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A developing journey in residential child care

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Abstract

This paper explores the development of practice in residential child care, initially within the context of generally negative perceptions of this and the wider care system. Discussion of therapeutic perspectives is set within the context of the development of Care Visions residential services and considers the significance of the Sanctuary Model of trauma informed care and social pedagogical principles. It is suggested that approaches primarily defined by procedures can stifle the intuition of professional carers to respond meaningfully to the needs of young people. Compassionate relationships accompanied by an ethical disposition offer an effective alternative. The article concludes with a discussion about what has been learned through supporting continued relationships between professionals and young people after they have moved on from care, and a commitment to applying this in residential child care settings. This promises to support an approach that foregrounds trusting reciprocal relationships as a medium for healing and growth that facilitates nuance and differentiation while ensuring safety.

Keywords

Hope, care visions, the sanctuary model, social pedagogy, haltung, caring relationships, compassion, solidarity, continued relationships

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Contemplation

We all enter the helping professions motivated by hope — the belief that we can contribute to a more just world. Vaclav Havel (1991) playwright and leader of the Czech 'velvet revolution' in 1989, describes this beautifully:

> hope is an orientation of the spirit, an orientation of the heart; it transcends the world that is immediately experienced and is anchored somewhere beyond its horizons… It [hope] is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out (Havel 1991, pp. 181-182).

Hope is more potent than the obligations written into contracts, policies or codes of practice. It is the embodiment of humanity, to give value to and receive value from others, in reverence to our common needs and aspirations. The motivation to become the difference is drawn from deep within the self, beyond duty, by an inherent belief that the cause is virtuous enough to risk failure and flex the limits of convention — it can be radical, dissenting and disrupting. In residential child care, whatever our role, the best we can do is honour hope and the worst we can do is ignore it.

Introduction

This article begins with an anecdotal account of a young person's introduction to residential child care involving the author. This is an illustration of the typical challenges of our work, the emotional and practical effects of these and the opportunities that can emerge from them. Drawing on similar themes, an exploration of perceptions of care follows, along with consideration of what these may necessitate in creating a culture of hope. This is supported by a reflection on the history of Care Visions Residential Services, the founding principles and how these have developed as the organisation has grown, including the implementation and application of the Sanctuary Model. These reflections lead to a discussion on caring relationships and how social pedagogical concepts have

influenced our approach in developing these. An exploration of our initiative supporting and facilitating continued relationships, between young people and staff members, proposes some suggestions about how we may improve care experience by further enriching the relational experiences of our young people.

Stories of Care

It was a warm summer's Friday evening, the kids were happy and settled, plans were in place for the weekend and the team knew what they were doing. It had been a busy week in preparing for the journey home, a sense of satisfaction excited a mild delirium. I considered I might have a beer, this sense of completeness, a fleeting certainty is elusive in residential child care and must be celebrated. Just as I picked up my bag the telephone rang. It was my manager, who explained that a young person needed an emergency placement and I was asked if we could accommodate her. Given her situation and that we had a vacancy there was no reason to refuse, this is what we do after all, right? This pragmatism was at odds with how I felt, a knot in my stomach inflamed as I considered the implications. How would this affect the plan for the weekend? Would the kids cope with another young person moving in? What if…?

Instead of a sojourn to the local, as planned, I was hurtling up the motorway to a service station where I was to meet the young person and her social worker and take her back to the children's home. When I met Kerry* a 12-year-old girl, my preoccupations and worries about how this had affected me, my pithy resentment, evaporated. Her bewilderment and disorientation was palpable. While my plans for the evening had been usurped, she had been uprooted and her assumptions about who she was and where she belonged suddenly interrupted in a terrible moment.

It transpired that Kerry had gone to school in the morning as normal and had been visited there by her social worker who had informed her that her foster carers were no longer able to look after her. She was taken from the school to

* For confidentiality, the name is a pseudonym and the young person was consulted on what has been written and is happy for this to be published

what had been her home to get her belongings, in bags that had been hastily packed and left inside by the front door to avoid an uncomfortable encounter.

