Chambers, Saunders, New, Williams & Stachurska, 2010). Similarly, Johnson (2017) found that of a sample of 74 boys and 22 girls in Scottish residential care, 51% and 68% had experienced emotional abuse and 58% and 68% had been exposed to domestic violence respectively. Additionally, a study by González-García, Bravo, Arruabarrena, Martín, Santos and Del Valle (2016) examined a sample of 1216 children aged between six and 18 years old in residential care in Spain. In over 60% of cases, experiences of abuse or neglect were the reason for admission to

residential care. Emotional abuse was experienced by one in four children and physical abuse was experienced by one in five children.

Post-Traumatic Stress Disorder and Looked After Young People

The concept of traumatic stress or psychological trauma has developed to explain how experiences like those listed above can impact upon young people. There have been many proposed definitions of trauma and post-traumatic stress disorder (PTSD, American Psychiatric Association, 2013) is perhaps one of the most studied of these. According to the diagnostic criteria, PTSD is defined as a traumatic event that involves exposure to actual or threatened death, serious injury, or sexual violence (APA, 2013). This may occur by directly experiencing the event, witnessing the event or learning that the traumatic event has occurred to a close family member or close friend. The subsequent symptoms are categorised within four separate groups: intrusion, avoidance, negative cognitions/mood, and arousal/reactivity. To meet the diagnostic criteria, symptoms must persist for at least a month. A recent study in the UK by Lewis, Arseneault, Caspi, Fisher, Mathews, Moffit, Odgers, Stahl, Ying Teng and Danse (2019) examined data on 2064 children across a range of social and economic status and found that 31.1% had experienced trauma and 7.8% experienced PTSD by the age of 18.

The PTSD concept and diagnostic criteria have been used to quantify the prevalence of traumatic experiences and subsequent symptomatology with looked after young people. For example, Ford, Vostanis, Meltzer and Goodman (2007) found that looked after young people are more likely to be diagnosed with post-traumatic stress disorder when compared with young people living at home in the community. They also found that PTSD was 19 times more prevalent in looked after children when compared with young people living at home (Ford et al., 2007). Furthermore, a study by Morris, Salkovskis, Adams, Lister and Meiser-Stedman (2015) assessed PTSD-like symptoms in a sample of 27 looked after young people using the Child Revised Impact of Events Scale (CRIES-8) as a screening tool. The study found the prevalence of PTSD symptoms to be high, with 75% scoring greater than or equal to the threshold

suggestive of PTSD, higher than estimates from samples of non-looked after children.

PTSD as a Mediator for Aggression

An association between adversity and aggression has led some researchers to suggest that there is a potential causal relationship between the two (Whitfield, 2004a, 2004b; Dierkhising, Ko, Woods-Jaeger, Briggs, Lee & Pynoos, 2013). This theory has been refined with some researchers suggesting that the specific symptoms of PTSD, rather than traumatic event exposure alone, may mediate offending and aggression (Kerig & Becker, 2010). This refinement emphasises the ongoing effects of the traumatic experience as manifested in symptomatology as important drivers of later violence, rather than solely the exposure itself. That is, it proposes that of the many later consequences of traumatic event and adversity exposure, it is the symptoms of PTSD that somehow drive aggression and violence.

For example, Ruchkin, Henrich, Jones, Vermeiren and Schwab-Stone (2007) found that PTSD symptoms partially mediated the relationship between violence exposure and self-reported commission of violence among boys in a community sample. Additionally, Allwood and Bell (2008) found that, for a community sample of girls exposed to violence, symptoms of re-experiencing were related to self-reported aggression against others. Whereas for boys, it was found that symptoms of arousal mediated the relationship between exposure to and perpetration of violence.

A study conducted by Becker and Kerig (2011) examined PTSD symptoms and their association with the frequency and severity of delinquency in boys held in a juvenile facility. They measured delinquency with a scale that incorporated both the frequency of arrests and the severity of charges and compared this to traumatic event exposure and PTSD symptoms. They found that the severity of the sample's PTSD symptoms, rather than exposure to the traumatic event alone, was directly associated with the degree of delinquency (Becker & Kerig, 2011). They concluded that detained boys not only had higher prevalence rates of PTSD than their non-detained peers but also that the association between

PTSD symptom severity and delinquency was present both in the past year and across the boys' lifetimes.

The researchers noted a number of limitations to their study including the use of cross-sectional rather than longitudinal data resulting in no comment being made on the potential for causal relationships between PTSD and delinquency. A key limitation that the authors did not comment upon is that PTSD symptoms and delinquency were measured over different periods. These periods did not synchronise temporally and were of different durations. That is, the two measures of delinquency were based on behaviour over either the previous 12 months or the whole lifetime whereas the PTSD symptoms were only measured over the previous month.

The lack of synchronisation is problematic and can be considered to reduce the rigour of the study. A more robust exploration of any association could be determined by using an overlapping, that is synchronised, time period. While this would suffer from the same cross-sectional limitations, it would enable a more rigorous analysis of the association between symptoms and aggression over time.

Rationale

Although looked after young people have been found to have high rates of traumatic experiences, PTSD symptoms, aggression and violence, there are as yet no studies that have explored the relationships between these factors with this population. The studies that have explored associations between PTSD symptoms and externalising behaviours with other populations such as young people involved in the criminal justice system have a lack of temporal sensitivity as the behaviours and PTSD symptoms were measured over different time periods.

The purpose of this study was to examine whether a relationship existed between PTSD symptomatology and verbal and physical aggression over a set 28 day period. Exploring the association between trauma exposure, PTSD symptoms and aggression in a looked after population could have important implications for how young people are cared for and supported, particularly when displaying harmful aggressive behaviour.

Method

Care Setting

The research was conducted at a large education and care centre located in Scotland that provides services to young people with social, emotional, educational and behavioural problems. An array of services is offered which includes residential and secure care for boys and girls aged between 12 and 18.

Ethics

Ethical approval was granted by the ethics committee at the care centre. Ethical approval was also sought and granted by the ethics committee of the affiliated university. Due to vulnerability of the young people in the care centre and the potential for this research to cause distress, the young people were not directly involved in the research and instead collateral and observational data was used. Young people and their social workers had previously provided consent for collateral information to be used for research purposes.

Young People

Of the 49 young people, 36 (73%) were boys and 13 (27%) were girls. At the time of the study, 16 (33%) of the young people were accommodated in secure care and 33 (67%) were accommodated in residential care. The young people in this study ranged in age from 12 to 17 years old, with a mean age of 14.79 years (SD= 1.09).

Procedure

The study adopted a mixed-method approach which involved obtaining data on a sample of 49 young people. Opportunistic sampling was used by approaching each residential and secure house unit and asking each key worker whether they wished to provide data on their key young person. A key worker/co-key worker is responsible for overseeing the delivery of a young person's care plan and is therefore well informed on the young person they are assigned to.

On two occasions, a key worker or co-keyworker was not available to complete the measure, therefore, another member of staff who felt they were well informed on the young person completed the measure.

To be included within the study, young people had to have resided within their residential or secure house unit for at least 28 days to enable sufficient observation of PTSD symptoms by the young person's keyworker. The study was retrospective in design and asked for observations from the previous 28 days. It was thought that a prospective design would significantly reduce the time that care staff had to perform their duties.

Measures

PTSD symptoms

One of the researchers verbally interviewed staff using the Posttraumatic Stress Disorder Reaction Index Caregiver Version (PTSD-RI; Pynoos & Steinberg, 2013) for DSM-V with each member of staff. The PTSD-RI is a structured screening measure which is comprised of three parts. The first part of the measure screens for exposure to various types of traumatic events. The second part is used to gather additional information in relation to any of the trauma types endorsed in the first part of the measure. The third part is the reaction index which contains 27 items assessing the presence of PTSD symptoms. Staff members were asked to rate the frequency of PTSD symptoms in the past 28 days based on their knowledge and observation of the young person.

The PTSD-RI is not a diagnostic tool but it can provide preliminary diagnostic information (Steinberg, Brymer, Decker, & Pynoos, 2004). Scores on the PTSD-RI are highly correlated with a diagnosis of PTSD (Steinberg et al., 2004).

Aggressive Behaviour

Two measures were used to capture the frequency of aggressive behaviour.

Case Note Review

Case notes are recorded and maintained by members of staff, at least three times per day with any information relevant to the young person. Case notes for the 28 days preceding the completion of the PTSD-RI were reviewed by a researcher for incidents of physical and verbal aggression. As such, aggressive behaviours were reviewed for the same 28 day period in which PTSD symptoms had been assessed.

For the purposes of this study, physical aggression was defined as inflicting bodily damage and may include behaviours such as kicking, biting, pushing, shoving and hair pulling (Sameer & Jamia, 2007). Whereas verbal aggression was defined as threats, shouting, swearing and being sarcastic with the goal of causing emotional and psychological hurt (Sameer & Jamia, 2007). Any behaviours logged within the case notes which matched the above definitions were recorded. One continual episode was noted as a single incident regardless of duration. By the nature of the case notes, the data focused on incidents of aggression while the young person was observed or which had been relayed to staff. Incidents unknown to staff such as those that may have happened in the community were not recorded.

Physical restraints

The number of physical restraints were included as it was thought that these may provide a proxy measure of severe externalising behaviours including aggression. Physical restraint was defined as a staff member placing their hands on a young person to change behaviour. This included the staff safely holding young people to prevent harm to themselves or others. No mechanical restraints or pain-based restraints were used in the centre.

The measure of physical restraints was also obtained from a young person's case notes. However, a separate record of physical restraints is stored within the young person's case file and this was also reviewed to ensure accuracy. Similarly, data on physical restraints was collected for the 28 days preceding the completion of the PTSD-RI measure.

Data Analysis

All statistical analyses were performed using SPSS version 24. Independent samples t-tests were conducted to explore the differences in PTSD symptom scores and the level of aggressive behaviours. Correlations were conducted to examine the overall association between variables. The dataset had no missing data and for all tests, $p < .05$ was considered significant.

Results

Frequency of Aggression

43 (88%) young people were physically or verbally aggressive during the time of the study. Of the aggressive behaviours examined, the most commonly exhibited was verbal aggression towards members of staff.

Frequency of Physical Restraints

14 (29%) young people had been involved in a physical restraint during the 28 day period that was measured. It is worth noting that some young people had been involved in more than one physical restraint during the 28 day period. The highest number of physical restraints recorded for a young person was five, however, the majority had only been involved in one restraint (n=9).

PTSD Symptom Severity

Importantly, 100% of the sample was reported by their key workers to have experienced at least one traumatic event as defined by DSM-V (APA, 2013). The PTSD-RI measure completed by key workers assessed for exposure to thirteen different types of traumatic events.

None of the young people were identified by their keyworker as having been in a disaster or a place of war, however, 6.1% (n=3) were identified as having been in a bad accident. 53.1% (n=26) had been punched or kicked at home, whilst 71.4% (n=35) had witnessed a family member being hit, punched or kicked at home. 53.1% (n=26) had been beaten up, shot at or threatened to be hurt and 59.2% (n=29) had witnessed someone being beaten up, shot at or killed. 12.2% (n=6) had seen a dead body, 14.3% (n=7) had an adult touch their private parts, 18.4% (n=9) had heard about the violent death or serious injury of a loved one and 10.2% (n=5) had experienced a painful and scary medical treatment. Furthermore, 12.2% (n=6) of the sample were identified as having been forced to have sex with someone against their will and 46.9% (n=23) were identified as having someone close to them die. Whilst the measure assesses for exposure to a range of traumatic events, the last question asks the caregiver to identify whether anything else has ever happened to the child that was really scary, dangerous or violent. 65.3% (n=32) of the sample were identified as

having experienced an event that was scary, dangerous or violent and not captured within the other traumatic events listed on the measure.

It is important to note that most of the young people in the sample had experienced multiple types of traumatic events during their lifetime. Results indicated that the young people had experienced an average of four different traumatic events. The most commonly reported traumatic event for the sample was witnessing a family member being hit, punched or kicked at home with 35 (71%) young people being reported to have experienced this.

25 (51%) young people were found to meet the PTSD-RI index threshold for "likely PTSD" whilst 24 (49%) young people did not. Furthermore, 6% (n=3) met the criteria for the dissociative subtype of PTSD due to the presence of dissociative symptoms.

Independent t-tests were conducted to compare the mean differences in the PTSD symptom scores. There was no significant difference in the PTSD symptom scores amongst young people who had experienced one type of traumatic event (M=19.50, SD=16.26) or those who had experienced multiple types of traumatic events (M=31.19, SD=15.42), t (47) = -1.049, p= .300. As such, the severity of PTSD symptom scores was not related to the number of types of traumatic events experienced.

An independent t-test was conducted to examine the PTSD symptom scores amongst the young people who acted aggressively during the time of the study and those who did not act aggressively. Overall, it was found that the young people who were aggressive during the time of the study had a greater PTSD symptom score (M= 32.39, SD=15.31) than those who did not act aggressively (M=18.66, SD=11.16) and this difference was significant, t (47) = -2.110, p= .040.

Correlations between PTSD symptoms and Aggression

Higher PTSD symptom scores were associated with physical aggression towards staff (r= .314, p= .028), and towards peers (r= .299, p= .037) plus verbal aggression towards staff (r= .570, p= < .001) and towards peers (r= .286, p= .047). PTSD symptoms were not found to be associated with the number of physical restraints.

Discussion

This study intended to investigate exposure to traumatic events, symptoms of PTSD and aggression in a sample of looked after children. The study identified high rates of traumatic event exposure and PTSD symptoms amongst the sample of young people. It also identified an association between the severity of PTSD symptoms and both physical and verbal aggression directed towards the young person's peers and members of staff.

The findings of this research are consistent with existing literature that has identified high rates of exposure to traumatic events amongst this group of young people. It is also consistent with literature in identifying an association between PTSD symptomatology and externalising behaviour in other populations (Becker & Kerig, 2011). However, it is the first study to identify such an association with a group of looked after young people.

The high rates of exposure and symptoms identified in this study suggest that practitioners should assess and monitor post-traumatic symptoms in looked after children. It also suggests that an important early step in responding to and supporting aggressive looked after young people is to consider the potential role of traumatic experiences and subsequent symptoms. A corollary of the results is that reducing PTSD symptoms may, in turn, reduce aggression and violence. A reduction in aggressive behaviours could have a positive impact upon young people’s lives. As an example, it may reduce convictions, which could have implications for life outcomes such as employment prospects. Additionally, a reduction in aggressive behaviour may potentially help to reduce staff turnover and burnout.

There are resources available to help inform practice with a trauma affected population. In May 2017, NHS Education for Scotland (NES) published in partnership with the Scottish Government Transforming Psychological Trauma, a knowledge and skills framework for the Scottish Workforce. The framework delineates the skills and knowledge required to meet the needs of people affected by trauma and deliver evidence-based trauma informed services. The framework can be used by managers/supervisors as a means of identifying strengths and weaknesses in the knowledge and skills of staff.

Clinical guidelines are available for the treatment of PTSD (National Institute for Health and Care Excellence [NICE], 2018) in a general population however there is currently no nationally recognised guidelines for this specific group of young people. Given the high and varied exposure to traumatic events in combination with challenging behaviours such as aggression, specific guidelines should be developed for looked after young people.

The care environment and milieu offers opportunities to help young people cope with traumatic experiences and symptoms and there is a growing interest in trauma-informed care (TIC) for this population (Johnson, 2017). Trauma informed care has been defined in many ways but includes acknowledging and responding to traumatic experiences and their ongoing effects. There is often a focus on safety, emotional development and support and staff competency (Hanson & Lang, 2016). This is being increasingly operationalised (Bassuk, Unick, Paquette & Richard, 2017). There is as yet limited evidence of the effectiveness of this approach with looked after young people and future research should focus on how best to support young people to reduce symptoms.

The study found no association between PTSD symptoms and physical restraint. However, this may be attributed to low statistical power so this would be worthy of further exploration in future studies. This was identified as a proxy measure of externalising behaviours including aggression and could be triggered by other behaviours such as self-harm or suicide attempt. Physically restraining a young person is viewed as the last resort and where possible, staff will use strategies to try and defuse the situation first. However, failure to physically restrain a young person when necessary can be dangerous to the young person and others (Davidson, McCullough, Steckley & Warren, 2005). All members of staff at the care centre are appropriately trained in restraining young people but even when done correctly, it can be a traumatising process for both young people and staff alike (Davidson et al., 2005). If the lack of association were confirmed, in larger studies, this would be encouraging given the potential for re-traumatisation and for restraint to become a means of releasing and coping with distress (Allen, 2008; Steckley & Kendrick, 2008). Given the high rates of aggressive behaviour

documented by the sample, the results suggest that members of staff were able to manage and defuse such situations well.

Limitations

There are a number of limitations to this study which includes that the sample size was small. This could be attributed to the availability of data and the reliance upon staff participation. Also, the PTSD RI: DSM-V version has not been validated on a UK population. A key limitation is a reliance upon observational data rather than asking young people directly about their experience of PTSD symptomatology. The measure is dependent upon observational skill, proximity to and time spent with the young person. The data on young people was dependent upon key workers consenting to take part and provide data. This may have meant that those who were concerned about potential PTSD or aggression were more likely to take part, therefore, biasing the results. An additional limitation is that the researcher was not independent and blind to the measures.

The measures of externalising behaviour were limited to aggression and as a proxy measure, physical restraint. Numerous other externalising behaviours could have potentially been examined such as destruction of property, absconding and self-harm. This may have provided a more comprehensive exploration of the association between PTSD symptoms and externalisation in looked after young people.

Lastly, the results of this study reflect aggressive behaviours exhibited within the residential and secure care centre setting. It is possible that the nature of the setting in which young people are placed could potentially make aggression more likely. Young people are rarely placed in secure care voluntarily. Lastly, aggression that was undetected by staff was not recorded and the findings may be different if there was a more accurate measure of aggression.

Future Research

Exposure to traumatic events amongst looked after children and their psychological and behavioural responses to these is an area which requires further research. Future research would benefit from using direct young person report, wider sampling procedures such as multiple looked after centres and

explore aggression both within and beyond the care environment. The temporal sequencing of this study could be improved by completing prospective longitudinal research that would be better placed to establish the direction of effects. The study did not investigate gender difference in relation to trauma exposure and future research should aim to examine whether gender differences exist in how looked after young people experience and respond to traumatic events. Additionally, future studies could examine potential protective factors to highlight what may ameliorate the development of PTSD symptoms following traumatic exposure.

Conclusion

At their core, these results highlight the importance of looked after services identifying and acknowledging the traumatic and adverse events their young people may have experienced. The results make a strong case for implementing sensitive and validated assessment processes that can be used with all looked after young people. It also suggests there should be rigorous research into what works to help support looked after young people after traumatic experiences both at the level of individual treatment and the organisational milieu.

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Developing team resilience to prevent burnout in statutory residential care

Adrian Graham and Campbell Killick

Abstract

This study reports on the outcomes of 15 semi-structured interviews undertaken with managers employed by one Northern Ireland Health and Social Care Trust within the residential child care sector. The purpose of the research was to explore the concept of 'team resilience' as a method to prevent burnout and compassion fatigue amongst residential social workers and care workers. The findings show that high levels of support already exist, but recruitment, communication, supervision, team meetings, team development, reflective practice, resilient individuals, team ethos and management style are all factors that contribute to team resilience. Teams need to be acknowledged, valued and nurtured to make them more effective and resilient. The more a team spends time together and is permitted to grow together the more resilient it becomes. Strong internal dialogues and communication are key functions to a resilient team that ultimately promotes the quality of care for service users. Developing a team to be internally self-aware, with an ability to embrace change whilst acknowledging individual core strengths, provides a solid foundation for promoting team resilience. The article discusses how trust and a sense of team purpose can contribute to the development of cohesion and resilience.

Keywords

Team resilience, burnout, team development

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Introduction

Resilience is recognised as an important psychological factor supporting individuals to deal with adversity (Masten & O'Dougerty Wright, 2010), however, there is little research on the influence of resilience within groups (Bennett, Aden, Broome, Mitchell & Rigdon, 2010, West, Patera & Carsten, 2009). Various studies within residential childcare focus upon the staff team and the importance of good teamwork (Campbell & McLaughlin, 2005, Mainey & Crimmens, 2006). Stress within the residential social work setting has been shown to cause burnout (Seti, 2008) and the secondary trauma of 'compassion fatigue' (Maslach & Jackson 1982, Figley 1995a, 1995b, 1998a, 1998b, 1999, 2002a, 2002b, Pearlman & Saakvitne, 1995) yet research to date has been somewhat inconclusive for providing solutions to these problems and has failed to make the connection of the importance of team resilience as an important factor for developing coping strategies. The focus has been mainly upon the individual excluding the importance of the team as a whole, where research would suggest that 'teams which display the ability to either thrive under high liability situations, improvise and adapt to significant change or stress...are less likely to experience the potentially damaging effects of threatening situations' (Morgan, Fletcher & Sarkar, 2013).

Literature Review

Research regarding resilience has long looked at individual resilience, however, recent studies within the realms of sport and business have undertaken the challenge to delve deeper into this concept and look at it from a team perspective (Alliger, Cerasoli, Tannenbaum & Vessey, 2015, Holt & Hogg, 2002; Nicholls, Levy, Taylor & Cobley, 2007; Noblett & Gifford, 2002). Workers do not often operate in isolation and therefore all aspects including overcoming stress should operate to a large extent from a team perspective. Recent research has

started to explore the concept of team resilience and an understanding has formed in the realisation of how groups can overcome adversity in the workplace as a team approach. (Bennett et al., 2010; West et al., 2009).

Over the past 30 years, research suggests that the concept of 'team work' and the importance of understanding the 'team perspective' within the workplace has grown. The world of business and sports place key importance upon aspects such as team building and training days and therefore the concept of team resilience training is gaining momentum as a way to supporting workers and strengthening the workforce, in turn providing better outcomes for clients or service users. Interestingly, research suggests that 'assembling a group of resilient individuals will not necessarily yield a resilient team', (Alliger et al., 2015) therefore highlighting the importance of building a separate concept of team resilience aside from the individual level (Alliger et al., 2015, Morgan et al., 2013).

