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Scottish Journal of Residential Child Care: An international journal of group and family experience

Volume 20.2

Editorial

Graham Connelly

g.connelly@strath.ac.uk

@DocCTweets

Welcome to the autumn/fall 2021 issue of *SJRCC*. This is the second issue of our new two issues per year (spring and autumn) format. Regular readers will have spotted that we have a new strapline - 'an international journal of group and family care experience' – to emphasise our international reach and a scope that encompasses all care experience.

This issue is published to coincide with the Scottish Institute of Residential Child Care conference – 'SIRCC 2021 Online' – on 29 and 30 September. The theme of this year's conference is 'The Workforce' – highlighting the experiences, challenges, and opportunities of those working in residential child care - and several articles in this issue, as well as the transcript of the 2021 Kilbrandon Lecture, also included, specifically consider aspects of the complex task of providing care. The journal will have a more obvious presence at this year's event, by means of a virtual meet the editor and authors' session and in the exhibition space.

As our special series of articles, 'Reflections on Residential Child Care During the COVID-19 Crisis'[1], shows, the workforce has faced the challenges of the pandemic in heroic ways, largely unknown outside the sector. We hope that the articles on workforce-related themes included in this issue serve to broaden understanding and recognition of the complexity of the work of child and youth care professionals. What is most striking about the articles submitted by our contributors is that authors have found time to reflect on their practice during the most challenging time in the recent history of the profession, continuing to

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[1] https://www.celcis.org/knowledge-bank/covid-19/reflections-covid-19

make everyday life for children and young people as full and stimulating as ever, and even innovating in the process.

In prefacing this issue, I want to highlight two important contributions which in different ways have highlighted the rights of care experienced people. April 2021 was designated ‘Care Experienced History Month’, a festival of commemoration and study of the history of care aimed at understanding ‘why care is the way it is and how the systems we have in place today came to be’.[2] The month, planned to be an annual event, was the brainchild of University of Glasgow history and sociology student Charlotte Armitage, herself care experienced, and involved partners in several countries, a network which no doubt will continue to grow. We are delighted that Charlotte agreed to contribute an article about History Month to the current issue.

In July, a significant legal provision came into force in Scotland requiring local authorities to ensure that where it is safe for them to do so, brothers and/or sisters can live together or as near to each other as possible. The new requirement, a provision of the Children (Scotland) Act 2020, arose from a commitment in ‘The Promise’, the findings of the Independent Care Review.[3] Work to prepare and draft the guidance for practice, ‘Staying Together and Connected’, was co-ordinated by CELCIS to help with implementation (Scottish Government, 2021).

Autumn 2021 issue

Opening this issue, and specifically on the theme of workforce and the learning culture of the workplace, the first of six peer-reviewed research articles published in this issue is contributed by Kevin Pollock and James Gillespie reporting on their study of the journey undertaken by a Scottish residential school, Kibble, to develop and embed an organisational resilience policy to anticipate and manage risk effectively. They review the significant organisational actions that support resilience and learning and explain how Kibble integrated

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[2] https://www.careexperiencedhistorymonth.org

[3] https://thepromise.scot

these into the organisation's strategy, structure, culture, and its people. They also discuss the requirements more generally for improving resilience and learning practice in care sector organisations.

Kiram Modi, Gurneet Kalra, Leena Prasad, Rajeshwari Narsimha and Jyoti Singh have analysed developments in alternative care in South Asia during the COVID-19 pandemic. Their desk review found that the pandemic is leading to the re-institutionalisation of many children due to government orders or the shortage of necessities in poor families, and that countries vary in respect of guidance that complies with the advice of major NGOs. The authors make several recommendations for practice interventions.

Terje Halvorsen presents a case for utilising philosophical discussions as a way of helping children in residential care and similar settings to develop their reasoning skills as a pre-requisite of advancing in education, and to help practitioners with professional reasoning. Amanda Keller, a PhD candidate at McGill University, has used narrative case study to explore the life course trajectories of two care experienced adults, allowing her to reflect on how residential foster care alumni describe their life history and the insights they can provide about adulthood and parenthood and their placement experiences. Among her conclusions is the observation that study of life trajectories ‘highlights important and complex histories of loss and trauma, which suggests that recovery is a lifelong process, and that healing can emerge later in adulthood than that the period on which researchers currently focus’. Forensic psychologist Carrie Mclaughlin reports on her research about how ‘distance’ relates to young people’s experiences of being looked after away from home. Her research used semi-structured interviews and thematic analysis, and Carrie says that ‘the overarching message from this research was that whilst geographical proximity to a young person’s home could impact on how close they felt from home, the importance of connections was significant’.

In the final peer-reviewed paper in this issue, Miriana Giraldi, Alexander McTier and Robert Porter present an argument for the added value that implementation science can bring to ensuring quality in residential care settings. Considering the concept of quality care, the authors say there is a ‘need to move beyond the more immediately tangible factors of, for example, recruitment of certificated staff, child-staff ratios, and the presence of policies and procedures, to consider in greater detail the complex environments in which residential care workers operate in’.

The issue includes nine shorter articles reporting on practice or contemporary issues. This section begins with Charlotte Armitage’s inspiring account of the planning and implementation of Care Experienced History Month 2021. A student of history and sociology, Charlotte was working for the campaigning and advocacy charity Who Cares? Scotland when she pitched the idea of hosting a month of digital materials and events to honour ‘the legacy left behind by Care Experienced people no longer with us’. Her article explains the aims of the project, the international collaborations, the process of putting it together, and the flavour of the content. University of Glasgow history lecturer Christine Whyte has contributed an article based on her blog for history month about the training ship HMS Mars which was moored in the river Tay near Dundee between 1869 and 1928. The ship, part of an approach to establish industrial schools for poor, vagrant, and destitute children in Britain, was home to up to 400 boys at a time. Christine says ships were meant to house and educate the poor, but ‘in practice, children were sentenced to time in an industrial school by magistrates for things like begging, to being in the company of reputed thieves’. The article is especially poignant for this editor: my paternal great grandfather Thomas was, according to a report in the *Dundee Courier* of 8 December 1877, ‘A waif sent to the Mars’.

Melissa Hunt and Elaine Adams examine the delicate balance between protecting children from harm and ensuring that children’s rights are maintained in the context of the Scottish children’s hearings system. They highlight the importance of engaging with children and finding ‘creative and innovative solutions that protect children’s rights, ensure their voices are heard and increase their meaningful participation in all decision-making that affects their lives’.

On the theme of ‘Workforce’ Paul Gilroy and Lawrence Wareing have documented the change process for staff and children involved in the migration of a residential school, which operated for generations in a grand castle setting, to more homely, family-style living in local communities. Despite the many attractions of the rural setting, 'the relative isolation inherent in the building's physical environment could only ever result in a reinforcement of otherness and the experience of living with stigma'.

The UN Nations Committee on the Rights of the Child held 'Day of General Discussion' online on 16 and 17 September 2021. In her article, 'Why engaging on children's rights internationally matters at the local level', Miriana Giraldi gives the background to the days and the aspirations for the 2021 event.

Next up are a further three articles on the 'Workforce' theme. Jenna Bollinger, Philip Mendes, and Catherine Flynn write about staff's roles and needs for providing stability for children in residential care. Based on interviews with 13 staff in New South Wales, Australia, they find that stability 'appears to be related more strongly to a consistent placement with whom the young people can forge and maintain genuinely caring relationships that are supported by the management of the organisation'. Kathy Grant contributes a reflective piece on her own experience of social work practice during the pandemic and realises that she has 'missed the relational focus, therapeutic potential and fun of the lifespace'. Frank Ainsworth reflects on his own and Leon Fulcher's interconnected professional journeys as practitioners and academics who have contributed massively to the global literature on the theory and practice of residential care for children and young people. They take the view that while no child should be placed unnecessarily in residential care, 'some children and youth can benefit from a period in a safe, well designed, professionally staffed and managed residential care programme'.

In the final article in this section, Petra Roberts of Ryerson University considers transitions out of residential care from the perspectives of young women in Trinidad and Tobago. She says: 'I suspect that young women everywhere…face different challenges than young men as they transition out of residential care. It is time to listen to their voices and consider a more gendered approach to thinking about such transitions'.

Also included in this issue, is the transcript of the 2021 Kilbrandon Lecture,4 this year given by the journalist and author Madeleine Bunting whose book 'Labours of Love: The Crisis of Care' I reviewed in our last issue. In her lecture, Madeleine said that the provision of care, and its complexity, is 'often overlooked, it is often misunderstood or not understood at all'. There is, she says, 'a cultural undervaluing of care, which is so extensive, so pervasive, and in many respects so subtle that we are all involved and compromised by it. We are all caught in a value system which does not actually accord care with the significance that it rightly deserves'.

And finally, Kate Mackinnon and Rosie Moore have contributed a review of 'Child Poverty: Aspiring to Survive' by Morag Treanor.

The *SJRCC* will be published next in spring 2022, when we all hope for better news on the pandemic front. Meanwhile, we send our good wishes to all our readers. Keep safe and well. Look out for our planned feature of articles from the journal archive over the winter.

Reference

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About the author

Dr Graham Connelly CPsychol is the editor of the *Scottish Journal of Residential Child Care* and an honorary senior research fellow with CELCIS and the School of Social Work and Social Policy in the University of Strathclyde. Graham's research interests have ranged over alternative care internationally and more particularly the education of care experienced children and adults. He is a non-executive

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[4] See https://www.strath.ac.uk/humanities/schoolofsocialworksocialpolicy/thekilbrandonlectures/ for the archive of all Kilbrandon lectures.

director of Kibble Education and Care Centre and a trustee of the MCR Pathways school-based mentoring programme.

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Moving towards organisational resilience: A practical application of the ‘Whole System Approach’ in the secure care sector

Kevin Pollock and James Gillespie

Abstract

Kibble is a Scottish specialist child and youth care charity and social enterprise. It has been a successful organisation since 1841, adapting and changing to maintain its ability to deliver relevant, high-quality services, in a high-risk and high-value sector. Kibble's organisational resilience is founded on sound risk management and learning from experiences. Since 2014, Kibble has introduced several related initiatives, including business continuity and enterprise risk management, improving resilience, and learning across the organisation. Key to its development as a learning organisation is its cohesive vision, open systems thinking, updating heuristic and practice models, team learning and improving individual capabilities while avoiding a blame culture when things go wrong. With this approach enhancing crisis-preparedness, Kibble continues to learn, develop, and provide high-quality services to support young people. However, there is limited research on organisational resilience and learning at establishments such as Kibble. This paper seeks to increase the body of knowledge and provide practical guidance for improving resilience and learning practice in the care sector. The Benchmarking Resilience Tool (BRT-13b) is introduced as an effective method for organisations to assess their resilience capability and address any performance gaps.

Keywords

Organisational resilience, learning, benchmarking performance

Corresponding author:

Dr Kevin Pollock, Academic Fellow, UK Emergency Planning College,

Kevin@PFResilience.com

Introduction

Since its establishment in 1841, Kibble has adapted and evolved to changes in the Scottish care and education system. Secure care is a high-risk and high-value service (Gough, 2016). In a changing environment, Kibble's priority remains the young people who need the most help. However, it is mindful that crises can occur when organisations fail to manage their risks effectively. Increasing crisis-preparedness requires changes to strategies, structures, culture, and people (Pauchant & Mitroff, 1992). For the purposes of this research, we adopt Schein's (2010) definition of organisational culture as the pattern of shared basic assumptions learned by the group as it solved its problems of external adaptation and internal integration, that worked well enough to be considered valid. In essence, not only does culture define the rules of the organisation but it also reinforces perceptions through its assumptions, understandings and implicit rules which govern workplace activity. Schein (2010) considered culture and leadership as conceptually intertwined or two sides of the same coin, and one could not be considered without the other. Therefore, as part of its journey towards organisational resilience, Kibble emphasised the important responsibility of organisational leaders to 'institutionalise' preparedness throughout the organisation (Kelly, 2007). This approach reflects how resilient organisations must anticipate, respond, and adapt to acute or sudden shocks and chronic or incremental changes and survive and prosper (BSI, 2014), which requires fully integrated policymaking and practices. Recognising that culture is capable of inhibiting changes to practices and behaviours, Kibble links its Organisational Resilience Policy to its strategic and management objectives and supports it with a change programme. In doing so, it considered that effective and sustainable outcomes require system-focused interventions tied to its business strategy (Schneider, 2000). This paper outlines the journey Kibble made in adopting a 'whole systems approach' towards organisational resilience and learning, and how it can be measured. It provides a practical approach, focused on the essential components of planning and adaptive capacity, embedded throughout the organisation.

Systems, learning and resilience at Kibble

The application of a systems approach to child protection services has been advocated (Munro, 2010; Kearney, 2013). The Scottish Government promotes a 'whole system approach' underpinned by Getting it Right for Every Child (GIRFEC, 2010) and The Promise (Independent Care Review, 2020). Interactions between system components create dynamics that influence the resilience of the whole system. The term resilience has many meanings in academic discourse (de Bruijne, Boin, & Eeten, 2010) and the components of a resilient social system vary between different layers, with distinctions between the individual, community, and institutions (OECD, 2013). Resilience is dynamic which makes measurement difficult at all levels. But making the case for investments in resilience requires facts and empirical evidence (Gall, 2013). Organisations can achieve resilience through an institutional approach to anticipating and preparing for crises and their consequences through knowledge, social collaboration, and innovation (Comfort, Boin, & Demchack, 2010). Key to resilience within an organisational system is learning. Residential childcare agencies exhibit many features of a learning organisation (McPheat & Butler, 2014). The five disciplines of a learning organisation at Kibble are its cohesive vision, open systems thinking, updating heuristic and practice models, team learning and improving individual capabilities while avoiding a blame culture when things go wrong (Senge, 2006).

Learning organisations are more resilient. They facilitate change, empower organisational members, promote collaboration and information sharing, create learning opportunities, and promote leadership development (Franco & Almeida, 2011). For the purposes of this study resilience represents the capacity of an organisation to manage risks and resources effectively. Kibble does this through adaptation of its actions, systems, and processes, to ensure that its core functions operate in a stable and significant relationship with its risk environment (Comfort et al., 2010). Vital is the capability to anticipate, respond, synchronise, and learn proactively (Provan, Woods, Dekker, & Rae, 2020). With Kibble's strategic vision and whole systems approach, it sees the 'big picture' and proactively scans the risk environment to anticipate and mitigate disruptive events. Its organisational resilience structure ensures disparate parts of the organisation are synchronised when managing disruption. Importantly, all critical incidents and near-misses are reported and analysed to identify learning opportunities.

Kibble's journey towards becoming a more resilient and learning organisation was incremental and practical, recognising the complexity of the care sector. Each stage built on the lessons of the former. The foundation was the 2015 Business Continuity Management (BCM) policy. It provided a clear statement of Kibble’s strategic leadership commitment and priority to improving resilience and learning. It set out the structure, roles, and responsibilities, including the subsidiarity principle of issues being resolved at the lowest possible level. The BCM system aligned to the international standard ISO 22301 and the Business Continuity Institute's Good Practice Guidelines. An important decision for the successful implementation of Kibble’s BCMS was the appointment of an Executive Director responsible for business continuity at Board level. Support was provided by a BCM organisational coordinator with delegated responsibility for oversight to ensure cohesion across Kibble. At the operational level, each business unit appointed a local coordinator responsible for its business continuity plan.

Once the BCMS was established, Kibble aligned its Enterprise Risk Management System (ERM) to the requirements of the international risk management standard ISO31000, which defines risk as the effect of uncertainty on objectives. The ERM focused on the strategic business objectives and the actions necessary to mitigate potential risks or seize opportunities. The system was tailored to Kibble, mirroring existing arrangements and avoiding unnecessary bureaucracy. The ERM ensured the Board and Senior Management had visibility of Kibble's risk exposure. A vital action was the production of a dynamic corporate risk register with strategic risks reflecting Kibble's objectives, integrated with business planning, and executive responsibilities for risks and opportunities assigned to relevant directors.

The subsequent development of the Organisational Resilience Policy integrated business continuity and risk management with other functional disciplines, namely security, crisis, and emergency response management. This created a multidisciplinary and holistic approach acknowledging different types of organisational activity contribute to resilience, while reducing duplication and bureaucracy and increasing learning opportunities. A crucial action in Kibble's successful implementation of the policy was experiential staff training using authentic and credible scenario simulation exercises, which provided opportunities to learn from crises without risk (Goldberg, Silverman, Samuelson, Katz, Lin, Levine, & DeMaria, 2015).

Having embedded the Organisational Resilience Policy, in 2020 Kibble conducted a benchmarking survey to critically assess its current resilience strategies and performance to address any capability gaps. A key decision was to use the Benchmark Resilience Tool (BRT-13b), which can be used to measure resilience in a range of organisations. Importantly it provides an assessment of staff behavioural traits and perceptions, therefore accessing the heart of the organisation's culture and beliefs.

Designed by Whitman, Kachali, Roger, Vargo and Seville (2013), the BRT-13b further developed previous research into organisational resilience measurement (McManus, Seville, Vargo, & Brunsdon, 2008; Stephenson, Vargo, & Seville, 2010; Lee, Vargo, & Seville, 2013). It is based on a two-factor model of organisational resilience — planning and adaptive capacity with thirteen resilience indicators listed in Table 1.

Table 1: Resilience indicators

Planning	Adaptive Capacity
Planning strategies	Minimisation of silos
Exercise participation	Internal resources
Proactive posture	Staff engagement & involvement
External resources	Information & knowledge
Recovery priorities	Leadership
	Innovation & creativity
	Decision making

Planning	Adaptive Capacity
	Situation monitoring & reporting

Research methodology

A qualitative approach combining document review, staff survey and semi-structured interviews, was adopted to ascertain the current level of organisational resilience at Kibble. The research proposal was approved following scrutiny by Kibble's Ethics Committee and complied with the British Sociological Association Guidelines on Ethical Research (BSA, 2017). Confidentiality of data and anonymity of the interviewees because of the sensitive nature of the research was assured. The data was interpreted by a combination of inductive and deductive approaches and triangulation enhanced its validity.

The research application preceded the COVID-19 pandemic, although the research was conducted during it. The document review began 15 May and continued throughout, the survey between 6 June and 12 July 2020, and the interviews between 19 August and 11 September 2020.

Kibble Quality Assurance sent an email link to the survey to 635 staff. The preamble explained, following approval by Kibble's Ethics Committee, the survey was part of a resilience project by an external researcher. One hundred seventy-nine were returned (28%), but 35 discarded, four failed to give consent, and 31 provided insufficient data. One hundred forty-four were completed correctly (23%). The completed questionnaires provided a range of opinions from the organisation, shown in Table 2 below:

Table 2: Survey responses

Organisational Role	Respondents	%
Board Member, Executive Director, Senior Leader	13	9
Operations & Service Managers	25	17
General Non-Management	102	71
Not Stated	4	3
N=144		

Visser, Krosnick, Marquette and Curtin (1996) found surveys with lower response rates (near 20%) yielded more accurate measurements than surveys with higher response rates (near 60 or 70%). Keeter, Kennedy, Dimock, Best and Craighill (2006) compared a study with a 25% response rate with that of 50% and found they were statistically indistinguishable. Moreover, Choung, Locke, Schleck, Ziegenfusset, Beebe, Zinmeister and Talley (2013) found a low response rate does not necessarily indicate non-response bias.

The survey used a 4-point Likert-scale to assess agreement with individual statements. The respondents score 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, and 4 = Strongly Agree. (See Appendix A for the associated benchmarking survey statements). Follow-up interviews with a purposeful sample of eleven respondents were also conducted. The interviewees represented Kibble services and included directors, managers, and staff. They were allocated an identifier R1 to R11. The interviews were thematically coded using organisational resilience indicators.

Findings

The two-factor model of organisational resilience: planning and adaptive capacity and the related resilience indicators and benchmark statements provided a thematic structure for the findings. Which are triangulated by interviewees comments and summarised below:

Planning strategies

Kibble's organisational resilience strategy included developing business continuity plans to manage its vulnerabilities in its risk environment. This required formal infrastructure changes to ensure timely feedback and decision making so that everyone understood the resilience principles. In effect, Kibble developed a culture change supportive of making mistakes as part of learning, building reliability, and trust. 'The one thing that Kibble did was align its strategic vision and underpinned it with an enterprise risk management approach to business continuity and all the other aspects around that, to its business plan...in line with the values of the organisation' (R11).

Participation in exercises

Kibble recognised that testing plans is critical, and resilience improves with adequate resources appropriately trained in their roles. Effective learning depends on balancing the experiences from the most recent crisis against existing knowledge and experiences (Renå & Christensen, 2020). This requires staff participation in regularly scheduled exercises designed to practice response arrangements and validate methods and plans. Using scenario building and exercises allows participants to integrate theory and practice. They learn experientially in realistic circumstances and gain awareness of their reactions in stressful situations (Blanchard & Thacker, 2013). ‘The most useful training I've had since been involved with Kibble is attending a multiagency desk exercise…Testing is essential. You know it's amazing the gaps that the desk exercise can show up’ (R6).

Proactive posture

A resilient organisation has the strategic and behavioural readiness to respond to early warning signals of change in its internal and external risk environment before they escalate into a crisis. Kibble’s strategic leaders successfully shifted its cultural mindset by developing and investing in a risk-based approach to decision-making, supported by proactive scanning, and learning from experiences and emerging risks.

> I think before there was a lack of commitment and investment. You know ‘it’s not important attitude’. But that’s changed with business continuity and risk management. Using experts to put systems in place. Looking at the organisation as a whole (R4).