On the journey back to the home, Kerry sat side-on leaning against the door, her presence accentuated by her wide-eyed gaze, was compelling of total attention. The story of how her life unravelled ensued, an inventory of unfathomable loss, adversity, betrayal and injustice. I couldn't and didn't need to speak, all I could do was bear witness to her pain. Reflecting on the experience, there is no memory of the journey, other than a visual imprint of how the young person sat beside me and the visceral affect of her appeal for something that would make sense of her experience. I was moved, in awe of the adversity she had endured, humbled and changed. The intensity of the experience was an awakening, or least a reminder of the significance of the role those of us who work in residential child care have and why I had chosen to work in it.

There was a welcoming party waiting for Kerry when she arrived at the house. Her demeanour immediately changed. She seemed relieved and relaxed. Kerry moved to another *Care Visions* children's home, closer to where she had come from a couple of weeks later. We kept in touch initially through mutual connections and over the last few years have had occasion to meet up regularly. We reflect on that day frequently. Being able to do so seems as important as the experience itself. Her perspective on what happened is surprisingly hopeful. Despite the difficulties, she derives a sense of being cared for from the experience. Kerry talks about finding herself, through a feeling of safety and trust, almost immediately after walking into the children's home, it being entirely different to the chaos and mayhem she expected. She names this move as the beginning of her identity formation, away from the reminders and anchors of adversity. She is doing well. I am privileged to know Kerry, to have played a part in a brief yet definitive moment in her life and to still be in contact with her.

This scenario is not exceptional in the world of residential child care. It perhaps exemplifies the inauspicious circumstances within which children and carers often find themselves. But it also demonstrates how through attuned, containing

interactions, hope, trust and development can arise from these intense encounters, however brief. At a human level they are extraordinary. They represent the challenges and opportunities that children and staff members negotiate and expedite as a matter of routine, encompassing the full range of human experience; sorrow, hope, tragedy and triumph.

Story telling around residential care suggests that it is necessary but unwanted. Care experience is associated with poor outcomes related to educational attainment, physical and mental health, homelessness, criminality and social lives (Cahill et al., 2016; Forrester, Goodman, Cocker, Binne & Jensch, 2009; Schofield, Larrson & Ward, 2016; Stein, 2012). These negative perceptions can blight the sector, those who need these services and those who work in them, compounding the negative affect of stigma (Stein, 2012). Those we care for can be the most disaffected and disadvantaged, having experienced multiple traumas and accumulated adversity probably more than most would experience across several lifetimes. We often meet them at a critical moment in their lives when they are at their most vulnerable. Forrester et al. (2009) argue that rather than being detrimental to wellbeing, care experience is more likely to impact positively on the life trajectories of young people.

There continues to be ambivalence about placing young people in residential care and various policy and regulatory initiatives privilege family placements over small group homes, which are now the standard forms of residential care in Scotland (Connelly and Milligan, 2012). Consequently, it continues to be the placement of last resort (Schofield et al. 2016). Young people often move into services amid crisis, with little time for them or carers to plan or prepare for their arrival. The length of time they spend in residential care has reduced in recent years and those who need these services are likely to have experienced several placement breakdowns before they arrive (McPheat, Milligan & Hunter, 2007). Despite these challenges, residential child care can provide invaluable support to the children who most need it and can benefit from the unique blend of social and individual care. Even the briefest period of stability can infinitely improve the prospects of our young people.

It would be hubristic to suggest that the care system doesn't need to improve. There are too many young people who move on from care that have had damaging experiences of being looked after. The most disaffected are those who need the highest level of support (Stein, 2005). If we consider what care experience can deliver to improve lives, what happens when it does work, we may learn what needs to be done to bring about the necessary improvements.

