‘Hard to know what to do’: How residential child care workers experience the mental health needs of young people

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Introduction

Over the last decade there has been mounting evidence of the high level of mental health difficulties that exist in the population of looked-after children accommodated in residential settings in the UK (McCann et al., 1996; Dimigen et al., 1999; Meltzer & Lader, 2004; Kendrick, Milligan & Furnival, 2004). Compared to the general child population, young people in residential care have been found to be between four and seven times more likely to experience mental health problems that can seriously interfere with their capacity to make positive and close relationships or succeed in an educational environment. Although many of these difficulties are the result of disadvantage, neglect or trauma within their own families or communities, they can also be exacerbated by failures of the systems designed to protect, care for, educate or treat young people. Although there is now a substantial body of literature that identifies the prevalence of various disorders among looked-after and accommodated children, there has been far less focus on the experience and perspectives of those adults who provide direct care for young people in residential settings. One focus group study looked at the interface between social care and mental health and identified the importance of

partnership working and some of the difficulties that carers experienced in gaining access to mental health professionals (Callaghan et al., 2003). Recent research has also highlighted that the difficulty in retaining residential staff is, in part, a result of having to work with increasing numbers of children with emotional and behavioural difficulties, and in particular dealing with physical and verbal aggression (Colton & Roberts, 2007).

In 2000, the Scottish Executive Health Department commissioned a project which sought to provide a needs assessment of child and adolescent health in Scotland. The project was called the Scottish Needs Assessment Programme (SNAP). The final report of this needs assessment was published in 2003 (SNAP, 2003) and its findings have had a major impact on policy in Scotland. Although the SNAP project investigated the emotional health of the entire child population, it also highlighted the particular needs of looked-after children. As part of the assessment process, the SNAP project also surveyed a wide range of professionals who worked regularly with children and young people but whose main focus of work was not mental heath. A report on the general findings of this survey has already been published (Furnivall, Wilson & Barbour, 2006). This paper seeks to describe the particular experiences and perspectives of residential child care practitioners in dealing with mental health difficulties of the children for whom they are responsible and compare their experience with that of other professionals.

Methodology

During 2002 and 2003, questionnaires were sent to a range of people who work with children and young people including health professionals, social care professionals, educational professionals, voluntary workers and those involved with the Children's Hearing system.

Table One: *number and response rate of survey participants*

Professional group	Number of questionnaires sent	Responses received	Percentage response
Social workers	234	107	46
Residential workers	289	104	36
Reporters	32	22	69
Panel chairs	32	19	59
Teachers	603	353	59
GPs	280	137	49
Health Visitors	142	71	50
Paediatricians	70	54	77
School nurses	230	10	4.3

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The sampling process for most professional groups was a pragmatic one of using health boards and local authorities to identify possible respondents. The Scottish Institute for Residential Child Care had, however, just completed its first qualification audit of all residential staff in Scotland, and had a comprehensive list of residential child care workers. Permission was sought and gained from employers to approach their staff and ask them to take part in the survey. A sample was identified that was as representative as possible of the residential child care workforce in Scotland across geographical location, setting and job level. Questionnaires were sent out to ten percent of the workforce (289 residential workers). Replies were received from 104 staff, giving a 36 percent response rate.

Questionnaires elicited both qualitative and quantitative responses and this paper reports on both types of responses. The qualitative data focused on three core questions that asked respondents to think about their **most recent** experience of working with a child or young person with mental health, emotional or behavioural problems, the **most worrying case** they had worked with in the past three years and the case that had given them the **most satisfaction** in the same timescale. For each of these three questions, respondents were asked to describe the problem and how they responded to this. They were then asked to reflect on how they might have tackled the situation differently with hindsight. Finally, they were asked to identify the barriers to achieving this or, in the case which had given most satisfaction, what had been the positive factors. The responses were coded and analysed using the QSR N6 qualitative software package using a detailed coding frame developed by the inter-disciplinary research team. These codes ranged from simple problem classification to codes that reflected the impact on respondents of the work they were engaged in. The quantitative data came from the frequencies of various types of responses to closed questions in the survey. These were analysed using data display and reduction. This paper reports upon a selection of the data which was particularly relevant to work in residential child care settings.