A resilient team can work more successfully together to delegate responsibilities in order to manage the more pressing concern (Meneghel, Salanova & Martinex, 2014). Members of a resilient team are more likely to support each other making for more successful outcomes. In order to manage stress, it is understood that resilient team members will be more willing to seek guidance, therefore being able to manage the situation to the best of their abilities. Individuals working alone may feel trapped or further stressed if placed in situations they feel unable or ill equipped to deal with (Alliger et al., 2015). Research suggests that resilient teams are better equipped to respond to stress than individuals working on their own, or even those within a team who do not feel united (Meneghel et al., 2014, Alliger et al., 2015, Morgan et al., 2013).

Kahn (2005) acknowledged that resilient teams can be developed by having a shared set of beliefs, however, these are rarely spoken about and need to be explored further. He also highlighted that the communication of emotions promoted greater resilience and generated safety thus improving better team functioning (p.180).

Method

Fifteen managers of Residential Child Care settings agreed to a semi-structured interview to explore the concept of team resilience and their individual perceptions and thoughts around how their teams could become more resilient. The interviews explored times when teams were working in a positive and constructive manner and were able to manage conflict and recover from adversity. Interviews were transcribed and analysed to identify key themes. A five-stage approach to thematic analysis was used as described by Braun and Clarke (2006):

- listening;
- transcription;
- coding;
- identifying themes;
- refining themes.

Findings

The 15 managers included in the study represented 68% of this grade of staff working in children's services. Residential settings included short and long term children's home, secure accommodation and intensive support homes. Interviews were transcribed and thematic analysis was used to identify key concepts and areas of agreement. By the fourteenth and fifteenth interviews no new themes were identified and data saturation was deemed to have been achieved. The themes identified were categorised under team management and individual factors.

Team factors

Recruitment

The initial recruitment of staff into the posts was widely discussed in 14 interviews (93%). Finding an appropriate candidate for the job was central to process of helping teams to function well.

> Are we always going to get the right people, no not always, but perhaps we could get people who have thought about it a bit more before they apply (Elaine).

Links were made about the interview process and the training and inclusion of a suitable service user being on the interview panel. There was significant discussion in the interviews (80%) of potential applicants applying for jobs after leaving university with little to no experience within the immediate setting. Information days, opportunities to shadow existing staff and probationary periods were identified as ways in which the best staff candidates could be recruited and initiated into teams.

A mixed skills base of workers was valued, but managers prioritised finding workers who are passionate about working with the client group and creating positive change in the lives of young people.

Team Ethos / Positivity

> Having a strong sense of 'team ethos' was central to making teams function to a greater level and promotes resilience and was discussed in 13 interviews. Having a shared belief in the work and a team aim or objective was central to functionality and the setting of realistic goals. The importance of implementing a realistic mission statement was deemed as a resilient factor. This was completed as part of the implementation process of a therapeutic model within the homes, however, it was felt that this should be reviewed and discussed more frequently. The ethos of a team working in residential child care should 'be with a strong foundation…based on trust…with the ability to be adaptable to change…based on the specific needs of the service users' (Jeff).
>
> Nine managers suggested a correlation between trust and how long a team has been together. The teams who have been together longer appear to have stronger links and a foundation of trust which has developed over time. 'Building trust can take a while…teams need to learn to grow together and every person in

> the team needs to respect each other' (Tim), however, this can prove problematic when conflict arises.

Team Meetings

Team meetings are the only dependable meeting that gather most staff together in the same room and was mentioned by all 15 interviewees. Emphasis was placed on occasions when team meetings are cancelled or rescheduled depending on circumstances within the home. It is on these occasions that 'splitting' and 'fragmentation' may appear within the team and causing friction that could be mirrored in service users' behaviours. Managers shared their frustrations that not all workers could be present at the team meetings which diluted levels of engagement and inclusivity from all members.

The findings highlight that it is important for staff teams to continually evaluate what they do, and the way they work together. Strong emphasis was placed on the need to collectively make decisions based on the needs of the young people and develop a plan of how the staff team will attempt to manage this. Ten managers identified that having psychological input from clinical psychologists was important to team resilience and working well together:

> sometimes we get stuck doing the same things…parallel process… and we need encouragement to think differently and come up with new ideas… (psychologist name) helps us see things differently and encourages us to think of new ideas, be more creative (Lorna).

Team Development

There was a perceived link between levels of resilience and teams gathering together for developmental activities and was mentioned in all 15 interviews. Although managers emphasised the difficulty for scheduling this due to pressures within the environment and managing the home, there was a strong sense of positivity that resulted from team building exercises. Teams growing together and learning together was a central concept that featured throughout the study. The findings highlighted that there was little to no discussion about teams training and developing together. On occasions it was felt that positivity

was generated when members of different teams meet up during the year at different training events and heard about how other homes were managing. There was a strong sense that staff and teams may feel less isolated when they acknowledge that other teams may be dealing with similar circumstances. However managers also acknowledged that if teams trained together then they may get to know each other better and perhaps there would be less resistance to change.

Socialisation of teams and involving teams in activities that placed value and importance on them as a team proved extremely beneficial:

> Some of the teams have really embraced this concept…the team leader has brought them to relaxation classes and sent them out to lunch together (Elaine).

This created a strong sense of 'being valued' as a team.

> I have explored alternatives therapies for the staff team, to help promote mindfulness and relaxation and will use these in the future (Lorna).

The evidence highlighted greater working practices and relationships that allowed the staff to support one another through a very difficult and complex time within the environment. Resilient factors increased and relationships with service users improved.

Reading journal articles as a staff team and introducing these to practice was viewed as a positive means to develop practice and was mentioned by three interviewees. It is important to prevent stagnation and promoting team resilience

> I know of practices in other countries where teams meet together and share literature with one another. Someone reads an article and it is debated within the team (Alan).

Eight managers saw their role as promoting a culture of learning and development within the team and talked passionately about positive growth and development. The role of team decision making against individual decision

making was also identified within the findings. It was felt that strong teams are better at supporting staff who are struggling. Acknowledging this by assisting in the reduction of personal decision making and taking a more collective response was strongly viewed as promoting resilience within the team. This was openly discussed in 11 of the interviews.

Managers recognised that sub groupings occur within the workforce and these friendship groups could have both positive and negative impacts.

> My team have a collective rapport with one another and enjoy socialising outside of work, however I have worked in a team with a number of small 'clicks' which was extremely difficult to manage (Lorna).

This had links to teams experiencing less stress, less anxiety, greater communication processes and betters ways to resolve both team and interpersonal conflict. A strong supportive internal dialogue within the team was deemed necessary when it came to managing interpersonal conflict between staff members and finding positive ways of resolving these.

Team Reflection

Fourteen managers identified a link between reflective practice and teams working productively and child centred practice. When staff can better understand the needs of the young people then responses are more in line with the needs of the young person. Complexity within the residential environment evolving processes of change requires consideration, coordination and co-operation. Eleven managers stressed the centrality of understanding and responding to the diverse needs of the group of young people being cared for. This included:

- making sense of behaviour;
- making sense of the environment;
- transference and counter-transference;
- the conscious and unconscious process that exist within the world of residential care;

- shared objectives in meeting the needs of the service users;
- minimise disturbances within the home.

The identification of an appropriate forum to implement critical reflection within the home was closely linked to reflective practice with one interviewee stating that:

> there is an inherent fear within the home that when staff issues are avoided or not challenged appropriately…destructive patterns start to negatively impact on the work and this creates a lot of resistance (Ivan).

Reflective practice was seen as an excellent way to make sense and dissect any immediate conflict or disturbances that might threatened the stability of the environment.

Management Factors

Leadership Style

Management style was seen as fundamental to the development of team resilience. A management style that recognises the therapeutic needs of young people as well as the individual needs of staff members was crucial. The importance of communication between managers was highlighted as central to the quality of the team and their levels of resilience.

> Teams are damaged by poor communication, especially if management are not communicating effectively with their team colleagues (Alan).

The role of team leader is a complex and difficult task requiring leadership on many different levels and expectations on the manager are high. Findings from 14 of the interviews identify that team leaders and deputy team leaders are expected to know their teams, each staff member's individual capacity, their strengths and weaknesses, what keeps them motivated, what triggers they have and to know when they are on form and when they are struggling. They need to have a strong and solid knowledge base of the most up-to-date research and changes in the system including all the governance arrangements. They should

be emotionally intelligent but able to manage the ever-present risks, being accountable for the lives of young people. They are expected to be positive, inspirational leaders, strong role models and advocating for the staff team. The findings identify that 11 managers are under considerable burdens with increased paperwork. Ten respondents felt that a healthy balance needed to be made between the leadership and governance functions. Six interviews identified that many homes have one leader who is more in tune with the therapeutic needs within the home whilst the other is more aware of governance arrangements and statutory requirements. This was viewed positive when both roles enhance one another's practice.

Having an open door approach to management was identified as promoting team resilience as mentioned in 12 of the interviews. A relational encouraging approach that recognised how staff members contribute to the greater good was seen as a prerequisite to a resilient team. This could include simply gestures like remembering birthdays and special occasions, anniversaries and personal circumstances for that individual. Assisting in the recovery from crisis, including debriefs, reflective practice and learning, was a highly favourable characteristic of managers and was discussed at length in nine of the interviews. Managing collective disturbances, and placing appropriate measures in a controlled and supportive manner, was also viewed as desirable.

Supervision

> We have got better at supervision…we are much better now than we ever were in terms of supporting staff (Alan).

Supervision was identified as a positive way to promote team resilience and was mentioned in all 15 interviews. It provided an opportunity for staff to reflect on the positive and challenging aspects of the work within a trauma aware climate. Increasingly, staff use supervision to discuss personal concerns and their impact on work.

> I'm not sure whether staff have changed or whether just humans have changed over the years and we have more casualties because of life (Annette).

> Findings suggest that the manager is more likely to hear about family problems, relationship difficulties, marriage problems and previous traumas. Managers feel the need to be empathetic to the personal needs whilst upholding the core values of the work and the need to provide high levels of support and care to the service users. 'Team leaders and deputies can't be all things to everybody' and 'getting the right input for staff at the right time to make them feel valued is essential' (Michaela).

Early detection of excessive stress and intervention is described as an essential task and therapeutic or clinical supervision was identified as the best way to provide that level of emotional support to help promote resilience. The findings from nine interviews identify that if staff feel valued and their personal, spiritual and emotional needs are recognised, there is a high probability that they will feel able to respond to young people in a similar manner.

Communication

Communication was central to all other identified themes and it was mentioned in all interviews. Having effective, structured, supportive and honest communication was seen as the 'veins' within the organisation. It was emphasised that there was a potential link between young people's feelings of safety and the quality of organisational communication.

> When communication breaks down then rumours appear in the homes (Tim).

The process of sharing knowledge was viewed as central to the development of team resilience allowing staff to feel:

> ...appreciated, listened to and treated with respect and dignity (Alan).

Ten managers recognised that staff teams make sense of their environment and the events that unfold through internal, informal communication. Ordinarily these are positive, however, whenever certain stresses impact on a team who cannot make sense of certain behaviours, this:

> …may lead the team to think more negatively and respond more punitively (Alan).

Communication within residential child care can be complex and on some occasions difficult to manage and co-ordinate and may lead to a reduction of resilience. Management of the multi-interdependent relationships between staff and young people is central to the core functioning of the team and the functionality of the residential home. Breakdowns in communication can have a devastating impact on staff as well as young people which can lead to the creation of an 'us and them' culture. The study identified how staff teams react when they feel like they are 'under threat' from a breakdown in communication. Staff members feel uncertain in themselves, fear that they will be judged or fear being viewed as a 'non-team player'. The process of misinterpreting other staff's views, work, judgement and motives can have a crippling impact to resilience especially when these are allowed to go unresolved or not discussed.

Individual Factors

The initial literature review suggested that resilient individuals did not always result in resilient teams but seven managers felt that having a strong and positive person working within the team was key to the strength of some teams and at times kept teams motivated.

> There will always be a team member who other staff look up to…they are a good worker and I like working with them (Jeff).

Further exploration identified the concept of 'conscious and unconscious modelling' where staff members try and model their practice on each other. This was directly linked to their internal processing and how they viewed the service user's response to the worker.

Exploration identified key characteristics and features of a positive person within the team who encouraged and strengthened resilience. This included:

- openness and a passion for the improvement of the lives of the service users;
- reflective and understanding of therapeutic processes;

- diverse skills set, ability to remain calm and focused in conflict situations;
- ability to see others point of view and place context around this;
- understanding of the impact of trauma on teams working in residential care;
- ability to be flexible and embrace change, and encourage change;
- integrity and authenticity;
- co-operation with, and inclusion of other staff members.

Interestingly, there was little consensus on the relevance of experience. In certain homes those staff members with the most experience acted as the 'cement of the home', whilst in other homes they produced a 'number of conflictual and negative aspects to the team'. The uniqueness and personality of the individual was key, irrespective of the length of time they have worked within the environment.

Discussion

Recent figures (Department of Health, 2016) suggest that there are 2,213 children in Northern Ireland who have been in 'looked after' placements for 12 months or longer. Of these approximately 6% live in some form of residential child care setting. It is recognised that this cohort of young people have often experienced disadvantage and adversity. As a result they can have complex needs and require the support of skilled staff. Residential care work can be challenging and at times distressing. Northern Ireland like other countries experiences a high turnover of staff. Recent strategy has included a commitment to:

> Securing earlier permanence and stability for children and young people in care and enabling them to build positive and supportive relationships; extending placement options; strengthening support for care givers; providing more effective regional specialist services; reconfiguring the skill-mix in residential care; providing effective interventions to deal with particular challenges including: substance misuse, poor mental health and

> emotional well-being outcomes; criminalisation and poor educational outcomes (Department of Health, 2018, p.14).

This study provides the perceptions of managers in relation to the important and under researched theme of team resilience. The respondent group did not include residential social workers who work alongside the service users but the findings provide a valuable insight into the functioning of teams within this setting. The managers identified a number of key elements within the teams that contributed to positive growth and change as well as an ability to manage conflicts within the environment. These included organisational processes including team meetings, reflective practice and supervision; however, the impact of such processes was not clearly described. Staff shared a deep sense of awareness of the needs of the service users and a desire to promote positive change, which needs to be central to all activity.

The promotion of team cohesion was evident throughout the findings and the desire to have teams functioning and responding effectively. Team development and team training were closely linked to this notion, however, it was alarming to see how underused they are within the homes. Managers recognised the team positivity that results from team development days, however, acknowledged that they may only happen once or maybe twice a year. Greater emphasis was placed on the value they bring to the teams levels of resilience. Menehel et al. (2014) explored the concept of collective positive emotions at work and team resilience. Team development and team building must aim to promote the unity of the team as well as promote trust, respect and ultimately enjoyment. The findings found clear links of positivity and resilience from teams that where 'nurtured' and 'looked after'. Teams who had collectively experienced time away or breaks from the environment and where immersed in doing fun activities, co-ordinated themselves better and developed stronger resilient bonds. Introducing holistic therapies within teams, including massage, reflexology, meditation and Reiki could support many aspects of the findings. This was acknowledged as an interesting way to assist in reducing team stressors and promote positive and fun engagement amongst team members. The exploration of team responses and effective ways of reducing team stress through the use of ongoing holistic or any other alternative therapies could be explored further in research. This is

closely linked to the findings in literature that identified the need to manage stressful and difficult situations with coherent responses in a team cohesive manner (Meneghel et al., 2014; Alliger et al., 2015; Morgan et al., 2013).

Contrary to the findings of the literature review, managers emphasised the value of resilient individuals working within teams. It seems that individual resilience and team resilience are different but interrelated. More in-depth analysis of the relationship between these two factors is required. Recruitment is an essential part of the process for identifying and employing the right person for the job. Findings identify that having a person who is not suited to the team may have a crippling affect to the milieu of the team. Careful consideration should be taken before employing someone into a team, exploring aspects including motivation, understanding of the role, and team processes. The characteristics and personality of the person entering the environment should be scrutinised to provide the appropriate make up for the team and the service users and every effort should be made to protect the team throughout this process. It was acknowledged that introducing agency staff to cover gaps within the home might not necessarily be the best response. It is evident that getting the right person is again fundamental. Suggestions included the introduction of information sessions for 'would-be' employees who could make a conscious and formal decision to enter the team work experience and work alongside traumatised service users. Including service users on the interview and making appropriate use of the probationary period could help identify an appropriate person to the post. However this would require assistance through HR processes and protocol and awareness needs to be made about the potential impact that the internal transfer of staff can have on the homes. Although not directly supporting this principal finding it does have some relevance to the literature from Alliger et al. (2015) who highlighted that resilient team members within a team are more likely to request assistance. This was further emphasised by Meneghel et al. (2014) who stated that resilient team members who ask for assistance have a positive impact on maximising team capabilities for the greater good of the team.

Emphasis was placed upon the character and the nature of the staff member within the residential environment and their ability to remain positive and

promote positivity within the team. The findings would suggest that irrespective of the length of time you have worked in the environment, managing your mental health and making sense of the environment was fundamental. The research highlighted that staff members who have worked within the environment for an extensive amount of time who find difficulty in remaining positive may be suffering from burnout or compassion fatigue. This was acknowledged as a sensitive issue that requires appropriate and effective management and can lead to feelings of fear and frustration. It would be important that guidance is provided for the safe and effective management of this process which upholds respect and dignity to the individual.

Members of a resilient team are more likely to provide back up and assistance to one another (Meneghel et al., 2014). The findings did highlight that there are strong elements of resilience within certain teams within the sector. It was unclear if these where professionally developed factors, traits that had happened due to the length of time the team had already been established or had happened through chance or coincidence. In many instances findings identified that teams support each other through team meetings, reflective days and group supervision and with increased involvement from therapeutic support services. The importance and validity of these meetings cannot be underestimated and was acknowledged throughout all interviews. They play a vital role in bringing staff together. It is in the 'togetherness' that strengthens bonds of trust and respect. When trust and respect is created and nurtured in all relationships throughout the team then true team resilience could be created. As the literature review identified, to mend from stress, resilient teams are better able, rather than individuals on their own (Meneghel et al., 2014; Alliger et al., 2015; Morgan et al., 2013).

The role of reflective practice within residential child care should become part of the ethos of the homes. This should be done on an ongoing basis, as creating the ability to withstand, overcome and recover from challenges is at the core of resilience. The findings clearly make links between reflective practice and changes to team thinking. This is in the infancy stages within the homes and more emphasis should be placed upon it. It was emphasised that having all staff invest fully in the reflective elements of the team is a tall order and has been a

challenge for many managers. It was acknowledged that the role of the facilitator is extremely important to promote inclusiveness. It is within the process of sharing and valuing individual interpretation on a given event that promotes resilience within the team. When each member feels supported and respected and comfortable in being constructively challenged by their peers that true changes could happen. This supports the literature around teams and their ability to overcome complex situations: when individuals feel a combined resilience from within a team, then positive changes can happen (Tugade & Fredrickson, 2004).

The importance of management and the management role was evident from the findings within the study. The role of team leader and deputy team leader and the formation of this unique relationship is central to the running of a residential child care home. So much hinges on the quality of this relationship. Research needs to be undertaken to dissect this role and identify key features of what creates a good partnership. The research identified that the leadership role within residential child care has so many demands and expectations. There are many aspects and requirements that are expected from one person that it would be extremely difficult to find someone who is able to 'be all things to all people'. Similar to the process of recruitment within the homes, specific attention needs to be placed on finding the right person for the role, complimentary to the needs of the home. Staff look to leadership for answers and place high expectations on this role. Findings identified that the relationships and bonds between staff and leadership is something that needs further exploration as this reciprocal relationship is critical to the functioning of the home. This was closely linked to the literature findings on Gittel, Cameron, Lim and Rivas (2006) and Kahn (2005) who acknowledged that resilience needs to be an organisational construct. Teams will develop greater resilience when they are supported within a resilient organisational framework.

The findings within the study highlighted the need for teams to grow and develop together. It was highlighted that team training days should become a central part of the fabric of the home. It may not be necessary to have all training events targeted at all team members at the same time, however, core training that is specific to team development and permits staff members to

scrutinise their own practice should become a requirement for all homes. Training of a therapeutic nature should become a team training day in order for all members to learn and grow together. Developing specific skills within certain individuals doing specialist training should be shared as part of a team process. Promoting an environment that encourages learning for all its members should be a strong characteristic of all teams. Assisting staff that show resistance to any level of training should be challenged by all members within that team. The findings identify that training is undertaken more so from an individual basis and rarely as a team response. This was linked to managers safely managing homes and maintaining high standards of practice and the difficulties associated with removing primary workers from the environment. This is strongly linked to the literature findings that had identified that teams learning together was critical to creating the overall characteristic of collective efficacy and resilience (Morgan et al., 2013; Hill, Atnas, Ryan, Ashby & Winnington, 2010; Lengnick-Hall, Beck & Lengnick-Hall, 2011). This strengthened bonds between members and had prepared teams to deal with complex and challenging situations.

The concept of team resilience has not been explored in residential child care homes or within any other care facility, and themes specific to these settings became apparent in this study. The residential home is a complex and challenging environment for service users, staff, and managers, as each endeavours to make sense of their role and establish an identity.

The development of a 'strong internal dialogue' was found to be a crucial aspect of team resilience that was not found within the literature. This could help explain the differences between making a pre-existing team more resilient compared to bringing people together to formulate a team. The research identified that within the realms of residential child care and the high number of children living in the same environment the 'communication' needs to be ongoing and accurate. Dialogue between staff members is key to the safe functioning of the home. When changeovers in staff happen up to three or four times daily, then breakdown in communication is highly likely. Greater emphasis needs to be placed on the importance of true and accurate communication on an ongoing basis and promoting ways that this can be strengthened. Communication happens on many different levels throughout the threads of the

team. This level of dialogue is specific and unique to the environment and adds an added layer of complexity; ways to make this improve and work could promote resilience within the team.

The study identified that there is already a high level of support both for individuals and for teams. Much of this was based on the implementation of a number of therapeutic models being introduced to the environment. However, findings suggested that not all staff members may be suited to the new styles of working and could be resistant to this change. Findings also acknowledged that individuals may be suffering from the impact of working within a trauma-focused environment and may need additional support to manage personal and/or environmental concerns. These are areas that need to be further explored and managed to assist in the process of team resilience.

Conclusions and Recommendations

This study has sought to investigate the concept of 'team resilience' as described by managers responsible for Children's Homes within the local Trust area. The study found that there are many layers to this process and there is no immediate panacea to this phenomenon.

Elements of the study were consistent with the extremely limited research on team resilience, and it could be argued that this study only managed to 'scratch the surface' in terms of highlighting team resilience. The study identified nine key themes:

- recruitment;
- communication;
- supervision;
- team meetings;
- team development / training;
- reflective practice;
- resilient individuals;
- team ethos / positivity;

- management style and leadership.