External resources

Improving its organisational resilience required Kibble to understand the relationships and resources it might need from other organisations during a crisis. These include the emergency services, local authorities and other agencies who can provide specialist equipment and services. In addition, the provision of formal reciprocal arrangements and mutual aid with other establishments in the sector. Together with planning, communication, and management to ensure access. To achieve this, Kibble appointed staff to work across unit boundaries to build relationships and enhance collaboration and coordination. They encourage participation within Kibble's resource network and promote mutual benefits that has led to more effective resilience outcomes. 'Tabletop exercises with multiagencies are exploring and groups are bringing it all together…we're all doing it, at all departments and levels, sharing knowledge, sharing expertise and experience. Communicating' (R5).

Recovery priorities

Kibble analysed and predetermined its priorities and minimum operating requirements in the event of disruptions. It ensured they were defined and communicated throughout the organisation. The critical services, recovery, and resource priorities were recorded and planned during the implementation of Kibble's Business Continuity Management System. These subsequently proved invaluable when preparing for the impacts of leaving the European Union and the pandemic. 'The corporate risks set priorities. The business continuity plans reflect them. There's a much more organised focused approach' (R2).

Minimisation of silos

Kibble promotes collaborative staff values. It recognised that silos prohibit the creation of shared views and communication and is a common cause of system failure. Breaking down silos fosters creativity and collaboration and productive staff relationships (Kowalski, 2017). To create a more collegiate approach to service delivery, Kibble critically examined all processes, procedures, and its culture to determine necessary changes that would enhance collaboration.

'Before, there was no organisational resilience at all. It was an ad-hoc approach with no understanding across teams. Now there's been a huge change…staff are now much more aware what the systems about. Working together to help young people' (R10).

Internal resources

Crises are disruptive and bring uncertainty affecting the availability of existing organisational resources, which often leads to conflict among responders (Comfort et al., 2010). However, a common thread in resilient organisations is active and engaged management by highly trained professionals. As part of its approach to learning and development, Kibble proactively provided staff opportunities for personal growth. Staff are encouraged to take sensible risks to develop resilience and nurture partnerships that enables joint learning.

> After crisis we ask how can we prevent that from happening again? How can we mitigate some of the risk factors? What do we need to do as an organisation? Do we need to invest in terms of infrastructure? Do we need to bring someone in who's a specialist? Because we recognise that we may not always have all the information or the skills within the organisation. But at Kibble, I think we're really good at recognising where the gaps are and filling these gaps with the right people (R3).

Staff engagement and involvement

Kibble's resilience, and its long-term success is underpinned by its staff. They have been empowered to use their skills to solve problems and understand the link between their role and the organisation's success. The policy encourages a holistic understanding of staff contribution to resilience. '[It's a] collaborative approach with everybody involved…a synergy of skills, experiences and talents. Not just "their wee bit is alright". There's a positive attitude towards standards and practices at Kibble' (R8).

Information and knowledge

Kibble developed induction training and cross-departmental exercising to share information and knowledge. It created a single repository for Organisational Resilience. It uses standard language to record information and decision making. This has improved the analysis and quality of information being shared across services and with multiagency partners. Data analysis informs adjustments to the organisational resilience system and learning is evidenced by changes to policies, structures, training and behaviours.

> Make sure its recorded and you've got all that information. But it's not just about that. It's about how you interpret some of that data and start the lessons learned process or learning from previous incidents. It's a huge thing (R11).

Leadership

Leadership is of primary importance to organisational learning. Only leaders can create and reinforce a no-blame culture and encourage staff to learn from failures (Edmondson, 2011). The leader's perceptions, or their resilience ethos, will influence the approach taken by the organisation (Pearson & Clair, 1998). Kibble's senior leaders' strategic approach emphasises resilience and learning at the core of its decision-making and culture. This message has been proactively and publicly advocated throughout the organisation. It provides service managers and practitioners with the authority to implement change in the direction agreed.

> There's strategic leadership and ownership about risks and learning. You know, if we don't all understand each other's roles and the importance of learning we'll regress (R9).

Innovation and creativity

Because of the nature of crises, innovation, and creativity are critical response skills (Kendra & Wachtendorf, 2003). Resilient organisations have a high adaptive capacity, can cope with change, and respond to it quickly and effectively. At Kibble, staff are encouraged to be confident in their professional expertise and contribution to achieving better outcomes. An induction programme has ensured staff share a common understanding of how changes in culture, systems, and practice enhance organisational resilience and crisis-preparedness.

> Across the organisation staff are able to step in and sort things. You're not just relying on people at the top. You've got people who can deal with things before they escalate. For me, Kibble, as part of the planning process and part of the training is ensuring a breadth of knowledge and having people who solve problems (R1).

Decision making

An essential characteristic of a resilient organisation is deference to expertise. Decisions should be delegated, not necessarily to those in command but to those with the most appropriate knowledge applicable in the circumstances (Weick & Sutcliffe, 2007). Kibble staff have the relevant authority to make decisions related to their work, with authority delegated to enable a crisis response. 'There's been a huge change in the last 5 years. Now decisions are made based on risks. It's systematic, thought through. Before it wasn't like that. Now there's more accountability' (R2).

Situation monitoring and reporting

In resilient organisations, situational monitoring and reporting is a notable characteristic (Hale & Heijer, 2006). Kibble requires staff to be vigilant about the organisation, its performance, and potential problems. They are encouraged to share good, and bad news about the organisation, including early warning signals, reported quickly to organisational leaders. Kibble's comprehensive BCM and ERM programmes formalised its incident escalation process with notification trigger points. A significant action was the establishment of a Resilience Committee which oversees and analyses risks and incidents for underlying trends and lessons. It has representatives from Kibble services with sufficient knowledge, experience, credibility, and confidence to drive change to ensure the continuous improvement of resilience and learning. 'We need to remember that people will move on. We'll lose organisational memory. So we need to make sure that this continuous and is not a fad. It's important that people know what happened and why' (R7).

Conclusion

Successful organisational resilience and learning are inextricably linked. Kibble's adoption of a systems approach has improved its resilience and crisis-preparedness. It sees interdependencies, uses multiple perspectives to contextualise learning and improve organisational resilience. Kibble actively seeks learning opportunities by critically reviewing its incidents and practices. The strategic intention is to deliver feasible and practical benefits to improve outcomes. The evaluation of potential action is essential, measuring it against existing standards and practice.

However, Kibble recognises that making changes requires the investment of time, effort, and resources. It has responded by establishing a formal change programme, which includes linked funding. It draws on the experience and understanding that staff have of the organisational environment where the change is required. This engagement ensures staff understand and commit to its success, which allows Kibble to demonstrate that its learning is not based solely on policy. The use of benchmarking enabled Kibble to go beyond the policies and structures and delve into the heart of the organisation by understanding the perceptions and beliefs of its people in relation to organisational resilience. There is now empirical evidence that the organisational resilience policy has meant fundamental changes at all levels within Kibble. Not only to policy and procedures, but also culture, behaviour, and planning assumptions.

An essential aspect of organisational resilience and learning was the introduction of monitoring and measurement of expected outcomes. Not just in the initial stages but continuously to completion and after that to ensure sustainability. The critical point is Kibble, as an organisation that frequently analysis itself, is aware of its current risk environment and its capabilities, which reduces the likelihood of failure and organisational crisis. To operationalise such learning, improve organisational resilience and be crisis-prepared, Kibble understands that: 'The strategies implemented in an organisation influence, and are influenced by, the organisation's structure and culture and the psyche of individuals' (Pauchant & Mitroff, 1992, p. 52).

In moving towards organisational resilience, Kibble understood the complexity of the care sector and adopted a practical approach, that was incremental and continuous. These research findings demonstrate that Kibble has taken key organisational actions that support resilience and learning and integrated them through the organisation's strategy, structure, culture, and its people. These also provide practical guidance for improving resilience and learning practice in the care sector. Organisations can achieve this by:

- Demonstrating a strategic commitment by leaders in proactively setting the vision and standards that values resilience and learning and is accepted as an organisational priority.
- Implementing a significant resilience and learning infrastructure with defined organisational responsibilities, which provides timeous feedback mechanisms, with resilience and learning objectives built into on-going operations, and part of personnel performance assessments.
- Creating a culture focused on continuous improvement, which critically monitors and evaluates against expected outcomes, reflected in changes to norms and practices, so embedding resilience and learning throughout the organisation.
- Communicating resilience and learning is everyone's responsibility, that all staff must be committed and involved, clearly understand their role and responsibility, and are trained and competent to do so.

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About the authors

Dr Kevin Pollock completed a PhD in Crisis Management and Resilience at the University of Glasgow. He is an independent consultant at Pollock Ferguson Resilience and an Academic Fellow at the UK Cabinet Office Emergency Planning College. Dr Pollock has lectured at Glasgow Caledonian University and was Assistant Professor of Policing and Security, Rabdan Academy, UAE. He has conducted previous research projects for the UK and Scottish governments and published in several academic journals.

Jim Gillespie joined Kibble in 2014 as an Executive Director. In September 2016, after two years of service, he was appointed Chief Executive Designate, before taking over as Chief Executive in May 2017. In 2006, Jim was awarded a Butler Trust Award by HRH Princess Anne and has completed his Master's in Business Administration (MBA). He has previously published in SJRCC and other publications.

Appendix 1: Resilience indicators & benchmark survey statements

	Resilience Indicator	**Benchmark Survey Statements**
Planning		
1	Planning strategies	We are mindful of how a crisis could affect us.
2	Exercise Participation	We believe emergency plans must be practised and tested to be effective.
3	Proactive posture	We are able to shift rapidly from business-as-usual to respond to crises.
4	External resources	We build relationships with organisations we might have to work with in a crisis.

	Resilience Indicator	Benchmark Survey Statements
5	Recovery priorities	Our priorities for recovery would provide direction for staff in a crisis.
Adaptive Capacity		
6	Minimisation of silos	There is a sense of teamwork and camaraderie in our organisation.
7	Internal resources	Our organisation maintains sufficient resources to absorb some unexpected change.
8	Staff engagement & involvement	People in our organisation "own" a problem until it is resolved.
9	Information & knowledge	Staff have the information and knowledge they need to respond to unexpected problems.
10	Leadership	Managers in our organisation lead by example.
11	Innovation & creativity	Staff are rewarded for "thinking outside the box."
12	Decision-making	Our organisation can make tough decisions quickly.
13	Situation monitoring & reporting	Managers actively listen for problems.
Source: Whitman et al., 2013.		

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A critical analysis of the recent developments in alternative care space across South Asia amidst the Covid-19 crisis

Kiran Modi, Gurneet Kalra, Leena Prasad, Rajeshwari Narsimha & Jyoti Singh

Abstract

In many situations of conflicts, natural disasters, or pandemics, it is always the children who are the most vulnerable. With the world shutting down due to the invisible threat to civilisation, the most affected are the children living in alternative care settings and the children who are on possible verge of family breakdown and ending up in institutions. Their limited knowledge and lack of independence often results in an increased exposure to several risk factors such as abuse, maltreatment, deprivations, and violations This paper aims at focusing on the recent developments in policies and arrangements in the alternative care space in the South Asian countries, namely Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, and Sri Lanka, amidst the COVID-19 pandemic. The purpose of the study is to understand the impact of COVID-19 on alternative care space in South Asian countries, its effect on the children living in alternative care, and to understand the measures taken by respective governments in these countries to support them during the pandemic. An assessment of the recent developments in the policies related to alternative care space in different countries is crucial for understanding the problems faced when dealing with children in institutional care as well as the impact on the de-institutionalisation process due to COVID-19. This paper is a secondary review of desk research on such developments to understand the possible post-COVID-19 impacts on functionary and regulatory changes in alternative care systems for 'Children without Parental Care' in the South Asian region.

Keywords

Alternative care, COVID-19, South Asia, family care, children in care, childcare institutions, foster carer

Corresponding author:

Kiran Modi, Founder and Managing Trustee, Udayan Care, Dehli, India,

kiranmodi@udayancare.org

Introduction

COVID-19 in South Asia in the alternative care context

Unfortunately, with the unprecedented disaster in the form of a pandemic, COVID-19 has paralysed all the progress made on children's rights, such as education, health, nutrition, safety, and well-being. Not only did it upend the lives of 600 million children in South Asia, but also jeopardised their future (UNICEF, 2020). Additionally, social workers, care staff, and administrators were also left defenceless and had to face the pandemic's wrath. It has become clearer now that the pandemic is much more than a mere health crisis; it is a socio-economic crisis, humanitarian crisis, security crisis, and human rights crisis according to the United Nations Comprehensive Response to COVID-19 published in September 2020.

Since 1989, when the UN Convention on the Rights of the Child was passed, until 2020, most nations have been working to bring about a change in the existing legislation to provide better care to children living in alternative care settings. Subsequently, the Committee on the Rights of the Child, i.e., the body of independent experts responsible for reviewing progress made by State parties in implementing the Convention on the Rights of the Child, devoted its 2020 Day of General Discussion to the issue of children living in alternative care. The main aim of this discussion was to examine the current situation regarding alternative care, its identity and complexity, as well as areas concerning the unnecessary separation of children from their families, and to find appropriate ways to respond to child separation and family in cases where it is unavoidable (OHCHR, 2020). With each new hurdle, both the governmental and non-governmental organisations have worked towards providing the best possible care for children.

The pandemic has not only directly exposed these children to health hazards but has also further pushed them, especially the most vulnerable ones into unknown socio-economic problems. The children, on the vulnerable side of the society, lack access to sanitation, proper nutrition, adequate water supply, and access to soap, sanitisers which are necessary to prevent the spread of COVID. Due to the deteriorating quality of the diets and the havoc created by the pandemic and its containment measures, more of the vulnerable children are becoming malnourished (UNICEF, 2020). 'At least 463 million students around the globe remain cut off from education, mainly due to a lack of remote learning policies or lack of equipment needed for learning at home during this pandemic' (UNICEF, 2020). Additionally, many children were susceptible to domestic violence with an increased risk of trafficking. Further, reports from the South Asian countries indicated that the immunisation report has dropped by 49% in March compared to February (WHO, 2020).

Acting upon these apprehensions, some professionals and agencies have come forward in various countries to provide some sort of psychological support and counselling services for children and young people. In most cases, these services are often not well-organised and not directed towards the specific needs of children (Dong & Bouey, 2020). UNICEF along with the Better Care network and The Alliance has prepared a list of recommendations that states/countries should follow in response to the COVID-19 outbreak. These recommendations are the guiding principles to support child protection practitioners and the government officials in their immediate response to the child protection concerns who are at risk of separation or are residing in alternative care during the COVID-19 pandemic (UNICEF, 2020).

For most of the 1.13 million children, institutional care had remained the only care option in South Asia. There have been quick changes to the on-ground child protection mechanisms, grave economic fallouts for families and institutions, availability of limited availability of resources, causing major caregiver burnout in the child care homes, and finally to the breakdown of social networks. In the early phases of the pandemic, complete lockdown of children's institutions led to a severe limitation to seek external help. Children residing in Child Care Institutions (CCIs) felt marginalised and deprived of education and learning more than ever, due to the inadequate reach to technology to access online education. The additional burden of keeping stocks for a longer duration of time, hygiene materials added greater financial burdens to the already stretched resources, due to donor diversion and fallout. The arrival of a new child into the

CCI or restoration of a child residing in the CCI amidst the lockdown, with limited staff available in CCIs while following the health advisories and catering to the psychosocial needs of the child and following the procedural guidelines remains to be one of the greatest challenges. Being confined in small spaces at home, while wearing mask and maintaining social distancing negatively impacts the emotional, physical, and mental well-being, which results in high stress among children as well as residential staff.

International standards, national policies, and guidelines on children's rights and alternative care remains applicable even during times of a crisis, however, there was widespread unavailability of professional staff in these spaces who lacked training in dealing with the new ramifications. Many institutions were instructed by the Child Welfare Committees (CWCs) to send the children back into the communities, due to the lack of space in the CCIs. The strategy was proposed without a careful deliberation of situations back home, and without any proper investigations and follow-ups. This was being done without a proper assessment of the readiness of the families, additional support, and absolutely no monitoring protocols in place which led to further cases of abandonment. Correspondence published by Lancet Child Adolescent Health, expressed concerns about how the best interests of the children might not be met in such a scenario. A report about the rapid return of children in residential care to family because of COVID-19 surveyed 67 NGOs and found that the participants:

> …frequently noted concerns that antecedents to the original placement into residential care were not resolved before the rapid return. For example, if a child was originally placed in residential care due to neglect, it was unlikely that the underlying reason for placement (i.e. neglect) was adequately addressed before the child being returned to parental care. NGOs further expressed concern that this would complicate the child-caregiver relationship and decrease the likelihood of long-term placement success (Wilke et al., 2020, pp. 110-119).

The pandemic and the South Asian Association of Regional Cooperation (SAARC) response

South Asia is one of the least developed world's regions with a large population. Thus, the South Asian region with less developed medical infrastructure and lack of availability of elaborate health and hygiene measures, is at high risk and more vulnerable to this infectious disease. Despite some media reports and sporadic studies on the situation in care homes, not much attention has been drawn towards children residing in care homes, or towards children, who were restored to their families, or even those who are at risk of being placed in residential institutions. Around the world, reports have emerged of various residential institutions for children being closed due to the pandemic. With the breakdown of a pandemic, residential care providers across countries are presumed to receive comprehensible guidance from respective governments, in South Asia, regarding managing symptoms, preventive measures, and measures to ensure quarantine measures inside institutions. Various resources and guidelines have been developed to support administrative staff to prepare themselves for the immediate response. The UNESCO recommendations give more strategic importance to the caregivers and child protection practitioners and for government officials who have to take immediate steps to prevent child rights abuse and give them a safe environment during the pandemic.

All the countries in the South Asian Association of Regional Cooperation, namely Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, and Sri Lanka have tried to implement the given 'Safe to Learn during COVID-19' recommendations in their respective capacities. The pandemic has not only impacted children in institutional care but its impact is also visible on foster care and adoption. As this has created an uncertain environment, critical components of foster care including home inspections have been stopped as most of the officials have been directed to work from home. Also, as research shows that neglect and abuse happen more often in high-stress situations, the doctors and teachers who typically report such cases in foster homes often fail to keep an eye on children during this environment. With government offices and courts closed in many states, parents who had planned to finalise adoptions are also now navigating a radically changed landscape (Dodge, 2020).

This paper is based on secondary data collection of material available, through which information on the impact of COVID-19 issues of alternative care and recent developments in the alternative care institutions during COVID-19 was studied. The paper highlights some of the major concerns alongside the recent developments in the South Asian Association of Regional Cooperation countries (SAARC) and concludes with recommendations for better planning during emergencies.

Afghanistan

Afghanistan, a country that has been exposed to deadly and prolonged wars in the past, continues to suffer the aftermath. Often relief efforts by international agencies remain insubstantial, as much more needs to be done in terms of structural changes. With high-intensity conflict zones adding to the pressure for many children and families, Afghanistan is on the verge of experiencing grave violations of child rights. Even before the pandemic had hit the streets of Afghanistan, famine was already an issue faced by most of the locals living there. This not only puts children at risk of malnutrition and impoverishment but also a risk of separation. A report by UNICEF (2015) says up to 80% of children between the ages of four and 18 living in orphanages were not orphans but were from families that could not provide basic services to their children. As the global pandemic began to infiltrate the nation, Afghanistan faced yet another crisis, namely, 'Seven million Afghan children risked hunger' (BBC, 2020). Based on findings of a report provided by the Ministry of Public Health 2.9% of the people infected with COVID in Afghanistan were children. It was stated that out of 9,794 children who were in orphanages before the pandemic, 8,133 of them were handed over back to their families or relatives and only 1,661 of them were quarantined in the orphanages.

In a report titled, 'Humanitarian Needs Overview Afghanistan', A representative of Save the Children stated that the country will be enduring a 'perfect storm of hunger, disease, and death' unless is acknowledged for the same by the international community. This statement was released after the findings of an initial report looking into the circumstantial conditions of children amidst the COVID-19 crisis, which had indicated that an estimated 7.3 million children in Afghanistan were to face food shortages. Save the Children also further managed to identify the ongoing challenges for children in Afghanistan and is working towards building local capacity for a humanitarian response, especially in the areas that are prone to disaster. Save the Children has also developed a disaster risk reduction toolkit for schools to mitigate the impact on education. Additionally, to cope with the economic hardships arising from no source of income, there has been an increase in the rates of child labour, child marriage, and sending the child off to distant relatives or wealthy benefactors, thereby increasing the risk of trafficking and exploitation (UNFPA, 2020). This, therefore, puts children at a high risk of separation from parental care.

It has set provisions of child protection services, particularly psychosocial support for children, adolescents, and caregivers, and provided masks, sanitizers to the caregivers. It has further created tools to address stress and anxiety, particularly during the lockdown or when a family member falls sick. As part of its child protection efforts, UNICEF has provided over 7,000 bars of soaps and around 8,000 masks to promote handwashing practices and the safety of children across the country (UNICEF-ROSA, 2020). As the country's response has been majorly targeted towards dealing with the hunger pandemic, not much information on government interventions specific to alternative care could be derived even after thorough secondary data research.

Bangladesh

As the countries across the globe began to impose lockdowns, officials in Bangladesh too ordered a 'complete lockdown'. The initial response was to close down the educational institutions, followed by non-essential businesses and services. Migration from the cities too was closely monitored to avoid a migration crisis. Bangladesh's efficient civil society machinery took immediate action by organising campaigns to increase awareness and disseminate information in the society.

According to SOS Children's Villages, there are around four million children without parental care in Bangladesh. But the country’s department of social services holds records of about 200,000 children who live in 85 ‘Shishu Paribar’ (government-run children's homes), and four thousand private orphanages). Many orphanages, particularly those attached to educational institutions such as madrasas, are closed and local guardians have been asked to remove children. In the wake of COVID-19, non-governmental organisations are also taking steps to fight and safeguard their children. Because the government and NGOs are falling short of hygiene safety measures such as soaps and disinfectants, local authorities have encouraged the NGOs to send the children home or to kinship care. (Chandan, 2020). Organisations, especially the non-governmental ones, have been falling short on finances and the donations have stopped or have been diverted towards other emergency funds due to the lockdown. ‘Due to the coronavirus outbreak, many donations have stopped. In this deadlocked situation, we are also unable to look for new donors. If the situation does not improve, many orphanages in our country will not be able to feed their children’, said Prof Samad (Chandan, 2020).