Considering the complex lives and circumstances of the children we look after and the complexity of the system itself, residential child care is the crucible in which these converge and clash. These services play an essential role within the broader network of support and care for a relatively small but incredibly important group within society. We have a responsibility to tell the remarkable stories that speak to the value of the people who live and work in residential child care and how services make a valuable contribution to society.

Care Visions – early days and new approaches

Care Visions' story began in 1998, with the opening of its first children's home in the South of Scotland. The initial idea came from two social workers who had led a community development project within the locality, working with young people, some of whom were in residential child care. Their interface with these young people, professionals and services suggested that the prevailing narrative around young people who were experiencing difficulties was that they were the problem. Characterising the young people in this way objectified them, compounded the exclusion they were experiencing and neglected their assets and agency, creating a systemic hopelessness. Through their experiences of working in the community and the relationships they had developed with young people, the community workers believed a positive alternative was possible.

The service was designed on the premise that behavioural issues were a manifestation of the difficulties young people had experienced and, as such, a communication of need. Intervention and support was focused on these unmet needs rather than on the behaviour itself. Retrospectively, this seems an obvious proposition. At the time it was radical and, if not unique, unusual.

Developing models of care

The home was supported by a psychotherapist who used Transactional Analysis and theories related to the impact of abuse to inform the approach to care, this was inherently trauma-informed, although not labelled as such until later. The therapeutic approach was created in a family-like small group setting, through daily rituals, rhythms and activities, while maximising the potential of the relationships that developed between those who shared the space. The origin of our organisation was based on an innovative and creative outlook. When hearing the stories from the early years, the pride and optimism is tangible, the proposition being that residential care wasn't something that was endured or survived, either by young people or staff members, rather, it was enjoyed. The supposition was that the solution to the problems that necessitate our services did not need to be the focus of the approach. Instead it was on creating experiences that model positive alternatives to those from which the problems arose. The character of these experiences was crafted through understanding and active interactions to create a nurturing environment and a culture of hope.

The growth and evolution of services was initially organic, in response to the emerging and developing needs of young people living in one home. As the reputation of the organisation developed, the number of enquiries from agencies looking for this kind of care led to the development of new children's homes initially in Dumfries and Galloway then in the Central Belt of Scotland. We now have 31 residential services, spanning the length of the country from the very South to Angus in the North, and from Ayrshire to the Lothians.

As the organisation grew maintaining the ideals upon which the first service was a challenge. A model of care was needed to ensure fidelity and coherence across the whole organisation. In considering which approach to adopt it was important to find one that would maintain those upon which the organisation was founded and would enrich what already existed. We wanted something which would enhance the knowledge and skills of our staff members and their ability to support the development of our children and young people. The Sanctuary Model of trauma informed care fitted this purpose and was first introduced in 2007.

The Sanctuary Model

The Sanctuary Model, developed by Sandra Bloom and her colleagues in the 1980s (Bloom, 2013), is a trauma-informed approach designed to bring about organisational change to create a therapeutic milieu within which people who have experienced trauma and adversity can heal. The model provides a methodology for creating this healing culture using a whole systems approach, encompassing the entire organisation, children, direct care staff, management, administration and leadership.

The evidence base for the model is drawn from constructivist self-development theory, burnout theory, systems theory and the valuation theory of organisational change. For a further explanation, see text box1.

The Theoretical Framework of the Sanctuary Model

Constructivist Self-Development Theory is concerned with personality development and provides insight to the effects of trauma on social and behavioural functioning and disruptions to attachment connections. This is mobilised in the Sanctuary Model through training and in creating a community environment within which relationships develop that build young people's ability to connect with others, regulate their emotions and develop self-worth.

Burnout Theory suggests that emotional exhaustion reduces the emotional availability of carers to act as attachment objects and can lead to depersonalisation of clients and a reduced sense of personal accomplishment. This can diminish commitment to the mission to provide healing relationships and leading to high levels of attrition. Attention to the wellbeing of staff members within a supportive organisation is integral to the Sanctuary approach.