There is a very strong correlation between teams and their influence in creating positive change within the lives of young people in residential care. The make-up, nurturing, and looking-after of teams is a complex and challenging experience that requires time, patience, and dedication.

Getting the right person for the job is essential for the safe running of a residential child care home and having a positive impact on the environment. Creating a strong internal dialogue of communication is paramount for the smooth running of the team and promoting resilience levels throughout. Supervision is the only consistent time a staff member and manger can meet together and the value of this cannot be underestimated. Team meetings are powerful places that staff members can exchange ideas and discuss team concerns.

Team development and training days should become a much stronger focus with the teams as a beneficial tool in promoting resilience. Reflective Practice needs to be embraced fully and used regularly and consistently in order to affect positive changes within teams.

The concept of resilient individuals within teams is a strong theme that needs much further investigation. Exploring the personal constructs of significant people working within the residential child care homes would benefit all aspects including recruitment. Having a team ethos and a belief in the work that is undertaken is key in developing levels of resilience within teams.

Management and leadership are central to the smooth running of residential child care homes and developing team resilience. The construct in relationship between the team leader and deputy team leader should be prioritised for future research.

The implementation of team resilience should be essential for all teams working in residential child care and arguably for all other teams within the care sector. Caring and nurturing for teams will make them grow positively and will encourage development. This is the expectation placed on staff when managing the Looked after Children's population so leading by example should be the priority.

Recommendations

There are a number of recommendations that should be considered from this study.

1. Further research needs to be completed on the subject of team resilience with specific emphasis being placed on the personal constructs of the person entering residential child care system.
2. Team development days need to be a regular and ongoing event within the calendar.
3. Supervision needs to embrace aspects of clinical and therapeutic input.
4. Reflection should become an ongoing experience for the team to assist in the management of the environment.

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Assessment of the Alternative Families System in Egypt

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Abstract

Since 2016, the Egyptian Government has made several changes in the Alternative Families System that aims to provide children without parental care, especially abandoned ones, with families. The study assesses this flagship programme using the UN Guidelines for Alternative Care for Children as the main guiding framework, combined with qualitative methodological approaches, based on a purposive sample of key informants, consisting of governmental officials, national and international organisations, using in-depth interviews as the main tool for data collection. On one hand, the state declares its responsibility towards children without parental care. Moreover, it involved the assembly of a new national committee for alternative families. On the other hand, there are limitations which affect the increasing number of abandoned children, such as the inability of unmarried mothers to register their children and thus find proper support. In addition there was the non-existence of preventive strategies such as families' rehabilitation programmes. Finally, negative societal stereotyping towards abandoned children was identified especially by government officials administering the programme. The study recommends reviewing the existing legal framework to ensure its proper execution through allocating financial resources, upgrading the existing human capital and related systems, and developing a national alternative care strategy.

Keywords

Alternative care, foster care, children without parental care, Egypt

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Introduction

Families are considered the best option for a child to be nurtured and developed (UN General Assembly, 2009). Accordingly many countries worldwide have taken solid steps towards securing foster care families, whether temporarily or permanently, to avoid institutional care settings (Petrowski, Cappa, & Gross, 2017) especially for children under three years old (UN General Assembly, 2009). The importance of these guidelines is that they clearly state the role of governments towards children without parental care (Cantwell, Davidson, Elselet, Milligan, & Quinn, 2012) as Article 5 clearly indicates:

> Where the child's own family is unable, even with appropriate support, to provide adequate care for the child, or abandons or relinquishes the child, the State is responsible for protecting the rights of the child and ensuring appropriate alternative care, with or through competent local authorities and duly authorized civil society organisations. It is the role of the State, through its competent authorities, to ensure the supervision of the safety, well-being and development of any child placed in alternative care and the regular review of the appropriateness of the care arrangement provided (UN General Assembly, 2009).

Extant literature affirms the importance of a family setting especially efforts to support the child to remain within the original family or the extended kinship care family (Megahead & Soliday, 2013). It also highlights the important role that foster care families can play whether a child is placed within these families on a temporary or permanent basis (Keshavarzian, 2015). This is where Islamic countries adopt an analogous scheme called 'Kafala'. According to this scheme, a child can be placed permanently within a family, however, without the right to carry the family name or inherit, although some permissions are allowed in accordance with Islamic sharia (these will be explained in the results section) (Assim & Sloth-Nielsen, 2014; Spaac, 2014). Other practices include training

families to deal with certain cases of children who need special care and treatment forming what is called 'specialised families' (Keshavarzian, 2015).

As for the case in Egypt, there are around 22,000 children within the Egyptian Alternative Care system; 10,000 within care homes and 12,000 within alternative families. Overall, there are six care options; four of them are listed in the Egyptian Child Law and the rest are based on the existing practices or future plans. All of the care options are under the supervision of the Ministry of Social Solidarity (MoSS) except for the Motherhood and Childhood centres. These centres take care of children under the age of two and are supervised by the Ministry of Health. The supervision entails frequent monitoring visits by government officials locally. In some cases, assessment visits take place from officials from the central level in case of complaints or abuse cases. As for the management of the social care homes, there are types which are entirely managed and owned by Civil Society Organizations (CSOs), while others are jointly managed by CSOs and government officials (Abdel-Aziz, 2019).

In Egypt, care homes are divided by age group: institutional nurseries that serve children from two to six years old and institutional care homes that serve children above six years old. As for the institutional care homes, there are two types. The first type provides care to abandoned children whose parents are not known in most cases and, in rare cases, for children whose parents are known. The second type serves children that were separated from their families willingly or unwillingly; this includes runaway children, children that live in the streets, children placed by their parents, and children placed by prosecutor decision. The total number of institutional care homes is 502 (Abdel-Aziz, 2019).

As for the family based options, there is a growing understating of the importance of the family care setting as opposed to institutional care. According to recent statistics from MoSS, the number of alternative families is around 12,000 compared to 10,000 children within 500 institutional care homes.

MoSS is the main entity responsible for social related matters generally, and children without parental care or children at risk specifically in accordance with the overarching legislative framework that governs all children-related issues

under the Egyptian Child Law (ECL) of 1996, amended in 2006, and further amended in 2016.

The amended article No. 96 of the implementing regulations of ECL states that the Alternative Families System (AFS) serves: 'children over the age of three months who are cared for by alternative families or within the shelters of the ministry concerned with social solidarity until the age of stability in the work or marriage of females'. The role of AFS is envisaged to: 'Provide integrated social, psychological, vocational and professional care for children over the age of three months that are unable to grow within their natural families and those who are unknown or abandoned' as per the amended article No. 85 (Egyptian Factsheet Journal, 2016).

The study was designed to assess the Alternative Families System (AFS) and its associated amendments to the law, which is considered the Egyptian government Flagship programme to improve the status of children without parental care. Towards that end, it attempts to answer three questions: To what extent is the existing legal framework abiding by the UNGAC?; To what extent are the existing legal and policy frameworks being implemented on the ground?; Finally, what are the desired improvements and necessary recommendations for the AFS moving forward?

Methods

The study used the UNGAC as the main framework to assess the Egyptian legislation framework and its associated practices. This was complemented by a review of the literature in academic journals and surveying web-based databases of organisations that work in the field of child protection and children in alternative care. To narrow the focus on the results specific terms were used: ‘foster care’; ‘adoption’; ‘kafala’; ‘alternative’; ‘deinstitutionalization’; and ‘alternative families’. Given the recent and rather rapid changes in the ECL and the Alternative Families System (AFS), only a few updated resources were available online. Therefore, for the Egyptian context, the author depended on published studies, reports, laws and their amendments to form an overview of the overall alternative care system and how it developed over time. Moreover,

grey literature[1] and unpublished reports were used to provide additional and updated information on the current status of the programme.

A qualitative methodological approach was followed, involving purposive sampling to identify key informants in the field of alternative care. Due to the small number of officials and experts that work within this field in Egypt, the purposive sampling was the most suitable option to target key players in the field that represented government officials, and national and international organisations to assess the current situation of the programme. The sample had 19 participants; five of them were government officials with two directly involved in the Alternative Families System (AFS), three more involved with the complaint system recently developed by MoSS, and the last one responsible for institutional care homes. The other 14 participants were officers and experts within the field who worked for international and national organisations: namely UNICEF, Save the Children, and Face for Children in Need. The study mainly used in-depth interviews as data collection tool.

The inclusion of alternative families as research informants was sought, however, this was not successful due to different challenges including the unwillingness of these families to stay connected with the official system through MoSS, after having the child. This is considered the study's main limitation as will be discussed later.

For the purpose of this study, children without parental care will refer to the definition provided by UNGAC as ' all children not in the overnight care of at least one of their parents, for whatever reason and under whatever circumstances' (Article 29a), whereas alternative care refers to formal care as:

> all care provided in a family environment which has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment, including in private facilities, whether or not as a result of administrative or judicial measure or informal care' and b. Informal care: any private arrangement provided in a family environment, whereby the child is looked after on an ongoing or indefinite basis by

[1] Grey literature refers to materials and reports published by organisations such as NGOs, third sector agencies and government departments – i.e. outside of commercial and academic publishers.

> relatives or friends (informal kinship care) or by others in their individual capacity, at the initiative of the child, his/her parents or other person without this arrangement having been ordered by an administrative or judicial authority or a duly accredited body (UNGAC, Article 29a).

The study will use alternative care to refer to all care options, whether they are family care setting or institutional ones, formal and informal.

Results

The results fall into two broad categories: related to broader issues that affect the Alternative Families System (AFS) and other findings that are directly related to AFS.

Findings related to broader issues that affect AFS

State's role in ensuring alternative care for children

Amended Article No. 4 in the Egyptian Child Law (ECL) clearly states the role of the government in securing alternative care for children deprived of care. This reflects a major change in the state's views towards children's parental care, as it explicitly takes responsibility towards them, which comes into alignment with the orientation of the UNGAC. This amendment was introduced in 2008 as a replacement for the original article that only stated the biological family's role towards children. Another clarification of the state's role was due to the 2008 amendment to Article No. 96 in which the law states 14 cases in which the child should be considered in danger (Egyptian Factsheet Journal, 2008). The cases that are related to families are stated in 96.2 and in 96.6. In the previous version of this article, before it was amended, there was no clear definition for children at risk in general or children who might be at risk within families. This made it almost impossible to take any formal action towards families who can be classified as posing a risk to their children.

Mother's rights to register her child

According to article no. 23 of the implementing regulations of ECL, mothers can register their children with a marriage certificate and without a marriage certificate (Egyptian Factsheet Journal, 2010). If a marriage certificate does not

exist, the mother can sign a formal written approval that this child is hers and accordingly only her name will appear in the child's birth certificate. ECL prohibits the mother from giving the name of the father unless he is also present and delivers a similar written approval. Although this right is mentioned clearly in the law, only one of the study's respondents was aware of this article, and on the contrary most of the study's respondents showed astonishment of the existence of this article. The only informant who was aware of the article was the representative of one of the national NGOs working in the field. He affirmed the practical challenge they face every time they try to support mothers with no marriage certificates to exercise this right, especially in the civil register where such procedure is normally carried out. They usually had to seek legal support in order to finalise the birth certificate of their child in such cases.

Lack of support mechanisms for families

Despite the fact the ECL clearly states the right of the child to be raised within a cohesive family (Egyptian Factsheet Journal, 2008), the law does not indicate any mechanisms to support disturbed families in practice, especially those needing rehabilitation and specialised support. Article No. 98 indicates that in any case of negative harm affecting the child, the local committee for child protection may request the child prosecutor give a written warning to the child's guardian which can be appealed against within 10 days (Egyptian Factsheet Journal, 2010). Although this committee is mandated to work on preventive measures to waive reasons leading to family separation, the ECL does not state any specific interventions to enable family rehabilitation or family reintegration. This lack of well-established systems for family support in Egypt to guarantee their cohesion was confirmed by all of the study informants.

Lack of explicit preference of family care setting

Most of the study's respondents emphasised the preference of a family setting versus an institutional setting, especially for new-borns. In addition, according to one of the few researches available on alternative families in Egypt, a family setting was preferred in the case of babies and children until aged two years old (Spaac, 2014). However, this means that children over two years old can be placed in institutional settings missing the opportunity to be placed within a

family setting (Spaac, 2014). Despite this, a preference for family settings is not explicitly mentioned in the ECL or its bylaws as the main overarching framework for children in Egypt.

Findings directly related to AFS

Alternative care and alternative families are used interchangeably

The second chapter of Part three of the Egyptian Child Law (ECL) is titled 'Alternative Care' and three components are listed: Alternative Families System (AFS), Child Club, and Social Care institutions for children without parental care (Egyptian Factsheet Journal, 1996). In the AFS section, the two terms 'alternative care' and 'alternative families' are used interchangeably as if they mean the same thing which might confuse the reader. According to the UNGAC, alternative care is the umbrella term that reflects the different options of care, whether family or institutional care settings, whenever a child is separated from his/her biological family. Therefore, alternative families are merely one care option. Yet, the study respondents referred to a strategy being developed by MoSS for alternative care that only focuses on alternative families and does not include any other care option, whether existing ones, such as social care homes, or new ones, such as kinship arrangements; it reflects the ambiguity of the terms and their practical implications. The literature emphasises the importance of having clear definitions for care options (Gale, 2015) as definitions further affect the implementation strategies.

As for Child Clubs, this refers to a set of different services, including leisure time activities that target children from the age of six until the age of 14 (Egyptian Factsheet Journal, 1996). According to its given definition, there is no rationale for including this type of care option as part of the alternative care chapter; especially as there are other chapters in ECL that are related to different social services targeting children. All the study's respondents were unaware that this type of care option exists as part of alternative care options in ECL or in practice.

Lack of family care options

UNGAC emphasises the importance of having a range of family care options and in particular encourages the kinship and community-based options that ensure care is provided within the same social and cultural settings that the children were used to when they were within their original families (Mcguinness & Arney, 2012). While no disaggregated data is available regarding the origin of children within social care homes, whether they were abandoned or have known families (Africa & Heights, 2012), the study's respondents confirmed that in Egypt there are children with known families but where there are no established mechanisms or specialised social workers to work with extended families or establish community-based solutions. Finally, the Egyptian system does not include foster families programmes that can serve as a temporary care setting as suggested by literature (Keshavarzian, 2015).

Assembly of Higher Committee for alternative families

This was a new addition by MoSS that has been formalised in 2016 through the addition of article No. 94, into the implementing regulations of ECL (Egyptian Factsheet Journal, 2016). The establishment of a higher committee for alternative families encompasses representatives of different ministries, social solidarity, education, justice and interior, as well as some national organisations. According to the study's respondents there was a need for such a national higher committee as the previously formed local committees did not have unified standards on how to select, support, monitor, and supervise families. The new committee is now serving as a policy-making entity to standardise families' selection criteria, contractual procedures between MoSS and families, and different mechanisms for supporting, monitoring and assessing the alternative families. The committee is also in charge of investigating complaints, which is considered a good measure to avoid conflict of interest, since previously the local committees were the ones that issued acceptance or refusal decision of families and at the same time investigated the appeals. Now there is a separation; local committees make the decisions, the higher committee investigates the appeals.

Changes in the Alternative Families System

In 2016, and as part of the different amendments that involved the Alternative Families System (AFS)-related articles in ECL, the new articles decreased the required marriage duration to host a child, and become an alternative family, from five years to three years with a possibility of waiving this requirement if the couples provided proof that they cannot have a child of their own. Also, the new articles reduced the required age for single females; whether they are divorced, widowed or unmarried from 45 years old to 30 years old under the condition that the committee approves their eligibility (Egyptian Factsheet Journal, 2016b). When it comes to facilitating the procedural steps, according to the study's respondents, especially from the governmental officials group, MoSS started an online system to start receiving families' requests to be able to track all cases starting from submission of the request until a decision is made communicating approval or rejection. MoSS also has a future plan to completely automate the submission process for requests to ensure that all requests are given fair opportunity and are not refused at a local level without valid reasons. Another change which is not indicated in the ECL, yet mentioned by one of the government officials groups, is the change in the required educational level of couples or single females that apply to the AFS, from being merely literate to having at least a high school certificate. The same participant indicated that after this change, the number of requests went down, yet there is no formal study that was carried out to verify the correlation between both events. Finally, one major change introduced is that families are not allowed to receive financial rewards as per article No. 99 in the implementing regulation of the ECL, as was stated in the previous articles of the ECL.

Lack of competent and sufficient workforce to assess, monitor and support families

In Egypt, there is a persistent challenge in relation to the social work workforce in terms of sufficiency, efficiency, and sense of motivation to carry out daily tasks (Forden Carie, 2016). Most of the study's respondents showed their concern about having a competent social work workforce that is able to track and monitor families after the child placement. Furthermore, they also

questioned the official work force's abilities to support and assess these families throughout the process. As a solution, MoSS is considering starting a new partnership programme with local NGOs to assist government officials in the whole process starting from family assessments, monitoring visits, and conducting support programmes (the programme is still under development). As another instrument, MoSS through its higher committee for the Alternative Families System (AFS), has partnered with two organisations to develop a procedural guide that explains clearly all processes, templates, programmes, and competencies that are related to AFS. The guide will be used as the main reference for government officials and NGOs who will be trained on once finalised. Yet a related challenge which was pointed out by most of the study's respondents, especially the ones that were affiliated to MoSS, is that within the coming five years most of the government officials in position will be retired. Although there is no exact number for the retired employees in each year, an expected gap in the number of employees is foreseen especially with the current decision of the Egyptian Government not to appoint new employees in any post across all governmental entities.

The challenge of tracking some of the children placed within AFS

MoSS representatives, on their regular monitoring visits, could not track around 5% of the children that were placed in the Alternative Families System (AFS) according to one of the governmental officials. According to this study's respondents, most of the families do not want to keep any relations with MoSS after they receive the child. They mainly attributed this to social reasons related to stigma towards abandoned children or families that care for children that they are not theirs (Ali, 2016; Spaac, 2014). This leads some families to change their home addresses after finalising the process of getting the child, which makes it impossible for MoSS to track the child (Spaac, 2014). In an attempt to tackle this challenge, MoSS now requires as part of the contractual agreement between them and the families to have two witnesses appointed in government positions to sign as a guarantee for the family. This new procedure will facilitate tracking the family even if they change addresses as the two official employees could always be reached through their contacts in official databases. This procedure is

rather new and not mentioned in the ECL. Another challenge is that some families change the name of the child legally through filing a case of proportionality of the child (Spaac, 2014). This also leads MoSS in many cases losing track of the child as they are not informed of such court cases or other incidents leading to change in the adopted child name. As a countermeasure, MoSS started a new procedure requiring all courts responsible for proportionality cases to first consult with them to ensure that the child being considered is not in the AFS database. A final challenge, which remains unresolved to date, is when these families decide to travel abroad. Though the ECL mandates in article No. 91.3 an official permission from MoSS to be granted and the diplomatic mission in the visited country to be informed to facilitate the family monitoring, this is not enforced.

Social stigma of abandoned children

Many of the study's respondents highlighted the challenge of the social stigma associated with abandoned children. Society does not welcome families having children, other than their own, living with them at the same place for religious reasons. This is despite having an Al-Azhar association, which is mandated to issue religious permission ('fatwa' in Arabic), allowing this kind of home care. This causes many families to exert a lot of effort to hide the fact that a child is not theirs, even among their extended families (Spaac, 2014). Furthermore, there are some government officials who administrate the Alternative Families System (AFS) at local levels that are not convinced by the programme and find it religiously untenable. This in turn affects their placement decisions and sometimes reflects negatively on the requesting families, which are most of the time in need of more support rather than someone making them hesitant with their care decisions. Also, Al- Azhar has issued another religious permission (fatwa) for the possibility of giving the last family name to the child but not the full name. The rationale of this fatwa is to strengthen the sense of belonging of the child to the family and to enforce his/her status within society, yet without changing the proportionality of the child something that is prohibited both religiously and legally. Another fatwa issued by Al-Azhar, and stated in the law, is that the family is allowed to allocate a certain amount of inheritance to the child as per article No. 99 in the implementing regulation of ECL.

Discussion

Working on the root causes

Based on the findings of this study, the Egyptian government is exerting minimum efforts when it comes to preventive measures, including family support programmes, family rehabilitation and reintegration programmes, which are crucial strategies (UNICEF, 2009). Besides, tackling the issue of abandoned children is made from one angle, which is securing an alternative family for the child, instead of addressing the reasons that led to separation in the first place. One reason for this is the inability of unmarried mothers to officially register and thus provide care for their child, despite the legislative framework that enables them to do so. The piece of information is neither widespread nor accepted by the relevant governmental officials, such as civil register employees. This suggests the need to communicate this article across related governmental entities and NGOs that work in the field of child care and women's rights.

Another procedure introduced by MoSS to overcome the disappearance of some children is that requiring every applying family to have two government officials as a guarantee. This is newly implemented, and accordingly it will be difficult to assess. Yet, working on building positive perceptions towards the programme in general and for children without parental care, especially abandoned ones, in particular, should make it more sustainable.

Balancing between short term and long term interventions

Based on the several interventions that the Egyptian government had made, it is clear that there is a lack of balance between short term and long term interventions. Most of the interventions being introduced are on the legal and procedural level and are quick and very much needed. Yet, the other interventions that require more time and resources are not moving forward at the same pace. For example, establishing a national database for both children and caregivers serving as a disaggregated data set for further use in decision-making would permit better understanding of the issue, yet it is not happening as it requires time and resources.

AFS expansion versus incompetent and insufficient workforce

There is a clear direction at MoSS to increase the numbers of alternative families across Egypt. Yet, literature suggests that countries have to take into consideration their readiness for such expansion (Bombach, Gabriel, & Stohler, 2018; Keshavarzian, 2015). Increasing the number of families without having proper infrastructure of human capital, information systems, well-established procedures and supporting mechanisms may lead to negative consequences rather than positive ones.

Building positive perception towards alternative families and children without parental care

The Egyptian government has to take more solid steps and allocate financial resources towards building a positive perception towards families that provide care for children without parental care. The current efforts are limited to a set of Frequently Asked Questions on a webpage affiliated to MoSS and some information sessions conducted by members of the higher committee of Alternative Families System (AFS). These efforts are insufficient in terms of the outreach achieved and depend on the efforts of very few people to travel around spreading the word.