While government-run children's homes enjoy regular funding, they too were affected by a lack of staff. Due to the closure of government offices, caregivers and other staff could not be regularly at work. Hence, the staff is required to stay in children’s homes for at least a week so that the needs of children are better catered to. International organisations like UNICEF supported the government in developing an emergency helpline for destitute children as the situation may worsen further. At the beginning of the crisis, Joining Forces Bangladesh and Child Rights Now (2020) praised the government for the nationwide lockdown and appealed for the necessary steps to be taken for the wellbeing of the most vulnerable children. It urged the government to adopt policies and allocate funds for COVID-19 responses, particularly concerning child protection (Relief Web, 2020).

Other organisations such as Distressed Children & Infants (DCI) are attempting to distribute books and study materials in children’s homes so that the children can continue their learning. However, as resources are rapidly depleting, the

CCIs face additional risk in sustaining the finances. A statement issued by one of the representatives of the NGO Universal Disabled Care-Taker Social Welfare Society, Ms. Kaur, revealed that there is a 90% drop in receiving donations. This drop is particularly alarming as a lot of children who remain in child care intuitions are also in need of immediate medical attention. Bangladesh issued an interim guidance note for alternative care institutions in response to the increased risk of COVID-19 in the country on 20 May 2020 about prevention and preparedness for COVID-19 and the temporary separation of children from their caregivers. Communities were asked to identify children who are at a high risk of family separation and in case of separation to identify the preferred alternative caregivers. Another issue is the stigma faced by those infected with the virus.

Bhutan

The Ministry of Health is responsible for the stewardship of health in Bhutan. Health is considered one of the foremost sectors in Bhutan and all residents are entitled to free medical care services.

The National Health Policy of the nation expresses that the state will ‘give free admittance to essential general health administrations in both modern and traditional medicines’ as drafted in the constitution. Hence, The Royal Government of Bhutan and the World Bank signed a $5 million COVID-19 Emergency Response and Health Systems Preparedness Project to help in prevention, detection, and responding to the pandemic across the country, including care homes. The project was set to facilitate Bhutan’s capacity to provide emergency support whenever required. The project was implemented by the Ministry of Health as it focused on advancing strategies like prompt contact tracing, early warning systems, training of frontline workers, procuring testing kits and laboratory equipment, etc. Additionally, Give2Asia too partnered with other local non-profit organisations to support the front-line workforce and child care institutions. The response programme focused on providing financial support for quarantine facilities and frontline healthcare workers along with securing medical supplies (Give2Asia, 2020).

In terms of engagement in general, more than 16 thousand people (Desuung volunteers, volunteer groups, local leaders, youth volunteers and CSOs, and school health co-ordinators), were engaged to reach a large population in the country with messages on COVID-19 prevention and access to services. By June 2020, 550 participants in total have been trained in the use of the Bhutan Child Development Screening Tool (BCDST) via Zoom. Bhutan’s Centre of Media and Democracy (BCMD) also made efforts to educate the mass by sharing useful tips on how to verify the information and sources related to COVID-19 by distributing multi-lingual online, printed, and audio versions of education materials. The Centre conducted many training workshops on advocacy and development of effective and efficient communication materials. UNICEF’s Youth Ambassador was engaged to advocate and educate young people and the public on COVID-19. There is insufficient information provided by the Bhutan government to indicate any substantial change in responding to the needs of vulnerable children amidst COVID.

India

COVID-19 pandemic has had multifaceted impacts on children, including psychological, physical, mental, cultural, and social (Dalton et al., 2020). Research indicates that nearly 41 percent of India’s population is under 18 years of age, which means that they fall under the laws applicable for children as per the definition by the UN Convention on the Rights of the Child. Their mental health must be addressed both during the pandemic and post-pandemic. These effects are not restricted to general well-being and health but extend to many dimensions of children’s lives, including their safety, education, and poverty (UNICEF, 2020a). Other factors, including poor nutrition, abuse, and violence where children continued to live in proximity to their abusers in lockdown, also play an irrefutably major role (Sengupta, 2020.)

As a result of lockdown, many children have had no physical access to schoolmates, friends, peers, and relatives for over many months. Limited opportunity for any kind of outdoor play and socialisation has had an adverse impact on children, making them frustrated, irritable, easily bored, and angry. In

India, there are approximately 370,000 children in more than 9,500 CCIs. The crisis due to COVID-19 has not only added additional pressure on the children residing in CCIs but has also negatively affected the ability of the CCIs to take care of children already present there (Mazumdar, 2020). The Apex Court has issued several Standard Operating Procedures (SOPs) for child care institutions at a national level since April 2020 to address the risk to the children in CCIs and put in place the preventive preparedness to the risk of COVID-19. These institutional level guidelines are laid down at children-centric and staff-centric levels and include procedures specific to utility and services, medical support, health and well-being, and capacity building of staff (WCD, 2020). Guidelines on handwashing/sanitisation practices, social distancing, cleanliness, medical consultation, awareness are mandatory for all care homes.

Despite curbs, a spike in child trafficking and child marriages was recorded during the pandemic and ChildLine had to intervene in many cases and the states' governments scrambled to cope and set up more monitoring systems (Chopra, 2020). The nationwide lockdown has brought all sorts of despair, stress, and anxiety (Kumar et al., 2020). The Supreme Court of India has suggested providing audio-visual means to maintain a connection with the outside world and continuity of psycho-social support and learning. India's Ministry of Women and Child Development has issued guidelines stating that the caregivers should make themselves available for the children and assure them of their wellbeing if they are ill or stressed out. Separate guidelines for disinfecting public places, including compulsory posters, are also issued by the Ministry of Health and Family Welfare.

The Health Ministry set up a national emergency helpline number (1075) and state/union territory helpline numbers. ChildLine intervened in more than thirty-five thousand cases of child marriage and received an estimated 4.3 million calls till September 2020 (ChildLine, India). Moreover, organisations like the National Indian Child Welfare Association have provided various resources to give foster children and their caregivers accurate information about the ongoing pandemic. Many organisations in India had responded quickly to the immediate needs of affected populations by working in collaboration with a host of local organisations to provide food assistance, nutrition, water filters, and hygiene kits to children in care homes. In state governments protection of child rights services have said staff and officials in childcare institutions should take extensive precautionary measures for COVID-19. Several INGOs, and NGOs have played a crucial role in ensuring that these guidelines are appropriately followed hence safeguarding children's and care staff's well-being. The Guidance for Persons in Charge of CCIs under the JJ (Juvenile Justice) Act, 2015 has been used to prevent and control the spread of COVID-19 in CCIs (New Concept & UNICEF, 2020).

CARA has issued certain advisories on procedures for adoption and foster care to be followed for safeguarding children during the pandemic. Limited virtual interactions, major co-ordination via mails and phone calls, virtual meetings with CWCs, and speedy process followed by online counselling sessions and feedback are certain measures directed to be followed post June 2020.

Nepal

Nepal's statistics reveal that out of 11.5 million children around a million are without parental care. Often these children are abandoned and forced to live on the streets, while some of them are also coerced into child labour. Although several organisations were working towards protecting the children without parental care by providing basic needs like food, shelter, education and medical care, the current crisis has put a lot of strain in the process. Initially, Nepal reported only two cases of patients infected by the deadly virus. However, in four months, the numbers had spiked exponentially. With over 17,000 confirmed cases and 40 deaths by June 2020, Nepal faced a huge challenge ahead in containing the spread. A spokesperson for Sukraraj Tropical and Infectious Disease Hospital in Kathmandu said:

> …what we are now witnessing is the community spread of the virus. Each day only 300 people are tested for free on a first-come, first-serve basis, though the number of persons visiting the hospital varies between 1,000 and 1,200. Unfortunately, those who are unable to get tests would have to return to their

homes as the hospital cannot manage more than 300 patients
(Jha, H. 2020).

Beyond the Orphanage has partnered with several other local organisations to deliver education and awareness workshops to help children understand and maintain good hygiene standards. while such initiatives were taken by several organisations, a report by Al Jazeera highlights the growing number of 'fake orphanages' that try to attract donations by exploiting the children for profit. A study stated that more than 80% of the orphans are trafficked from remote areas to make profit through deception. The National Child Rights Council issued a public statement instructing 153 childcare homes in Nepal to reintegrate children with their families. It was reported that 1,503 children from 38 childcare homes were reunified with their families (Bhushal, 2020).

Several NGOs, including Save the Children, collaborated with ministries, and submitted insights and evidence garnered through the 'Ministers with Children' campaign to promote the child-centred policies and plans to protect the rights of children during emergencies.

Pakistan

With the help from international and national humanitarian and development partners, the government of the Islamic Republic of Pakistan has responded by strengthening co-ordination, case management, contact tracing, testing services, and community mobilisation. The country saw cases of transmission of the virus from the elderly to the children in a family. This led to the separation of children from their parents and many of these children have been thereby sent to care homes (International Crisis Group, 2020).

In the wake of spreading awareness about health and hygiene, WHO Pakistan prioritised the Clean Care initiative as integral to the government's response to COVID-19. UNICEF found that changes in their care home life are somewhere linked to increased stress in children along with reduced patience in caregivers. As a result, many social service professionals have been trained in psychosocial support along with prevention based on a UNICEF's support response.

Sri Lanka

Christian Care Reforms in Sri Lanka are working with the government to facilitate and improve family-based care. Using fostering and domestic adoption routes, attempts are being made to find ways to offer family-based care. World Vision is also setting up operations in Sri Lanka by working with the community to promote development and relief programmes. Amnesty International highlights how the school closures due to COVID-19 have increased the risk of a child’s exposure to abuse, exploitation, violence as well as child labour. Female children continue to be the most affected by this situation. Lack of robust child rights protection services and mechanisms exacerbates such risks among the vulnerable children without parental care. Save the Children Sri Lanka says there is an increase in child abuse cases reported to the National Child Protection Authority (NCPA). The NCPA helpline data revealed that the number of reported incidents increased by 40%, alerting government authorities to take immediate steps to reform policies and services. These data are particularly alarming as according to CRSA 2018, there is a high prevalence of physical and sexual abuse against children in Sri Lanka.

UNICEF introduced digital case conferencing which has been adopted in Northern, Eastern, UVA, and, Central provinces. Standard Operating Procedures (SOPs) on digital case conferencing were developed, supported by the Department of Probation and Child Care Services. The SOPs were to be translated to both local languages and distributed to all divisional secretaries for implementation. UNICEF through this programme had already managed to reach 83 children in need of care and protection and 18 children were supported on proper alternative care arrangements by August 2020. The lockdown brought with itself a range of mental health issues for children. Staying at home has induced stress, boredom, anxiety, and depression. UNICEF is establishing a virtual psychosocial support network via NCPA (National Child Protection Authority) psychosocial team with the partnership of NCPA, Save the Children, LEADS, and World Vision Lanka. Furthermore, Mental Health and Psychosocial Support (MHPS) networks have been established in the Eastern and Northern

Provinces for effective Psychosocial First Aid (PFA) support, counselling, and further referrals.

UNICEF has partnered with the National Institute of Social Development (NISD) to reach the children in quarantine centres for PFA support. UNICEF Child Protection Programme is also working with the national NGO, Advocating the Rights of Children (ARC), for the prevention of violence against children, through social media targeting parents, caregivers and children.

Conclusion

India and Bangladesh have done major work and provided appropriate guidelines that comply with the recommendations of UNICEF, Better Care Network, and The Alliance for responding to COVID-19. They have more specific guidelines to cater to the needs of children in alternative care spaces.

The pandemic is leading to the re-institutionalisation of many children due to government orders or due to the shortage of basic necessities in poor families such as in Bangladesh and in India (Khan Chandan, 2020).

Our desk review also suggests the other countries reviewed have general guidelines and orders in place but nothing for child care institutions spaces specifically. In Afghanistan, where the most pressing issue is the hunger pandemic, little work in the area of children in need of care and protection has been done. Most of the recent developments that took place in these South Asian countries have been initiated primarily by governments, international organisations such as WHO, UNICEF, SOS Children's Village International, Better Care Network and Save the Children. The national governments of India and Bangladesh have supported these initiatives to a great extent. There is also a lack of proper governmental guidance particularly focused on preventive measures and ways of implementing the WHO guidelines in an institutional setting, as with most of the guidance in general. Several care homes do not have enough space for social distancing, and no proper health care provisions due to lack of funds. Several countries, such as the Maldives, Bhutan, or Sri

Lanka, could not provide substantial data on the number of children affected by COVID-19.

Advocate for clear and child-friendly intake and discharge procedures to promote family unity and reduce the risk of separation

Authorities could support the transition to family-based and community-based programmes and services for children in an organised and planned manner, including those children, who find themselves homeless or orphaned after this pandemic. Kinship care is the most broadly used form of out-of-home care for children unable to live with their parents. Kinship families should be strengthened to take care of children who need out-of-home care support. Due to the vulnerability of older people to COVID-19, some grandparents or other relatives might not be able to care for kin children. Discrimination worsens when resources are scarce, and therefore it is even more essential that child care institutions and facilities are appropriately supported to have funds to sustain the livelihood of the children without parental care, and carers. Work with relevant authorities to establish a registration system to prevent long-term separation and to facilitate reunification is required. Facilitation of safe and regular communication between children and parents/caregivers who are temporarily separated should be encouraged.

Develop an inter-agency plan, in collaboration with relevant authorities, to strengthen the care of vulnerable children

Developing common standard procedures for documenting and referring the cases of children between child protection and health services to ensure children receive appropriate, safe, and family-based care even during the pandemic is needed. Collaboration is required to ensure child-friendly health facilities or access to health care, including direction for health staff on communicating in a child-friendly manner and ensure special measures to support children’s psychosocial well-being.

Health, nutrition, and hygiene

Identification of alternative mental health and psychosocial support along with educational activities is required for children in care homes. Ensuring the provision of child friendly, safe and hygienic promotion activities before and during a pandemic outbreak, including the development of infographics and posters targeting children and caregivers, is crucial. Other supports include child safeguarding training for health workers, collaboration on safety audits to assess and address any safety needs at wash facilities, and ensuring that children in self-isolation or quarantine in care homes have access to adequate nutritional support.

Education

It is necessary to use child friendly distant education methods in alternative care spaces, such as TV, radio, or online learning, thereby limiting the impact of school interruption. Advocating with government and other private employers is required for a flexible working arrangement for caregivers who may have little or no experience in this regard, and thereby enable them to continue care and education of children in care home facilities. Support providers need to work with schools to ensure safety messages and protection are delivered to children and caregivers in a way that limits distress and panic. It is also important to ensure that teachers and volunteers have the required knowledge and skills related to risk mitigation, child safeguarding, prevention of sexual exploitation and abuse, and safe referral practices.

Working across sectors and with governments: timely response, advocacy with government, collaboration with other sectors, and child protection-specific programming are key priorities for the COVID-19 response

Immediate decision and timely co-ordination are vital. It is important to ensure that care homes do not run out of essential supplies, along with developing and imparting training on safety measures to caregivers and children. A co-ordinated approach for protecting and caring for the children and youth is required along with ensuring all efforts for monitoring children who are living in or going out of the residential care systems. Child protection specialists can advocate for measures to address COVID-19 which accord with international standards, in line with WHO and UNICEF advice and are human rights-based, proportionate, and non-discriminatory. The vulnerability of children can be reduced by engaging them proactively and including the perspectives of children. Governments and NGOs can work with community members to develop child-friendly messages on COVID-19.

Work with caregivers

Targeted support to interim care centres and caregivers should be provided, including child-headed households and foster families, to support children emotionally and engage in appropriate self-care. Provide training and support to caseworkers and existing child helplines on COVID-19, including basic facts and myths, impact on child protection concerns, and support services. Revision of the existing SOPs with the health sector and others basis the current situation is necessary to ensure the safe identification and referral of children at risk, as is identification of risk mitigation measures for caseworkers and alternative methods for follow-up if home visits become impossible.

It is vital to assess the long-term impact of the pandemic to prevent this crisis from turning into an epidemic of abuse in South Asia. It will take a long time to heal the ruptures and breakdowns and to rebuild the social and economic infrastructure. We should establish safe, child-friendly complaints and feedback mechanisms in care homes to keep children at the centre. Collective action on the part of the civil society and political will and commitment are non-negotiable. Central and state governments across South Asia must continue to engage with civil society and practitioners to understand the realities and produce new policies and priorities. Awareness of alternative care and the implications of COVID-19, and recommendations of NGOs should be spread to the public by governments wherever lacking. This can be achieved through webinars and social media awareness campaigns. Training for staff working in alternative care should be functionalised to deal with emergencies especially in dealing with issues related to mental health. In order to deal with the impact of a pandemic, it is important to work with individual countries' local health officials, school districts, child care accreditation bodies, child care licensing boards/bodies, health consultants, and other community partners to determine the most appropriate plan and actions to protect the children and other stakeholders in the alternative care space from the aftermath of COVID. The role of mental health carers and counselling is paramount to mitigate the increased risk of anxiety, violence, abuse, and care-giver burnout. Regular monitoring of each child under care and protection is necessary to mitigate the risk of abuse.

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About the authors

Dr Kiran Modi is the founder managing trustee of Udayan Care. Holding a doctorate in American Literature from IIT Delhi, she has 27 years of experience in working on Child Rights and Alternative Care. She is the founding member of several other trusts, working for the disadvantaged, including children's theatre and health; as well the bi-annual academic journal, Institutionalised Children: Explorations and Beyond, a journal focused on alternative care of children out of home care. She has been responsible for organising many training sessions, consultations, national and international conferences on alternative care.

Dr. Gurneet Kaur Kalra is a trained criminologist, with a PhD in social work from Jamia Millia Islamia University and is committed to research and field-work practice for the past seven years. She is currently engaged as an assistant manager in the Advocacy and Research Department in Udayan Care. Within the advocacy, research and training department, she is responsible for facilitating International Collaborations for various field-based research. She is also an administrator to Institutionalized Children: Explorations and Beyond.

Ms Leena Prasad, LLB, is a lawyer by profession and currently placed as associate director in the Advocacy and Research Department, Udayan Care. She specialises in litigation, advocacy, and training on women and child rights issues.

Ms. Rajeshwari Narsimha is a communications executive at Masoom Education, Mumbai, and is also in her final year of master's in social work from S.N.D.T. Women's University, Churchgate, Mumbai. Rajeshwari graduated in psychology from Banaras Hindu University. She is a writer and editor at The Social Construction Club.

Ms. Jyoti Singh is in her final year of a master’s in social work from S.N.D.T. Women’s University, Churchgate, Mumbai. Jyoti graduated in history from Banaras Hindu University.

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Developing philosophical discussions with children and young people in residential care homes

Terje Jostein Halvorsen

Abstract

Philosophical discussion in small groups is a method already known in the field of residential child care, through Kohlberg's theory on how to promote young people's ability for moral reasoning. This paper offers a presentation of two philosophers, Matthew Lipman and Gareth Matthews, who advise approaches similar to the Kohlbergian approach but where the aim is to promote cognitive development in multiple domains. Their approaches may prove useful in the endeavours to improve the educational achievements of children and young people in residential care homes. Moreover, these approaches may also promote social competence and social functioning. According to the author, the philosophical knowledge needed to initiate and lead discussions, can yield an additional benefit in the form of a more stringent and in-depth professional reasoning.

Keywords

Philosophical discussion, Socratic Method, cognitive development, educational achievement, social competence, professional reasoning

Corresponding author:

Terje Jostein Halvorsen, Professor, Faculty of Social Science, Nord University, terje.j.halvorsen@nord.no

Introduction

Since the 1980s, an increasing number of researchers have focused on the educational attainment of looked-after children (cf. Aldgate, Heath, Colton & Simm, 1993; Berridge & Brodie, 1998; Berridge, Dance, Beecham & Field, 2008; Cameron, Connelly & Jackson, 2015; Jackson, 2001). Children in residential homes are in high risk of educational failure, and such failure may cause social problems later in life. Several scholars have called for efforts to promote looked-after children's ability to cope with academic challenges. According to Francis, residential care professionals should 'Develop a learning culture', 'identify and support the child's interests and talents', and 'look beyond the school for learning opportunities' (2008, p. 30). Philosophical inquiry as proposed by Lipman and Matthews meets these claims and may be part of the effort Francis calls for.

Another issue that has attracted increased attention in the field of residential care and adjacent fields is how poor reasoning skills might get children and young people into problems in social interaction. This new focus can be traced to changes in professional theories. Both psychoanalysis and behaviourism have undergone a 'cognitive turn'. In the former, Fonagy and colleagues (2004) have described the importance of mentalisation, that is the capacity to interpret human reactions as manifestations of mental entities. This meta-cognitive capacity is a prerequisite for affect regulation and for the ability to adapt to the needs of others. In the behaviourist tradition, several scholars have described how clients can learn to identify self-instructions and self-evaluations that promote and maintain problem behaviour and replace these with thoughts that bring alternative behaviours (compare Bandura, 1986; Meichenbaum, 2017). Also Kohlberg (1984), who has logical constructivism (compare Piaget, 1953) as his starting point, has put reasoning skills on the agenda in social pedagogy. His approach where young people are invited to discuss dilemma situations is included in ART, Aggression Replacement Training (Goldstein, Glick & Gibbs, 1998). Since the late 1990s, residential care professionals in many countries have attended training programmes to qualify as ART-educators. Also philosophical inquiry as proposed by Lipman and Matthews may have a positive impact on social function. Their approaches can promote social competence in form of an ability to articulate problems and give reasons and a habit of actively listening to others and exploring disagreements reasonably.