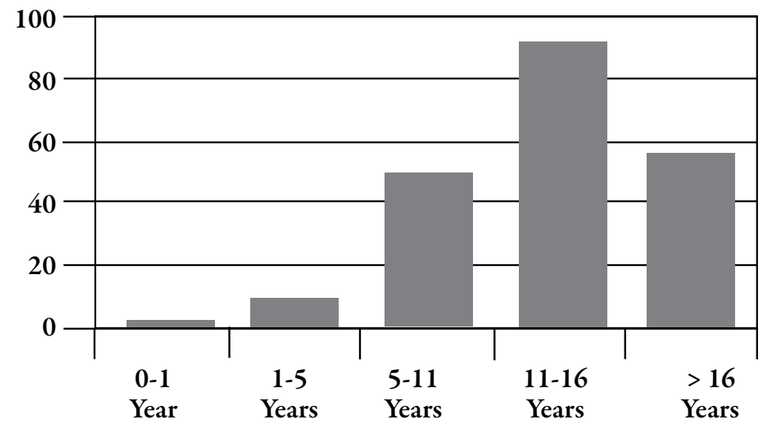
Findings

The nature of the residential setting

Findings demonstrated the complex social systems that exist in many residential settings. It has been recognised that stability of placement is important in maintaining emotional health (Beck, 2006; McAuley & Young, 2006) and also increasing educational attainment (Jackson, Ajayi & Quigley, 2003; Stanley, 2005), but even where children are able to remain in the same setting, the structure of residential child care means that they are often exposed to a constantly changing group of adults. Eighty-seven of the 104 residential workers (83.7 percent) described settings in which more than 11 people worked regularly with the young people. Forty of the respondents in this group worked in places where more than 20 adults were involved with the young people. Such inherent instability makes it more difficult to create an environment in which strong positive relationships that can protect against emotional ill health are able to develop.

Policy in many local authorities and perceived good practice dictates that children under twelve should not be accommodated in residential care (Milligan, Hunter & Kendrick, 2006). Despite this, 48 residential workers described working with children under the age of 11 years. Six workers had had children under five in their care and two respondents worked in settings where infants under the age of one had been accommodated. The clash between policy and actual practice means that in some cases these younger children are being cared for in settings that are not designed to meet their needs, by staff who may be more comfortable working with teenagers.

Table two: *age range of children with whom respondents had worked*



(Although the total number of respondents was 104, most of them worked across more than one age group.)

Respondents were asked to estimate how many hours a week of direct contact they had with children who had emotional, behavioural or mental health difficulties. Seventy-eight residential workers (74 percent) had more than eight hours a week contact with such young people, with almost half of them having more than twenty hours contact per week. This is in stark contrast to the pattern of involvement of other professional groups. The social work respondents were all drawn from child and family specialist teams, and their caseloads comprise a similar group of young people. Their direct exposure to distressed young people, however, was on average substantially less than that of residential workers. Of the 34 teachers who had more than twenty hours contact with these young people, 31 worked in specialist units for children with emotional and behavioural difficulties and thus had a level of exposure similar to residential workers.

Table three: *number of hours of direct child contact by professional group*

Professional group	Number	8-20 hours	More than 20
Residential workers	104	31 (30%)	46 (44%)
Social workers	105	35 (33%)	19 (18%)
Teachers	366	56 (15%)	34 (9%)
School nurses	100	1(1%)	1 (1%)
Health visitors	71	3(4%)	0 (0%)
Voluntary workers	55	5 (9%)	12 (22%)
Paediatricians	54	4 (7%)	1 (2%)
GPs	137	0 (0%)	0 (0%)

Nature of the problems

Residential workers described dealing with children who experienced a wide range of problems that confirm previous research (Meltzer & Lader, 2004). The most frequently described difficulties included violence and aggression, self-harm, externalising behaviour, emotional difficulties and problems with substance abuse. In addition, workers identified a number of young people who had formal diagnoses of learning difficulties and/or mental health problems. Attention Deficit Hyperactivity Disorder (ADHD) and depression were most commonly mentioned but five workers had cared for a child with a psychotic illness and five had worked with a young person suffering from Obsessive Compulsive Disorder (OCD). Interestingly residential workers mentioned family difficulties or abuse less frequently than some other professional groups, unless the situation was particularly troubling, which perhaps reflects the 'normality' of such experiences in the group of young people for whom they care. Residential workers frequently faced violence and aggression from the young people they cared for but they also worked with many young people who injured themselves. Although being exposed to violence and working with self-harm were common experiences for several professional groups, they were more frequent for residential workers. Although some professional groups describe such problems as frequently as residential workers, the level of their direct contact with young people experiencing emotional difficulty is much lower so that they tend to be exposed to aggression and self-harm to a lesser extent.