Formulation of a national strategy for alternative care

It is highly recommended that a strategy is formulated that clearly articulates the state's direction towards family care setting as highlighted several times by the study's respondents. The strategy should also have a clear definition of alternative care, work on developing a wider range of care options, and establishing a strong connection and linkages among these options. It is imperative for the strategy to have clear, measurable indicators regarding decreasing the numbers of social care institutions, in addition to a clear plan of utilising existing institutions as a resource in the state's deinstitutionalisation strategy. This is in addition to working on the challenge of having a sufficient and competent workforce whose individuals are well compensated and exhibit a

positive perception towards children without parental care and the Alternative Families System (AFS).

Conclusions

The alternative care system in Egypt has different challenges affecting the government's flagship programme for the Alternative Families System. The programme has had several improvements since 2016, most prominently the assembly of a higher committee to regulate the system, formulate national policies and investigate complaints. Though this step is considered a major improvement, the system still faces several challenges. These include the inability to track some of the children, the lack of competent and sufficient workforce, the negative stereotypes and stigma towards abandoned children who are one of the main target groups of the programme, and the inability of mothers to register their children in case of not having a marriage certificate. Accordingly, the main recommendation of the study is to formulate a national strategy for alternative care in Egypt that tackles all these challenges and provides a framework for different stakeholder to coordinate and collaborate. This is in addition to reviewing the existing legal framework and ensuring its proper execution through allocating needed financial resources and upgrading the existing human capital and related systems.

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About the author

Amira Abdel-Aziz has 13 years of experience in the fields of Public Policies, alternative care for children, youth development, social entrepreneurship, and organizational culture.

Currently, Amira is a Ph.D. candidate at Cairo University, Faculty of Economics and Political Science, Public Administration. Her dissertation focuses on assessing alternative care system in Egypt. In 2017 she was awarded by Open Society to expand her Ph.D. research into both Jordan and Morocco. Amira worked in the field of alternative care for more than 8 years starting 2011; in which she provided technical advice to the Egyptian government on developing

quality standards for institutional settings. In addition, she designed two technical programs related to institutional capacity development for care homes in 2014 and youth program for care leavers in 2011. Worth mentioning, that this practice was awarded by "Dubai international award" in 2014.

In addition Amira was the lead researcher for a new strategic initiative undertaken by UNICEF that focuses on Public finance towards children in Egypt in 2018. On the regional and international level, Amira has work experience in Jordan, Lebanon, Yemen, Morocco and Libya. And participated in different international events; i.e. Alternative care Conference in 2016 and World Economic Forum in 2008.

Amira holds a master degree from Tor-Vergata University, Rome in Economic Development and Bachelor degree in Economics from Cairo University.

One moment you're covered in blood and next it's what's for tea? An interpretative phenomenological analysis of residential care staff's experiences of managing self-harm with looked after children.

Alicia Madeleine Brown, Raymond Chadwick, Lisa Caygill and Joyce Powell

Abstract

Young people in care have been found to have a higher incidence of self-harming behaviours. However, despite research findings that managing self-harm can be stressful for carers, there has been a dearth of literature which has specifically examined residential carers' experiences of this. Therefore, the current study used an interpretative phenomenological approach to explore the experiences of residential carers in relation to self-harm. Three superordinate themes emerged from the study, each with a number of subordinate themes. 'Surviving' illustrated how managing self-harm can be a difficult experience for residential carers and therefore they need a number of coping strategies to draw upon to manage. 'We're out here alone' represented participants' feelings around being held individually responsible for managing acts of self-harm and also feeling as though outside agencies were inadequate or slow to respond to the young people's needs. 'Losing control' reflected when coping strategies failed, and participants were left feeling uncontained. It also demonstrated the potential negative consequences on their life outside of work. Recommendations are discussed for future practice, including regular staff supervision, team consultation, training and shared risk planning.

Keywords

Residential care, care staff, experiences, self-harm

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Introduction

The challenges of working in residential childcare

Residential carers are those who support young people living in children's homes. The young people who live in such homes often have extensive abuse histories, with complex attachment, social and educational needs. Residential carers who work directly with these young people are regularly exposed to daily stressors within the home, including but not limited to physical and verbal aggression, efforts to run away, self-harm and suicide attempts (McLean, 2015). Intervening in such situations can be highly stressful for the residential carers and can often leave them as the target of aggression (Seti, 2007). They are arguably supporting some of the most complex children in society, however, official reviews have highlighted that often their level of training does not adequately prepare them to manage such complex children (Department for England, 2012). Although there has been some headway in improving the training standards with the introduction of the Level 3 Diploma in Residential Childcare there is still no minimum training standard agreed across the UK (Narey, 2016).

Looked after children and self-harm

Self-harm is believed to be due to a combination of genetic, biological, personality, psychological, social and cultural factors (Evans, Hawton & Rodham, 2004). Hawton, Saunders and O'Connor (2012) set out a list of factors based on previous research, which can increase the risk of self-harm. Looked after children are often exposed to an increased number of these risk factors,

including: poverty, low income, parental relationship breakdown, substance misuse, mental health problems and / or chaotic or unstable patterns of parenting (Sweeny, 2008). Hurry and Storey (1998) reported that although looked after children only make up 1% of the population they account for 10% of the young people who present in accident and emergency following self-harm.

Specifically those in residential care are at the highest risk of self-harm. This is perhaps not surprising as they often have the most serious forms of mental health problems (Hawton et al., 2012). Meltzer and Lader (2004) found that in Scotland 39% of young people in residential care self-harmed compared to 18% living with birth parents. More recent studies have found proportionally similar prevalence rates. Harkess-Murphy, Macdonald and Ramsey (2013) reported that 32% of young people in care had self-harmed or thought about self-harming, compared to 12% who were not in care (Doyle, Treacy and Sheridan, 2015). Caution should be taken with the more recent studies though as these were taken from much smaller surveys. Given the high rates of self-harm in residential homes it is likely that the residential carers who support these young people encounter intense experiences, which may produce powerful emotional responses (Furnivall, Wilson, Barbour, Connelly, Bryce & Phin, 2007).

In caring professions it is well acknowledged that self-harm can be a particular stressor for staff (Saunders, Hawton, Fortune & Farrell, 2012; Tofthagen, Talseth & Fagerstrom 2014). The majority of studies in this area are quantitative in nature and examine hospital staff's attitudes towards those who self-harm (Friedman, Newton & Coggan, 2006; Mackay & Barrowclough, 2005). A smaller number of qualitative studies have also explored nursing staff's experiences of inpatient mental health settings and found themes relating to feelings of uncertainty and concerns over potential fatality (Thompson, Powis & Carradice, 2008; Wilstrand, Lidgren, Giljie & Olofsson, 2007). In addition to the literature on nursing professions, studies have been conducted with parents of children who self-harm. This is particularly significant because those who care for looked after children take on a therapeutic parent role, which hybrids their formal job role of carer, with the more emotional investment that a parent would usually provide. Ferrey, Hughes, Simkin, Locock, Stewart, Kapur, Gunnell and Hawton (2016) undertook a qualitative study in the UK with 35 young people who had

self-harmed and their parents. Thematic analysis highlighted the on-going emotional impact on parents. One parent stated that 'she was surprised she never got carted away in a white jacket' (p. 3), while others stated they had problems with sleeping and eating due to anxiety. Parents also reported the negative impact on their marriages, other children and jobs, as well as the isolation brought about by feelings of guilt from what others may think. Similar findings have also been elicited by earlier studies (McDonald, O'Brien & Jackson, 2007; Oldershaw, Richards, Simic & Schmidt, 2008).

The experiences and impact of self-harm on residential carers

Despite the evidence that the role of residential carers in children's homes is challenging, there is a scarcity of literature about the impact of working with self-harm.

Furnivall et al. (2007) conducted a survey-based study of residential childcare staff in Scotland. The aim was to compare the results with other professionals' opinions, which had previously been collected in the Scottish Needs Assessment Programme (SNAP, 2003). Questionnaires were sent out to 10% of the workforce (289 residential carers) and replies were received from 104 (36%). Residential carers described the nature of the problems, including violence, aggression, self-harm and substance abuse. One item on the questionnaire invited comments on the most recent and most worrying experiences of working with looked after children. One respondent reported 'self-harm with cutting to all areas of the body especially the genital area' (p. 6). When asked about the impact of their experiences, one residential carer stated: 'I am only a carer — this was way over my head' (p. 9). Overall the results from the survey offer insights into the views of residential carers. The response rate although only 36% compares favourably with other studies of this kind.

The only qualitative study identified, which has concentrated on residential carers' experiences of self-harm in looked after children was that by Williams and Gilligan (2011). One theme elicited from their interviews was *the impact of young people's self-injurious behaviour on staff*. Participants spoke about how the impact of the incidents encroached on their family life 'you'd be thinking

about it at home, telling your partner or family. I was very shook up' (p. 18). One participant reported the incidents to be harrowing, stating that she had 'nightmares after the incident' (p. 18). Another participant described the incidents as being quite traumatic reporting that that she was a vegetarian with a fear of blood but had started to buy red meat so she could desensitise herself as she felt her reaction to blood was escalating incidents. Unfortunately this study does not specify any recognised qualitative research method. It appears that no systematic analysis was used but rather patterns were identified intuitively and reported.

Rationale for the research

In summary, looked after children, and specifically those in residential care, are at increased risk of self-harm due to being exposed to a greater number of associated risk factors. There have been numerous studies investigating the impact self-harm has on parents and caring professionals with them all reporting that these experiences evoke strong emotional reactions. Conversely, the experiences of, and the impact self-harm has on residential carers specifically, has been relatively neglected. A thorough search of the literature only discovered one paper, Williams and Gilligan (2011), which did not use a systematic analysis to derive the themes.

The rationale for the present study was that a robust phenomenological analysis of residential carers' lived experiences of self-harm was needed.

Method

Residential carers' experiences of managing self-harm is suited to a qualitative approach as this allows the participant, without restraint, to reflect on their experiences in their own words. Interpretative Phenomenological Analysis (IPA) is a method described by Smith, Flowers and Larkin (2009) and emphasises how people, although experiencing the 'same' environment, may perceive it in different ways (Willig, 2008, p. 53). Therefore the stance of IPA assumes that data collected allow access to people's interactions with the world and the sense they make of it.

IPA is underpinned by a number of theories including phenomenology and hermeneutics. Phenomenology relates to putting aside our 'taken for granted' experiences and instead concentrates on our perception of them. While hermeneutics is the study of interpretation — the whole is understood in terms of the parts, and each part is understood in terms of the whole. IPA involves a 'double hermeneutic', in that the individual participant is making sense of their experiences, while the researcher is making sense of the individual's meaning making (Smith & Osborn, 2008).

Participants

Participants were residential carers and senior residential carers (in the UK this title is used for senior members of the team who have a higher level of qualification or experience) who worked in Local Authority (LA) children's homes in the North East of England. Participants had to have had direct contact with a looked after young person who had self-harmed in the home within the last three years. Nine participants were recruited for the study (four males and five females; four senior residential carers and five residential carers — pseudonyms are used throughout).

Ethics

Ethical approval was granted by Teesside University School of Health and Social Care Research Governance and Ethics Committee. Further to this the LA's Research Advisory Group granted approval.

Interview format

Data was collected via semi-structured interviews guided through an interview schedule. An hour was set aside for each interview to take place. Participants were asked open-ended questions about their general and specific experiences of self-harm, the impact self-harm had on their relationships and the support received in relation to managing incidents. All interviews were taped with a digital recorder and transcribed verbatim.

Data analysis

The transcripts were analysed using IPA. Firstly the transcripts were read repeatedly to help the researcher become immersed within them. The next stage

was initial noting, whereby the researcher noted down anything of interest under 3 types of comments: 1) *descriptive comments* (describing the content); 2) *linguistic comments* (exploring the specific use of language); and 3) *conceptual comments* (conceptualising what had been said). Emergent themes were then identified from the initial notes. Each transcript was then attended to separately by reorganising emergent themes into related clusters. At the end of this, an initial map of how emerging themes fit together for each transcript was produced. The final step entailed looking for connections across the whole sample. The list of themes was drawn up for the whole and then reconfigured into superordinate themes, which represented shared higher order qualities.

There are a plethora of guidelines, which assess the quality of qualitative research and Smith, Flowers and Larkin (2009) recommends Yardley's (2000) guidelines. These are made up of four principles: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. A number of these methods were employed in this study to enhance the credibility of the findings. These included participant validation, where members were contacted after the analysis to check that themes were reflective of their narratives. Six out of nine participants responded with comments stating that the themes reflected their experiences. The remaining three participants did not respond. Triangulation was undertaken with supervisors to improve the validity of the research. A reflective diary was also used to make the researcher's assumptions and existing beliefs transparent as it is inevitable that the researcher's own preconceptions will have an impact on the interpretation of the research. The researcher used to work in residential care; therefore it is likely that this will have had an impact on the interpretation of the data. The reflective diary helped to circumvent this, as well as keeping as close to participants' accounts as possible.

Results

The analyses of the nine interviews led to the emergence of three superordinate themes, which contained varying numbers of subordinate themes. Figure 1 illustrates this.

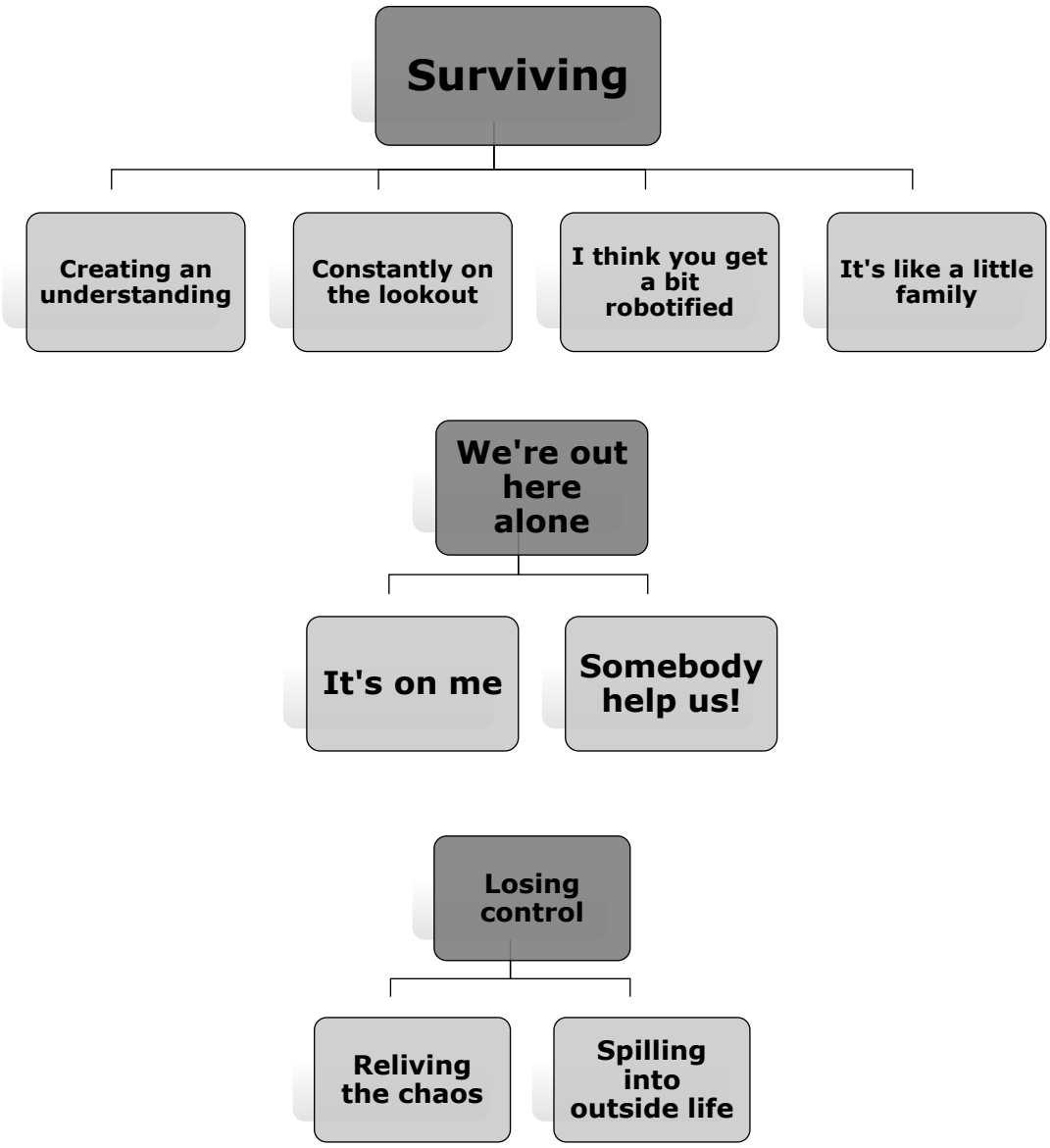

Figure 1: Superordinate themes (dark grey) and subordinate themes (paler grey)

Surviving

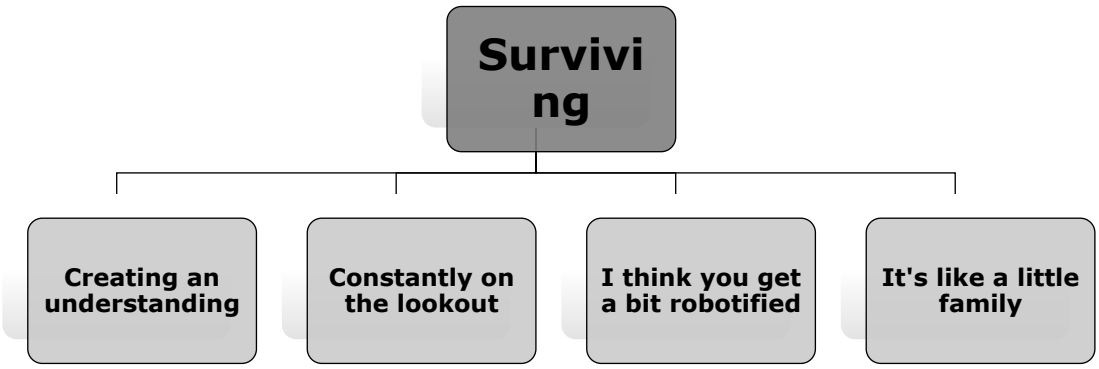

Figure 2: Superordinate 'Surviving' theme (dark grey) and its subordinate themes (paler grey)

The first superordinate theme illustrates how participants need a variety of coping strategies to manage self-harm both in relation to the behaviour itself, and to their own responses to it.

Creating an understanding

Participants tried in a variety of ways to comprehend the behaviour and seven out of nine participants imposed a self-defined framework of categories:

> Rachael: I think some self-harmers, even myself rightfully or wrongfully probably have them in three categories; your kind of minor superficial self-harmers, a little bit of a cry for attention, your middle ones that are hurting themselves and they're a little bit more serious and then I think you have your high end self-harmers (…) ones that really do damage when they cut themselves and it's kind of a life or death situation.
>
> Nick: If someone cuts on the inside of the arm very deep, I'm severely concerned about that person but scratches on the outside, I'm not as concerned that it's life threatening.

> Victoria: It seems to be for me 2 levels, people who self-harm (…) to follow trends and then you'll get the other end of the scale where people (…) use it for a coping mechanism.

The participants seem to use the categories to help guide how risky the behaviour is, which may assist them in feeling as though they have some control in managing it.

Rachael also made sense of the behaviour in an intellectualised way rather than in a way that connects with the young person's story at an individual level:

> Rachael: But on the emotional side, that's a little bit more different because you want to get to the root of what is driving it, it's quite hard to listen (…) it's just not nice to hear their stories and how sad they feel inside to make them want to hurt themselves. So the physical bit I don't find that difficult to deal with (…) I'm not scared of blood.

In this excerpt Rachael names that it is difficult for her to deeply connect with the young person's history. It appears that the correction aspect of the act, that is the problem solving, is much easier for her to put into action than the connection side, where she has to relate with the affect being communicated.

Constantly on the lookout

This subordinate theme reflects how participants are often on high alert either to pre-empt self-harm or to respond quickly if necessary.

> Adam: [Y]ou've got to try and be aware at all times, especially with this young person, you have to be on alert from the moment you come in to the moment you leave your shift.

> Tracey: It's worse for me if someone doesn't know how to safely self-harm (…). So you've always got to have your eyes peeled and be ready to respond.

Stephanie goes on to explain how this can be mentally tiring:

> Stephanie: You're constantly on the look and on the go. It's mentally draining. It's not so much a physically draining job but

> the self-harm and stuff as well, it's mentally draining and I think it's because you're constantly on the look and on the go.

I think you get a bit robotified

A number of the participants talked about how they have learnt to manage situations of self-harm in a robotic fashion, which incorporates both an autopilot type response to a situation and also a way to detach from their own feelings. Participants use a variety of words to describe these responses. Rachael and Eric discuss what they call the robotics:

> Rachael: We explain to some of our kids that, 'we are humans too you know, yes we might deal with some incidents like robots because we're that used to, but, do you think we'd be doing this job if, if we didn't care?'

> Eric: I think you get a bit robotified and just deal with it.

Nick discusses how he goes into autopilot:

> Nick: I think you kind of go into sort of autopilot (…) you go into this alright ok, I'll dress the wounds, I'll talk to them, I'll see if I can get the root problem(…). So it just kind of like clicks in.

It's like a little family

Team support was described in nearly all of the participants' accounts; however there was some variation in how participants described this. Janet speaks of it like a family:

> Janet: We're all quite close in here as well, so, it is like a little family, so, you can be quite open about how you feel;

Tracey talks about the team in an intimate way too:

> Tracey: It's a strange place residential because you spend that much time with people I can go to the kettle and put 13 cups out and I can make everyone's cup of tea and coffee, exactly how they like them (…). You spend so much time with people, you do become very important to each other and I think that's when it's

> difficult, when there's a lot of self-harm that them relationships are really important.

The way she talks about the specific preferences of tea and coffee exemplifies the importance of each individual relationship to her. Calling residential 'a strange place' also links in with how intertwined this job role is in comparison to other jobs.