Two unusual philosophers

Matthew Lipman and Gareth Matthews worked as philosophers at American universities in the last part of the previous century and the beginning of this century.

They both by coincidence entered the field of pedagogy. Even though they did not work together their efforts were partly parallel. Unfortunately, neither Lipman nor Matthews have yet received much attention in the field of residential child care.

Lipman was born in 1923, grew up in New Jersey and studied at universities in America, England and France (Lipman, 2008). Philosophy of art was his major area of specialty (Lipman,1967, 1973). After completing his PhD Lipman became a lecturer at Columbia University in New York City. In his work with students, Lipman made an observation that aroused an interest in pedagogy. As an elite university, Colombia had talented students who worked hard. The students read a lot and had extensive knowledge in their special fields. They did not, however, reason as strictly and profoundly as Lipman had expected. They lacked what he describes as sufficient thinking skills. He concluded that there was something fundamentally wrong in the school system: that teachers imparted knowledge but that students got no guidance or training in how to reason in a stringent way. Therefore, a far-reaching educational reform was needed. Lipman was aware that Dewey had come to the same conclusion:

> John Dewey was convinced that education had failed because it was guilty of a stupendous category mistake: It confused the refined, finished end products of inquiry with the raw, crude subject matter of inquiry and tried to get students to learn the solutions rather than investigate the problems and engage in inquiry for themselves. Just as scientists apply scientific method to the exploration of problematic situations so students should do

> the same if they are ever to learn to think for themselves. Instead, we ask them to study the end results of what scientists have discovered; we neglect the process and fixate upon the product (1991, p. 15).

Lipman (1988) came to the original idea that the best way to promote cognitive skills is to bring children in contact with philosophy. In this field, scholars for centuries have described how to avoid shallowness and ambiguous or erroneous ways of reasoning. Gradually Lipman moved from philosophy of art to pedagogy and started formulating what became known as Philosophy for children or Philosophy for children and young people.

In 1972, Lipman was offered a position as professor at Montclair State University in New Jersey. Here it was arranged so that he could pursue his new interest and he established The Institute for the Advancement of Philosophy for Children. Lipman was active as a researcher until shortly before his death in 2010.

Gareth Matthews was born in 1929. As a young man he studied philosophy at universities in America and West Germany. For most of his academic career Matthews worked as a professor in philosophy at the University of Massachusetts, in the city of Amherst. This position he held until he died in spring 2011. As a professional philosopher Matthews was engaged in the study of the antique period and the medieval period (Matthews 1990, 1999). He also worked with issues related to philosophy of mind (Matthews, 1992). Through his research Matthews became a recognised professor in philosophy. Matthews' private life was one of a quiet family life with wife and three children. It turned out that one of these would make a decisive impact on Matthews' career.

In 1963, a special incident took place. The family's cat, Fluffy, had contracted fleas and Matthews realised that he had to fumigate the cat. Matthews' four-year-old daughter Sarah watched the process. She wondered how the fleas had come into Fluffy's fur. Matthews answered that they probably had come from another cat Fluffy had played with. He presumed that this was a sufficient answer. However, he was wrong. Sarah wanted to know where the other cat had got the fleas. Nor was she satisfied with the answer that also the other cat had got fleas from a cat, a third cat.

It can’t go on like that forever, Sarah objected. One of the topics Matthews often taught to students was the cosmological argument for a first cause. This argument implies to rule out a line of causes, and thereby prove the existence of a first cause. Matthews recalled reflecting: ‘Here I am teaching university students the argument for a First Cause, and my four-year-old daughter comes up, on her own, with an argument for the First-Flea’ (1994, pp. 1-2).

Sarah’s ponderings brought her father on a new track. Through further discussions with his own children and with children in schools and institutions, he came to realise that children are able to enjoy, and to benefit from, philosophical discussions:

> I don’t want to come right out and say that children are philosophers, or that philosophers are children — though there would be some point in saying each of those things. Instead, I want to say this: what philosophers do (in rather disciplined and sustained ways) is much closer than usually appreciated to what at least some children rather naturally do (albeit fitfully, and without the benefit of sophisticated techniques) (Matthews, 1976, pp. 14-15).

While many professionals, often with reference to the theory by Piaget (1953), oppose the idea that children can do complex, abstract reasoning, both Lipman (1991) and Matthews (2009) argue that children’s cognitive potential is underestimated by Piaget and his followers.

Prepared or spontaneous discussions

When it comes to educational methodology the two pioneers to some extent split up. While Lipman advises prepared and manual-based discussions, Matthews proposes spontaneous discussions.

Lipman has developed an educational program package in form of manuals for the pedagogue (for example Lipman, 1996; Lipman & Sharp, 1984) and textbooks for children about children who come in contact with philosophical issues. In the books about Pixie (Lipman, 1981) a young girl is protagonist and narrator. According to Lipman, each session should start with a reading of an excerpt from one of the books. Then the children should be invited to respond to the text by suggesting questions the text raises. The manual contains several instructions about how the pedagogue can facilitate the discussion. Before starting, the children are encouraged to underpin their conclusions with arguments. They are also asked to listen carefully to the arguments of others. The group is embarking on a joint venture, a teamwork project, not a competition. According to the manual, the pedagogue must not show off with his/her wisdom and philosophical insight. Instead, the Socratic Method (see Brichouse & Smith, 2009) is advocated. The pedagogue should give careful hints for further exploring by asking thought-provoking questions. Lipman (1988) uses the term community of inquiry to name the advantageous educational context where the educator and the children work together to clarify a philosophical issue.

Lipman’s books for children deal with different branches of philosophy, especially ontology, epistemology and ethics. The excerpt below touches on the ontological schisms materialism versus idealism and monism versus dualism:

> Pixie: When something happened to a thing, did anything happen to the idea of that thing? I mean, if a chair got burned up, did the idea of the chair get burned up too?
>
> Brian: No, nothing can destroy ideas. The things that share in those ideas can get destroyed, but not the ideas.
>
> Pixie: And is that the same with people?
>
> Brian: It could be. Abraham Lincoln was killed, but was the idea of Abraham Lincoln killed? (Lipman, 1981, p. 94).

Teachers in many countries have attended training programmes where they have learned to apply Lipman’s programme, and several schools have included philosophy in the curriculum. At these schools, philosophy is listed in the timetables. Applied in a residential care setting prepared discussions as proposed by Lipman could be organised in the form like a ‘philosophy club’ or weekly discussion meeting. Such meetings should be arranged so that the children or young people would like to attend. Those who participate must find that they learn something they benefit from. In addition, something to eat and drink and time for nice informal chat may motivate.

An objection that might be raised against Lipman's approach is that philosophy is a subject that not easily fits into educational programmes. Even though the inquiry most often follows the predicted trajectory, unexpected turns may occur. The children might have unforeseen associations and might come up with thoughts that are not described in the manual.

While Lipman offers detailed manuals to follow, Matthews presents anecdotal examples from which to be inspired. According to Matthews, children often realise by themselves how philosophical ideas are embedded in, and underpin, everyday reasoning. Children may also question some of the presuppositions our reasoning is based on. Matthews (1984, 1998) describes how children's philosophical awareness expressed through statements or questions may be starting points for philosophical discussions. Some recognisable examples can substantiate Matthews claim:

'Giraffes are similar but also different', says seven-year-old Jenny. She scrutinises the picture on her lunch box and has noticed that the spot near the corner of the mouth on the giraffe to the left is slightly smaller compared to the other giraffe. Jenny's statement deals with concept theory, defining characteristics, additional characteristics, similarity and uniqueness.

'Why do we call penguins birds even though they cannot fly?', asks Tom. He is ten years old and is about to colour a drawing with different birds. His questioning is about conceptual vagueness and the distinction between categorical and dimensional classification.

'Pluto has been a planet and it may become a planet again', says Frank with an important look. He is twelve and has a special interest in astronomy. He reads books and magazine about celestial bodies and hope that one day he can afford an astronomical telescope. In one of the magazines, he has read that the International Association of Astronomy changed the definition of planets in 2006.

This entailed that Pluto was excluded from the actual category. Frank's statement is about the problem of universals. This is a schism in ontology and epistemology, where realists oppose conceptualists. The former claim there is a natural system of categories whilst the latter disagree and argue that all categories and classification systems are social constructions.

'Is Hero responsible for its mischief?', asks Jim. He has discovered the three-month-old puppy on the beach while it was chewing a pencil box. The question Jim raises in a humorous tone is about the schism between determinism and indeterminism, and about the difference between causal explanations and motive explanations.

'Why do giraffes have long necks?', asks Jean. She is fourteen and is attending an excursion to the zoo. The answer to this questing is in the history of evolution and in functional explanations, a kind of explanation describing how a phenomenon is sustained by its effects.

'Is there something like false knowledge?', asks Tom. He is sixteen. At school he has noticed that the teacher uses the expression true knowledge. Tom wonders if such usage implies that there is something like false knowledge. His pondering is about the definition of knowledge. A widely held view is that genuine knowledge is infallible, and that true knowledge consequently is a tautology, similar to unmarried bachelor.

'Can it be morally right to tell a white lie?', asks Jenny. She is sixteen and explains that there is a girl in her class who walks alone most of the time and often looks sad. Her name is Sheila. Usually, Sheila wears outdated and worn clothes. Her parents are poor. Jenny says that she feels sorry for Sheila and has tried to be kind to her. Today Sheila attended school wearing a new but weird looking jacket. She had asked Jenny if she fancied the new jacket. Jenny answered that the jacket was nice because she didn't want to hurt Sheila. The question Jenny raises is about the difference between duty ethics that tells us to follow rules, and utilitarianism that tells us to consider consequences, but also about act utilitarianism versus rule utilitarianism. The former tells us to consider the consequences of the single act, while the latter tells us to follow the rule that brings the best consequences in the long term. Jenny has acted in accordance with act utilitarianism but fears that Sheila may see through her and become even more hurt and upset.

‘Can teachers decide the meaning of words?’, asks seventeen-year-old Frida. She is a bit agitated because of an argument with the English teacher. According to the teacher Frida and several other students use the word unique incorrectly. The correct meaning of the word is one of a kind and not unusual or great as Frida and her classmates seem to believe. Frida’s question is about etymology and the tending of a language but also about the distinction between words and concepts and the fact that some words change meaning, the subject of pragmatics.

Attentive child and youth care workers will experience countless such incidents. These are golden opportunities that should be utilised. If the professional responds in an adequate way the child’s wonder may transform into philosophical reflection and discussion, a joint inquiry that promotes cognitive development. The discussion may involve one child or several. It may be short or long and take place in a wide range of situations, for instance during meals, homework sessions or outdoor activities, or after watching a film or a television programme.

As described in the introduction, vulnerable children and young people may need to improve their ability to think about problems and issues of different kinds. While some of the examples above are particularly relevant for the ability to cope with academic challenges, others are about social interaction.

Although there are methodological problems associated with evaluating the impact of philosophical discussions, there is a substantial body of empirical research which suggests positive outcomes (Fair, Haas, Gardosik, Johnson, Prince & Leipnik, 2015a, 2015b; Gorard, Siddiqui & See, 2017; Millett & Tapper, 2012; Topping & Trickey, 2007a, 2007b).

Professional reasoning

To be able to practice philosophical discussions with children or young people, the professional must be familiar with actual topics. The professional must foresee what directions the discussion might take and what conclusions might be reached (Chesters & Hinton, 2017). Such capacity is particularly urgent when practising the approach proposed by Matthews, where there is no manual to lean on and the professional himself/herself must come up with the questions that motivate for further exploring.

Repeating and expanding one's philosophical knowledge can be laborious. This effort may, however, yield a double pay-out. In addition to a better understanding of the child or young person and an ability to promote development, philosophical insights enable the professional to understand fundamental aspects in theories and research, and thereby avoid shallowness and vagueness in his/her professional reasoning.

This latter claim can be substantiated by returning to some examples above and connecting them to professional reasoning. The example of the penguins dealt with categorical versus dimensional classification. Insight in these two approaches of classification is of utmost importance for those who work with vulnerable children and their families. Earlier researchers in most fields solely applied the categorical approach to classifying. This is based on the Aristotelian theory of meaning where a concept definition is a list of necessary and sufficient characteristics (Aristotle, 1963). To be assigned to a category, a unit needs to have all the characteristics listed in the definition. To lack one implies exclusion. A unit is either included or excluded from a category. To belong to a category to some extent is not possible. In recent years, dimensional classification is used as an alternative, or complementary, approach. This approach is based on Wittgenstein's (1953) theory of meaning. According to Wittgenstein, the tool for categorising is not a list of necessary and sufficient characteristics, but the conception of a prototypical category member. In assessing units for classification these are compared to the prototype. When this approach is applied in a professional field, lists holding a large number of traits are worked out. To be assigned to a category, a unit only needs to have some of the characteristics listed. Knowing this is a prerequisite for a realistic understanding of psychiatric diagnoses, and thereby the dimensionality of mental disorders. Several mental problems are not all-or-none phenomena, but something most people to some extent suffer from (American Psychiatric Association, 2013).

The example with Pluto was about the problem of universals. Insight into this is necessary to fully understand professional debates about classifications. There are several such debates ongoing. One is on psychiatric diagnoses. Mental disorders are classified in two different catalogues, International Classification of Diseases (ICD) (World Health Organization, 2018) and Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013), both designed with the ambition to provide a complete overview of the disorders that exist. The categories described in the two catalogues, however, are not identical. Consequently, both catalogues cannot be a correct account of a natural order. The foregoing is an understatement. The professional should be aware how his/her reasoning might be biased by professional classifications (Bertolino, 2015).

Insight into the problem of universals also helps the professional to realise how children's and parent's perception and reasoning may be influenced in some special way by the concept structure in a language variant. There is an analogy between the problem of universals and the phenomenological approach in social pedagogy.

The example with the puppy Hero was about motive explanations. This kind of explanation is rooted in the ideas of Kierkegaard (2015) and Sartre (2007) and is a building block in both humanistic psychology (Glasser, 1999; Maslow, 1968) and in empowerment theory (Freire, 2003; Eichsteller & Holthoff, 2011). Professionals who apply these theories believe that the client's self-perception very often is self-fulfilling. Therefore, an important professional task is to present motive explanations and an existentialist view on human life in a stringent manner.

The example relating to giraffes' long necks was about functional explanations. This kind of explanation is a central element in attachment theory, which is a theory of relevance to residential care (Graham, 2006). To fully understand attachment theory, one must know that the theory is a synthesis of object relations theory and ethology, the branch of biology concerned with the adaptive, or survival, value of behaviour.

Moreover, one must know that ethology provides attachment theory with a special kind of explanation. According to Bowlby (1989), the child's inclination to seek towards caregivers is a result of the genetic selection that has taken place during the history of evolution. Imprinting and critical period are some of the ethological concepts in attachment theory.

Conclusion

As we have seen, philosophy is not just a weird interest for some scholars in an ivory tower, not a third party one can choose to invite in. Philosophy is present in professional reasoning and in the everyday lives of ordinary people, also the lives of children. By acquiring philosophical knowledge, the child and youth care worker is able to practise an exciting approach that may support children and young people in a decisive way. Moreover, philosophical insights enable the professional to trace, clarify and evaluate presupposition underlying professional reasoning, and thereby contribute to a greater degree of intellectual cohesion in the field.

Several scholars have continued the work of Lipman and Matthews. In addition to the books of the two pioneers, there is an extensive body of professional literature discussing methodological issues and offering useful advice and examples (such as Cam, 2006; Gregory, Haynes & Murris, 2017; Kaye & Thomson, 2007; Lone, 2012; Wartenberg, 2009; White, 2001, 2005; Worley, 2015). Hopefully, some of these texts will inspire professionals within the field of residential child care in years to come.

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About the author

Terje Halvorsen PhD is a professor at Nord University in Norway. Here he teaches students who qualify for child welfare work. His research interests are child welfare, residential care, foster care, social pedagogy and developmental psychology. Before he became an academic scholar, Halvorsen worked for 12 years at a residential care home.

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Life after residential care: A narrative life-course case study

Amanda Keller

Abstract

This exploratory narrative case study delves into the life trajectories of two English-speaking adults age 50+ who spent over three years in youth protection-based congregate care and aged out of these services in Quebec, Canada. It examines how residential foster care alumni describe their life history and what insights they can provide regarding their transitions to adulthood and parenthood, and their placement experiences. Policy makers, clinicians, and researchers should observe that insights from adults over age 40 are under-examined, and these data point to complex interpersonal difficulties that continue well beyond emerging adulthood. The research indicates intergenerational challenges as an important theme, with both individuals reporting relationship struggles with their families of origin, and healing during their fourth decade of life after crises related to their parental roles. Exploring care leavers' perspectives on healing across their life course may provide invaluable insights about resilience and youth protection practices. These narratives highlight several promising areas of future inquiry that may lead to restitution, healing, and transformative change in child welfare practices.

Keywords

Residential care, congregate care, life course, foster care, narrative analysis, case study, Canada

Corresponding author:

Amanda Keller Ph.D. Candidate, McGill University School of Social Work, 3506 University Street Suite 300, Amanda.keller@mail.mcgill.ca

Introduction

Follow-up youth protection studies in North America tend to track children leaving care for three to nine years, roughly from the ages of 17-27 (Courtney et al., 2010; Goyette, et al., 2019; Pecora et al., 2006; Hook & Courtney, 2017). The exception to this rule is the Casey Family Alumni study, which follows a cohort including some individuals in their 40s who were placed in foster homes by Casey Family Services, a private American agency operating in several US states (Garcia et al., 2012; Roller-White et al., 2011). However, the Casey family longitudinal study does not report on congregate care outcomes at all, or specifically document youth who age out of the system. Instead, it reports on a subset of adults serviced in foster care placements by Casey Family Services at any point during their childhood, not necessarily those who age out of care. Therefore, scant attention has been paid to individuals over the age of 27, or towards those who spent many years in residential care. The well-documented challenges facing this population in early adulthood necessitate a closer examination of later adulthood. Despite the calls of other narrative researchers such as Refaeli (2017) to explore the experiences of alumni of care beyond their mid-twenties, the dominant research paradigm focuses on the transition to adulthood, missing large portions of the life course. Exploring the life history of older individuals may provide unforeseen insights into the transition to adulthood for this under-examined population and help to identify needs across the lifespan and areas to improve within clinical interventions, and to document the pathways to emerging and sustained resilience later in life.

Congregate care services are often considered last-resort placement, and children assigned to these facilities have significantly higher trauma exposure rates, behavioural, and mental health issues than children who reside in traditional foster care (Briggs et al., 2012; Collin-Vézina et. al., 2011; Li et al., 2019). In North America, during the sensitive transition to adulthood, youth from congregate care demonstrate significantly higher rates of mental health and behavioural issues (Dregan & Gulliford, 2012), lower rates of high school graduation (Courtney & Hook, 2017; Goyette et al., 2019), increased rates of homelessness (Reilly, 2003; Dworksky et al., 2013), and higher criminal justice involvement (Shook et al., 2009) than youth in transitional family-based foster care placement. These disproportionalities suggest that the challenges faced by youth aging out of congregate care are more severe and persist well into adulthood.

To document the life course of this population, this narrative case study examines the life stories of two adults aged 50+ who spent over three years in residential and group care placements, ‘aging out’ of services between 17-18. Seeking to illuminate residential foster care alumni’s own meaning-making of their life history, this exploratory study garners insights about how these individuals transition to adulthood and parenthood decades after their congregate care placement experiences. Using rich pilot data originating from English-speaking Quebec alumni, the study explores care-leavers’ life course history in detail along with relevant research, policy, and practice recommendations.

Theoretical framework

Residential care in this paper refers to youth-protection-based institutionalised-care, often rehabilitative or psychiatric in nature (Frensch et al., 2001; Sholevar, 1995). It is sometimes referred to as congregate care (Freundlich & Avery, 2006) and these terms will be used interchangeably throughout this paper. Mishler (1995) describes narrative as a problem-centred area of inquiry, an assumption this writer shares. It employs a social justice (Caine et al., 2018; Johnson & Parry, 2015) and feminist lens (Doucet & Mauthner, 2008) with strengths-based perspective (Saleebey, 2000) to examine the struggles surrounding the transition to adulthood for alumni of residential care. It postulates that simply telling untold stories is an act of social justice (Caine et al., 2018) and that all individuals, regardless of life condition, have strengths that can be examined and harvested (Saleebey, 2000). This research examines these stories with life course perspective (Elder et al., 1998).

Methodology

Approach

A narrative case study design was developed to engage a modest number of people to bring to light the longer-term life trajectories of individuals who spent several years in residential care services as children. This investigation uses elements of both peer research methodology (Lushey & Munro, 2015) and episodic interview approaches in the interview process (Flick, 1997). For example, the interviewer, who is an alumna of group care, employed self-disclosure at times during the recruitment and interview process. Given the focus on the transition to adulthood and parenthood, a four-question interview guide was developed to concentrate on these temporal periods, employing a modified episodic interview method.

Recruitment

Two adults over the age of 50 participated in my in-depth narrative case study. I recruited both participants directly from Quebec Province's public Laurent Commission hearings in January 2020. The Laurent commission was a year-long public inquiry into youth protection challenges following the untimely death of a young child failed by the system. I individually approached these two adults at the commission after they gave testimonies on their congregate care placement history. I informed them about the study’s purposes, and both subjects provided their contact information. The participants were provided a consent form via email a few weeks later, and subsequently agreed to schedule an in-person interview. There were no individuals who refused or dropped out of this pilot study.

Data collection

Two semi-structured audio-taped interviews were scheduled in person with each participant in early March 2020. The interviews lasted roughly one hour each. I did not execute the second interview with participant one, referred to as Thomas, owing to research restrictions connected to the COVID-19 outbreak. However, I believe that participant one’s first interview provided a ‘saturation of knowledge' (Bertaux, 1981, p.37) such that the second interview was unnecessary.