Systems Theory considers the organisation as a system, comprised from a set of sub-systems, recognising the complex relationship between individuals and groups that influence experiences and actions. The organisation and all its constituents is the focus of the intervention of the model.

Valuation Theory of Organisational Change seeks to elicit the personal meaning members of the organisation bring to their work in terms of thoughts, feelings values and beliefs, so as they can be renounced or reinforced in the change process. The model includes training to build skills and tools to support self-confrontation to ensure the change processes encompasses the whole organisation and everyone involved in its activities.

Adapted from Esaki, Benamati, Yanosy, Middleton, Hopson, Hummer & Bloom (2013) The Sanctuary Model: Theoretical Framework

These theories inform the Four Pillars of the Sanctuary Model which are designed to create a community of common purpose through shared knowledge, values, language and practice. For a further explanation, see text box 2.

The Four Pillars of the Sanctuary Model

Shared Knowledge

Knowledge is delivered through training related on the effects of trauma and stress on behaviour to facilitate a change in mindset from a negative perspective to one that considers this behaviour a result of injury. Behavioural difficulties are the result of traumatic experiences, a response to perceived threat and necessary for survival, functional within a dysfunctional environment. The implications post-trauma are chronic hyper-arousal, hypervigilance long after the threat has dissipated, pre-cursors to traumatic re-enactment when experiences trigger traumatic memories.

Shared Values

The seven commitments provide a common value base for the model, in subscribing to this we are committed to nonviolence, emotional intelligence, sharing power, communicating openly, being socially responsible, learning from each other and growth and development. In applying the Sanctuary Model these commitments guide decisions and actions and provide a compass for resolving problems and dilemmas.

A Shared Language

A shared accessible language is supported by the S.E.L.F. acronym, informed by core components of recovery: Safety, in ourselves and in relationships; Emotions Management, being able to recognise and regulate emotions; Loss, processing personal losses by honouring these through grief and understanding that all change invokes loss, and — Future, trying out new behaviour and developing aspirations. The model proposes that safety precedes all development and the principles described are used in routine meetings and engagement as part of tools offered.

Shared Practice

The Sanctuary Model provides a toolkit to support trauma informed practice. This includes: Community Meetings to support emotional literacy, identity affirmation and to seeks help from and offer help to others; Safety plans that support healthy coping strategies when we are risk of becoming overwhelmed, Red Flag reviews, a forum for confliction resolution and restoring relationships when these may have become strained, Psychoeducation, creative engagement to support young people understand their experiences of trauma and integrate these into a coherent narrative, and, Self-Care plans as way from staff members to develop strategies to maintain their physical, psychological, health.

Adapted from:

http://sanctuaryweb.com/TheSanctuaryModel/THESANCTUARYMODELFOURPILLARS.aspx

When the Sanctuary Model was introduced to our residential services there was some resistance. This was motivated by loss aversion and a sense that there had been a negative judgement made about what we were already doing. The predominant approach had been based on what we perceived to be providing a normative experience of growing up for our young people. The model challenged assumptions that what we thought had worked for us as children, would not necessarily work for those we looked after in our children's homes. This was also related to concerns about applying an approach that was developed in large institutional environments to small group settings in Scotland. If we were to accept that trauma and loss were universal and surface the effects of this, then we would have to confront and accept our vulnerability and fallibility. This invoked loss related to giving up a power and the disturbance of an established sense of competence.

Trauma theory made an emphatic case for change to set aside previous assumptions about how our own behaviour may impact on the behaviour our young people. Early practice iterations of the model were clunky as we struggled to adapt our existing routines to accommodate trauma informed approaches. Community meetings were awkward as we grappled with naming emotions, perhaps because we had been culturally conditioned to ignore these and push them down. Responding to incidents through Red Flag Reviews was initially mechanistic, as we struggled to understand the theory and purpose of what we were doing. The model, stressing the importance of safety, may initially have led to the avoidance of uncomfortable, rather than unsafe, interactions. This coupled with concerns about re-traumatising children created some hesitance in setting appropriate limits and boundaries. These issues, although unhelpful, reflect the reverence and sensitivity that exists within the caring environment and are preferable to the de-humanising impact of blunt institutional care.