We're out here alone

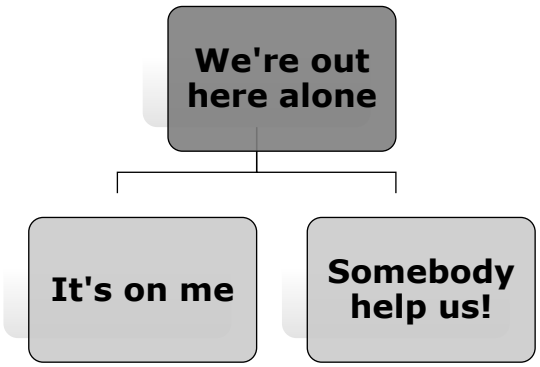

Figure 3: Superordinate 'We're out her alone' theme and its subordinate themes (paler grey)

The second superordinate theme focuses on how participants can feel a host of responsibilities for managing self-harming behaviour, whilst also feeling unsupported from outside services.

It's on me

This subordinate theme focuses on the responsibility participants feel for managing the act of self-harm correctly.

> Rachael: [B] ut I definitely worry about the blame thing. So, some people might try to avoid dealing with a self-harmer because they're that fearful that if something goes badly wrong and there's a fatality (…) are you going to be blamed and hung out to dry (…) so, it's very worrying, if there was a very serious incident, how you would be treated as a member of staff and how that would be looked into (…). It's bad enough trying to live with that anyway, especially if you were caring for that young person, without all the other pressure of the organisation or the police (…) or whatever investigations have to unfold, looking into the ins and outs and trying to point a finger somewhere as if there's a negligence.

There is a strong sense that any efforts to do the right thing would be criticised and her concerns seem to relate to the fact that someone has to be blamed regardless of whether this is warranted as she states 'and trying to point a finger "as if" there's a negligence'.

Nick refers to the many questions which run through his mind:

> Nick: I think in work you're more concerned about doing the right thing. 'Have I ticked these boxes? Have I notified the right people?' Your mind is ticking over about legalities. You know 'have I done the right thing?'

Again Nick has to ensure everything has been done correctly so that if there were any repercussions he would be covered. It may be that staying close to policy helps him feel more secure and that the risk is shared.

Adam also speaks about the amount of pressure he feels in making decisions:

> Adam: If something happens to them we're going to have to live with it and then answer the questions of why didn't we do this or why didn't we do that?

Somebody help us!

This subordinate theme was heavily present in certain participants' accounts and referred to participants feeling unsupported from those outside of the home.

> Tracey: [I]t's just that, there's a need for support amongst ourselves but it can …almost feel like a deafening silence from the other side of that bubble that we're in and as a team we can send off long emails and concerns and two days later you're back and you're like, nobody has heard me (laughs);

Tracey's use of metaphor to describe the home like a bubble illustrates something which is penetrable and visible to others but yet untouched. She explains how she makes attempts to break the bubble, which often go ignored. Roger also talks about his frustration with not having help from outside agencies:

> Roger: [W]e make the referral and we get told there's a six month waiting list and there's a four month waiting list and we sit and watch our young people get destroyed;

Tracey goes on to express her concerns that the looked after world is intentionally kept concealed, and this is perhaps a societal defence because the truth about what children in care have been through is too difficult for people to absorb.

> Tracey: I think people want to not acknowledge the truth about children in care.

Losing control

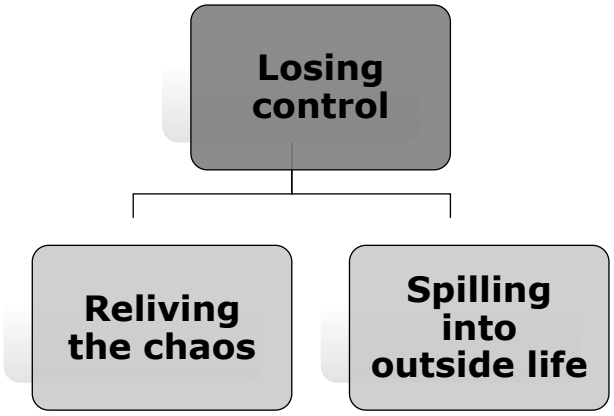

Figure 4: Superordinate 'Losing control' theme and its subordinate themes (paler grey)

The third superordinate theme describes how participants' coping strategies can at times fail them, leading to problems both in the moment and after the event, which can manifest as a loss of control.

Reliving the chaos

This subordinate theme illustrates how participants can experience a breakdown in coping strategies, which can leave them feeling stressed. Stephanie's extract shows an example of this:

> Stephanie: Time slows right down, so, a minute can seem, like (…) 15 minutes but it must have only been 5 or 3 or 2 (…) and you're just thinking, safety, safety, safety, all the time, keep them safe, you know. And your brain gets busy and you can't think properly. You're thinking you haven't got gloves, shit you haven't got gloves, you'd get shot if you didn't put gloves on but you know you have to put the bandage around but I've got no gloves on but you know, you have to stop that bleeding.

Stephanie's account describes how her stress impacts on her ability to both estimate time correctly and think coherently. Her language in the extract also appears to mirror her stressed state as she repeats herself on numerous occasions and discusses how her mind gets more active at these times.

Other participants' recollections also encapsulated the traumatic element of these events. Roger summaries this succinctly:

> Roger: I think they stay with you all the time. They do stay in your brain like, (pause) they can be quite traumatic sometimes.

Spilling into outside life

The majority of participants spoke about how their work spilled over into their home lives in a variety of forms. Tracey talks about how difficult it can be:

> Researcher: How has the experience affected you outside of work, do you think?
>
> Tracey: I think, it's just (…) learning to find ways to switch off and jump back into normal life, like you can be walking around a supermarket thinking, last night I was covered in blood and somebody cut their wrist all down here and were bleeding all over and I wrapped it up and I went to the hospital and got them sorted and now I'm trying to decide whether I want chicken or pork and it's like, it can seem so hard sometimes to switch that back to normal.

This seems to show the contrast between her two worlds and how she struggles to manage the disparity between them. Stephanie also discusses how she takes things home with her:

> Stephanie: I take it home with me but often when you're home, you've got no one to talk to, so you have to wait until you go back to work.

Eric goes on to speak about how the work has impacted his home life:

> Eric: Yeah, you miss out on a lot of social life, relationships and things. I've had (*xxx*) marriages since I've come here and that's not normal. I started sleeping when I sort of go home, do what I need to do and then have an hour and half's sleep, drink a lot more (pause);

Eric talks about how the job has caused ruptures in his relationships and appears to attribute this directly to the work. He also states that he uses alcohol as a coping strategy outside of work and pauses after he says this as if he knows that it is not an effective way to manage.

Discussion and clinical implications

This study is the first to use a robust qualitative method to analyse residential carers' experiences of managing self-harm with looked after children. Participants spoke about the challenging nature of managing self-harm in residential homes. For this reason they had learnt to develop an assortment of coping strategies which provided them with some assistance for managing these difficult situations and feelings.

Participants discussed the emotional detachment they experienced as a way to manage difficult aspects of the job. Whilst this may serve a purpose in the short term it is likely that this could impact on compassionate care in the long term as participants stated that over time they became cut off, which has implications for both the carer and the young person. Hughes (2004) discussed the concept of 'blocked care' whereby stress impacts on a parent's ability to provide love and empathy to a child which leads to a narrower focus on the child's behaviour. Empathy is a central tenet in the work relating to traumatised young people and if the staff struggle to feel empathy for the young person they are unlikely to make an emotional connection with them, which is vital for the young person's recovery (Hughes, 2004). To assist with this, reflective practice could be used to facilitate residential carers' understanding of the reasons for and impact of emotional detachment. Previous studies have found similar responses whereby nurses had learnt to 'shut off' in order to manage their feelings (Thompson, Powis & Carradice, 2008).

Another finding of the study relates to the stress of managing incidents of self-harm due to the fear of blame. Participants found that at times the weight of responsibility for managing self-harm was a foreboding concern. Yalom (1998) states that people actively try to remove themselves from responsibility due to the fear of being held responsible. In relation to this, Maurizio (2008) discusses the blame function logic, whereby people are either 'right' or 'wrong' for their

actions. He notes that this logic is often applied to frontline staff as opposed to seeing the linear causes which may have led to the events. Reason (1997) states that due to the high levels of autonomy in Western culture individuals are taught to be individually responsible, thereby when an incident occurs people search for a culprit. In this respect a blame culture develops, as Rachael says. 'trying to point a finger somewhere "as if" there's a negligence' as opposed to looking at the system. It is possible therefore that staff members' reliance on ticking boxes and following procedure is a way to externalise some of the responsibility back to the system. Previous research has found similar results whereby nurses found the responsibility for potentially fatal actions difficult to tolerate (Thompson et al., 2008; Wilstrand et al., 2007). Williams and Gilligan (2011) also found that residential carers worried about deviating from procedure because the responsibility was left with them. To help overcome this, risk management plans could be put in place by the care team with the support from appropriately trained mental health professionals such as Child and Adolescent Mental Health Services (CAMHS) clinicians and specialist Looked After Children Services. This could further be supported by wider systems such as education and in-house parties. Such forward planning provides a more collaborative approach which means the whole system works together with carers feeling they are working in partnership as well as being validated in terms of the importance of their role.

There was also a strong consensus amongst participants that external support was not readily available or adequate for the young people and participants relayed their concerns about long waiting times. There also seemed to be a feeling amongst participants that the looked after system was being concealed from society. This appears to demonstrate the concept of societal defence, which is a way of protecting against the truth around the trauma which children in care have suffered (Jacques, 1955). Foulkes (1948) first discussed the concept of the social unconscious and Weinberg (2008, p. 15) defined it as 'the co-constructed shared unconscious of members of a particular social system such as community, society, nation or culture'. Hopper (2003; 2012) states that social trauma is particularly prevalent in relation to the social unconscious as collectively society defends against the difficult feelings associated with trauma

through secrecy and taciturnity. This fits with the account that the looked after world is hidden, perhaps so that society do not have to tolerate the uncomfortable feelings it engenders.

Another finding of this study was the feeling of participants 'losing control' which related to when participants' coping strategies started to fail them which led to problems with their own containment. For some participants this loss of control manifested as a stressed response to the child's self-harming behaviour. This is perhaps not surprising given that they are expected to be responsible for managing the act 'correctly', yet as discussed in other themes they feel inadequately supported and scrutinised. It also goes against their presumed inherent want to care and protect. It is also possible that the participants' stressed response may be a reflection of the powerful projections and re-enactments that the young person uses to communicate their internal world.

Johnson (2016) states that residential staff are at risk of primary traumatisation, due to the witnessing of violent behaviour including self-harm; and also secondary traumatisation due to being exposed to another's traumatic experiences and symptoms. Trauma was not the focus of this study, and this therefore remains a tentative link; however there did appear to be indications of trauma present in participants' accounts. Senior managers should be aware that the situations care staff deal with may cause lasting psychological effects. Perry (2003) states as there is a lack of investment in frontline services for secondary trauma, supervisors are left with the task of managing this within the homes (p. 8). In this respect, services need to be better informed about how trauma impacts on care staff and how supervision, consultation and training can be used proactively to address these issues sensitively.

Participants also spoke about how the work impacted on their life outside of the home. This relates to previous research by Ferrey et al. (2016) who found parents of children who self-harm to have on-going problems with their emotional state which had ripple effects into family life. Williams and Gilligan (2011) also found managing self-harm to have a negative impact on home life for residential carers. Tyler (2011) reports that in order to manage these feelings, care staff may leave the organization, go on sick leave or build up more rigid defences, which further perpetuates the problem.

Although it sits outside of the realms of this research it is possible that the three superordinate themes reflect the children's internal world: surviving, feeling alone and struggling to cope. Previous work by Hindle and Shuman (2008) reported similar findings with their play therapy case study 'Sam': a 9 year old boy who had been in care. Through his plasticine modelling of a war zone they interpreted his internal world as one of 'standing alone, taking on the whole world and surviving' (p. 83).

Recommendations

- Reflective practice groups facilitated by professionals with appropriate training and experience to help staff better understand their emotional reactions to self-harm and the implications of these.
- Professionals who are appropriately trained in risk management to consider supporting the creation of risk plans when the young person is stable which incorporate the views of the carer. This will help the residential worker to feel more empowered and supported in their role.
- Training for managers and staff in supervisory positions relating to the psychological impacts of managing self-harm and how this could be incorporated usefully into their supervision.
- Consultation and training for residential care staff on trauma informed care and its associations with self-harm.

The current study only focused on residential carers and senior residential carers. Future research could explore home managers' experiences of self-harm to see how the results compare to the current study.

Limitations

Every effort was made to ensure the results of the study were robust, but it is important to acknowledge its limitations. Only six of the nine participants responded to the participant validation and therefore it is possible that the three who did not respond did not agree with the themes. Also the researcher's previous experience of working in a children's home may have influenced the themes elicited.

Conclusion

Managing self-harm was reported to be an emotionally demanding experience for care staff and they had learnt to manage using a variety of coping mechanisms. In the short term these were effective but had potential to incur longer-term damage to both themselves and the young people. Clinical implications included the need for more focused supervision around the potentially traumatic elements of managing these events, consultation for staff teams and a move towards shared risk planning. As this study is relatively novel, future research is recommended to expand on the specific findings of the research in more depth.

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The 16th Kilbrandon Lecture (University of Strathclyde, 22 November 2018): A Fifty Year Journey: What have we learned? Reflections on the 50th Anniversary of the Social Work (Scotland) Act 1968

The Right Honourable Dame Elish Angiolini DBE, QC, FRSE

Keywords

Kilbrandon Lecture, children's hearing system, youth justice, Social Work (Scotland) Act 1968, Scotland

Minister, honoured guests, ladies and gentlemen: it is an immense honour to be invited to deliver the Kilbrandon Lecture, particularly in this, the 50th anniversary year of the Social Work (Scotland) Act 1968. As many of you know, the statute was passed to promote social welfare, including the implementation of the crucial reforms on child justice and welfare recommended by Lord Kilbrandon's Committee. I speak with well-deserved trepidation, following many years of outstanding lectures from experts on the Children's Hearing System and child development and in an audience full to the brim with similar experts.

It is also a real pleasure to return to my alma mater. An infectious passion for the study of law and dedication to their students has left me with a profound debt of gratitude to the members of the Law Faculty of this great University.

Given this significant anniversary, may I also take this opportunity of thanking our social workers in Scotland who have worked in child care and with families over many decades, as well as those working with offenders and victims. Good news only rarely sells newspapers but bad news always does. Day in and out our social workers go where others fear to travel, doing brilliant work on our behalf. They are the front line in dealing with issues from which many of us had the luxury of distance to consider. I thank you all for your vocation, your dedication and incredible resilience. I will come to Reporters and panel members and their army of supporting volunteers in due course.

I am most certainly not an expert on the Children's Hearing System but as a Scottish prosecutor in various capacities over many years, I worked closely with Reporters, with child witnesses and with young offenders, some of the latter having sadly crossed over from that system to the criminal justice system. The guiding principles, ethos and operation of the Children's Hearing System have always been a source of inspiration and encouragement to me as I matured as a prosecutor, and indeed, as a human being (though the concepts are not, I hope, mutually exclusive).

The title of my lecture this evening poses a simple question, 'What have we learned?' This anniversary presents a further opportunity to consider how our approach to children in trouble has evolved over those years, along with our understanding of what is in the best interests of the child. The further

adjustments brought about by human rights considerations and a greater recognition of what works in tackling children in trouble have also obliged us to accommodate different perspectives within the setting of the Hearing.

Moreover, the passage of those 50 years challenges us to ask why the insightful thinking and radicalism of Kilbrandon was not imported into the adult justice system with any alacrity. Why did that radicalism halt at the age of 16 or 18? The problem solving approach characterising the Children Hearing's System has been very slow to develop in the adult courts where we continue to imprison excessive numbers of offenders, despite the knowledge of its inefficacy in securing desistence and its exorbitant costs to society. While we have learned much, I conclude, in response to my question, that we have not yet learned enough.

Maya Angelou, the brilliant poet and writer who survived a hellish childhood once wrote: 'Do the best you can until you know better. Then, when you know better, do better' (popular attribution, no source).

Few could argue that in 1964 Lord Kilbrandon and the members of his committee not only did their best but in doing so created a visionary and insightful alternative to the then juvenile justice system; an alternative which thrives today, despite the passage of time, the rapid development of human rights jurisprudence and a social environment so radically different from the 1960s. In 1964 the Committee described its fundamental business as being about children in trouble. 'Trouble' was a condition exhibited by delinquent behaviour, being in need of care and protection, beyond parental control or involved in persistent truancy – or any combination of these.

The essence of the Kilbrandon Report has been described as proposing a philosophy of 'needs not deeds'. The Report emphasised that the distinction between offending by children and children in need of care and protection was of little or no substance when the child's family environment, social conditions and needs were considered. The Committee determined that both aspects should be dealt with under the one system, explaining:

> 'If public concern must always be for the effective treatment of delinquency, the appropriate treatment measures in any

> individual case can be decided only on an informed assessment of the individual child's actual needs' (Para 12).

The Committee's report continues:

> 'in terms of the child's actual needs, the legal distinction between juvenile offenders and children in need of care and protection was, looking to the underlying realities, very often of little practical significance' (Para 13).

In what Lord Hope[2] was to describe at the occasion of the Kilbrandon lecture in 2014 as: 'the genius of the Kilbrandon reform', the Committee followed a model already in place in some Scandinavian countries and described by Professor Bill Whyte as, one separating out the adjudication of the legal facts — requiring a professional judge — from the disposal of the case, in which criminal judges had no particular claim on expertise.

What came about was a juvenile justice system, founded on the principle of the welfare of the child and presided over by a lay tribunal. The decision to refer the matter to a Hearing and the presentation of the evidence supporting the referral was given to the Reporter, an independent official with the power to determine who should be referred to the Hearing for consideration of compulsory measures of care, or to be dealt with by more informal means.

First Encounters

My first encounter with the notion of what became known as The Children's Panel occurred in 1973 when I was 12. My friend and I were in the habit of climbing up and into a tall hedge in Brighton Place, where I lived in Glasgow. The hedge formed, ironically, the perimeter of the Govan Child Guidance Clinic and was divided by a gate. Both of us would sit, camouflaged and high up in the hedge on either side of the gate, as if keeping sentry, while we chatted and observed the world passing by below, making the occasional noise to disconcert passers-by. One evening a policeman walked by beneath us and caught us, perched up there in the hollows of the hedge. He took out his notebook to 'book'

[2] Lord David Hope gave the Kilbrandon Lecture in 2014.

us as it was called and asked for our names because he said he might have to refer us to the 'Panel'. He was of course just scaring us but his use of the phrase, 'The Panel', seemed deeply sinister to me and I associated it with being sent to a List D school.[3] I accordingly provided him with a false name and address — and he duly pretended to write it down. This pastime was not my first encounter with the police, however, who used to chase us off when we pursued our other shady hobby of 'watching' football supporters' cars outside Ibrox Park for a small ransom.

My much closer encounter with the Panel came in 1984. I had just started my traineeship as a procurator fiscal with the Crown Office (COPFS, Scotland's prosecution service) and in January 1984 was sent to spend three weeks with the late, great Alan Finlayson, a child law expert and senior lawyer, who became the very first Reporter to the Children's Panel and who was at that time the Reporter for Edinburgh. On my first day, it snowed very heavily and the pavements were sheets of ice. I had come from Glasgow dressed for the weather in a purple padded coat, purple woolly hat and red moon boots. Moon boots as most fashionistas know have no grip. As I approached the Reporter's Office I slipped and fell over three times within a distance of about 20 feet. I looked up and saw who I now know were Alan Finlayson and his wonderful colleague Malcolm Schaffer standing at the window holding their coffee mugs and looking very concerned, more so when they realized that this strange looking, walking duvet was inching her way towards their doorway.

Despite the inauspicious start, my time listening to these men and their colleagues and observing their work over the following three weeks had a profound influence on my entire career. Watching the hearings and absorbing in those weeks the sheer awfulness of the lives of the children referred to the hearings made it clear why poverty, violence, and the absence of reliable nurturing were such potent predictors of troubled behaviour in childhood and beyond. The compassion, expertise and pragmatism with which these two men, their staff, and the Panel members responded was remarkable. The notion of

[3] A now redundant category of residential school.

such a problem solving approach to justice in the adult courts was, however, still a long way off at this juncture.

But what I also observed during that visit was, that the children had no legal representation, that the proceedings were more formal than I had anticipated, with a large table separating the members of the Panel from the child, and that the Reporters were very clearly highly influential in the decisions made by the Panel. The whole atmosphere was very benign but the children were nonetheless tense. It did occur to me somewhere deep in my psyche then that, despite the benevolence, the children could do with an independent check on the assertion of what was in his or her best interests. The introduction of the role of independent Safeguarders in 1985 for circumstances where there existed a conflict between parents and the child came soon after my visit, with the role further extended to all children in the system in 1995.

Children in trouble

The characteristics of the life of a child likely to enter the Hearing System over the years were described compellingly by Sir Harry Burns in his Kilbrandon Lecture in 2011 as those who had experienced multiple adversities in early life, he said,

> 'The way in which we nurture children, the way in which we bring children into the world, and the way we in which we look after them in the first years of life is absolutely critical to the creation of physical, mental and social health' (p. 3);

He continued,

> 'Adverse events lead to subsequent poor behaviour in that child. The child is learning that he has no control and doesn't develop a sense of coherence. The stress response is such, that the brain growth pattern changes as a result…Unless we look after children properly, nurture them consistently, support them and their parents, who often don't know how to be parents, we will continue to reap the consequences in terms of criminality and poor health' (p. 25).

He was, of course, right and we have.

Darren McGarvey's brilliant but polemic work, *Poverty Safari*, about his early life in Glasgow provides a brutal glance into the disastrous environment that has been the childhood experience of thousands of citizens in this country. He wrote about the autonomic response of disassociation and the constant hyper-vigilance his body developed as default mechanisms because of the violence, and the sustained threat of violence, in his family home (McGarvey, 2017).

His description of his mother's reaction to his interruption of a drinks party she was hosting when he was five years old are all too familiar to me from my 27 years as a prosecutor. His book presents an eloquent portrayal of the hell experienced by children living in an unpredictable tinderbox when he wrote:

> 'she gave me a final warning to go back upstairs. I defied her. She held my gaze for a moment, before leaping out of her seat and charging into the kitchen. She pulled the cutlery drawer open, reached in and pulled out a long, serrated breadknife. Then she turned round and began pursuing me… I scrambled up the stairs as fast as I could but she was closing the distance between us. With nowhere to hide I ran into my bedroom slamming the door behind me, but it just seemed to bounce off her as she came charging through, clutching the knife… now I was trapped in my room, pinned against a wall with a knife to my throat. I don't remember what she said but I do remember the hate in her eyes' (pp. 12-13).