The first interview had a predesigned interview guide which featured four broad questions pertaining to experiences in late adolescence, transitions from care, as well as perceived challenges and strengths across adulthood. The opening of the initial interview was largely unstructured. Participants were invited to direct the interview process and share their insights and concerns.

The second interview with participant two focused on themes pulled from the first interview of trauma within care and healing aftercare. Member-checking occurred with both parties over the phone after they had read their transcripts and again when a final report was written.

Analysis

Both participants' interviews were transcribed. The narratives were examined for holistic content to create their individual lifelines (Gramling & Carr, 2004). The turning points of their life course (Beal, 2013) were scrutinised for their episodic commonalities (Flick, 2000, p. 81).

Researcher positionality statement

I am personally and professionally connected to this research area. Professionally, I am the founder of CARE Jeunesse, a grassroots non-profit organisation that provides support to youth and alumni of child protection services. Furthermore, I worked as a case manager for 10 years with youth leaving care in Montreal. Personally, I am an alumna of residential and group home care. I spent five years in these placements between the ages of 13 and 18.

Ethical considerations

Given the emotional quality of the content, I advised interviewees before starting the interview and reminded in the mid-point of the interviews, they could decline to respond to any query, take a break, or stop. Both participants received the contact information to an independent rapid response clinical service should they require clinical support related to the interview process.

The study used member-checking to ensure participants were comfortable with the material they shared. Participants viewed their full transcripts and lifelines. I invited them to adjust any content which they felt inaccurate or uncomfortable sharing prior to submission for publication. To ensure confidentiality, I refer to both individuals by aliases. Their residential care placements names, when mentioned, are also obscured, and referred by pseudonyms. I deliberately left information out such as identifiable descriptions of ethnicity, birthplaces, and residential districts. The study design was approved by McGill University Human Ethics Research Committee, approval # 20-09-043.

Results

A written summary of both individuals' profiles, including a pictorial display of the lifeline of both participants is summarised below.

Profiles

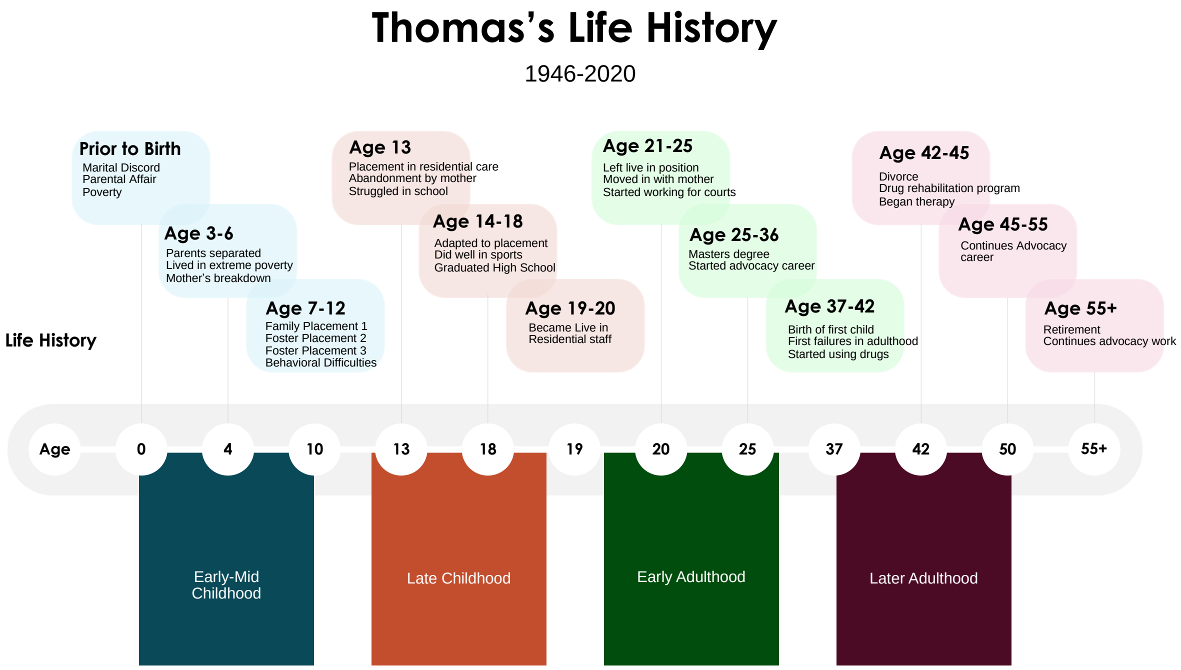
Thomas

Thomas is a 74-year-old, self-identified biracial alumnus of care. Attributing his placement in care to poverty, he shared that his single mother became overwhelmed raising three boys during the 1940s-1950s, when little public assistance was provided to parents in need, and she suffered a breakdown. Thomas was unclear on the exact dates of his placements; however, he reports leaving his home around age six, spending a certain amount of time with family friends, then spending roughly four years in foster care between two traditional family-based foster care placements and a subsequent five-year placement in a cottage-based residential care facility campus in Montréal, Québec. Thomas shared he was fortunate to be placed in the same well-resourced public school district for much of his education, something his brother did not experience.

When Thomas aged out of services, he was invited to stay on as a live-in residential care staff. Unclear on dates, he reported becoming a staff for a couple of years after aging out of placement, mostly while he was in university which was funded in part by child welfare related scholarships. Thomas achieved his B.A. in his early twenties and worked for several years as a criminal justice professional. Going back to university to pursue his master's degree in social work in his late twenties resulted him becoming a well-known social justice advocate.

Thomas got married in his late thirties and became a father in his early forties. Thomas reported although he always dreamed of being a father, he could not cope as a parent because of his unresolved childhood wounds which were triggered by parenting. Reporting that he became addicted to drugs, which ultimately cost him his marriage, intact family life, and career shortly after his children's births. He divorced his wife and his children stayed with their mother. Undergoing substance abuse treatment and therapies in his 40s he recovered from drug addictions and regained a successful professional career. He has remained actively involved with his children across their lives. Thomas has developed a meaningful life maintaining an active mentoring relationship with other alumni of residential care, engaging in social justice advocacy, and playing an active role as a father of his two adult children. Thomas's timeline is displayed in Figure 1.

Figure 1: Thomas's life history



Carmen

Carmen is a 50-year-old Caucasian woman who attributes her placement to childhood behavioural and mental health issues, including undiagnosed autism, post-traumatic stress disorder, and early hyper-sexualisation. After becoming pregnant around age 13, she was forced against her will to have an abortion by her mother and medical professionals, irrevocably harming the maternal bond and her trust in authorities. She reported being placed shortly after her abortion and spending roughly four years alternating between 12 unlocked and locked facilities. She described frequent run-away episodes, unmet emotional needs in most of her placements, and the abusive use of restraint in some facilities.

Victimised by peers and unprotected by residential care staff while in placement, she and her group home sisters were often approached by pimps and older men outside facilities. Carmen reports that staff actively encouraged the girls' involvement with older men, particularly when they bought gifts or picked girls up in cars. Furthermore, Carmen met her first serious boyfriend while in her group home, a man in his late twenties who made an attempt on her life when she subsequently fell pregnant.

Around the age of 16, Carmen went on a youth protection outward-bound-type sailing adventure that altered her entire life trajectory. Rife with challenges and a near-death experience, this programme reconnected her to nature and changed her perspective. Leaving care after completing high school at age 17, she reports she quickly became pregnant gave birth to her first daughter at age 18. Feeling unsafe in her romantic relationship and ill-prepared to protect or care for her child, she ultimately gave her first daughter up for adoption and struggled emotionally for the following year.

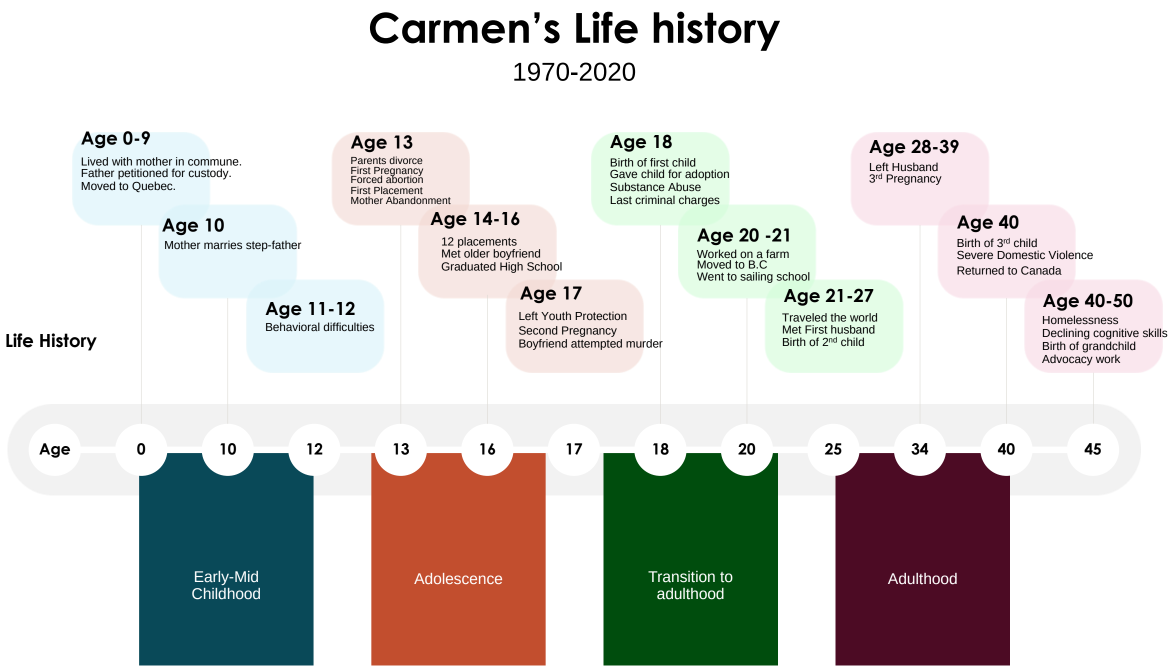
Leaving Quebec to work on farms across Canada as a day labourer, she found her first well-paid job around age 19 on a sailboat and enrolled in sailing school in her early twenties. Her subsequent sailing career enabled her to travel the world and move abroad, ultimately developing multiple successful businesses with her now ex-husband in a foreign country.

However, her romantic life has not been one of safety, as she reports severe episodes of domestic violence by all three men who fathered her three children. Beyond the psychological trauma associated with domestic violence, Carmen fears that her lifetime of traumatic injuries, specifically her head traumas, has affected her cognitive capacities. She reports that she currently suffers from a progressive neurodegenerative condition which is affecting her balance, impulse control, and memory. She identified these issues became more pronounced following a severe domestic violence episode that occurred 10 years ago, when she was forty years old. She reports she felt forced to flee the country she was living in and that her oldest daughter was taken from her at the border. She eventually regained custody of her second daughter. She maintains her maternal role with all her children.

Carmen reports self-chosen celibacy as she recognises an inability to choose romantic partners safely. She reports experiencing periods of homelessness and food insecurity over the past decade, because of her sudden inability to maintain employment. Carmen reports struggling with basic tasks such as adherence to the bureaucratic demands of maintaining welfare benefits.

However, Carmen reports being proud of everything that she has accomplished despite struggling a great deal. She has recently become a grandmother and she reconnected to her daughter that she gave up for adoption. Carmen finds meaning in life through parenthood and engaging with nature. She supports women experiencing domestic violence and continues to advocate for children in care. She is also currently working on a business plan offering educational services for children like her with special needs. The outline of her life story is depicted below in Figure 2.

Figure 2: Carmen's life history



Summary

This investigation highlights the complex life histories of two older alumni of residential care. It explores their cumulative losses and traumatic experiences. Seeking to provide a forum for these two adults to share their experiences, this research documents both their experiences and insights towards recovery from trauma. Notably, both participants experienced early losses and neglect prior to care, multiple moves, paternal and maternal abandonment, traumatic experiences in care, loss of their communities of origin, as well as difficulties adapting to both adulthood and parenthood. They both reported a lack of access to mental health services in placement. Furthermore, both found themselves faced in a state of personal crisis in their fourth decade of life related to their parental roles and this forced a period of post-traumatic growth. Admirably, both continue to advocate for reform, to serve others, despite extraordinary hardships. They both show significant resilience, but researchers and clinicians should nonetheless take note of important challenges over their lifespan.

Discussion

This narrative case study shares compelling stories of trauma and resilience in two alumni of residential care over the age of fifty. These stories highlight the need to better understand the long-term impact of residential care and early childhood trauma on the life course. Both participants reported witnessing and experiencing multiple traumas while in placement. Their narratives are consistent with the literature, which documents greater rates of maltreatment and cumulative losses for children in placement (Greeson et al., 2011; Riebschleger et al., 2015), and trauma exposure is particularly elevated for children and adolescents in residential care (Euser et al.,2013; 2014; Hobbs et al., 1999). Studying transitions from care into adulthood is critical to inform policy discussions, but we must better recognise the evolution of strengths and needs across the life course as people enter different phases of life and assume new roles.

While the interviews focused on examining the transition to adulthood, both individuals demonstrated a preoccupation with the multiple losses and traumas accumulated prior to and during placement. In addition to discussing their lost relationships with their mothers, they both also reported the lack of a positive relationship with their fathers. While less prominent a preoccupation for both subjects, the absence of their fathers may nonetheless have played an important role in the breakdown of their families. Beyond experiencing critical parental losses, they each moved multiple times, losing personal and communal connections, which ultimately created a gap in their support system. Major separations and traumatic experiences have cumulative effects for youth in congregate care and can create a lifetime of vulnerabilities if unattended (Euser et al., 2014; Hobbs et al., 1999; Hyde & Kammerer, 2009). It is important to consider the impact of cumulative losses across the life course, and potential harms to future relationships and other developmental domains. Clinicians should thus consider developing programming geared at maintaining relationships with parents, extended family members, or their broader community.

Carmen’s story illustrates a poignant example of how young women from congregate care are vulnerable to increased victimisation and exploitation (Coy, 2009; Giordano, 2021). Carmen’s reports of being groomed by older men for relationships and sex work reflect the issue of sex trafficking minors in care across jurisdictions, which researchers have acknowledged since the mid-2000s (Badawy, 2010; Gragg et al., 2007; Kotrla, 2010). However, Carmen’s experiences during the early 1980s reveal a longer history of abuses, with decades of governmental failure to protect children from sexual exploitation and trafficking. The fact she was routinely approached by pimps indicates co-ordinated victimisation of vulnerable minors in care. Unfortunately, Canada continues to lack the co-ordination between agencies to monitor and prevent sex trafficking of this young population (Kimber & Ferdossifard, 2020). Carmen’s story also highlights that domestic violence may continue across the lifespan for vulnerable women — an issue with dire health and child safety consequences. While I was unable to locate post-care literature on domestic violence, one study confirmed that seventeen-year-old youths in care have significantly higher rates of intimate partner violence, particularly young women (Jonson-Reid et al., 2007). If women from foster care experience higher rates of intimate partner violence while simultaneously having fewer resources and limited support systems, interventions that support care leavers experiencing domestic violence may be warranted. I would argue that this is a moral obligation of society, who served as their ‘corporate parent’, but I would also point out that a contextually sensitive response could prevent intergenerational child welfare involvement, thereby mitigating societal expenses.

Thomas showed remarkable resilience and expediently achieved life’s milestones in early adulthood, showing great academic and sporting capacity for which social workers touted him as a success. Employable at a young age, he was the first young adult from his large residential care facility known to pursue a graduate education. However, even with his clear resilience, his unresolved trauma and grief ultimately resulted in the breakdown of his growing family, thus showing that we may lack clear insights about the developmental trajectories of ‘resilient’ individuals if we examine them in snapshots in time. Thomas’s later life experiences with parenting add to Mark Courtney’s concerning findings that 67% of 21-year-old men who age out of foster care do not live with their own children (Courtney et al., 2007). However, Thomas was over age 40, with an established career and a graduate-level education when he first had children, demonstrating that it is not merely immaturity or economic instability that hinder a healthy transition to parenthood. Indeed, parenting itself may trigger memories of traumatic experiences from childhood. Parenting from individuals on the full spectrum of profiles should be better examined in future, ensuring that researchers include mature and resilient alumni in their participant pools, as those studies of very young care leavers may miss nuances that can only be understood by examining individuals with diverse placement histories, capacities, and outcomes.

Despite significant hardships, these two individuals have shown tremendous resilience and post-traumatic growth. They both have raised healthy children and continue to contribute to their communities. Furthermore, both individuals had insights about what supported their strengths. Thomas is thankful for the sense of community he received from his high school while in placement. His flourishing in high school set him up for a lifetime of career successes, while Carmen’s lack of placement and educational stability prevented her from following an academic path after graduating high school. However, she was thankful that the sailing programme not only helped her emotionally but also redirected her career path in a rewarding way. While life-course flashpoints are hard to predict, Thomas and Carmen’s narratives show that offering youth placement stability, educational stability, and traditional and alternative therapies can provide greater opportunities for future success.

Finally, these stories point to the importance of understanding and documenting historical trauma in childcare institutions (Karim 2017). Thomas and Carmen’s stories are but two of many, as the province of Quebec has an ongoing class action litigation in process for abused alumni of residential care (Feith, 2019). Examining these stories between regions, placement types, and decades may yield valuable insights about both positive and negative childcare practices that may affect children currently in placement, while equally helping identify paths to restitution and healing.

Limitations

This research selected subjects from a public forum that included politically active alumni of care, and therefore the sample is not representative. It did not aim to develop generalisable conclusions. Since they were reporting on experiences that took place decades ago, it is challenging to use their life stories to shape current policies and programmes, which have transformed over the decades. However, while the details of their histories are period-specific, the overarching theme of loss and trauma continues to be pertinent to the youth protection system today, and this study further underscores the importance of life course developmental perspectives (Elder, 1998) in child welfare research to better inform care-leaving practice and policy.

Finally, while the peer interview process has tremendous merits, it also involved unanticipated challenges. One participant took on a mentor-like role during the interview process, which is common in the alumni movement but altered the content of the interview, possibly due to the age differences between the interviewer and both participants. Peer interviews are an appropriate way to approach marginalized individuals or those with traumatic life histories. Yet the content of each interview may qualitatively differ depending on discrepancies between the ethnicities, cultures, ages, and life conditions of the interviewer and participants, even if they have important commonalities.

Implications for future research

This paper highlights the long-term struggles that alumni of congregate care face (Copeland et al., 2018). These findings suggest that healing is a lengthy process (Fahs, 2011) occurring well into the forties of both individuals. This research extends the findings of Dregan & Guilliford (2012), who found life course impacts up to age 30. Few researchers examine alumnae of care beyond the third decade of life. I was unable to locate a single peer-reviewed Canadian child welfare outcome study focused on emancipatory youth. I was additionally unable to locate a single qualitative study that interviewed care-leavers over the age of 40 in North America.

Therefore, this article identifies several important gaps. Canadian outcomes need to be better documented in the peer-reviewed literature, while longitudinal research needs to follow alumni of all forms of care longer to understand life course outcomes. Research focusing on domestic violence and parenting experiences for alumni of congregate care should likewise be better developed. Researchers may want to examine resilience less from a snapshot in time of care-leaver deficits, and more through the progressive and frequent documentation of development, possibly with a typographical approach scrutinizing more holistic areas of functioning. Given the intergenerational impact of trauma (Bar-On et al., 1998; Bombay et al., 2009), future research could delve into the intergenerational impact of congregate care, as both participants verbalized some challenges in family life. Working to understand how social networks and family relationships evolve for care-leavers from various types of placements would also be beneficial. Developing community-based responses for this population with a research-based framework may help to build the case for appropriate and sensitive community responses while simultaneously helping to expand the available life course data.

Conclusion

This case history analysis captures the life stories of two adults over age fifty who spent more than three years in residential care, to share their stories and highlight the need for an expanded research agenda that incorporates life course developmental perspectives. It highlights important and complex histories of loss and trauma, which suggests that recovery is a lifelong process, and that healing can emerge later in adulthood than the period on which researchers currently focus. In sharing these life stories of hardship and resilience, I hope that understanding and awareness can be gained about the plight of youth from residential care across the lifespan. Future research protocols must be advanced to better understand the developmental, ecological, and intergenerational trajectories of these individuals to help guide more holistic and responsive interventions and to improve upon transition age supports.

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About the author

Amanda Keller is a PhD Candidate and Vanier Scholar at McGill University in the Centre for Research on Children and Families. She uses multidisciplinary and mixed method approaches to examine child welfare policies and practices, to help improve child welfare outcomes. She has a particular focus on informing and reforming congregate care. Through her advocacy work and novel research, she is recognised as being one of the most prominent voices fighting for transformative change to child welfare services. She is the founder of CARE Jeunesse, a grassroots peer support organisation for alumni of foster care in Quebec. Beginning her career as a homeless youth outreach worker she has ten years of community based clinical experience working with youth aging out of care. She combines her personal, professional, and academic knowledge to help transform child welfare practices.

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An exploration of distance and home when looked after: Views of young people

Carrie F Mclaughlan

Abstract

This qualitative research explored how distance relates to young people's experiences of being looked after away from home. It sought views of young people living in residential care in Scotland using semi-structured interviews. Thematic Analysis was used to elicit key themes. A global theme of 'Connections' was identified. Feelings of distance were related to how connected or disconnected young people felt towards relationships and places. These 'Connections' were supported through Contact and Familiarity. Themes of feeling disconnected from home, and subsequently feeling further away from home related to a perceived sense of control and constraint from being in care. Shame, guilt and anxiety contributed to feeling disconnected. Feelings of connectedness and/or disconnectedness to home influenced young people's views of their own risk-taking behaviour. This research highlights the relevance of other factors, not just proximity when considering placing young people in care away from home.