The views of residential staff about their work

The open questions in the survey invited the respondents to outline some of the issues they dealt with in more depth. This helped to give a richer view of their work

with this group of children and young people. The responses noted in subsequent parts of this paper are the actual written responses of the staff themselves.

Residential workers often described very complex cases in which a number of problems co-existed. Seven workers gave descriptions of violent and self-harming behaviours in the same child as in this description of one worker's most worrying case:

> *Young person displaying violent (physical & emotional) behaviour. Uncommunicative. Self-harm. Unable to form any attachments. Para-suicidal* (RW0133).

The nature of these difficulties was often particularly troubling and could challenge practitioners' normal work practice as described in this account of another worker's most worrying case:

> *Young person was extremely violent/aggressive on a daily basis, issues around seeking sexual satisfaction from violence and restraint situations* (RW0032).

Situations such as this pose a dilemma for workers. They have a duty of care to other children and staff and thus have to intervene, but are concerned about the implications of physically restraining a child. The problem of sexual aggression was particularly worrying for residential workers and sexualised behaviour was a compounding factor in the violence described by 11 respondents. The following is an example of the complexity and worrying nature of such situations:

> *The child was sexually abused and was forced to abuse his siblings by his parent and their partner; they were also physically abused also diagnosed as being ADHD* (RW0160).

Self-harm is a common problem in institutional settings and it is known that for many distressed young people it is a coping mechanism that enables them to manage better on a day-by-day basis (Brophy, 2006). Much of the self-harm described by residential workers fitted this pattern. Some of the self-harm described, however, was very serious and appeared to indicate extreme emotional distress and a genuine wish to die. The quotation below highlights this point:

> *Self harm with cutting to all areas of the body especially genital area, attempted suicide on weekly basis, frequent assaults on staff. Absconding for long periods* (RW0062).

Two respondents described situations in which young people had succeeded in killing themselves and one gave a history of such severe self-harm that the child was sectioned under the Mental Health Act. Involvement in such situations gave workers a sense of powerlessness:

> *I would like to have avoided his eventual death by drugs overdose; perhaps some form of compulsory or coercive intervention might have helped* (RW0073).

Difficulties in making a difference

Residential workers were more likely than other professionals to comment on the intractability of the problems that they faced in their work. Nine workers commented that the nature of the problem was such that there was little possibility of change within the setting in which the child was placed:

> *With someone so chaotic and damaged it is hard to know what to do. The young person's attitude makes living very difficult. Very needy and melodramatic. Tends to suck dry staff* (RW0153).

As well as the nature of the problem, workers identified other factors that made it very difficult to make a serious difference for particular young people. Twenty-nine respondents commented that one of the main barriers to achieving a positive outcome was the young person's refusal or inability to engage with help if it was offered. For several young people this was seen as a failure by them to recognise the seriousness of the problem. Respondents, however, consistently mentioned the impact of stigma as a disincentive for young people to engage with services. Eleven respondents also believed that the refusal of parents to recognise the seriousness of their children's difficulties or to engage with services prevented young people receiving the help they needed. Ten respondents commented on the failure of professionals to engage appropriately with the needs of young people. This was partly caused by gaps in services created by geographical boundaries or the interface between adult and child services. More worryingly, however, respondents were also identifying reluctance on the part of service providers to become involved with the complexity of need that was often presented by children and young people in their care:

> *This is a continuing theme; there appears to be a lack of integrated services who are willing to work alongside residential staff with children with very complex needs* (RW0032).

The system itself was frequently reported as failing children and exacerbating their problems. Nearly a quarter of respondents complained about delays in accessing outside help and a similar number were frustrated by lack of funding. They understood the importance of early intervention and were clear about the human cost of delays:

> *Work should have began at an early stage to address problems. Assessment made by psychiatrist but due to waiting list and availability of this, problems tend to spiral out of control* (RW0074).