Implementing the Sanctuary Model was a disruptive process, the focus on training, developing practice through the toolkit and dealing with the inevitable loss that is incurred by change, interrupted the established order. The initial mechanical articulations of the approach evolved as the meaning and intent of the model deepened. Creative approaches emerged that integrated the

knowledge, skills, and values of the model and were practiced naturistically, without script or instruction. Within *Care Visions* the adaptions of the Sanctuary model included community meetings taking place in the car on the way to school and Red Flag reviews were organic conversations, rather than formally arranged meetings. Reflecting on this perhaps surfaces the need to co-author our own approach to trauma-informed care and to involve the entire organisational community. The model has bequeathed us with a coherent actionable understanding of trauma and the effects of this and a shared language. Our application of the Sanctuary Model has imbued a person-centred culture in the organisation that is revealed in how we positively describe our work and the children and young people we care for.

The model has clarified the purpose of our services, in creating safe, nurturing communities within which benevolent restorative relationships can thrive, through shared experiences and mutual accountabilities. What follows is a consideration of what constitutes the kind of caring relationships that can facilitate growth and healing and what has influenced our perspective on this.

The Influence of Social Pedagogy

Several of our staff members have engaged in social pedagogy training and participated in the EU mobility work-study visit to children's services in Copenhagen to learn about social pedagogy in practice. The training and mobility programme was hosted and facilitated by Thempra, Social Pedagogy. The impact of this was described as transformative by those involved. Returning from Denmark they were determined to practically implement what they had learned and to continue exploring the relevance of social pedagogy in our work. The social pedagogues encountered in Copenhagen invariably described their professional identity in terms of developing a relationship with the child and *working in solidarity* with them to support their integration into society.

Solidarity may be a contentious term, given the association with political resistance and concerns about insularity and self-interest (Illingworth, 2016). Described by Schuyt (1998) as a benevolent orientation that involves the

sharing of feelings, risks, responsibilities and interests, it has relevance within the frame of caring relationships. Jennings (2018) proposes that solidarity in a caring context is based on the recognition of those we care for as moral subjects, with agency to decide and act in their own interest and the interests of the greater good. By working in solidarity with young people we stand up, with, for, and, as them, integrating rights, responsibilities and ensuring their agency and dignity. In doing so interdependencies can develop through which need emerges collaboratively creating a moral community that supports wellbeing by activating the collective potential that is contained within this. Being in solidarity with our young people from this perspective is an act of relational care.

The concept of *haltung* (Eichsteller, 2010), a German word, is without equivalence in the English language, widely used in social pedagogy training. It broadly translates as the stance, disposition or essence of a person and embraces the integration of the personal and professional from a values perspective. Our work from this perspective is an existential endeavour, pertaining to who we are, our purpose and the meaning derived from identity and intent. It is as much about much concerned with being as it is with doing, not only what is done but how this is done and requires interpretive skills (Garfat, Freeman, Gharabaghu & Fulcher, 2018).

Caring relationships

We've long recognised the significance of positive relationships between young people and carers in improving outcomes for children in care. Residential child care staff are uniquely positioned to form and influence the experiences of young people through their relationships with them (Coady, 2014). While this appears to be universally understood there is less known about the character and practice manifestations of these relationships and what it is that supports positive outcomes (Cahill et al., 2016).

Healthy relationships require a nurturing environment, where safety is elicited through rhythmic activities and engagement, structure and boundaries, that form the foundations for relationship building in the space and experiences

shared by carers and young people. These can be anchored in simple personalised acts within day to day interactions, such as deference to the young person's preferences at mealtimes. They are based on the premise that attentive recognition of others is the moral imperative with which caring relationships are primarily concerned (Jennings, 2018). This warmth and genuine affection, communicated through responsive interactions can then be accompanied by a demanding parenting style that stretches development, through which young people feel a sense of being cared for, importance and mattering (Morrison, 2016; see also Hawthorn, 2020, in this volume).