Keywords

Youth, adolescent, looked after, residential, secure care, distance, risk, offending, qualitative

Corresponding author:

Carrie F Mclaughlan, forensic psychologist in training, Highland Council, carriemclaughlan@highland.gov.uk

> 'Yes, what else but home?
>
> It all depends on what you mean by home.
>
> Home is the place where, when you have to go there,
>
> They have to take you in.'
>
> **The Death of the Hired Man by Robert Frost**

Background

Children are placed into the care of local authorities for a range of reasons including protection from harm and involvement in offending behaviour (The Scottish Government, 2008). The care provided is often in the form of foster care, residential care and secure units. There is much to be gained by improving young people's experiences of care, particularly if one considers the proportion of the prison population with care experience. With estimates suggesting almost one third of the adult prison population identifies as care experienced (SPS, 2016) deepening our understanding of this correlation could contribute towards significant benefits, including potentially improving looked after children's outcomes.

The Children Act 1989 places a duty on local authorities in England and Wales to provide such care within their area and as far as possible allow children to live near to home. The importance of distance between the care provision and a child's home has received increasing attention with numerous reports highlighting the need to keep young people closer to their 'home'. A report by the Children's Commissioner for England suggests that 30,000 children live out of their own local authority, and that over 11,000 of these children are more than 20 miles from home, with over 2,000 further than a hundred miles away (Children's Commissioner, 2019). The increase in English young people being cared for in Scottish residential units is a clear example of this (Gough, 2016).

The National Audit Office (2014) argued for the importance of placing children close to home if safe to do so and suggested that 20 miles or less be considered as close. An independent review of children's residential care in England

(Residential Care in England 2016), concluded that the goal for local authorities should be to have the right home and situated reasonably close to a child's home. Furthermore, the Care Inspectorate produced admissions guidance to residential services in Scotland recommending the need to provide clear information about the practical considerations for young people placed far away from home and how contact, where appropriate, will take place. (Care Inspectorate, 2019). Doran & Berliner's (2001) proposed placement guidelines for young people in the USA and concluded that generally children benefit from placements near family members and children who have continued contact after placement with parents, siblings, or other relatives are less likely to experience disrupted placement. Unfortunately, the evidence they cited for this conclusion is vague and methodologically limited as it explored the role of placements generally rather than distance specifically (Thoburn 1994; VanBergeijk, Kupsinel and Dubsky 1999; Leathers 1999). Doran and Beliner did not gather any evidence themselves to support their position.

The available literature around geographical distance generally sees greater distance between the child's home area as problematic and to be avoided. The Children's Commissioner report (ibid., p.7) states that: 'distance creates obstacles in meeting a child's needs, both practically and emotionally' and 'distance is inherently destabilising for children'. Literature assumes that increasing miles are worse than small miles where in fact this is over simplistic. The literature fails to account for ease of travelling, cultural changes or differences (e.g., Scotland vs England) and how this may impact on young peoples' sense of how close or far away they are from home.

Perhaps more relevant to Scottish young people living in care, are the findings of the Scottish Independent Care Review (Independent Care Review, 2020) which places a significant emphasis on keeping families together and maintaining relationships between children and those who care for them. This points towards the importance of relationships over geography, albeit geography may create obstacles in maintaining such relationships (e.g., distance to travel).

This stance has real face validity and will resonate with anecdotal evidence of many practitioners, as well as being supported theoretically when one considers the importance of relationships through attachment. John Bowlby's attachment theory defines attachment as 'a lasting psychological connectedness between human beings' (1969, p.194). Support for the relevance of attachment theory in practice is evidenced in the work of Ian Sinclair and colleagues who reported that a successful placement is linked to the formation of an attachment relationship (Sinclair & Wilson, 2003; Wilson, Petrie & Sinclair, 2003). A more current perspective, and particularly relevant to care experienced children, is that of Garfat and Fulcher's work (e.g., Freeman & Garfat, 2014; Garfat & Fulcher, 2012) which captures the significance of belonging and connection in their 'Being, Interpreting, Doing' framework.

There is a wealth of 'guidance' aimed at local authorities and the care sector when placing young people in care, albeit the guidance is not always based on robust scientific research. Independent reviews across Scotland and England (Residential Care in England, 2016; Independent Care Review, 2020) both highlight the perpetuation of trauma for children, and the overall failures of the care system. However, these reviews do not offer clarity around the difference to being close to home, remaining in the child's home community and remaining in the child's local authority. The English review referenced 20 miles being far away without a rationale of why this figure is suggested. It is also plausible that there are children who live over 20 miles from their family's home yet are still placed in the same local authority.

Other reviews conclude similar recommendations around the need for proximity to home, yet offer poor or even a lack of methodology, do not provide a clear definition of home and make assumptions that being far from home equates to being far from their home local authority. (HMI Probation, 2012; Ofsted, 2014). Assumptions were made that being placed 'hundreds of miles away' is more traumatic and challenging than being placed a shorter distance away without any rationale or clarification of what the young people felt about being closer to or further away from home (Children's Commissioner, 2019). Both literature and guidance published make assumptions that home is a positive element in a child's life and will reduce risk, and that home is a single geographical place that remains constant. The guidance appears to assume that geographical distance is problematic without clarity over what distance equates to close or far away.

Despite this, local authorities need to 'be cautious about following any hard and fast rule about placement distance and…recognise that the right placement for a child is more important than location' (Residential Care in England, 2016), and distance shouldn't necessarily be assumed as negative (Moodie, 2015).

Notwithstanding the criticisms, guidelines and reviews consistently advocate looked after young people remain closer to home. However, in addition to these criticisms is the difficulty of implementing such recommendations. For example, the Children's Commissioner's report referred to above suggests that local authorities cannot match the level of need locally and therefore become reliant on separate care providers which are often out of area and that children are pushed away from home not because it is best for them, but because of a lack of alternative. This is aligned to the findings from national UK inspections that reported young people are often placed away from their home area due to a shortage of suitable resources closer to home (Audit Scotland, 2010; Ofsted, 2014) and is further reflected in Scotland's Independent Care Review (2020).

A significant criticism of all the literature available is that it does not explore what home means to young people, nor does it recommend to practitioners that they should explore this. The literature generally equates home area with that of the governing local authority area. This is a clumsy and insensitive definition particularly given the complexities of the looked after population, their fragmented histories, and the likelihood they have experienced multiple moves since coming into care. Furthermore, the literature does not explore how young people define home. This is essential given that distance is in turn defined by how home is defined.

Defining home is problematic, indeed rarely is there a clear definition of home that relates to all. Home does not specify whether this should be closeness to birth family, the community in which one has spent most time, or the local authority of the birth family, nor does it take account of those who do not have or never knew their birth family. The definition of home was central to the research reported here and may vary greatly across young people. To ascertain the young people's view on the role of distance, young people's definitions of home were therefore also explored.

Research that uses established methodology to explore the effect of distance from home on looked after young people and their lives, including an understanding of young people’s definition of home and their views of being away from home, is therefore required. The importance of seeking young people’s views is acknowledged in a range of guidance for the valuable and unique evidence this can provide (Save the Children, 2000; NICE guidance, 2015; United Nations, 1989). Indeed, ‘the voices of the children and young people in the care system must be heard at every stage’ (House of Commons Education Committee, 2016, p.3) and should ‘be empowered to have a more active role in decisions about their placements to increase the likelihood that they will be stable and successful’ (p.27).

Furthermore, guidance from the principles of good transitions highlights the importance of young people being at the centre of decisions and planning and decision making should be carried out in a person-centred way (Scottish Transitions Forum, 2017).

This research therefore sought to undertake qualitative interviews with young people in the hope that it would enable greater understanding of how home and distance affects young people by listening to the views of looked after young people and enable those caring for young people to make informed choices that can potentially improve care.

This study aimed to explore the lived experience and views of young people in residential and secure care. It aimed to inform and improve practice so decision makers and care staff effectively support young people who may live away from their home area.

When setting out to undertake this research, the purpose was not to conceive distance from home as negative or positive, but to explore young people’s view of both advantages and disadvantages of living away from what they defined as home. As stated, given the complexities and fragmented lives of looked after young people, they were invited to define home for themselves.

The study explored the following research questions:

1. How do young people who live in residential and secure care define home?

2. What do these young people consider to be positive effects of distance from home?
3. What do these young people consider to be negative effects of distance from home?
4. What do young people think carers can do to help with distance?

Using thematic analysis, key themes were identified and discussed to develop an understanding of how distance interplays with the concept of home and how young people's views on distance impacts their care experiences.

Method

Papers discussing sample sizes have indicated main themes are highlighted within four to six cases analysed (Guest, Bunce & Johnson, 2006) and in the case of hard-to-reach populations six to 12 cases can offer insight (Baker, Edwards & Doidge, 2012). This research therefore aimed to recruit at least six participants (Sandelowski, 1995), and once initial coding of the data indicated repetition of themes then data collection stopped. All young people who expressed an interest in taking part in the research were thanked for their time.

Participants

All young people were residents in a care centre in Scotland. A total of seven participants, aged 14 to 17 years took part in a semi-structured interview, lasting between 16 and 26 minutes. These interviews ended at the young people's request and when they stated they did not have anything further to add. The relatively short duration may reflect numerous factors and is given further consideration in the discussion. The sample included two females, four males and one young person who identifies as transgender.

Procedure

Ethical approval from the ethics committee of the residential care centre was sought prior to advertisement and recruitment of participants. The ethics committee raised concern about the process of recruiting young people and the potential complications of them having different definitions of home. This was clarified by the author and measures were taken to ensure the organisation supported the recruitment process which involved disseminating posters to all units within the centre. A young person was invited to give feedback on the design of the poster and amendments were made accordingly. All young people currently residing at their care home had the opportunity to participate in the research.

A set distance of how far young people lived from their local authorities was not a criterion for involvement. As highlighted, the young person's definition of home may vary and subsequently their view of distance may change depending on what is being explored (e.g., feeling close to home when thinking about how long it takes to get home, but far away from home when thinking about friends). Therefore, all young people interested in participating could provide useful contributions.

All advertisement and promotion of the research project took place at the centre. Young people who expressed an interest in the project met the researcher to discuss what was required including issues around consent and confidentiality. Social workers allocated to each young person were asked to assent to participation. Parents and carers were contacted via letter and given the opportunity to 'opt out' and/or raise any concerns about the young person participating.

Once consent and assent were obtained, the interview was scheduled at a convenient time to the young person. All interviews were conducted individually, and all interviews were completed by the same researcher. Interviews took place either within the young person's care-home, or within a building on the campus. All participants engaged in one interview which was recorded by the author. Interview transcripts were anonymised and stored securely on electronic file.

Promotion of the research project continued during the process of interviewing the seven participants. Initial coding of the data suggested repetition of themes and therefore no further participants were sought.

Analysis

Themes were identified at a semantic, explicit level (Boyatzis 1998). The author and a colleague analysed the data, independently and then collaborated and conferred findings following the initial identification of the basic themes. The second analyst (a colleague) helped to ensure the data was being rigorously analysed. The author used reflective logs as part of their role as researcher recognising possible bias and influence. This was particularly relevant given the researcher's situation at the time of data collection, as they were living 'away from home'. Collection of data was terminated when it was felt data saturation had been reached, i.e., when no new themes were being identified (Strauss & Corbin, 1998). The data used was analysed using thematic analysis procedures described in Braun and Clarke (2006) and Attride-Stirling (2001). After transcriptions of the interviews were completed, the data was read carefully, and an inductive approach used to identify initial codes from all data.

The next stage of analysis involved grouping the data that referred to similar topics, with some data being included in more than one category. Basic themes were identified and reviewed to determine organising and global themes. These were named and described. The final stage of the analysis was reviewing the data to ensure the organising and global themes were all sufficiently supported by the data. Quotations in the results section are used to illustrate identified themes around young people's views of being looked after away from home. One global theme, two organising themes, and five basic themes were identified.

Results

The analysis elicited one global theme described below:

Home is 'connections'

Young people defined 'home' in a range of ways, with some reporting it as something not fixed and could change over time. Others related it to where their family lived at any given time, and others described it as where they were born.

After defining home, the principal findings from the data suggested that the physical, geographical distance was not the fundamental cause of young people feeling far away or closer to home.

Young people repeatedly referred to the connections they had to home, either through relationships, the place itself, or the space they had there. The maintenance of these connections contributed towards feeling closer to home, regardless of the actual proximity.

> It’s my family and they love me and they’ve got a room for me in both houses if I go and stay...they have a bed each for me in each of the houses.
>
> I don’t really call anywhere home apart from my family house.
>
> where my Nana and Papa live

Despite young people suggesting home could change over time, the key to defining home was around where those relationships and connections to others were:

> unless they moved [home] would never change

For those young people who had moved more than once, or for those who had been in care for some time, the message of connections to people and places remained:

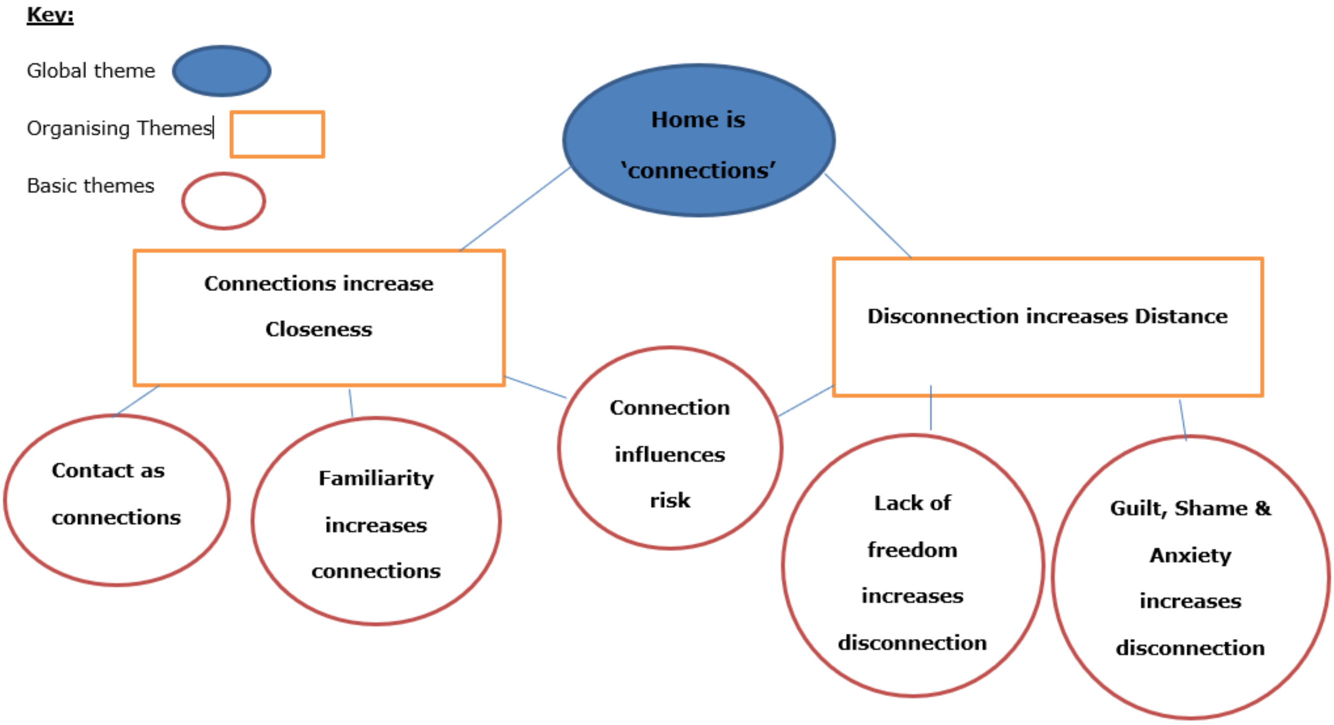
> as you’re younger it’s where you are brought up, your house your home stuff like that but I think as you get older…is where I am now…is probably home.
>
> where you’re brought up…just the school, where your family are based.

For one young person, there was a lack of connection to anyone or any place, and he was not able to identify home as anything other than the place he slept:

> so even if I had to live outside and sleep in a doorway or
> whatever I would still class that as where I lived and my home

Figure 1 below depicts the themes identified.

Figure 1: Global, Organising and Basic Themes Organising and Basic Themes



Two organising themes were identified: *'Connections increase Closeness'* and *'Disconnection increases Distance'.*

Connections increase Closeness

Various factors not directly related to geographical distance or proximity affected how far or close young people felt to home. The connections young people made to a place or through relationships impacted their feelings of closeness to home. This suggests how far or close they felt to home was significantly related to how connected they felt to these things.

Two basic themes relating to the concept of Closeness increasing Connections are described below:

Contact as Closeness/Connection

Young people felt connected to their home through contact. Some of the data suggests that availability and access to contact with friends and family contributed to feeling closer to home, with young people describing how access to resources such as telephone contact and travel led to lesser or greater feelings of distance.

> my family aren't able to come down as much because of the distance.
>
> [Home] it's not that far away it's like a train distance.
>
> [access to phone and speaking to family] makes them feel closer.
>
> allowed to go visit them [family] [reduced how far away they felt].

Young people spoke of how supporting contact through resources may provide a means to maintain the connections which would reduce the feelings of distance:

> maybe having visits with them every so often…a letter would be nice
>
> I think even if we could have Skype or something I could see my mum on a daily basis.

> [Access to your phone]…yeah, it makes them feel closer

> [makes you feel far away]…now I've disappeared and I'm in a secure unit… I can't speak to them on Facebook or nothing so I don't really know who my friends are anymore.

Familiarity increases connections

The theme of familiarity emerged throughout the data with young people reporting how this impacted on their feeling of distance to home.

Unfamiliar accents of staff and young people impacted upon feeling far from home:

> getting used to the accents and all that

Being unacquainted with the residential home, having never visited before also increased feelings of distance:

> when I first came…I'd never been [here] before…so home felt a million miles away, like I didn't know the place

> I didn't know how to get home…it's not always distance'

Lack of familiarity with the type of residential resource the young person was moving to, along with the setting also increased feelings of distance:

> I'd never been to a placement that had six beds…this place was massive, there was a ****, a ****, all these big places and I didn't know how I got here, how to get back home…so it was different.

Young people offered suggestions of how to feel more familiar in their environment so to reduce the feelings of distance from home:

> [felt closer to home]…when I'm sitting around with pictures and stuff…if I've got pictures of home it will make me feel a bit better…because there is a bit of home in my hand

> a lot of the stuff in my room is from home so it makes it feel more homely

> like when the staff kind of sit and talk with you [at supper] …makes you feel a bit more like home before you go to bed…. Because it's just like things that previously happened at my old house.

Disconnection increases distance

Young people spoke in varying degrees about the emotional impact of being away from home. Significant to these feelings was the loss of connection with their family and/or friends:

> I never wanted my sister to come up…I felt ashamed of what it looked like here.

> there's always at least one time of the day when I just feel rubbish because I know I can't be home …. something bad has happened and I can't just go home and make sure everything is ok.

> you'll just feel miserable all the time, just feel worthless and just be like…you don't care.

Lack of freedom increases disconnection

Young people's perceived barriers imposed by being in care contributed to feeling far away from home, which was related to feelings of disconnection from family, friends and/or a certain place:

> [Home]…feels far away…. Well I can't just go and see them [family]

> [family feel] …miles away…because I'm here and I'm not even allowed outside

> [Home]…was like walking distance…I could go and visit whenever I wanted

> It's just the freedom that makes me feel like I'm home or closest to home

Distance influences risk

The two organising themes of 'Connections increases Closeness' and 'Disconnection increases Distance' were linked to one final basic theme of 'risk'. The experience of feeling connected or disconnected (to people and to places) both appeared to impact the young people's risk of re-offending and risk-taking behaviours:

For some young people, feeling low in mood when feeling far away from home influenced their risk-taking behaviours:

> I think there's probably more chance of getting high away from home…. Because I'd just feel rubbish because I wasn't at home.

> [when away from home] you might just start going out doing stupid things like take drugs or something…you could start offending

Young people reported the paradox of how being 'disconnected' to certain things may increase their likelihood of risk-taking, as well as reducing it. Some young people reported that remaining connected and close to negative peer influences when closer to home had an impact on their offending behaviour.

> …you get too carried away…. you can get into trouble…get too confident and get really pally with your friends and you think everything is going good and you get over-confident and then you go and commit a silly crime like I did and get yourself put back in secure.

In addition, data suggested distance and the subsequent disconnect from people and places positively impacted the risk of re-offending as being away from home had allowed time away from peers and time to think about their offending behaviour without negative influence:

> [Distance]…is good because it's gave me a time to rehabilitate and think about what I've done

> [being far away from home]…gave me a chance to change my behaviour…like. I can't just go out and do my own thing when I'm here.

Discussion

Young people's definition of home varied, it was changeable and not necessarily where their local authority was. This is in turn impacted on their view of feeling closer to or further away from home. Any reference to home was based on the young person's definition of home.

The overarching message from this research was that whilst geographical proximity to a young person's home could impact on how close they felt from home, the importance of connections was significant.

Young people highlighted the importance of familiar connections with their surroundings, as well as physical connection with their family and friends through contact when feeling closer to home. Young people's emotional response to being in care, coupled with the perceived lack of freedom and constraints from being in care, was linked to disconnection with family, friends and places and in turn increased feelings of distance to home and the people they associated with home.

The impact of being away from home on young people's risk of re-offending and risk-taking behaviour differed depending on those who felt being 'disconnected' from certain influences was beneficial, versus those who felt losing the connections with others contributed to their risk-taking behaviour.

Findings suggested that whilst proximity of a young person's placement to their home should be considered when accommodating young people, proximity alone does not determine how close a young person feels to home. Supporting young people to maintain the connections they have to people and places may be significant in reducing the feelings of being far away, as well as supporting them to make new positive connections where they currently are placed. Exploring what home means to young people when looked after is also important for establishing where, who with, and how these connections can be maintained.