Some years later he reflected on his alcoholic mother's own difficulties and explained how she had also suffered a violent childhood.

Although the consequences of violence for children may vary according to its nature and severity, its impact can be profound. The 2006 United Nations Study on Violence against Children found that:

> 'Violence may result in greater susceptibility to lifelong social, emotional, and cognitive impairments and to health-risk behaviours, such as substance abuse and early initiation of

> sexual behaviour. Related mental health and social problems include anxiety and depressive disorders, hallucinations, impaired work performance, memory disturbances, as well as aggressive behaviour. Early exposure to violence is associated with later lung, heart and liver disease, sexually transmitted diseases and foetal death during pregnancy, as well as later intimate partner violence and suicide attempts'.

The late Professor Fred Stone, who delivered the 1995 Kilbrandon Lecture, a member of the Kilbrandon Committee, confirmed that the complexity of the challenge of the behaviours exhibited by severely disturbed children was not underestimated by the Committee in its deliberations in 1964 and there subsequently developed a realism that where such problems exist, 'children do not simply "grow out of them"' (p. 8). Part of the reason for the persistence of such behaviours was explained by Professor Stone as:

> 'because [such] children act in ways that create environmental stress which puts them at further risk.'

What was recognised in 1964 therefore was the critical need for early recognition of the severity of the problems faced by so many troubled children and of early intervention directed at the wellbeing of the child. What was less obvious and less understood or recognised for many more years was the horrendous extent of the less patent but deeply damaging sexual abuse of children, both in their family environment and, tragically, in some of the very institutions to which they were sent to address their recognized vulnerability to chronic abusive behaviours. As Lord Hope (2015) observed about the Report, in a previous Kilbrandon Lecture: 'The phenomenon of child abuse was not mentioned. There must have been a lot of it going on, but it still lay under the surface — unobserved, not talked about' (p. 2). Sadly, we have learned a great deal since. (In the early 1980s the word 'grooming' had not yet entered our prosecutorial vocabulary).

Profile of cases

Despite the explicit recognition of some of the underlying realities of troubled behaviour in the Kilbrandon Report, the dominant profile of cases referred to the Hearings for a substantial number of years arose from offending by older children and young people. This emphasis was unsurprising in the early years given the considerable concern about youth delinquency in the early 1960s and the criminal behaviours that had been the main catalyst for the Report. There therefore followed a dramatic and massive surge of such offenders from the criminal justice system into the hearings. List D schools were a regular destination for some children. Nina Vaswani and colleagues describe the approaches in these schools as harsh regimes — the norm in the 1970s (Vaswani, Lightowler and Dyer, 2018). Malcolm Schaffer has explained however that over the years the type of referral changed to reflect growing concerns about younger children at risk and that,

> '…more regulation and control has been placed on residential child care placements, especially concerning the use of secure accommodation, and far greater use has been made of foster and kinship care' (Schaffer in Vaswani, Lightowler and Dyer, 2018, p. 11).

As a young Procurator Fiscal in Airdrie in the 1980s I used to meet Reporters to discuss older children and young offenders under 18 who had been the subject of joint reports from the police to the Procurator Fiscal and the Reporter. The meetings formed the basis of often vexed discussions as to whether such children should be retained in the Children's Hearings system or considered for prosecution. It was clear then that many of these teenagers had several previous referrals to the Reporter on offence and care and protection grounds and that the Reporters felt that the range of disposals available to the Hearings could not adequately address this older group of hardened, gallus[4] but vulnerable children. They felt that the Panel was not well placed to deal with this older group and that there was a pressing need for more creative and effective disposals that could deal with their complex needs and behaviours.

[4] *Scots*: self-confident, daring, cheeky

The reality at that time was that entry into the adult system was even less likely to produce outcomes that could tackle offending behaviour; behaviour which was often by this stage already ingrained in their lifestyle and in respect of which there existed a paucity of well researched, nationwide and effective alternatives to prosecution. This absence of alternatives meant that there was little available to inhibit their almost inevitable and futile progress towards imprisonment.

The need for diversion from prosecution is still uppermost in the mind of the prosecutor and over the years much more use of diversion has become possible but there is still a need to make significantly more effective programmes and resources available to the Crown and the Hearing System to prevent these young people entering jail. As the Solicitor General, Alison Di Rollo QC, observed at a recent conference: 'prosecutors are fully aware of the devastating consequences of prosecuting a child and are fully alive to their responsibilities' (2018).

While Vaswani et al. (2018) note the absence of reliable data over many years, they confirm that youth crime remained fairly steady in the decade between 1977 and 1988. There was then a sharp rise in youth crime and in non-offence referrals with numbers peaking in 2006, (the numbers swollen by the many children referred by police because of domestic violence in the household). In 1972 the number of children and young people referred to a Children's Hearing was 17,950. In 2017/18 that figure has fallen to 13,240 or by 38.6%, (figures produced by the Scottish Children's Reporter Administration).

Most significantly, of those 13,240, 11,268 were non-offence referrals. In fact, 84% of the children and young people subject to a Compulsory Supervision Order as at March of this year (2018) have only ever been referred on care and protection grounds. This of course is almost a complete reversal of the profile of cases dealt with in the early years.

This sea change has been attributed to the growing expertise of all those in the system about the impact of family and home environment on the lives of children. That knowledge of the damage created for children who are the subject of, or living with, domestic violence or sexual abuse, alcohol and/or drug abuse or psychological harm has become much wider in our communities as has the

impact of a childhood starved of reliable love and affection. The effect of the extent of that growth in understanding was noted by Malcolm Schaffer as resulting in 8527 children aged under four being referred to the Reporter in 2013 compared to 478 in 1976.

The dramatic reduction in the number of offence related referrals by children is also mirrored in a similarly steep reduction in recorded crime in Scotland in 2017-18 to 244,544 crimes, the second lowest level since 1974 according to National Statistics (Scottish Government, 25th September 2018).

The introduction of a brilliant new child strategy in 2007 known as GIRFEC or Getting it right for every Child, has encouraged much greater inter-agency identification of cases requiring referral and early intervention and of those that can be diverted from formal measures. Schaffer attributes the dramatic changes in referral rates to the success of this whole system approach, an approach he considers could have been achieved many decades earlier if the Kilbrandon recommendations on integration in social education departments of the functions of child and family social work with those of education departments had been implemented. The resources to maintain the success of this initiative will also be crucial if we are not to burn out those taking it forward.

So while those in the system have been able to put in place practices allowing long standing knowledge about early intervention, prevention and inclusion to prevail, what we have also learned is the need for much better integration of those with relevant functions if existing expertise is to be put to better effect for every child. What seems eminently sensible, indeed, obvious, should not have taken so long to come about. Hard questions need to be asked about why it took us so long to learn, given Lord Kilbrandon's exhortation for the need for integration in his Report in 1964.

Changing legal framework

Over the years we have also had to develop a far greater understanding of why the child's right to participate in the Hearing involves more than the appointment of a Safeguarder. While a challenge to the grounds of referral brings with it the

full rights to legal representation before the Sheriff[5]), the decisions made by the Hearing can also clearly have a profound impact on Convention and other rights of the child.

Although the Kilbrandon Report envisaged the child as an active participant in the hearing, the paternalistic approach as to how the child could exercise that right effectively meant that those rights were given less emphasis than we now know to be necessary. The decision of the European Court of Human Rights in McMichael v UK [1995] 20 EHRR 266 dealt with the right of access to all papers considered by the Hearing for those of relevant person status, followed in 2001 by children having the same right depending on age and maturity. For many years only those children who could pay for a lawyer had legal representation. The development of knowledge of the rights flowing from the European Convention on Human Rights has also brought with it a wider range of grounds of appeal to the Sheriff for both the child and relevant persons in the child's life.

The fundamental issue of who is deserving of the special legal status of relevant person has also altered the prism through which the nature of the hearing must be perceived. The case of Principal Reporter v K [2011] SC (UKSC) 91 determined that the Panel must deem a person to be a relevant person if the individual has or recently had, a significant involvement in the upbringing of the child. The very recent unreported case of ABC v Principal Reporter and Others [2018] CSOH deals with the collateral rights of siblings as a relevant person, while the recent unreported decision of Sheriff Reid at Glasgow in G and L upheld an appeal against the Hearing's decision to exclude a relevant person's legal representative while the child spoke to Panel members on their own, the reasoning stated by the Panel being inadequate to justify the exclusion.

The march of lawyers into the Hearings system has been feared by many as heralding an end to the welfare based inquisitorial approach of the Children's Hearings with the substitution of the aggressive and regimented approach sometimes used to characterise adversarial proceedings. Certainly, the significant increase in the numbers of appeals against findings by the Panel

[5] That is, the judge presiding over the Sheriff Court in Scotland, the principal local civil and criminal court dealing with all cases except the most serious which are head in the High Court of Justiciary.

might be interpreted in that way with increases in appeals from 19 in 1976 to over 900 in 2014 but as Schaffer notes, the number of appeals in relation to the total number of decisions is still insignificant out of a total of 32,000 hearings in the year. These cases nonetheless illustrate the existence of significant challenge for the system in how it seeks to balance the child-centred welfare approach in which the hearings are grounded, and a rights-based model which protects all participants rights and interests, but edges hearings towards a more legalistic focus.

I believe the system has nothing to fear provided our Panels are adequately trained and supported and that solicitors practicing in this sensitive and critical area of law are competent to do so. This means a very much more nuanced and expert approach to their role than applies in general court practice. The 'cross' in cross examination has never referred to being angry but the aggression and sarcasm of some forms of grandstanding advocacy has no place in this context. The need to develop a specialism in representation and advocacy for both children and relevant persons is crucial and I am delighted the Scottish Legal Aid Board has moved on this through the excellent CELCIS study on the Role of the Solicitor at Hearings (2016) and in the Board's subsequent publication of the Code of Practice in relation to Children's Legal Assistance Cases. The Code requires evidence of competence in understanding child development and the principles of communicating with children. While this is a welcome development, I believe the Code needs to go further to require an understanding of abusive behaviours affecting children from outwith and within families. A fundamental understanding of the impact and the range of behavioural responses to the different forms of abuse on children, their siblings, and the non–abusive parent is also critical.

The establishment of the CHIP (Children's Hearings Improvement Partnership) to seek continuous improvement in the conduct and practice of participants in the Hearings is a very positive development and it has in turn set up a short term working group (known, I believe, as CHIPLET!) to identify the essential areas of knowledge that solicitors require in order to engage constructively in the Children's Hearings System.

Membership includes a mix of representatives drawn from the Scottish Child Law Centre, Scottish Legal Aid Board, CELCIS, private practice, Children's Hearings Scotland, the Law Society, the Adoption and Fostering Alliance, Clan Childlaw, Scottish Children's Reporter Administration and social work. The CHIP is also undertaking some development work focusing on the role and conduct of solicitors at hearings with a view to making best use of their contribution but also to modify the adversarial approach with which they have become accustomed over many years.

Concerns have also been expressed about the perception of the increasing complexity of the Children Hearing's system. Ruth Woods and colleagues Henderson, Kurlus, Proudfoot, Hobbs and Lamb (2018) describing claims of complexity as 'almost a mantra' explained that:

> 'This increased complexity in child protection has implications for all those working within the Hearings System, especially for the training of Children's Panel Members and professionals, and in their decision making to protect vulnerable children. Importantly, it has implications for those families who find themselves involved in an increasingly complex legal system…Moreover, there are suggestions that complexity in child protection and families' lives is growing over time, as a result of changes in levels of social inequality, drug and alcohol use, family fragmentation, professional practice, thresholds for entering care, and legislation' (pp. 6-7).

Whether that complexity suggests the need for an assessor to support the Panels must be a live issue but it would be a tragedy if we were to lose the community's major contribution to the care and protection of our children because of the need to compose increasingly complex articulations of the basis of their decisions.

It is clear therefore that much has been learned in the context of the Children's Hearing system over the last 50 years but there are many challenges for our learning and creativity still ahead. It is a system that is continuing to mature and develop as its collective knowledge, refined practices and enhanced appreciation

of the rights, as well as the interests, of its participants prevail. The development of more effective informal approaches with children who, otherwise, appear destined to arrive at the Hearings system also signals a more creative and proactive recognition of not just early intervention but intervention that works.

A Kilbrandon for the adult justice system?

The adult system of criminal justice has, in contrast, proved more resilient to the need for a very fundamental review of our responsiveness to what truly has the propensity to change the complex sets of behaviours we see in courts throughout the country for the better. The huge prison population in Scotland serving very expensive short term sentences still persists despite the evidence of the inefficacy of imprisonment in tackling their criminal behaviours and the underlying mental health problems, addictions and lifestyles of so many. The Report of the Commission on Women Offenders which I chaired in 2011 along with Sheriff Danny Scullion and Dr Linda de Caesteker found that many women in Cornton Vale prison came from generations of abusive and offending families and continued to exhibit the same behavioural problems and mental health problems as their parents. Many of these women were also mothers themselves.

We emphasised among much else the need for a comprehensive programme of problem solving community courts across the country. That need still persists along with a corresponding need for a robust programme of community based sentences to give our judges the resources and confidence to desert the well worn but ineffective patterns of short term sentences of imprisonment. While the Aberdeen Community Court pilot, and the presence of other problem solving courts across Scotland is encouraging, the progress towards a large scale transformation of the nature of the sentencing work of Sheriffs has moved very slowly.

If problem solving justice is to replace short terms of imprisonment with community-based alternatives this also needs an infrastructure and resources as comprehensive and nationwide as our police, prosecution and prison services with sentencing options that research shows can reduce recidivism. While our Children's hearing system is a remarkable demonstration of a bold pioneering

propensity, have we proved 'too feart' (*Scots:* too frightened) to move forward from the comfortable practices of imprisonment to disposals that ask much more from all of us, including the accused? The forthcoming introduction in Scotland of a statutory presumption against prison sentences of less than one year can only work well if the sentencing options are more effective and the outcomes thoroughly researched.

It also requires lawyers and judges to acquire ever more understanding of what has the propensity to change human behaviour and an expert understanding of human behaviour itself; this can no longer remain in the sole domain of experts and a group of enlightened judges. The Law Society of Scotland, the Scottish Prosecution College, the Judicial Training Institute and our universities must scrutinise the training provided to prospective lawyers and judges to address this need. They are the future judges who must understand intimately autonomic responses, characteristics of post-traumatic stress disorder, symptoms of mental and psychological health, the manifestation of distress and the impact of prolonged abuse and addiction. What features of sentencing have the potential to change or reduce the criminality that develops as a result of any or all of these issues? We cannot afford to rely on lawyers eventually absorbing this knowledge over years by exposure to experts, complainers and accused. This is a competence that we need to acquire long before any of us are let loose in the courts.

The time has come for us to take up the challenge set by the ingenuity of Kilbrandon's boldness and to show the Scottish system as one which is still moving forward both for our children and for the many who are yesterday's failed and troubled children. We can do this while all the while providing more effective remedies for our communities and the victims of crime.

We have been left a legacy from Kilbrandon that carries with it the expectation of a country that is confident enough in itself to challenge what we do, to be open to learning and developing what we do in the public interest from the cradle to the grave. As Maya Angelou's exhortation reminds us, we now know better so we need to up our game. So I hope we will abandon the appalling age of criminal responsibility of eight years and amend the unsatisfactory and odd political compromise of no prosecutions until after 12 years. I hope we will

abolish corporal punishment of children and adopt the international standard of 18 in how we define children. And I hope we will incorporate the United Nations Convention on the Rights of the Child in the same way that the European Convention on Human Rights now permeates our domestic law.

I also hope that we will continue to be blessed with the thousands of volunteers who form the children's panels and by their actions demonstrate that this is a nation that loves its children. Love is a sort of schmaltzy word for a former state prosecutor to use (at least in public) but I was delighted to listen to the First Minister, Nicola Sturgeon, remind us in her own Kilbrandon Lecture in 2017 that,

> '[Love] is… the birth right of the vast majority of children in Scotland — and those who grow up without it are disinherited in ways which we can scarcely begin to imagine. So we must, and we will, make sure that the way in which we provide care for them puts love at its heart. Every young person has a right to be loved' (p. 11).

The outstanding child expert Professor Kathleen Marshall also spoke with great eloquence and persuasion in her Kilbrandon Lecture of the 'love that binds' (2009).

I have only met a few handful of Reporters over the years but their dedication and deep concern for the welfare of children has been one of the most significant manifestations of that love and a huge influence on my own professional life, so much so, that as I trailed back along the North Bridge in Edinburgh in 1984 (still in my Moon boots) towards the train back to Glasgow, I contemplated defecting from the prosecution to become a Reporter. Thankfully, Alan Finlayson and his brilliant team were spared that ordeal!

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About the 2018 Kilbrandon Lecturer

Dame Elish Frances Angiolini QC (b. 1960) is the Principal of St Hugh's College, Oxford, Pro-Vice Chancellor of the University of Oxford and Chancellor of the University of the West of Scotland. Born in Glasgow, she studied law at the University of Strathclyde, after which she pursued legal training with the Crown Office and Procurator Fiscal Service in Scotland and became a procurator fiscal. Following a distinguished career as a public prosecutor, she was appointed Solicitor General for Scotland in 2001, and from 2006-2011 she held the position of Lord Advocate, the Scottish Government's most senior law officer. Dame Elish then entered academic life, first as a visiting professor in the University of Strathclyde Law School. She has also led several high profile public inquiries, including the investigation into the disposal of baby ashes at Mortonhall Crematorium in Edinburgh (2013), and the practices of crematoria across Scotland (2014) and for the Home Office on Deaths in Custody in England and Wales (2017).

A video of the lecture is available on YouTube here: https://www.youtube.com/watch?v=PndA_9AIuc0

An aeroplane without wings: Educational psychology support for a children's home staff team prior to and following a critical incident

Cath Lowther, Jo Dunn and Julia Powell

Abstract

Outcomes for looked after children and young people tend to be poor across numerous domains. To address this, some children's homes in England are supported by educational psychologists using Pillars of Parenting. This 'Emotional Warmth' approach is based on the theoretical and empirical knowledge base of applied psychology. It has been shown to have a positive impact on the lives of looked after children and young people (Cameron, 2017; Cameron & Das, 2019). This paper shares the story of a traumatic incident which occurred in a children's home supported by a Pillars of Parenting psychologist consultant. Using the strong relationships built up with staff through Pillars of Parenting sessions, other tools were used to provide support for staff over two meetings. This support was given in the lead up to this event and following it. Prior to the incident, the psychologist consultant used the MAPS tool to help staff acknowledge their gifts and plan for a positive future. A critical incident response to the event was provided by two educational psychologists using a bespoke process shared in this paper. Anecdotal evidence suggests that this support was appreciated and beneficial.

Keywords

Critical incident, educational psychology, pillars of parenting, residential child care

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To protect anonymity due to the sensitive nature of the narrative contained in this paper, the county in question, and therefore workplaces, will not be named.

Introduction

On 31 March, 2018, there were 75,420 children and young people looked after by local authorities in England (DfE, 2018a). Under the Children Act 1989, a child (under 18) is legally defined as 'looked after' by a local authority in England if he or she is subject to a care or placement order, or has been accommodated by them for a continuous period of more than 24 hours (Section 22).

Outcomes for looked after children are characteristically poor (see Cordis Bright, 2017, for a review). Academically, school attainment across all educational phases by looked after children is 'much lower' than non-looked-after children (DfE, 2018b). The mental health of looked after children has been consistently found to be worse than their peers, with 'almost half' of them potentially meeting the criteria for a psychiatric disorder (Luke, Sinclair, Woolgar & Sebba, 2014, p. 7). Knapp, King, Healey and Thomas (2011) observed a significant association between being taken into care as a child and lower earnings as an adult, particularly for males. Further negative outcomes in adulthood include increased risks of homelessness, teenage pregnancy and coming into contact with the criminal justice system (DfE, 2015). It is worth noting, however, that outcomes for looked after children are better than those for 'children in need' (DfE2018b). (A child in England is considered to be 'in need' if it is deemed that he or she needs local authority support to ensure that his or her development is of a reasonable standard and not impaired in any way or if he or she is disabled. These children typically stay in their own homes (Children Act, 1989, Section 17)).

Of the children who are looked after in England, 11% of them were living in 'secure units, children's homes and semi-independent living arrangements' in 2018 (DfE, 2018a). Wharton, Lomax and Thomasoo (2017, p. 6) suggest that 'generally, outcomes for children in residential homes are worse than for other looked-after children. This is not surprising, given their high level of needs and often poorer pre-care experiences'.

Pillars of Parenting

The Pillars of Parenting provides an 'Emotional Warmth' approach; designed to enhance residential carers' (and foster or adoptive parents') understanding of the complex psychological needs of the children and young people in their care to enable and empower them to provide even better support than they already do (Cameron & Maginn, 2008, 2009, 2011; Cameron, 2017; Cameron & Das, 2019).

The model is based on psychological theory and research and involves monthly consultation meetings with a psychologist who provides the bridge between the expertise of the carers regarding individual children and the theoretical and empirical knowledge base of applied psychology (Cameron & Das, 2019, p. 7). Research indicates that this model has had a positive impact on LAC in foster care or who have been adopted (Cameron, 2017) and who live in residential children's homes (Cameron & Das, 2019).

Educational psychologists

Pillars of Parenting support is ordinarily provided by educational psychologists (EPs). EPs support children and young people in a range of ways. Mackay (2011) sees EPs as 'uniquely placed to provide holistic psychological services' and says,

> With regard to their position, their training defines them as the most generic child psychologists, with more postgraduate professional training time devoted to the child and adolescent sphere than for any other branch of psychology (p. 11).

The story which follows occurred within a local authority maintained children's home in England supported by an educational psychologist using the Pillars of Parenting approach.

Our story

Towards the end of 2017, a young man living in a residential home (let's call him Sam) looked like he was about to buck the trend of negative outcomes experienced by looked after children. He was doing well in college and was looking forward to going to university. However, as December loomed, Sam

began to come off the rails. A member of staff likened this to an aeroplane: 'The plane isn't just coming down, the wings have come right off'. We attributed this to the anxiety Sam must have been feeling around moving into adulthood, leaving his home, doing exams and the transition to university. He also had additional mental health needs related to developmental trauma and experiences of rejection as well as a diagnosis of Autism Spectrum Condition.