The young person's history of relationships may have led to an absence of trust, and transitory existence and inconsistent relationships with professionals may hinder the development of positive connections or a sense of felt security. Relationships are a critical medium for our young people, to re-establish trust, in themselves, in others and their wider world through relational repair. Based on mutuality and enabled within the life space through reciprocal exchanges, emotional and social. This requires self-disclosure and authenticity. Trust is also embedded in reliability and consistency of self, showing up and being present and willing to make contact, even when this involves the risk of exposure to distress. Relationships boundaries are essential as a precursor for safety and engagement, rather than a barrier to these (Fewster, 2005). If they are to be congruent and authentic these are inherently personal with the terms of engagement negotiated between the participants in the relationship, enabled and empowered by the organisation through supervision and a culture of transparency, nurturing trust.

Emotional connections (attachments) are necessary but will not alone provide the stimulus for growth and development. Li and Julian (2012) argue that these contribute to one 'active ingredient' of developmental relationships. Progressive complexity, reciprocity and the sharing of power are also essential components. These evolve as personal mastery develops and the skills to manage responsibility increases.

Compassion is an essential component of caring relationships, described in our values statement as caring through relationships based on empathy, warmth and affection that restore trust and hope in young people (Care Visions, 2017). Tanner (2019) attests that compassion is synonymous with care giving and while containing an empathic element, attunement to the emotions of others. It is characterised by warmth and concern and a motivation to act to improve the wellbeing of the other in the in relational dyad and in compassionate communities. Tanner also notes that empathy can lead to avoidance of distressing situations for fear of being overwhelmed. Compassion as an element of caring, means we must muster the courage needed to overcome this fear to actively respond. We need to be affected to be effective, but not so much so we become overwhelmed and unable to act. Succinctly, empathy visits, while compassion acts and endures.

Personal, compassionate relationships in the care setting have the potential to repair or remediate relational trauma and can impact positively on the social, emotional, psychological and moral development of young people that can endure across the life course. They are also integral to developing resilience through facilitating support networks. These become critical when the young person moves on from their care placement in mitigating loneliness and anxiety through continued relationships with carers, (Schofield et al. 2016).

This perspective necessitates a challenge to the prevalence of the policy-driven procedural approach that has dominated practice in recent years. It also challenges the authority given to professional objectivity and the preference given to rationalism in decision making. The imperative to act compassionately can be diminished by the valorisation of objectivity in the 'delivery' of care and the prevailing construct of professionalism and the concerns about the impact on the emotional health of workers of becoming emotionally involved with those they support (Tanner, 2019). This construct of professional behaviour has developed in response to abuse inquiries. It reflects an inherent mistrust of those working in social work and social care and is focused on control and compliance, as a means of regulating the workforce rather than meeting the needs of the children we care for. Moreover, it blunts the inherent intuition or

'moral impulse' (Smith & Steckley, 2012) to care, in a meaningful sense. It has also created cultures that limit the adaptive capacity of the sector (Helm, 2011).

While Helm's perspective relates to child protection social work, in residential care, we too, may have become pre-occupied by attending to the needs of the system. Displacing our energy and attention from the needs of the young people we care for. These issues can be overcome by reframing what it means to be professional and care from a compassionate perspective by recognising and embracing the interdependencies that exist in human relationships. Notably, creating the conditions for professions to act on their compassionate impulse is likely to lead to 'compassion satisfaction' improving the emotional health and wellbeing of professionals that care, augmenting their resilience, building on capacity rather than reducing it (Tanner, 2019). We cannot create systems, legislation or policies that adequately address the complexity of the human condition or cover all the infinite individual situations that people find themselves in. What we can do is truly commit ourselves to a hopeful orientation. Hope is actionable through the development of trusting relationships.