These findings are perhaps consistent with other research that found young people with experience of residential childcare reported a sense of belonging to people and places not conventionally associated with home or family (Wilson & Milne, 2012). Similarly, Scotland's Independent Care Review (2020) took a holistic view of families, in recognition that children reported a variety of settings and homes felt like family.

If one is to consider the importance of attachment theory in the understanding of relationships, it is perhaps unsurprising that the findings of this research are supported by psychological theory. The 'lasting psychological connectedness between human beings' that Bowlby (1969, p.194) defines is ever relevant in the lives of looked after children. The young people in this research described their feelings of connectedness through their experiences of relationships, despite a lack of proximity. These findings are echoed in the work of Garfat and Fulcher (2012) in their Child and Youth Care (CYC) approach, which states that relationship is the foundation of all CYC work, and that connection is the foundation of relationship.

The significance of connection and its impact on young people's sense of closeness to home further supports Milligan's observations (2003; 2005) that home 'is as much a social and emotional concept as a physical one' (Clark, Cameron & Kleipoedszus, 2014, p.5).

Current guidance (e.g., Moodie, 2015; House of Commons Education Committee, 2016) states that continuity and stability is important in achieving positive outcomes for looked after young people. This supports the finding that young people who feel more familiar in their placement are less likely to feel disconnected from their home and disconnected from relationships. Furthermore, multiple placement moves could potentially contribute towards feelings of unfamiliarity.

The significance of familiarity to young people may serve to highlight the importance of managing the sense of unfamiliarity in advance of any planned move, and in the initial stages of moving to a new placement. For example, supporting the young person to know where their placement is, how they would travel to and from it when visiting 'home', showing the young person on a map so they can see more visually, or supporting and encouraging the young person to have access to items, foods and other things that may contribute towards them feeling more familiar with their new surroundings.

Such findings are in line with literature and guidance around the principles of good transitions for children (Scottish Transitions Forum, 2017) which highlight the importance of young people being at the centre of decisions and that planning and decision making should be carried out in a person-centred way. The principles of good transitions argue it is crucial for young people with additional support needs (such as looked after children) to receive effective co-ordination of transition planning and support at a local level.

The level of resource available to young people and their families, such as contact, access to Facebook or ‘Skype’, accessibility to transport also related to young people’s connectedness and their feelings around distance from home. Whilst there may be risk management considerations around contact and access to such resources, these findings generally highlight the importance of having access and contact to their families and friends so they can feel connected to home. Inevitably, proximity and geographical distance can impact on families’ abilities to travel longer distances for contact. Family members’ health can also contribute towards this, with adverse health issues potentially preventing them from travelling further distances. Residential care services should consider the resources they have available to them and how these could be best utilised to support contact (e.g., Skype, Facebook) whilst still considering relevant risk management factors.

Further related to the concept of ‘risk’, young people held some contrasting views in relation to being disconnected and the impact it had on their level of risk-taking behaviour. A significant issue noted was the emotional impact on being away from home which may contribute to barriers to change their offending behaviour as well as leading to potential increase use of substances to manage their feelings of hopelessness. However, the positive impact of distance was also noted, with reports that distance led to reduced contact with negative influences that had previously contributed to their offending behaviour. Those with responsibility should therefore consider the potential positive and negative impact of moving a young person from their home and determine on an individual basis what would best meet their needs. Collaborating with young people about what they feel may reduce their risk when exploring suitable placements is recommended where possible. What supports and reduces risk for one young person may well increase the risk for another.

Whilst proximity to home did not appear an overwhelming factor to young people in relation to how close, or far, they felt, it still held relevance in relation to contact with family which in turn affected their feelings about their placement. The research suggests that when considering placing young people away from their home, distance should still be considered, but more importantly the impact this distance may have on their risk of offending (if relevant) and how familiar they feel with the placement should be prioritised when identifying placements.

Perhaps, when making decisions about young people’s placements, if those making decisions see ‘home’ as being an important resource and contact with family and friends as a positive, stabilising factor, then it may emphasise the importance of proximity to home. However, as such findings appear anecdotal, proximity to home is not necessarily always deemed a ‘resource’ or positive for certain young people, either in terms of current placement stability or future outcomes. In which case, it puts in to question the relevance of the guidance that suggests proximity to home is important and emphasises the significance of considering the young person’s definition of home. Quantifying where the young person feels a sense of connection is perhaps more relevant than a geographical location.

When interpreting the current findings and making recommendations it is important to note limitations. This study presents the views of seven young people who were living in the same residential care setting at one moment in time. It is a small number, and it would be beneficial to compare the views of more young people across different settings, to consider if these findings were specific to the care setting or if they can be generalised across residential care placements across Scotland and wider.

It is also relevant to consider the influence of the researcher in this study and the potential for bias in interpreting and analysing the findings. Whilst the researcher was conducting this study, she herself was living ‘away from home’ and the potential for her experiences to influence her interviews, and her view of the analysis are recognised. To manage this, regular supervision and reflection took place and the researcher kept regular reflective logs during the whole process of the study.

Essentially, the literature highlights the need to explore in more detail the criteria that connects children's characteristics and circumstances when considering placements (Doran & Berliner, 2001). Such criteria should include but not solely focus on geographical proximity to home, family, and resources, including all that is encompassed in the young person's definition of 'home'.

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About the author

Carrie Mclaughlan is a forensic psychologist in training and has worked in her local authority for over 15 years within youth justice, as well as periods working in residential care including secure care settings. She continues to work as a practitioner as well as offering consultation and advice to social workers and voluntary agencies.

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Quality is everyone's responsibility: Applying implementation science to residential child care

Miriana Giraldi, Alexander McTier and Robert Porter

Abstract

With millions of children worldwide living in alternative care settings, this article applies the learning from implementation science to advance the sector's thinking around what needs to be in place to ensure consistently high-quality residential care. Building on the quality indicators identified by Farmer et al. (2017), an international review of the residential care literature (Porter et al., 2020) and focusing on smaller residential care settings, the article discusses how the eight implementation drivers within active implementation (Fixsen et al., 2005; 2019) can encourage a more nuanced, multi-dimensional understanding of what is needed to enable quality in residential child care. Greater attention to value-based recruitment of staff; the coaching of staff; the collection, analysis and use of meaningful data; and feedback loops from the practice level to engaged and adaptive leadership all emerge as areas for further attention. The article concludes by asserting that implementation science can constructively challenge the planning and delivery of residential care and, importantly, do so in a manner that recognises the different contexts, settings and environments in which residential care is provided to children and young people internationally.

Keywords

Residential care, active implementation, implementation science, quality care, children's rights

Corresponding author:

Miriana Giraldi, International Associate, CELCIS, miriana.giraldi@strath.ac.uk

Introduction

Millions of children worldwide continue to grow up in various forms of alternative care. While providing early support to families to prevent separation is rightly the first objective within child protection and alternative care systems worldwide, there remains a need to better understand how residential care fits within the range of options envisaged by the UN Guidelines on Alternative Care of Children (Guidelines for the Alternative Care of Children, A/RES/64/142, henceforth 'the Guidelines'). This need arises from the ongoing use of residential care worldwide, which requires us to ensure that it is 'specifically appropriate, necessary and constructive for the individual child' (UN Guidelines, para 21).

An international review of the residential childcare literature conducted by this paper's authors (Porter et al., 2020) found that there are many variations of residential care worldwide, relating to different national settings, systems, and terminologies, not always clearly distinguished in the literature. While residential care encompasses all non-family-based care, not all forms of residential care are suitable. In this article, we propose that the multiple forms of residential care can be grouped into two distinctive groupings: institutional care and (quality) residential care. Institutional care encapsulates care provided in large settings, often isolated from the broader community, housing high numbers of children, with high child to caregiver ratios, and mainly attending to children's physical needs, rather than their psychological, social, and emotional well-being and development. Residential care is more individualised and provided in smaller, 'family-like' settings, with fewer children living in these settings and low child to caregiver ratios. Such settings offer greater opportunity for stable and meaningful relationships between children and their caregivers to form, and for children to maintain connections within the wider community. We highlight this distinction as there is widespread agreement in international policy, evidence and practice that institutional care is unsuitable and needs to be phased out. Accordingly, this paper focuses on quality within residential care and the added value that implementation science can bring to ensuring quality in these settings.

Much remains to be understood about how residential care fits in the care system today, for whom it may be the most desirable care option, what factors constitute quality care, and how such quality factors can then be delivered consistently. The Porter et al. (2020) international review of 111 papers spanning data from 68 countries found that only a limited literature exists that specifically considers what constitutes quality in residential childcare. This paper therefore seeks to contribute to the wider literature by first drawing on the Farmer et al. (2017) review into quality in residential care and the quality domains they identify, before introducing and learning from a related and growing field of international social science research – namely, implementation science. In particular, we focus on how the use of the implementation drivers (Fixsen et al., 2005; 2019) can advance our knowledge of what needs to be in place to achieve and maintain quality residential care. The paper concludes by considering what implementation science offers in terms of understanding high quality practice within residential care and provides direction on priorities for future research.

In approaching our analysis, we take as a starting point considerations of what all children need to thrive, to help us understand how residential care – and the alternative care system as a whole – can support healthy development. Attending to children's specific needs, such as providing services to address early trauma and attending to the circumstances that lead children into alternative care in the first place, needs to be conducted on a foundation of what all children need, in order that residential care can be a place where children thrive.

Quality in residential childcare

Farmer et al. (2017) conducted a literature review from which they proposed a framework for looking at quality. It highlights four key domains of quality within residential care: setting, staffing, safety, and treatment. A fifth domain – outcomes – was also identified but was not widely discussed or articulated. When looked at collectively, the domains identified by Farmer et al. (2017)

contribute to quality care based on enduring, loving relationships and the realisation of children's rights.

Looking at each of the quality domains individually, it is clear that setting is one of the more prominent domains discussed in policy and practice. This encompasses the physical construction of the residential setting, the connections and integration within the wider community, and the routines and rules which shape daily life and activities. Generally, the greater the extent to which these elements replicate or produce a family environment, the higher the quality achieved within this domain (Garcia-Quiroga & Hamilton-Giachritsis, 2017; Llosada-Gistau et al., 2017).

Safety is the most regulated of the domains proposed and is frequently cited where there are failings of residential care (Farmer et al., 2017). The physical safety of children and young people within residential settings is often the subject of legislative direction and may also be impacted by health and safety legislation related to workplaces or places where the state is responsible for physical safety. Aspects within the safety domain include rules and structures (Swerts et al., 2019), discipline processes (Steels & Simpson, 2017), and freedom from abuse (Sherr et al., 2017).

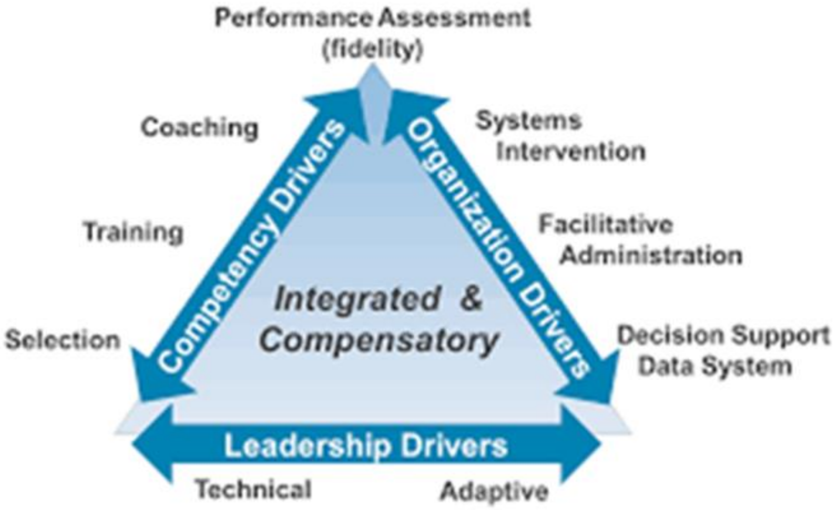
Conversely, staffing is less commonly considered and, where it is, often focuses on staff certification, qualifications, and turnover (Colton & Roberts, 2007; Curry et al., 2013). However, caregivers represent a critical factor in the quality of care provided within residential settings (Chernego et al., 2018; Garcia-Quiroga & Hamilton-Giachritsis, 2017; Steels & Simpson, 2017), with caregiver affect and relationships with young people, alongside more examined areas such as training (Mota et al., 2016), retention (Bailey et al., 2019), and children to caregiver ratios (Batki, 2018), all important.

Finally, the treatment domain is highlighted as a complex yet essential component of quality residential care. The high probability that children and young people will have experienced significant trauma in their lives prior to admission to residential care makes therapeutic processes essential to providing quality care (Bailey et al., 2019), and understanding and openness to trauma informed practices has increased within the residential care sector (Galvin et al., 2020). Farmer et al. (2017) highlight treatment as the central domain of quality residential care, and indicators of quality may include using an evidence-based treatment (Gander et al., 2019), having a focus on child agency, rights, growth, and development (Hueche et al., 2019), and maintaining appropriate family-like routines (Mota et al., 2016).

Implementation science

In light of the limited literature dedicated to quality in residential care, this paper contends that implementation science can be used to advance our knowledge of what needs to be in place to deliver quality on a consistent basis. For those readers new to implementation science, Blasé et al. (2012) define it as 'the study of factors that influence the full and effective use of innovations in practice. The goal of Implementation Science is not to answer factual questions about what is, but to determine what is required'. Implementation science can therefore address the widely experienced scenario of the knowledge of 'what works' not filtering down to practitioners or only being adopted slowly (Ghate, 2016). Within implementation science, a widely used framework to help ensure consistent, high quality delivery of innovations, practices and programmes is the drivers' framework (Fixsen et al., 2005; 2019; see Figure 1).

Figure 1: Drivers Framework within Active Implementation



Source: Fixsen et al. (2019)

Not to be confused with the drivers' diagram used within improvement methodology (Langley et al., 1996), the drivers framework consists of three clusters of infrastructural factors, attending to competency, organisational and leadership factors that the evidence finds need to be in place to implement practice as intended and achieve improved outcomes (Bertram et al., 2015; Fixsen et al., 2019). These are selection, training, coaching, systems intervention, facilitative administration, decision support data system, technical leadership, and adaptive leadership (see Figure 2). Implementation as intended is conceptualised by the term 'fidelity', with each driver contributing towards achieving fidelity, as individually and collectively the drivers are designed to ensure that the competency, organisational and leadership factors are all in place so that implementation can happen as intended. Attention to the eight drivers is also found to support the sustainability of the practice (Bertram et al., 2015; Kaye et al., 2012).

Figure 2: The Eight Implementation Drivers

Competency Drivers	
Selection	The goal of the selection driver is to select the 'right staff' who are ready, willing and able (Fixsen et al., 2019; Kaye et al., 2012). Acknowledging that selection may come from individuals both new and existing to the organisation (Aarons and Palinkas, 2007; Kaye et al., 2012), the selection driver requires attention to the skills, qualifications, attitudes, values and coachability of potential recruits (Bertram et al., 2015; Fixsen et al., 2019). Of these, implementation science places greater emphasis on the personal qualities of individuals, as opposed to their qualifications and employment history. Bertram et al. (2015), for example, highlight the importance of assessing for individuals' values such as compassion and empathy, and of assessing for coachability with regards to their openness to receive coaching, feedback and data. Aarons and Palinkas (2007) also highlight the importance of selecting for personal qualities, such as those who can demonstrate perseverance, flexibility and experience.

Training	Training follows selection and its goal is to teach practitioners the knowledge, skills and abilities required to deliver the practice (Fixsen et al., 2019). In doing so, training should include adequate information to help practitioners understand why the practice is necessary and likely to be effective, as well as allow for some shared exploration and feedback in how the practice is delivered (Fixsen et al., 2009). Indeed, Aarons and Palinkas (2007) and Bertram et al. (2015) find that training is best delivered where it involves opportunities to practice and apply the learning as well as didactic explanation, and is provided by competent, experienced, and flexible training staff who can provide supportive, constructive feedback in a safe learning environment. The intended outcome of the training driver is for all practitioners to have a shared knowledge of the children and young people to be supported, the rationale and theory of change for the practice, the practice itself broken down to its key elements, activities and phases, and its intended child and young person outcomes (Bertram et al., 2015).
Coaching	Coaching is distinct from training and is the continual cycle of providing information, consultation, and feedback to practitioners as they implement practice changes (Fixsen et al., 2009). Through 'on the job' coaching, practitioners advance from having knowledge of a practice to being able to apply their learned skills and practice at a consistently high quality (Fixsen et al., 2019; Margolies et al., 2021). As a process, coaching should consist of direct observation of the practitioner to accurately assess and then provide feedback on their skills, delivery and judgement (Bertram et al., 2011; Burkhauser & Metz, 2009). The observer (i.e., the coach) ought therefore to be an experienced practitioner who is expert in and can model the practice, can assess quality of practice, and build constructive and instructive relationships with those that they are coaching (Burkhauser & Metz, 2009).
Organisational Drivers	
Facilitative administration	Facilitative administration focuses on the internal organisational factors that best support practitioners to practice as intended, such as practitioner caseloads and allocations, staff rotas, length of

	sessions with children and families, access to IT, and availability of training and coaching (Fixsen et al., 2019; Margolies et al., 2021). Sitting below the senior leadership level, facilitative administration often lies with operational managers who listen out for organisational factors that inhibit high quality practice and then act on these.
System intervention	If facilitative administration focuses on internal organisational factors, system intervention relates to an organisation's external environment and the wider system(s) in which it operates. Given that residential childcare is part of a multi-agency children's services system, addressing discontinuity and seeking alignment across different partners is critical (Jonson-Reid, 2011). The system intervention driver revolves around strategies for working with external systems or organisations to ensure the availability of the financial, organisational and human resources required to support implementation of practice (Fixsen et al., 2009). For example, if selection of new staff is affected by shortcomings in universities' social work curricula, the system intervention driver would involve engaging with higher education leaders and influencing their curricula. System interventions can span local, regional, national and even international systems, meaning that some issues may be resolved quickly but others may take many years (Fixsen et al., 2019).
Decision Support Data System	A decision support data system (DSDS) is a low burden system for identifying, collecting, organising, and analysing data that are useful to the staff, coaches, managers and leadership implementing a practice (Bertram et al., 2015; Fixsen et al., 2019). Spanning process, fidelity, capacity and outcomes data (Fixsen et al., 2019), the data system needs to provide timely, accurate, and reliable data for decision-making. Indeed, for data systems to truly become DSDSs, attention is paid not only to what data is collected but also how the data is used and analysed in a timely fashion to inform decision making and improvement at the individual child and practitioner level up to the strategic leadership level (Bertram et al., 2011).
Leadership Drivers	

Technical leadership	Technical leadership is most needed in circumstances characterised by greater certainty (Bertram et al., 2015). For example, there is agreement about both the nature of the challenge and the correct course of action, and a precise answer can be provided. In this respect, Heifetz et al. (2009) note that technical challenges may be complex, but can be addressed by current knowledge, expertise and structures.
Adaptive leadership	Adaptive leadership is most needed when there is greater uncertainty and the problems and their solutions are less clear (Fixsen et al., 2019). In these situations, Heifetz and Laurie (1997) identify the need for six broad approaches: *getting on the balcony* (to see the bigger picture), *identifying* (and understanding) *the adaptive challenge*, *regulating distress* (so striking the delicate balance between having people feel the need to change and having them feel overwhelmed by change), *maintaining disciplined attention* (with a collective, joined-up focus that overcomes diverse values, views and experiences), *giving the work back to the peopl*e (so that all staff can assume responsibility for changes), and *protecting all voices* (as change can come from all levels in an organisation).

There are examples in the literature of the drivers framework being used to good effect, particularly in the implementation of evidence-based practices in new settings (see for example Margolies et al., 2021), but this article takes a forward look by considering how the drivers' framework could help facilitate the consistent implementation of 'quality' residential care and inform stakeholders on the features to look for when assessing whether quality residential care is in place. The next section therefore discusses each of the five quality domains identified by Farmer et al. (2017) in the context of what the implementation drivers can bring to their understanding and application.

Implementation science’s contribution to quality in residential childcare

When we look at the components identified by Farmer et al. through an implementation frame, we can see that there are a range of drivers that need attention to facilitate the successful and long-term implementation of high-quality care. It is important to note that we are not suggesting that the activities we discuss here are ‘new’ or have not been attended to already. However, learning from active implementation indicates that it is not enough to look to one or two of these drivers, but rather that they all need to be in place for the desired practice to become successfully embedded in the long term.

Setting

The creation of a setting which is conducive to quality care requires us to think about setting through a variety of perspectives. We need to think beyond the immediate physical space in which children and young people live, to incorporate the wider community setting and connections to it, as well as the social structure and setting, the rules and routines that govern daily life, and that contribute to creating a familial, home-like atmosphere. This wider perspective highlights the influence that a range of drivers can have on helping or hindering the development of a high-quality setting.

At first glance, the competency drivers may not appear particularly applicable to setting quality yet incorporating the social structure and community aspects highlights the importance of considering setting factors when recruiting and training staff. The right value base and approach to children and young people, risk, and rights will facilitate the creation of a positive, high quality, social setting. Staff who are dogmatic and like a high degree of control and authority are less likely to produce a family-like setting which allows children and young people to express themselves. The creation of constructive routines that provide stability and predictability for children and young people also contributes to the setting.