Over December and January, Sam's behaviours escalated enormously. He began accessing the dark web and exploring sado-masochistic and child pornography. He complained to staff that a prostitute he had engaged would not allow him to hurt her. He alienated the other young people in the home by telling them that children want and deserve to be sexually abused. He was verbally and physically aggressive towards staff and the other young people in the home. He burned one member of staff and appeared to enjoy it. He wondered with some members of staff if he might be a psychopath and was extremely interested in the lives of serial killers. Staff were understandably massively stressed and were experiencing vivid and frightening nightmares.

The MAPS meeting

As a result of Sam's behaviours, the levels of stress being experienced by staff were identified by their manager as needing out of the ordinary support. An adapted MAPS was used (Forest, Pearpoint & O'Brien, in Newton, Wilson & Darwin, 2016) to provide a positive and supportive shared experience for staff. MAPS is a tool that facilitates the imagining of positive and possible futures and the planning for these, drawing on a person or group's unique gifts (strengths, qualities and positive characteristics). The meeting is recorded graphically on large sheets of paper.

Figure 1. Adapted MAPS template

(Please note that while this template is being shared, it does not capture the full experience of the session which was facilitated by a skilled and experienced psychologist).

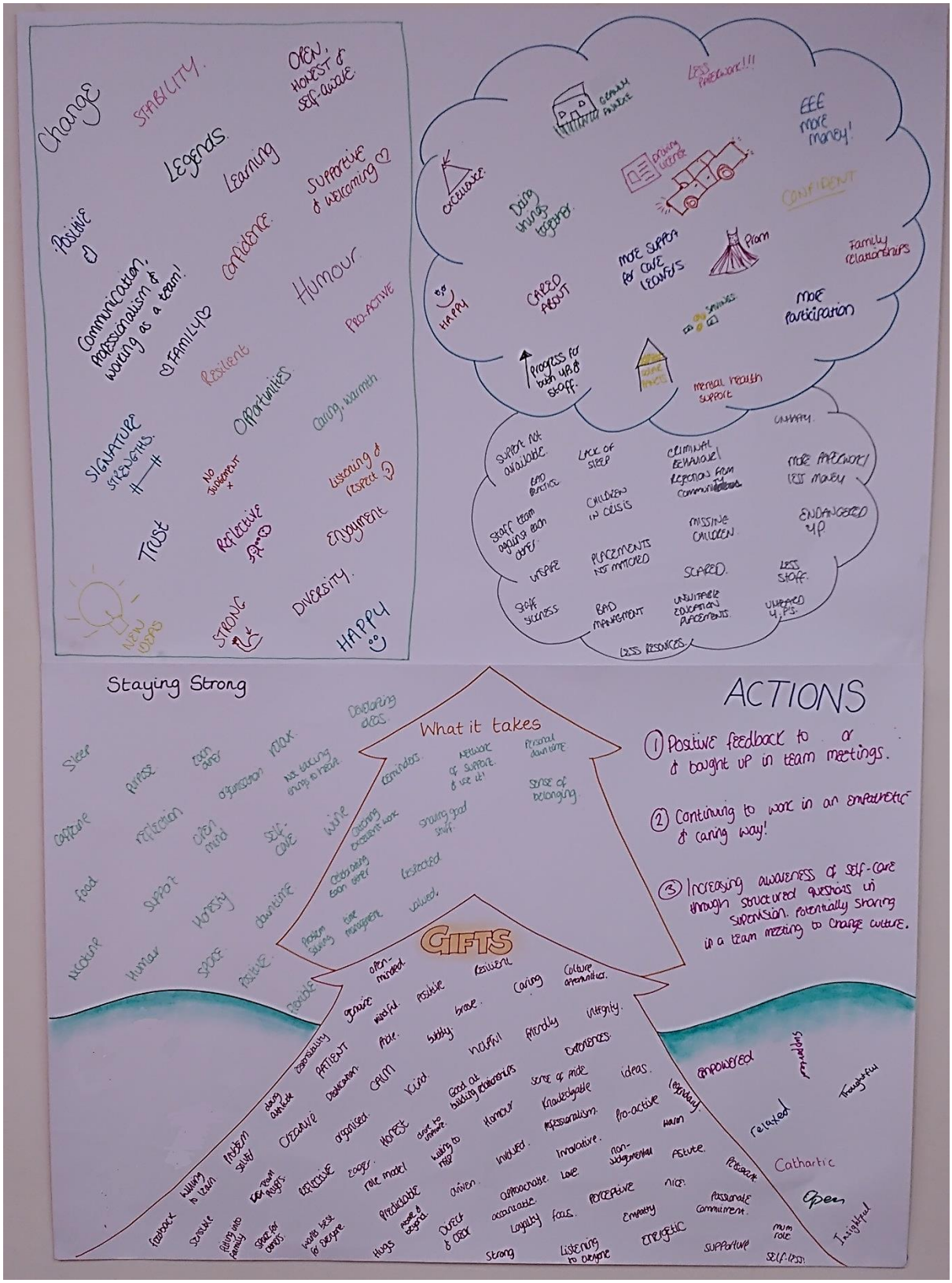

Figure 2. Photograph of MAPS (anonymised)

The staff team were able to reflect on the strong work they were doing with all the children to help support them and keep the home stable. This meeting

enabled staff to explore their thoughts and emotions in a safe place. After the meeting the staff team felt drained but a 'weight had been lifted'. They had the opportunity to address 'unspoken fears in a safe forum'. By exploring the team's strengths they also had a renewed energy that supported them in working with Sam. The only thing staff struggled with was the feeling of being emotionally drained after the meeting, especially as two members of staff were on a 24 hour shift.

Our story continued

What follows includes content taken directly from an account of the incident written on Thursday morning at 3am by the home manager.

At the end of February, the situation worsened. On the Tuesday of the week in question, Sam attempted suicide by drinking bleach. He was taken to hospital and released back into the care of the children's home staff team the following morning. Although Sam had been assessed as safe to come home, staff were highly anxious about his state of mind. A plan was put into place with Sam, the hospital, his stepmother and the manager of the home to help keep Sam safe until he saw a forensic psychiatrist the following day.

On Wednesday there was tension for most of the evening between Sam and two other young men in the home (let's call them Richard and Harry). Staff were constantly trying to distract and separate the boys who were saying hurtful things to one another. Harry responded to this and head-butted Sam. A member of staff was in the middle of the two and Sam reached forward. He was holding a Stanley blade in his hand. Harry shouted, 'He's stabbed me in the eye!' The member of staff was disorientated as he had been hit several times around the head trying to break them up. He said to Sam, 'What have you done?' and Sam said, 'I've stabbed him, that's what happens when you f**k with a mental person'. He laughed and locked himself in his room. 999 was called and the ambulance and police requested. Sam voluntarily gave up the blade to staff. The police arrived and arrested Sam. He tried to laugh and joke with them. Harry was taken to hospital and had surgery on Thursday morning. At the time it looked likely that he would lose sight in that eye.

Critical incident response

EPs have been noted for their input in what are termed 'critical incidents'. Beeke (2013) defines a critical incident as a 'sudden and unexpected event that has the potential to overwhelm the coping mechanisms of [an organisation or community]. A serious and significant event, it is likely to be outside the range of normal human experience and would be markedly distressing' (p. 3). High profile events that have received such support from EPs include the Grenfell Tower tragedy (BPS, 2018) and the Manchester Arena bombing (Jimerson, Muscutt, Russell, Regan, Quinn Ewbank & Sundhu, 2017). While not of the same magnitude, the stabbing described above was felt to meet the criteria for critical incident support provided by the EP service. During March, staff were again given support to process what had occurred, this time from two EPs. The process was first discussed with the home manager and then developed to address the needs of staff. Again, the meeting was recorded graphically.

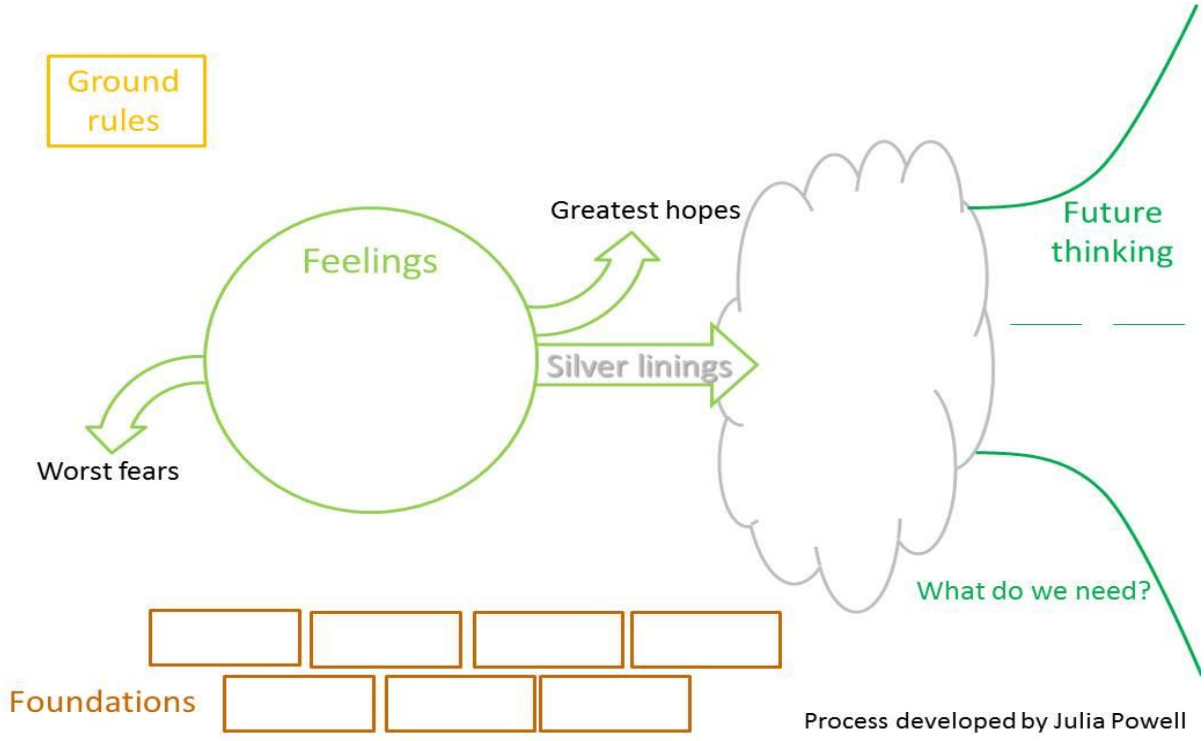

Figure 3. Critical incident session template

(Please note that while this template is being shared, it does not capture the full experience of the session which was facilitated by highly skilled and experienced psychologists).

The manager shared that she could not 'put into words' the 'positive impact' that the second session had had. The staff team cried, laughed and spoke about a huge range of emotions during this session. They all felt safe enough to openly explore how they felt. No one was made to feel 'stupid' and everyone's feelings were valid. Guilt came up a lot: staff took this incident very personally and were devastated that it had happened within their home. The staff team reassured one another that they had done all they possibly could. The incident brought everyone closer together and the session afterwards enabled staff to park their very heightened emotions and focus on the children. Staff felt emotionally exhausted but reenergised by the session which helped to re-stabilise the home surprisingly quickly.

After the incident Richard and the other young person went to school the next day. Harry came out of hospital on Friday and was back in college on Monday. Behaviours were settled and the boys talked about loving each other and being like brothers.

One year on

A year later the staff team are settled and managing their next round of challenges. They have moved into a newly built home and welcomed two additional young people into their care. One member of staff had a baby, another got married and another has moved into a deputy manager role. Harry moved into semi-independent living and quite enjoyed the notoriety of his experience. He came to the new home for Christmas day, visits monthly and calls regularly with updates. Sam was arrested and, following trial, detained in a secure mental health facility where he is getting the help he needed all along. Richard also moved into semi-independent living and is looking forward to moving in with his dad overseas. He is currently finishing his full-time college course, working part time and riding his motorbike. He visits the home twice a month and often pops in for help with his college assignments. The other young person who witnessed the attack remains in the home and is attending college full time whilst volunteering at a local riding stables.

The incident was investigated by the Safeguarding board, CAMHS (Child and Adult Mental Health Services) and OFSTED (School Inspectorate in England). All

these organisations came to the same conclusion. The home went 'above and beyond' in the support and protection offered to the children. The national shortage of specialist provision was highlighted as hugely problematic. The risks associated with Sam were flagged early and it was agreed that a specialist placement was urgently needed in January. Unfortunately, what was needed was not available and over 100 placements were approached with no success.

Conclusions

Staff in children's homes do a phenomenal job of looking after, caring for and parenting looked after children who have experienced very high degrees of developmental trauma. This invaluable work is enhanced when informed by psychological research and theory. Psychological input can also provide staff with reassurance at times of crisis, helping them to process difficult feelings and begin to look to the future. In this instance, the work of EPs contributed to a rapid stabilisation within a children's home which experienced a traumatic critical incident.

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Cath Lowther and Julia Powell are educational psychologists working in a local authority educational psychology service in England. Cath is also a Pillars of Parenting psychologist consultant supporting a local authority maintained children's home. Julia is an area senior educational psychologist with responsibility for providing critical incident support. Jo Dunn is the manager of the children's home in which the incident described in this paper occurred. She manages a phenomenal team of staff. The home in question is rated by Ofsted as good with outstanding features.

The New Direction of the Social Foster Care System in Japan

Keiji Noguchi, Kayoko Ito and Norifumi Senga

Abstract

Social foster care services in Japan were primarily provided through Residential Care Institutions for Children (RCIC). To improve the foster parent placement rate, the Japanese government is now reorganising measures to arrange for foster parents to be central to service provision. The turning point for social care in Japan was a 2011 government report Challenges and the Future Vision of Social Foster Care. It aims to build societies in which approximately one-third of children under state care are placed with foster parents or in family homes. Another one-third would be placed in group homes and the remaining third are to be placed in RCIC. The direction of promoting foster parent placement has accelerated since the 2017 report, The New Future Vision of Social Foster Care, which set specific goals to stop the placement of children in RCIC and increase foster parent placement. This short article outlines the reorganisation of the Japanese social foster care system and explains the factors influencing the changes.

Keywords

Social Foster Care, foster carer, Residential Care Institution for Children, Convention on the Rights of the Child, Japan

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Introduction

Child welfare services in Japan serve over 46,000 children in social foster care. The majority of these children are receiving these services at care facilities, and foster parent placement rates are low. To improve the foster parent placement rate, the Japanese government is now reorganising measures to arrange for foster parents to be at the centre of service provision. This short article introduces the current state of the social foster care system in Japan and the new direction towards reorganisation that the Japanese government is promoting for its advancement.

The current situation of children placed in social foster care in Japan

The number of children placed in the social foster care system in Japan remains unchanged from 30 years ago. However, the number of children in the population is decreasing. While the number of births in 1980 was 1.61 million, by 2017 this had reduced to 950,000 births. This means that the proportion of children who are protected and placed in social foster care has increased, indicating a decrease in the ability of families to maintain a healthy home environment.

Child abuse is a serious issue that cannot be ignored. With no sign of a decrease in child abuse cases, the number continues to rise each year. In 2017, the Child Guidance Centre (CGC) gave consultations on 133,778 child abuse cases, which were 20 times more than the 6,932 cases Japan saw in 1998 (Figure 1). What makes child abuse such a serious issue is the large number of children who suffer from the abuse, and the effects that continue into adulthood. Additionally, this increase in child abuse affects social foster care. The number of children placed in Residential Care Institutions for Children (RCIC) has dropped since 1990, reflecting the declining birth rates in Japan. However, the number of children placed in RCIC increased after 2000, when the Act on Child Abuse Prevention came into force. It then became clear that 59.5% of the children placed in RCIC had been abused.

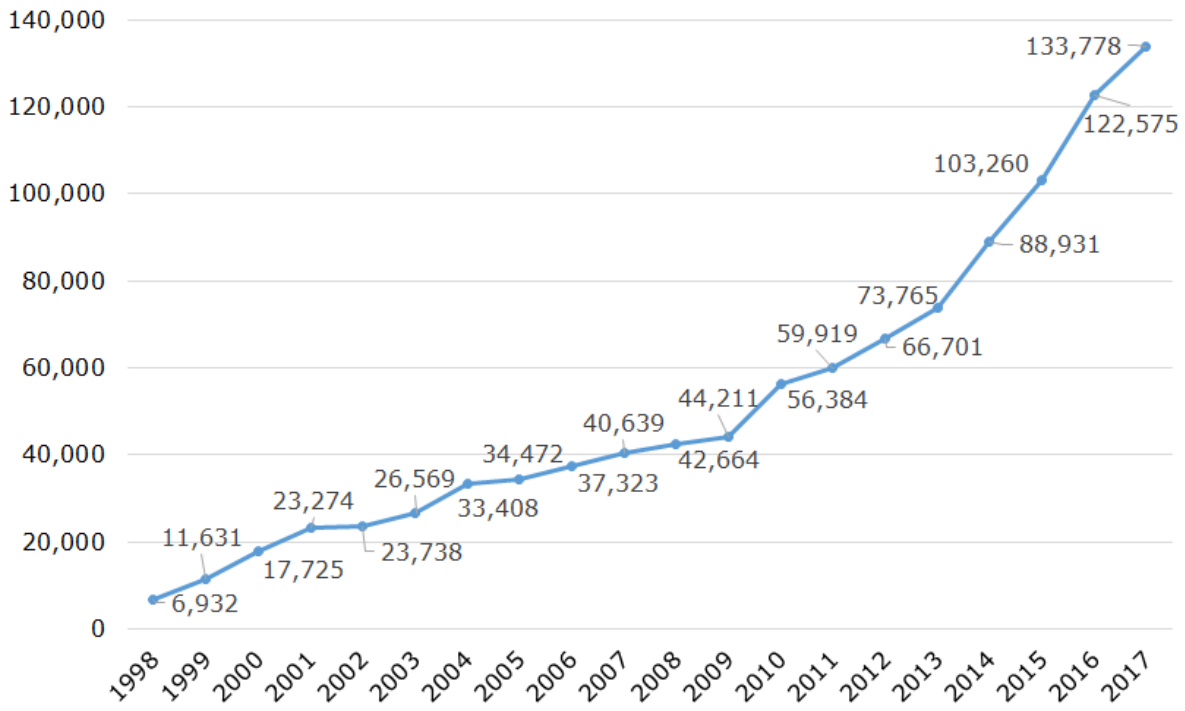

Figure 1: Changes in number of child abuse consultations responses at CGC

As the number of abused children rises, it becomes increasingly more difficult to care for them adequately. This is due to the damaging effects of the environment surrounding child abuse and the ways it impairs a child's development. Sugiyama (2007), a child psychiatrist, pointed out the characteristics of abused children: nearly all of them show borderline intelligence, they often have difficulty learning, and exhibit features of hyperactivity behavioural disorder. He further indicated that many abused children had poor control over their impulses and displayed panicked behaviour, even over minor issues. Furthermore, Sugiyama found that traits commonly found in people with developmental disabilities are also present in abused children. Research shows that 28.5% of children who have been placed in RCIC have some type of disability. Meanwhile, the number of children with developmental disorders is increasing by the year. Developmental disorders are often noted as risk factors for child abuse, because many parents of children with developmental disabilities have difficulties raising their children. What the authors would like to emphasise here is that many abused children have behavioural characteristics classified as developmental disorders, and the

increase in the number of such children makes it difficult to provide sufficient care for them in RCIC.

A new direction in the Japanese social care system

In 2011, the Japanese government established the Committee on the Future Vision of Social Foster Care to address various issues related to social services, including foster homes, and summarised its findings in a document titled, Challenges and the Future Vision of Social Foster Care (*Shakaiteki Yougo no Kadai to Shourai-zou*). As components of a basic roadmap for social foster care, this document outlines the need to: (1) promote home-based foster care, (2) enhance professional care offerings, (3) promote self-reliance, and (4) encourage family and community-driven support. Over the next decade, this strategy aims to build a society in which approximately one-third of children under state care is placed with foster parents or in family homes. Another one-third would be placed in group homes (such as satellite foster homes in locations separate from RCIC), and the remaining third are to be placed in RCIC (the term 'foster homes' comprises all small-scale group homes). Although social service providers were surprised by this expansion of placements with foster parents to one-third of children in state care, in addition to the promotion of home foster care by transitioning from RCIC to small-scale group homes, this direction was in fact a response to pressure from the international community.

The influence of the Convention on the Rights of the Child

In the past, social foster care services in Japan were primarily provided through RCIC, and the foster parent placement rate stood out as comparatively lower than that of other countries. The international community viewed this as a problem, after Japan ratified the Convention on the Rights of the Child in 1994. Japan first adopted this convention at the 44th session of the UN General Assembly in 1989, and its provisions took effect in 1990. The Convention guarantees children the rights prescribed by the International Bill of Human Rights and outlines detailed and specific considerations required to realise and

protect them. The Convention establishes the use of residential care as a less readily utilised option. The Committee on the Rights of the Child, tasked with implementing the Convention's provisions, requested a review of the RCIC-centric approach to foster parent care in Japan. In 2010, the Committee issued a series of recommendations, strongly urging Japan to reform its social foster care services. Movements in the international community were also a major factor that influenced the direction of these reform efforts.

The traditional social foster care system in Japan

The emphasis placed on the notion of standards harmonisation by the international community is an inevitable trend in this highly globalised age. It is nonetheless surprising that the direction of the aforementioned reform efforts has not been met with firm opposition from RCIC. This is because, even in the midst of the worldwide hospitalism controversy of the 1950s, Japan decided to steer away from foster parent care and continue to have RCIC-based group care play a central role.

'Hospitalism' refers to the observation that RCIC-based group care can lead to delayed emotional development, even in the absence of personal hygiene or nutrition-related issues, as well as serious and permanent developmental problems due to maternal deprivation. These findings are based on surveys investigating the development of children living in RCIC.