Ideas around 'wholeness' and the use of self are not new in residential child care. There is ambivalence about the extent to which this should be enabled and how and by whom it is regulated. This can be communicated to young people in their day-to-day interactions with carers, who may fear rebuke if they are perceived to have overstepped limits of what it means to be professional (Steckley & Smith, 2012). Applying *haltung* (Eichsteller, 2010) in practice, proposes a dispositional orientation that requires reflective and reflexive interrogation of our personal and professional values. Designing experiences that foreground relationships with a person-centred orientation that informs process and practice. This suggests an alternative to rule-bound governance through procedures that can be prohibitive and based on risk aversion, by empowering carers to navigate the multiple dilemmas (Gharabaghi, 2008) inherent in developing authentic trusting relationships with young people.

Why Not? Continue Caring Relationships

In 2014, Care Visions Children's Services developed a project to support continued relationships between young people moving on from care services and adults, with whom they have developed trusting relationships, while they were being cared for in residential and foster care. This was inspired by *You Gotta Believe*, a New York based Organisation that provides a 'moral adoption' service for young people ageing out of the youth care system.

Why Not? Community and Connections is now part of the *Why Not? Trust* for care experienced young people, a Scottish Charitable Incorporated Organisation. It has supported more than 60 young people to engage in continuing connections with former staff members and carers through person centred planning. Carers and young people are helped to maintain these relationships with the ongoing support of a dedicated manager and coordinators, who ensure safety and provide facilitation.

The project started in recognition of the significance of the relationships in enabling young people's wellbeing and resilience, in preparation for, and after they have moved on. Mann-Feder (2007) argues that preparing to leave care placements can agitate a renewed sense of loss caused by the anticipation of being alone. This amplifies previous attachment loss, related to family separation and can result in regressive behaviour. In preparation for moving on, focusing on continued relationships with adults with whom young people have an emotional connection is likely to reduce the potential for attachment re-mourning. Young people who have left care are also more likely to develop a coherent narrative of their identity, a key element of resilience, when they are able to review their experiences with the carers with whom they developed a trusting relationship as children (Cahill et al. 2016, Stein, 2005). Given the importance of ensuring that young people are supported to prepare emotionally before they move on and have an emotional safety net when they do. It does not seem sufficient merely to permit continued relationships. They need to be actively resourced supported, facilitated and encouraged.

As the number of young people engaged in *Why Not?* grew, gatherings were arranged so young people could share their stories and experiences and connect with the network of people involved. From these, a community of common interest developed. This has become a vibrant network of talent and creativity- a repository of social, emotional and skills capital in which everyone contributes, and everyone benefits. There are already signs that engagement in the community is improving personal and collective resilience and that the relationships and interdependencies that have developed are becoming self-sustaining. At times this involves standing up for, with and as one another, in solidarity (Jennings, 2018).

Some of the care experienced community have been employed to review care services and in supporting other young people preparing to move on, have given feedback to professionals from the care review and board members. A playgroup has also been co-created by community members, for care experienced adults to attend with their children.

This approach to facilitating relationships offers a high level of autonomy and organic development, affording nuance and differentiation without compromising safety. Safeguarding and governance is administered through transparent processes and engagement with the young people, to support agency and discretion.

In conclusion

Our work in supporting continued relationships and co-constructing a community with our care experienced young people is the most recent phase in our continual journey of practice development. This has involved interrogating our approach and being open to new ideas. What we have learned can be embedded into our practice in residential care. At *Care Visions* we have always aspired to be steadfastly 'relational' in our work. We are now reviewing our care practice through a deeply a collaborative approach, in solidarity with our care experienced community, surfacing and acting on the wisdom that exist within

this. As hope-keepers for our children and young people we will continue to be critical thinkers and courageous, compassionate carers.

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About the author

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