Respondents were left feeling frustrated and powerless as they watched young people becoming more distressed and their problems more entrenched:

> *Prevention and early intervention can make all the difference. There is nothing worse than watching a young person suffering and be unable to help due to lack of provision* (RW0153).

The respondents also recognised the problems within their own settings that made it difficult to provide appropriate help to young people. The continuous requirement to balance the needs of the individual and the group was frequently mentioned and experienced as very frustrating:

> *Generally as you are working with a group of young people it is often difficult to spend the time required to go over all the issues as other young people may need your attention, or colleagues needing support in dealing with other incidents* (RW0057).

Often, residential workers believed that young people required more focused individual work but were unable to provide this because of pressure of time or low staffing level:

> *I would have liked to have been able to give more one-to-one care but staffing ratio and levels are never adequate enough* (RW0195).

Nineteen residential workers believed that the young person they were describing required a specialist therapeutic resource but many of them qualified this by saying that such provision was rare or that there was no funding to pay for it. Although the desire for specialist therapeutic input was frequently expressed, the features outlined in the next staff quotation describe what should be possible to provide in a well resourced and appropriately supported residential unit:

> *Would have liked to have been able to offer more intensive treatment in a residential placement for the young person where their needs could have been met within a living environment offering a nurturing environment combined with mental health treatment* (RW0281).

Although respondents were frequently frustrated and pessimistic about the possibility of change they had clear ideas about how service could be improved. The following response identifies many of the factors that workers believed could make a difference:

> *Young person-friendly building + location - reduce stigma. Greater access to service e.g. broader referral remits, shorter waiting times, more responsive service. Greater flexibility e.g. practitioners meeting young people within units if they would rather, not just in their office. Consultation with staff if appropriate* (RW0286).

Impact on workers

The intensity of contact and the degree of distress that residential workers are exposed to means that they are likely to experience powerful responses to their work. The residential workers in the study were more likely to express fear, despair, uncertainty and a sense of being overwhelmed than other professionals, as the following two comments demonstrate:

> *I am only a carer - this was away over my head* (RW0254).

> *I have seldom witnessed outright success in this area* (RW0073).

Even when workers were expressing such powerful responses, however, there was usually an attempt to understand and make sense of the behaviour:

> *There have been many situations where I have felt unable to cope with extreme behaviours - cases where young people have attempted suicide or attacked others or ransacked the unit. In all these cases emotional & behavioural difficulties are to the fore-front of the young person's actions* (RW0251).

The most commonly expressed response was uncertainty and confusion and residential workers were very keen to access knowledge and skills to help them in their work. Twenty-eight respondents mentioned that improved training for staff could have helped in dealing with the young person's problems. Training was not seen as a sufficient solution, however, and 36 respondents would have welcomed direct access to a trained professional to support them in their work. Some practitioners would have welcomed immediate telephone access 24 hours a day to deal with crises but others such as the respondent quoted below wanted the opportunity for regular discussion to enhance their understanding of the young people:

> *To assist us on a weekly visit. To help us understand - to try other ways to work with the young person. To enlighten us what they are going through* (RW0254).

Sources of satisfaction

Although many residential workers expressed frustration and concern at how difficult it was to provide effective help to children and young people, most of them were able to identify an example that had given them a sense of satisfaction. Unlike many of the other professionals, the satisfaction was only rarely the result of a child recovering and being able to move into a successful future. The following example was unusual and even the respondent recognised it as a relatively rare experience:

The child moved on a great deal. Moving to live with a foster family and has been re-integrated back into mainstream school. It is evidence that a residential environment can be a therapeutic process that works. Confirmation and validation of job (RW0063).

Most of the examples that were given of a satisfactory outcome involved the residential workers being able to access external help for a child or identify a new placement and support the child in transition. In a number of cases, workers reported a reduction in severity of a worrying behaviour such as self-harm or aggression but this did not mean that other aspects of the child's life had improved although it made it easier to maintain placements. Often changes such as this were connected to staff teams being able to work well together as in the following example:

It was satisfying because the whole staff team pulled together and his behaviour and difficulties are still there but we can manage them and get a lot out of the young man (RW0243).