Researchers such as Hori (1950) and Urisu (1954) thoroughly discussed the issue of hospitalism in Japan, pointing out the negative effects that living in RCIC has on children's physical development and personality formation. As potential solutions, Urisu (1954) advocated for: (1) the establishment of a foster parent system, (2) the introduction of a system of smaller-scale care facilities, and (3) the transformation of dormitories into more domestic spaces reminiscent of traditional homes. However, these ideas were not broadly accepted and gave way to the group-based foster care theory (Seki, 1971); originally an opposing principle that gained prominence, even among the Nationwide Research Council of Directors of Foster Homes ('Zenyokyo'), as well as the Study Group on

Nationwide Issues Related to Foster Care ('Youmonken'), which comprised care workers. Rather than passively addressing the issue of hospitalism, this theory positions RCIC as 'places for group activities promoting children's human development' (Ito, 2007, p.34). Foster care providers began considering a shift towards prioritising placements with foster parents, a response to the hospitalism controversy in developed Western nations. However, though there is significance in the review and debate surrounding the benefits of group-based care provided by RCIC, the fact that the group-based foster care theory gained such widespread acceptance among foster care providers brings to light various aspects that are characteristic of Japan's social services.

For this reason, social care policies prioritising placements with foster parents could not garner even small-scale support for many years. Nevertheless, the new direction seen today is exactly what Urisu (1954) proposed decades ago, which foster care providers had disregarded until recently.

One of the reasons for the lack of a sizeable reaction from foster care facilities is the financial revitalisation mechanism proposed by the Japanese government in case of a reduction in scale. However, based on the current state of foster homes, confusion arising from problems with children and poor retention rates among caregiving staff could make institutional care more difficult. The status quo is believed to be unsustainable, and this has created an attitude of openness to change.

New classification of social foster care system in Japan

Challenges and the Future Vision of Social Care, prepared by the Committee on the Future Vision of Social Foster Care on issues related to social services, proposed a numerical target in which one-third of children under state care should be placed with foster parents, a substantially higher proportion than the current reality (Figure 2).

When this plan was issued, the government altered the concept of social services. Traditional notions of family-based care were reconsidered. To date, the idea of foster parentage has not been recognised as a parent-child

relationship under the Japanese Civil Code, commonly being referred to as 'family-like' care. However, after noticing that childrearing was actually occurring in foster households, this type of care was reclassified as family-based care, while the family-like care model conducted in RCIC was re-categorised as family-like care. These concepts were adopted from the Guidelines for the Alternative Care of Children (United Nations, 2010).

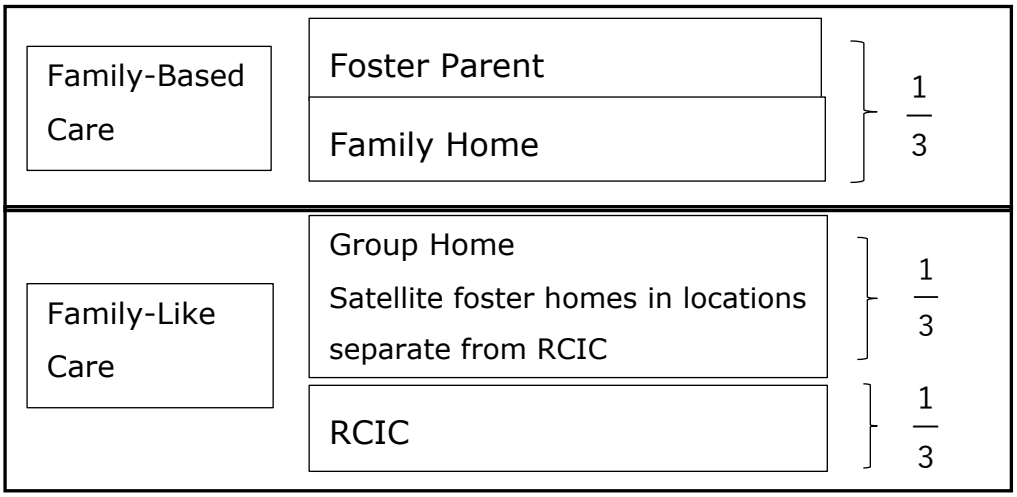

Figure 2 New classification of social foster care system in Japan

Family-based care

In 2011, to promote foster parent placement, the government issued guidelines for foster parents at the Child Guidance Centre (CGC), which is authorised to officiate placements of children with foster families, and clarified the principles guiding the prioritisation of prospective foster parents. Coinciding with the government's clarified plan, the rate of placements with foster parents is rising. In 2002, the placement rate was 7.4% but rose to 19.7% by the end of March 2017.

Most remarkable was the number of family homes systematically implemented after 2009 suddenly rising to 347 locations, during the relatively brief eight year period between 2009 and late March 2017, and successfully placing 1,434 children. Of the 6,858 foster parent placements, 20.9% were to family homes. Family homes are now officially labelled as 'small-scale residential-type childcare services' (Child Welfare Act, Article 6-2(3) and Subsection 2) and are considered

a new mode of state foster care services. Presently, many family homes have transitioned from foster parenting to foster home placements. As mentioned earlier, confusion is arising due to the scaling down of care settings and the increasing number of issues faced by children under the current foster care regime. Given that the stable and continuing relationships with adults offered by family-like care are essential, as well as the context of the anticipated rise in such relationships with adults as more people leave the workforce every year (Fukuda, 2015), family homes offer a system that provides the benefits of foster parentage (such as living at home with children). Rather than working as employees of RCIC, caregivers become home residents and build a life with children, and this readily leads to the formation of strong relationships between children and adults. The impact of maintaining these emotional bonds is substantial.

Conclusion

Although social foster care in Japan was centred on Residential Care Institutions for Children (RCIC) based care, the foster parent placement rate is increasing due to the influence of the trend of the international community and the 2011 government report, Challenges and the Future Vision of Social Care. Efforts towards promoting foster parent placement have accelerated as a result of the 2017 report, The New Future Vision of Social Foster Care, which set specific goals to stop the placement of children in preschool children's RCIC and raise the foster parent placement rate to 75% within seven years.

With an assignment of family social workers in 1999, RCIC became responsible for promoting foster parent placement. In addition, with the assignment of foster-support social workers in 2012, RCIC began to play an important role as a hub to support foster parents and group homes in the community. Recently, fostering institutions of non-profit organisations (NPO) also provide foster parent support.

By changing from RCIC-based care to family-based care, it becomes more important to improve foster parent support, because foster parents play a

central role in family-based care. With the increase in the number of difficult cases, including children with attachment and development problems, providing support for foster parents is crucial. It is urgent that Japan's social foster care structure works to strengthen the support systems for foster parents, applying a level system and classifying types of foster parents, as well as providing training and supervision.

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Care Experienced Information Rights and Organisational Practice

Caroline Anderson

Abstract

This paper provides a commentary on how organisations can close the gap and build their capability to better meet the information rights of care experienced adults seeking access to records about their childhood in the care of the State. It provides an overview of requirements in respect of access to records by people with care experience, and of advocates who campaign for improvements to information rights. Looking beyond the legislative compliance aspects of how organisations meet those information rights, it highlights root cause issues in the broader holistic records access and information rights agenda. The paper discusses potential learning about care records from an organisational perspective, describing the complexities inherent with their identification, form, content and meaning. The paper concludes with possible solutions that could be applied to organisational practice today.

Keywords

Care experience, information rights, corporate parenting, organisational practice, access to records

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What are the issues with records?

Our understanding of the issues facing our care experienced communities – individuals who have been cared for by the State as children - and their ability to access records about their time in care has been steadily growing over the past 20 years. The key recurring issues they face include getting access to those records, the number of redactions contained within those records, if and when they receive them, and the lack of support provided by the responding organisation to allow meaningful interpretation of the information those records contain (MacNeil, Duff, Dotiwalla, Zuchniak, 2018; Murray, 2017; Evans et al., 2015; Murray and Humphreys, 2014; O'Neil et al., 2012; Humphreys and Kertesz, 2012; Kendrick and Hawthorn, 2012; Goddard et al., 2010; Duncalf, 2010; Shaw, 2007; Horrocks and Goddard, 2006; Pugh and Schofield, 1999).

On the face of it, it might be anticipated that recent changes to Data Protection legislation in 2018 may have resulted in organisations improving the provision of access to records for care experienced communities exercising their information rights. However, underlying the provision of organisations complying with the legislation and meeting the needs of care experienced communities' information rights is a complex set of additional issues that underpin a more holistic rights agenda. Unless the root cause issues are addressed, the active solutions available to organisations to improve those holistic underpinning practice issues, will not meet our care cxperienced communities' information needs. This paper explores some of these issues in more detail to highlight possible solutions that could be applied in practice.

Who are Care Experienced communities?

According to research by Kendrick and Hawthorn (2012), an estimated 480,000 children had experienced State intervention care in Scotland between 1915 and 2005. Two-thirds (320,000) were still alive at the time the research was conducted, with the oldest of that generation aged 98 years. Figure 1 shows the breakdown of these figures across the defined year range and age group.

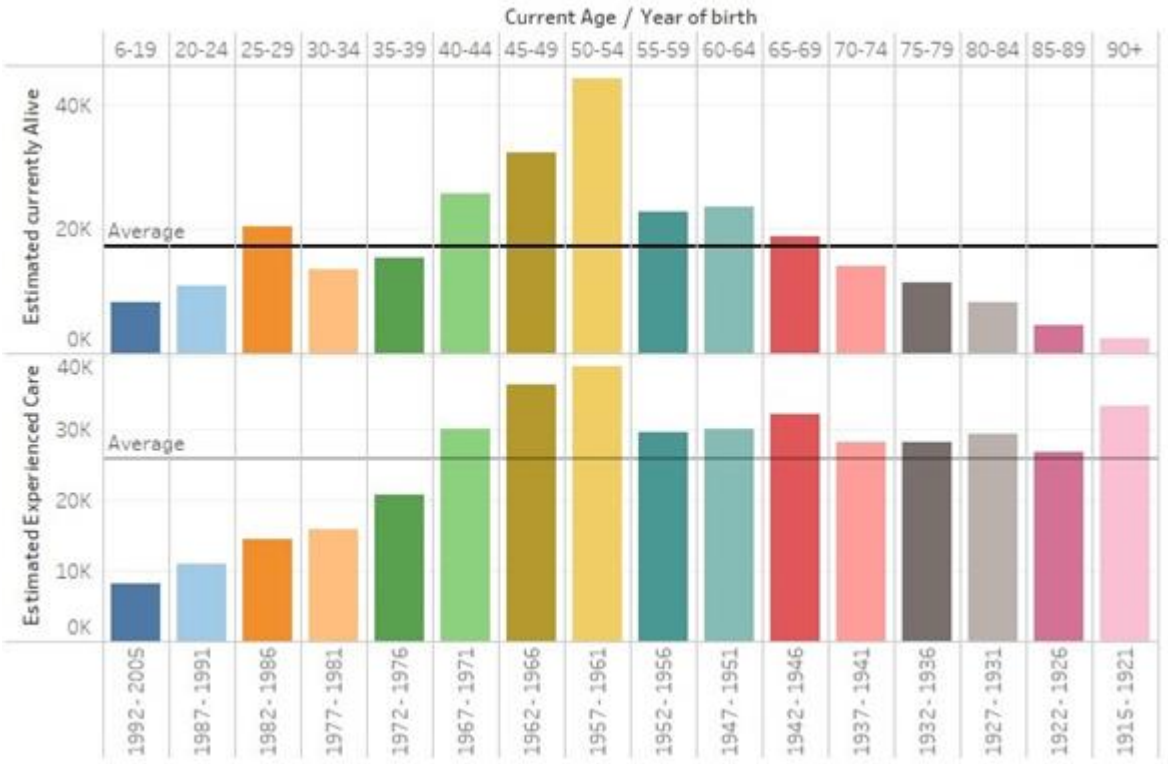


Figure 1 Estimates of children who have experienced care and those still alive (Kendrick and Hawthorn, 2012)

The care experienced figures estimated here represent all communities of children who have experienced statutory care provided by the State as part of their duties to ensure the care, welfare and protection.

It is important to note that these figures are estimates, based on census data, and may not provide the accuracy levels we would expect now. Given the historic nature and duration represented here, they do however provide an indication of the significant number of children, now adults, who may want to exercise their information rights to access records.

Mapping the type of care interventions, provided for children by the State, or on their behalf, now commonly referred to as 'corporate parenting', has been in place for decades, in different guises (Norrie, 2018; Shaw, 2007). The records created by organisations over this period have changed as dictated by the legislative and regulatory environment over that time (Norrie, 2018). Whatever form the records created takes within this time period, this is the child's personal family album, charting their childhood from their time in care. However, given

the extensive historic time period in scope, in many instances, if the applicant is successful in their request, the records received are far from what traditional family albums would contain, or could be discerned from family networks.

What are care experienced communities' records needs?

It is now recognised that care experienced communities' records needs are complex because they do not have the same access to a family album, through traditional family relationships and networks, but are instead reliant on the organisational recordkeeping of those providing that care. The impact of records on any care experienced individual's sense of identity, providing them with an understanding of what happened to them, when it happened, and why, is something that might only be available through records, if they exist (MacNeil et al., 2018; Murray, 2017; Evans et al., 2015; Murray and Humphreys, 2014; O'Neil et al., 2012; Humphreys and Kertesz, 2012; Kendrick and Hawthorn, 2012; Duncalf, 2010; Shaw, 2007, Horrocks and Goddard, 2006; Pugh and Schofield, 1999).

The main issues cited by care experienced communities about access to records are the difficulties in getting access and, if successful, making sense of what those records contain. If unsuccessful, the key issue is coping with the prospect of never finding out specific details of when they were in care, why they were in care, and what happened while they were in care. Records often do not contain any meaningful descriptions of the child and their personality, likes and dislikes, developmental milestones: all things that within a birth family would be more easily known and accessible through family photos and recalled memories. These records, if received, usually consist of reports produced as an organisational account and justification for actions taken. Reports, when they are made accessible, are often heavily redacted, with any sense of the child, who may be reading these reports as an adult, and seeking a more meaningful understanding about what happened, and why, being lost.

The childhood memories care experienced individuals have shaped their sense of self and their ability to reflect on their childhood as adults. These often trigger a

need to clarify or re-create those memories and understanding. Care experienced individuals may seek knowledge that can encompass a spectrum of unanswered questions they may have, including what happened to their birth parents, their siblings and other family members, to what sort of child they were, and in some cases whether there were any known hereditary health conditions.

The existence of records for an individual's care experience is dependent on a number of factors, including: the type of care they received; when historically that care was provided; by whom and for how long; and the legislative and regulatory framework governing that type of care at that time.

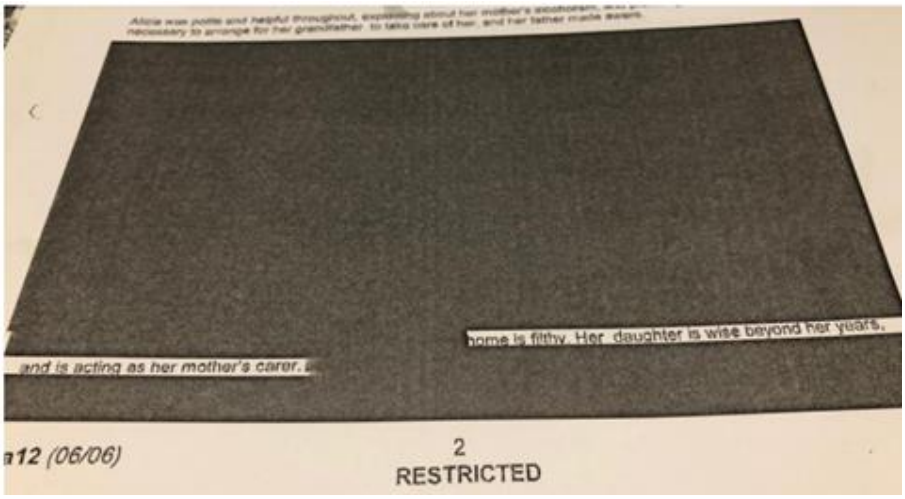
Records can help clarify or validate specific childhood events and memories:

> [I] wanted to know where I came from.....because I thought I had been lied to and not told the whole truth about what happened to me (Who Cares? Scotland, 2019, p. 3).

Adults with care experience may experience feelings of confusion or frustration when reading records of their childhood journey:

> I sat up in my bed until 3am reading details of my life on these pieces of paper that summarised my childhood. I read countless police reports that I was a part of because of my mum, but they would refer to me as 'the subject': I am not a subject or an object. Care Experienced people are not 'subjects' or 'objects', we are human beings with feelings that are valid... A lot of my file was heavily redacted too ...There are hundreds of pages that

look like this (Who Cares? Scotland, 2019, p. 6):



This example of a record in redacted form provides a stark illustration of a Care experienced individual's reaction to the records they received. However, it can be devastating for Care experienced individuals when they are unable to access records because they cannot be found or because they no longer exist.

> I just want to fill in the blanks. I want to make sense of the worst time in my life, however, I cannot do this with the little information I remember (Who Cares? Scotland, 2019, p. 13).

For some individuals, the duration of their care experience was short, for example, if a parent was ill. For others, the experience of care could span their entire childhood. Records created about the individual's time in care will be dictated to some extent by the historic time period, and duration of care, but, as is now more commonly understood, the further back in time we go, the more difficulties there can be with identifying records.

Advocates for care experienced communities

Several care experienced communities have set up groups to provide mutual support and campaign collectively for their rights. In Scotland, there are a number of these groups such as In Care Abuse Survivors (INCAS), Former Boys and Girls Abused of Quarrier's Homes (FBGA), and Who Cares? Scotland. One

specific campaign issue they all have in common concerns care experienced individuals' information rights and access to records.

Research into the needs of care experienced communities worldwide spanning 20 years highlights recurring issues of access to records. More recent examples include: 'Setting the Records Straight for the Rights of the Child' in Australia (Evans, 2017); 'MIRRA: Memory-Identity-Rights in Records – Access' (University College London, 2019); and 'Our Lives, Our Stories, Our Records' (Who Cares? Scotland, 2019). Projects like these are trying to move the debate on access to records towards practice solutions, but progress is slow with few active solutions being deployed in organisational practice. Despite these efforts, the impact on those who are able to access their records today cannot be minimised, as exemplified in this example:

> Fairly straightforward but ultimately left more questions unanswered. There was little in my Care File. I was in care for 7 years but there was not one photo, no parental letters, not one school report, no mention of how I was doing at school, nothing insightful. My Care File had all the use and interest of an old shopping list. It seems to have been written by complete strangers about a complete stranger. Some of the remarks were about someone else, they must have been (Male, 58, Hull). (Duncalf, 2010, p.39).

It would appear that despite current research, advocacy group campaigns, and care experienced communities' records needs being better understood, there is a gap between improvements at the organisational practice level and the ability to meet expectations of care experienced communities.

Possible solutions versus organisational practice

The Who Cares? Scotland (2019) access to records campaign, driving improvements to practice at national level, is starting to establish ways in which these improvements can be shaped at the organisational practice level. A recent collaboration with Aberdeen City Council to co-design improvements with care

experienced communities to create national good practice standards that promote openness (minimal redactions) and care (support and ease of access) (2019), commenced in early 2019.

The motivation for Aberdeen City Council to embark on this collaboration stems from organisational research conducted into how the Council prepared for responding to the Scottish Child Abuse Inquiry in 2017: 'Making Records Ready: Responding to the Scottish Child Abuse Inquiry' (Anderson, 2018). Some of the insights revealed from this research highlighted specific challenges for the organisation in the identification of, and access to, historic organisational records – its corporate memory – in its capacity as corporate parent.

Pulling the care experience and organisational parts of the access to records issues together, what we are now beginning to understand is that these issues are multifaceted and extend much further than previously known. They also suggest that any solutions adopted will be dependent on the organisations that provided care engaging with these issues and the relevant communities. Knowledge of exactly what organisational records are held in relation to their historic corporate parenting role and responsibilities, what information those records contain, and a willingness to invest in that approach is key to the organisation's ability in practice to relate to care experienced individuals' information rights in a compassionate and meaningful way.

The recommendations from this research revealed the multifaceted challenges facing the organisation regarding their own access to, and understanding of, records they hold in relation to their role and responsibility as corporate parent. As organisational records identified and accessed increased, in different forms, often containing handwritten text, spanning considerable time periods, they became voluminous. The ability to analyse, understand and interpret these records requires specialist roles and skillsets and the time to do this work. Skills required include determining meaning from what was expressed in records using dated language about a child and their care journey, and the organisational decision-making process within that journey that were reflective of the legislative and regulatory environment of the time.

The complexity of information held within records about a child's care journey and experience often includes many references to third parties. Under data protection law, strict considerations must be made about what personal information can be released about an individual, to that individual. The challenges this poses for an organisation, and the decision-making processes required, can be immense when the records contain an array of personal detail about other parties, including siblings, extended family, friends, practitioners and other contacts.

Each request received from a care experienced individual relates to a unique person with a unique care journey and can contain a variety of records about when, why and how that care was provided. It is perhaps not surprising that the attention and specialist skills required to go through records means that considerable time is required to analyse and contextualise such a request on behalf of the organisation. It also goes some way to explaining why many Care Experienced individuals receiving information report difficulties, frustrations and upset when trying to absorb and translate the information in redacted form about their lives in a meaningful way (Who Cares? Scotland, 2019).

Concluding comments

Marrying the knowledge and understanding available to us from care experienced communities, advocacy groups and research introduces a complex set of additional issues that underpin a more holistic rights agenda. This paper explored some of these issues in more detail to highlight possible solutions that could be applied in practice today.

This paper has explored some of the issues facing organisations and how they could develop their capability to comply with legislation and respond meaningfully when meeting the information rights and access to records needs of our care experienced communities. It has described from an organisational practice perspective some of the root cause challenges in organisational practice in identifying whether records exist, as well as interpreting and analysing records with an understanding of the historic landscape in which that care was provided.

These practice issues are fundamental to an organisation's ability to exercise its duty as corporate parent and meet the broader holistic information rights of care experienced adults seeking access to their family album.

The collaboration between Who Cares? Scotland and Aberdeen City Council could be the start of a national collective across Scotland to improve access to records at policy and practice level. If, collectively, we have that better understanding of the historic landscape and the records that exist, we can better articulate this publicly and manage the sensitivities and fragility around care experienced communities' information needs and rights. It would also enable us to better manage our role as corporate parent, to articulate the personal aspects and events of someone's care experience journey where, in some circumstances, no records of their personal journey have survived.

Our understanding of the landscape in which care for children was practised could enable organisations to learn and make the improvements to root cause issues now. If we accept the moral and ethical requirements in which historic State interventions have been applied to ensure the care, welfare and protection of our children, we must do all we can to provide that holistic, national narrative; and do this with a care that constitutes our responsibility as corporate parents, producing a family album for those seeking to reclaim any part of their childhood at any time in their adult lives; past, present and future.

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