Residential workers were the professional group who most frequently cited working within a team as a source of satisfaction in itself. Twenty-eight residential workers said that the reason a case had been satisfying was the experience of good teamwork, as highlighted by this example:

Talking with all staff members, calibration of all necessary information and trying to stick to the plan that has been identified. As a staff team it gave us the feeling of success (RW0188).

Teamwork was not just valued internally. It was one of the factors that residential workers appreciated most in external professionals and they linked it clearly with better outcomes for young people. This example identifies the components of good inter-agency teamwork:

There were clear objectives from the start and everyone involved worked to make it a success. This was true working in partnership. Good to see that support can make a difference and improve quality of life for child and family. Good to see agencies communicating and working collaboratively (RW0057).

Residential workers particularly valued being given an appropriate place in the work with young people and appreciated professionals who were able to recognise the importance of the relationship they had developed with the children in their care. This example demonstrates how a young person was able to accept external help because of such mutual understanding between professionals:

I found the young person's willingness to accept support a major fact. This was done because the young person trusted the individual involved in the care. Good lines of communication were drawn and the young person did not feel totally detached from the unit when receiving the services (RW0285).

Discussion

Although the SNAP (2003) report has been influential in developing awareness of the needs of looked-after children, many difficulties still exist in ensuring that appropriate resources are available to meet them. The descriptions provided by residential workers in this study give a human dimension to the statistical reports of high levels of mental health problems in looked-after and accommodated children. They also paint a vivid picture of the experience of working with distressed and sometimes violent young people on a daily basis. What is clear from the accounts is that for a substantial proportion of these young people, their experience of being in residential child care has not been able to ameliorate their mental health difficulties in any enduring way. The residential workers who responded to the survey were clearly committed professionals who wanted to be able to provide a high quality service but a number of factors impeded this. Internally it was clear that staff found it difficult to balance the extreme needs of the most disturbed young people with the needs of the other young people. There was a clear recognition that when staff were able to spend substantial time with young people, it was experienced as very helpful. The reports of poor child/staff ratios and insufficient time meant that it was rarely possible for practitioners to offer this. Respondents also stated that in many cases the unit in which they worked was not structured and supported to provide the therapeutic help that a child needed. It was clear that within the sector there was a strong belief that more specialised, smaller units which could allow a more in-depth approach were needed. Gaining access to external help seemed fraught with difficulty, partly as a result of a general lack of capacity within services but also because these children posed a particularly difficult challenge for some external professionals to engage with. The reported inflexibility of services and the stigma associated with them meant that even when a service was offered it was not always possible to encourage the young person to access this.

The impact on staff of working with such intense emotional and behavioural difficulties appears to be high. The data showed that residential workers have greater exposure to the problems than any other professionals surveyed. There was a strongly expressed need from many respondents for support and training for themselves in their day-to-day work. Support and training for staff can have two helpful purposes for this group of staff. First, it can help staff to survive the psychological onslaught that working in this intense environment can provoke. Second, it allows staff to remain in touch with the distress behind behaviour and enables them to plan positively and therapeutically for young people, rather than sliding into angry punitive responses. Conlon and Ingram (2006) describe how staff consultancy can support staff to work in a therapeutic way.

Although many of the respondents identified very troubling situations in which they felt that little positive help had been offered to young people, they were also able to identify situations in which they had experienced considerable satisfaction. Almost invariably residential workers linked these positive outcomes to people working together well. This could be at the level of the residential setting but also

included occasions in which outside professionals or agencies had worked closely with residential workers and each other to provide a planned integrated service which had had positive outcomes for young people. Often the positive relationship that residential workers had with young people was the vehicle through which help was provided with advice from external professionals. Alternatively these relationships allowed staff to support young people to access external services themselves.

Conclusion

Many young people in residential settings suffer serious mental health difficulties that cause them and others around them considerable distress. There is a strong commitment from residential workers to try to provide help to such young people but this is not always possible. Most residential settings are not staffed well enough to provide the individualised attention that such young people require and insufficient specialist resources exist within Scotland to provide a proper service. Residential workers themselves suffer emotional stress as a result of their intense exposure to young people with emotional and behavioural difficulties and should be provided with appropriate targeted training and have access to regular external consultancy. The particular skills that residential workers possess both in developing relationships with young people who are hard to engage with and also working well in teams should be more widely recognised and used in planning the care and treatment of emotionally distressed young people who live in residential settings.

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