While staff and their shared understanding between children and young people can influence setting, often it is organisational drivers that have a direct impact on it. For example, practice and policies which heavily regulate interactions with children and young people may detract from the nurturing of strong, stable relationships and the creation of a high-quality setting. Alongside regulation, attitudes towards risk are likely to heavily influence the degree to which children and young people in residential care feel, and are facilitated to become, integrated into their communities, or able to maintain established connections, such as through school, extracurricular activities, or with their friends. Attending out-of-setting activities may require greater flexibility in the hours that staff work and the activities that they are expected to be engaging in. Developing a new approach to risk which incorporates a trusting relationship with the child, and recognition that restricting opportunities to integrate into the community is a risk in itself (Duncan, 2020). These can be organisationally challenging and rules and procedures around authorisation, consents, or risk assessments (issues which might all be addressed through attention to facilitative administration drivers) are likely to limit the opportunities available to children and young people.

The quality of care can also be improved through focusing on the setting domain. Thinking about how the setting can respond to children and young people's needs can drive improvements and innovations, such as the establishment of therapeutic spaces (e.g., sensory rooms) and the opportunity for young people to express themselves (e.g., decorating personal spaces).

Leadership also has a role to play here, in acting as a champion for the values which are claimed by the setting. Children's rights represent a crucial component of care settings, and leadership which recognises and actively pursues the realisation of children and young people's rights to be involved in decisions affecting their lives, and values the autonomy of the children and young people in their care, can empower staff to embody these values, and to implement them in practice.

Safety

Implementation science teaches us that recognising and understanding the ‘invisible infrastructure’, the complex system within which organisations operate and implement programmes, is crucial for programmes and innovations to be successfully implemented as intended, and sustainably so over time. It also stresses the importance of co-creation, the desirability of working together alongside policy makers and practitioners to harness their respective knowledge and know-how (Ghate, 2016).

This is particularly relevant when considering the domain of safety, which as noted earlier, is the most regulated one, requiring services to abide by policies and legislation, as well as to rules and regulations set at the organisational level. Keeping in mind what is good and necessary for all children and young people and what conditions need to be in place for their healthy development can help us think about safety and how it is ensured in a residential care environment in such a way as to move away from a focus on risk mitigation towards a focus on all relational aspects, between children and caregivers, as well as among children and young people. This builds on the notion that stable, loving relationships and healthy routines are at the heart of quality residential care, so safety can be ensured by putting arrangements in place that are based on trusting relationships rather than over-relying on rigid rules and structures.

Additionally, given the importance of caregivers’ expertise, values, affect, and attitudes, the question of safety needs to be pondered alongside considerations of professional autonomy and discretion. While rules and clear daily routines aimed at creating positive group climates contribute to enhanced safety and are therefore positive strategies that facilitate the delivery of quality care, (Farmer et al., 2017; Leipoldt et al., 2019) bureaucratic requirements and rules and regulations should not hinder professionals’ practice.

The literature highlights the importance of a positively focussed-motivational system, and indicates how, for example, the use of humour is highly valued by children, as are positive reinforcements of good behaviour (Farmer et al., 2017). Caregivers need to be able to use their knowledge, professional skills, and judgement to be physically and emotionally available for children and deliver relational based practice. A number of implementation drivers can support in this area: at the organisational level, both facilitative administration and leadership drivers can play a role in ensuring that practitioners are supported in their role and in delivering the practice to the best of their ability, while also allowing for a level of autonomy so that adaptations based on context can happen. The competency drivers of training and coaching are also useful in this domain, as they can help caregivers gain a solid knowledge and understanding of the practice and of the children they work with and are actively supported and encouraged to improve through coaching, observation, and feedback.

The literature highlights the importance of involving children and young people in assessing not only the quality of their care, but also their quality of life and their well-being. (Farmer et al., 2017; Llosada-Gistau et al., 2017; Swerts et al., 2019). Additionally, involving children and young people in collaborative planning, including in areas concerned with the mitigation of risk, can contribute to strengthening practice and quality of care (Johnson et al., 2017). In this domain, young people stress the importance of trusting relationships, being listened to, lack of judgement and feeling that someone cares for them as essential, as is the availability of peer support (Johnson et al., 2017). Farmer et al. also note that lesser reliance on restraint is associated with more positive longer-term outcomes. This invites us to think about co-production of care services as going beyond engagement between policy makers and practitioners, to creating and nurturing opportunities for service users (i.e., children and young people) to be actively involved in service planning and ‘quality assurance’. Competency, organisational and leadership drivers can help services create opportunities for children and young people to provide their views on their care and ensure that this feedback is listened to and acted upon.

Staffing

The individuals who care for children and young people in residential settings clearly have a critical role to play in ensuring that high quality care is provided. Accordingly, the quality domain of staffing is one which has previously received significant attention in terms of attending to the recruitment, training, qualifications, and retention of staff (Colton & Roberts, 2007; Curry et al., 2013). However, below the skin of these practical components, are the less tangible qualities or opportunities that residential carers need in order to provide high-quality relationship-based care: the space to provide trauma-based care (Baker et al., 2018); the right motivation (Beckler, 2014); and the empowerment to provide individualised care (Cameron & Das, 2019). Too often, however, these elements are looked at from an individualised perspective, asking the question ‘how can the residential worker provide better quality care’? Active implementation stimulates a slightly different question: ‘What is needed to enable quality in the staffing domain to be achieved’?

Active implementation consequently encourages us to look beyond the more immediately relevant selection, training, and coaching drivers. These drivers remain key to quality staffing, and attention to selection on the basis of personal qualities and beliefs (Levy & Reuven, 2017) and the provision of high-quality training and coaching (Hueche et al., 2019; Baker et al. 2018) are significant factors in the provision of high-quality staffing. However, we also need to consider other organisational and leadership factors that are comparatively neglected in thinking about improving staffing. At the individual practitioner level, for example, they will be supported by facilitative administration and appropriate leadership. If quality care requires individualised approaches for each child and the opportunity to develop relationships with key individuals, then workers need not just the training and coaching to support their work, but a working environment that enables and facilitates these. Accordingly, we also need to attend to the organisational drivers to ensure successful and long-term implementation of quality in the staffing domain.

Facilitative administration might support quality staffing by providing flexible scheduling of staff to ensure that key relationships are not just possible, but actively promoted and facilitated through ensuring that shifts coincide with opportunities to spend time with the child or young person. Facilitating flexible working that allows individual children and workers to build interests, skills and hobbies together, further supporting the development of positive relationships. This includes providing staff with the permissions to provide the care that they think is necessary for each child and gives them the freedom – and protection –

to take ‘risks’ which may result in perceived ‘failure’ to support the tailored individual care for every child or young person. Reductions in paperwork, risk assessments and authorisations for activities can represent an administration striving to facilitate high quality, individualised care for all their young people.

At the organisational level, factors such as consideration of support for staff, supervision, promotion of professional self-awareness, provision of mental health benefits, adequate holiday and working conditions will help ensure that caregivers are available for the children, both physically and emotionally.

Systems intervention requires us to think beyond the individual worker, and even beyond an individual setting, to try and effect change in the ecosystem within which residential care operates. The policy drivers which influence residential care relate to national strategic aims in respect of providing care for children and young people at a national level. The development and proliferation of quality care in residential settings requires that appropriate attention is paid to developing policy which makes the space in which quality can flourish, and which rewards and promotes quality initiatives.

Treatment (or Therapeutic Approach)

The fourth of the Farmer et al. (2017) quality domains is entitled ‘treatment’, a term that reflects that their article centred on the learning from the Teaching Family Model, which they refer to as ‘a specific treatment model’. It is on this basis that Farmer et al. use ‘treatment’ as the fourth domain name. However, we propose using a more inclusive, non-medical and international term for the domain – namely, ‘therapeutic approach’; while another option might be ‘evidence based programme’. Irrespective of the name of the domain, Farmer et al. find it to be a central but complex component of quality care. The strengths, trauma and needs of each individual child needs to be assessed, the most appropriate therapeutic approach selected, and then from an implementation science perspective there needs to be firm attention to ensuring the therapeutic approach is delivered as intended.

In this context, the concept of fidelity is particularly relevant to the delivery of identified therapeutic approaches. Attention to the competency drivers will mean that staff are selected with the values and skills that align with the approach, and then have the training and support to deliver it as intended (Cameron & Das, 2019; Hurley et al., 2017). The organisational drivers ensure staff have the administrative, data, funding and policy environment that is conducive to work in (Bertram et al., 2015; Kaye et al., 2012). Leadership helps to ensure the purpose and means of delivering the therapeutic approach are articulated clearly and can then attend to and resolve any technical aspects related to the approach’s implementation, which might include affirming adaptations so that individual children’s needs are met within the parameters of the approach. In summary, the striving towards fidelity provides a clear focus to each of the activities within the eight drivers and, by doing so, will help achieve positive outcomes for children.

Outcomes

Outcomes is the fifth quality indicator identified by Farmer et al. (2017) but one that is separated out and under-developed compared to the four other domains. By treating outcomes as distinct, Farmer et al. (2017) are reflecting the widely found disconnect in the literature between delivery and the outcomes to be achieved through delivery; very much akin to the disconnect between the desire for headline, long-term outcomes, yet little attention to shorter-term indicative measures that can help evidence whether progress towards those outcomes is being made. A key contribution that active implementation can therefore make to the design and delivery of residential care is that the collection, analysis and use of data is a core aspect of high-quality practice and service delivery. Indeed, data are not only collected for the measurement of outcomes but also for measures relating to the scale, quality of and capacity for delivery (termed ‘process/inputs’, ‘fidelity’, and ‘capacity’ measures respectively within active implementation). Conceptualised within active implementation as the decision support data system (DSDS) driver, this multi-faceted collection and use of data helps to ensure there is no disconnect between delivery and the measurement of the outcomes to be achieved.

While active implementation encourages the collection of data under the domains of process/input, fidelity, capacity and outcomes data, this approach does have relevance and application to the Farmer et al. (2017) quality indicators of staffing, safety, setting and treatment.

- For setting, a key measure due to the importance of small-scale, family-based settings would appear to be child to staff ratios, but other measures could extend to assessments of how nurturing a residential setting is. For example, Robinson and Brown (2016) set out an environmental checklist for residential settings to assess how space, light, smell, and other sensory elements can support or affect children and young people, and McCool (2008) and Wilson (2013) highlight the importance of assessing how settings communicate with children and young people.
- For safety, and with overlaps with staffing measures below, measures might include child-staff ratios and staff completion of mandatory training and qualifications, while observations of practice can provide managers with quality assurance as well as fidelity data.
- For staffing, process/inputs data measures might include staff recruitment, retention, sickness, absence, and vacancy levels; while fidelity measures can be taken from observations of staff practice and direct feedback from children about their experiences of the care they receive. For example, do they feel listened to? Do they feel supported? Do they feel loved?
- For treatment (or therapeutic approach), fidelity measures, such as observations of staff practice and direct feedback from children, can evidence whether practice is being delivered as intended. However, therapeutic approach can also extend beyond the quality of practice and include the capacity within a residential setting to implement a new approach. Implementation capacity measurement tools can therefore be used to assess the extent to which an implementation team is, for example, in place to embed a designated approach within a setting.

Active implementation encourages a more comprehensive and creative approach to the collection and use of data. It is an approach that extends beyond only collecting what is easily measurable (e.g., staff attendance at a training course) to one that attends to the measurement of quality and what truly matters to children. In doing so, existing administrative data is complemented and enhanced by observational and experiential data from children and young people, staff, and coaches to collectively provide insights into staffing, setting, safety, therapeutic approach, and outcomes. As a final point however, and one relating back to the competency and leadership drivers, this approach to data does require a staff and management group that is skilled and enlightened to the value of the data in helping to inform future improvements.

Conclusions

This paper has sought to contribute to the limited literature dedicated to what constitutes quality in residential care by considering the value that an implementation lens brings. Building on the quality domains identified by Farmer et al. (2017), the paper has sequentially discussed how the eight implementation drivers (Fixsen et al., 2005; 2019) and the concept of fidelity provide a more nuanced understanding of what is needed to enable quality in residential care. In doing so, the paper highlights the need to move beyond the more immediately tangible factors of, for example, recruitment of certificated staff, child-staff ratios, and the presence of policies and procedures, to consider in greater detail the complex environments in which residential care workers operate in. With the prompts provided by the implementation drivers, we can start to ask questions of whether the training, coaching and observations, day-to-day flexibilities and permissions, IT, data, and leadership supports are truly in place for workers that enable them to deliver high quality residential care to children on a consistent basis.

The paper also underlines some of the critical contextual factors that impact on service delivery and the ability of services, and all those that work within them, to achieve their stated goals. These include an understanding of the broader context and systems, and all the ways in which they can impact individual organisations and the services they provide. The presence of a feedback loop between practitioners, policy makers, and children, young people and families that rely on services can help ensure these are actually leading to intended outcomes, and that policies and plans can help create and adapt child protection and alternative care systems to respond to the needs of each child.

In this respect, collection, analysis and use of meaningful data can support not only delivery of specific services, but also monitoring of progress towards targets set within national or international policy initiatives, such as the Sustainable Development Goals. Goals to eradicate poverty, ensure health and well-being for all, provide access to inclusive and equitable quality education, promote inclusive economic growth, reduce inequality, and promote peaceful, just, and inclusive societies are particularly relevant for children in out of home care, and their families and communities. Collection and analysis of meaningful data would ensure that all children are counted, including those in out of home care, and thus ensure that efforts towards leaving no one behind are truly meaningful and measurable.

The planning and delivery of residential care services for children is the lot of policy-makers and practitioners worldwide, across widely different economic, social, and cultural contexts. Implementation science helps us understand that the implementation or replication of appropriate services or programmes is not sufficient; they also need to ‘function in context-sensitive ways’, and adapt to local circumstances, reflecting local practical considerations or cultural preferences (Ghate, 2016). Effective practice relies on practitioners in the field making use of their own professional skills and judgement, and this is a factor leading to successful achievement of outcomes (D’Andrade, Austin & Benton, 2008 and Chambers et al. 2013, cited in Ghate, 2016.). This is particularly relevant when considering the provision of ‘technical assistance’ to support efforts towards reforms of child protection and alternative care systems in third countries.

Researchers have a significant role to play in the exploration of implementation and quality within residential care. While Farmer et al. (2017) provide an outline of quality, there is still a lot of work to be done to determine what aspects of each domain are the most influential, the degree to which these are inter-related, and, crucially, how quality is experienced by children and young people. Attention to rights is required in research as much as practice, and researchers should continue to work alongside children and young people to learn about how individual quality domains and changes within them are experienced, and to develop ways of working that attend to the views, wishes, and needs of children and young people in residential care.

For practitioners, the implementation literature provides guidance in how the environment in which care takes place can be adjusted to maximise the chances of change taking place in a sustainable manner. The literature on quality also highlights the critical focus on creating opportunities for children and young people to develop the stable loving relationships that they need to thrive (see Duncan, 2020). However, the implementation literature also teaches us that this is not the work of a single individual practitioner, manager, or organisation. While some change may be within the locus of control of some individuals, systemic change and improvements in quality will only be achieved through all actors working in concert to deliver the change that children and young people in residential settings deserve.

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About the authors

Miriana Giraldi is international associate at CELCIS and has a background in European and international policy. She is interested in strengthening the evidence base to inform policy and practice.

Dr Alexander McTier is an evidence and evaluation specialist at CELCIS and has used active implementation approach in working to enhance children's services data.

Dr Robert Porter is research lead at CELCIS. He conducts a range of research projects in relation to alternative care. @bobbporter

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The story of the first-ever care experienced history month

Charlotte Armitage

Abstract

The first-ever Care Experienced History Month took place in April 2021. Announced in Scotland in September 2020, Care Experienced History Month was celebrated across the world by Care Experienced people and their allies. The month aimed to draw attention to the rich and far-reaching history of Care Experienced people by connecting the past with the present and sharing the legacies of Care Experienced people who lived before us. This article explores the process that led to the creation of Care Experienced History Month, worldwide collaborations involved in the delivery of the month, the overall aims of the month, and an overview of the content created and shared throughout April 2021.

Keywords

Care Experienced, history, culture, Scotland, Care Experienced History Month

Corresponding author:

Charlotte Armitage, Public Affairs Officer, The Scottish Parliament, @charlottearmit7

Introduction

Care Experienced people have existed in societies across the world since the earliest forms of civilisation. As far as records go back in history, Care Experienced people can be found. The oldest existing codes of law, from the Third Sumerian Dynasty of Ur, featured laws protecting orphans (Finkelstein, 1968). The Greek philosopher Plato wrote extensively about orphans and, of course, his student Aristotle was himself an orphan (Internet Classics Archive, n.d.; Rist, 1989). Why is this important? Well, simply put, this recognition tells us that we have been trying, for millennia, to get it right for Care Experienced people. Since the end of the Second World War, there have been constant attempts to reform and improve the 'care system'. The most recent attempt in Scotland was the Independent Care Review, which was different in that it was largely led and shaped by the opinions and experiences of adults and children who had lived, or were living, in care. Care Experienced History Month is likewise led by Care Experienced people, with support from allies. It continually strives to report on the history of care from the perspectives of Care Experienced children and adults.

I am a Care Experienced young woman. That means I have experienced state intervention in my life. As a teenager, I experienced foster and kinship care. My Care Experienced peers might have lived in a residential or secure unit, been in kinship or foster care, lived at home with the involvement of social workers or were adopted. The term Care Experienced, I believe, originated in Scotland, and arose from a consultation with Care Experienced people by Who Cares? Scotland in the campaign which led to the Independent Care Review. Throughout history, Care Experienced people may have been referred to as orphans or foundlings, among many more derogatory terms.

At the time of the launch of Care Experienced History Month, I was an employee of Who Cares? Scotland for four years. It was during my employment here I began researching the history of Care Experienced people in Scotland, and then across the world. This research subsequently led to the idea of hosting an entire month of activity dedicated to telling the history of care from past to present; sharing the stories of Care Experienced people throughout history and honouring the legacy left behind by Care Experienced people no longer with us. The idea came to life in April 2021, in Scotland and indeed across the world, with the official launch of Care Experienced History Month.

This article will examine the process that transformed an idea into an internationally recognised and celebrated campaign. It will explore the UK-wide and international connections and collaborations required and created to ensure the month's success. I will outline the aims of the project at the beginning and explain how and why these aims developed with the assistance of Care Experienced people, academics and organisations involved who inspired a new focus as planning progressed. Finally, I will share an overview of the content produced in advance of and throughout April 2021, specifically focusing on the content that stood out to me the most as the project lead.

Laying the foundations

I started exploring the history of care in 2018. My research initially focused specifically on Scotland and went no further back than the 20th century. The scope of my research naturally expanded to going further back into the past and soon included the United Kingdom, and then was followed by several other countries as I found myself discovering moments in the history of Care Experienced people in Australia, the United States, and other imperial colonies of Great Britain.

I was struck to learn the first record of Care Experienced people in history dated back to 2047bc, under the rule of Sumerian King Ur-Nammu of the Third Dynasty of Ur who created the oldest surviving codes of law which included the protection of orphans (Finkelstein, 1968).

It was at this point it became clear to me that the history of Care Experienced people dated back thousands of years, in all corners of the world, and yet so little of this history was understood to be the history of Care Experienced people and consequently had often been overlooked.

In February 2020, my findings were collated and transformed into an incomplete timeline of the history of care in Scotland. This was then developed into a facilitated session that was delivered on Care Day, presenting an introduction to the history and culture of Care Experienced people in Scotland to the First Minister, Nicola Sturgeon, and Scottish Labour Leader, Richard Leonard. This event was important in laying the foundations of Care Experienced History Month as it revealed that senior politicians had an appetite to understand how care, as we know it today, came to be and showed they were interested in hearing the lessons in the present day that are still to be learned from the history of care in Scotland.

An elevated session including moments in the global history of care was delivered in July 2020 to the International Federation of Social Workers' annual conference. The input was met with curiosity from participants from across the world, who expressed a desire to understand the history of Care Experienced people in their respective countries. This feedback and the feedback from the Care Day event, coupled with the collated findings from my research, solidified my personal realisation of the universal need for Care Experienced people to understand where we come from, what our heritage and culture is, and the history of our community. I then looked to other liberation campaigns to understand how to address the history of a community of people and I drew inspiration from Black History Month and LGBT History Month. This ultimately led to the idea to create an annual commemoration of the history of Care Experienced people, through a dedicated month of activity — Care Experienced History Month.

The process that led to April 2021

Following the success of the two events at the beginning of 2020, a formal pitch was made to Who Cares? Scotland, who supported taking the project forward. At this stage, it was agreed that sponsorship would be required to fund the month and steering groups made up of Care Experienced people and allies were to be established.

Conversations with partner organisations in New Zealand and Australia took place in August 2020 to gauge interest outside Scotland. These discussions confirmed there was indeed international interest but also highlighted the delivery of Care Experienced History Month would have to look different in each country — particularly with differing levels of coronavirus restrictions in place — if the month was to be successful.

Care Experienced History Month was officially launched on social media in September 2020 following confirmation of international interest. Once it was announced, the process of creating a sponsorship model and three steering groups progressed.

Sponsorship

In the early stages of planning, there was a recognition of the need to bring others alongside the delivery of Care Experienced History Month. Sponsorship allowed the project leads to bring on paid consultants to sit on the steering groups (detailed below) to advise on and shape the direction of the planning for the month. The sponsorship model formulated followed a three-tier system — bronze (£250), silver (£500) and gold (£1000), with the latter two tiers offering a larger reward for sponsors. In the first year, Care Experienced History Month was able to secure a total of nine sponsoring organisations to fund the steering groups created.

Steering groups

As this was the first-ever Care Experienced History Month, two steering groups were created to guide the direction of the month. It was identified in the early stages of planning that the team responsible for delivering Care Experienced History Month would require support from skilled and experienced people to ensure the success of the month. Other solutions for this were explored, however, it was ultimately decided that a steering group function would provide the correct model required to deliver the work intended. The Scottish Steering Group's purpose was to direct, shape, create and lead the delivery of Care Experienced History Month in Scotland – including creative outputs, planned activity, social media and web content and Scottish resources. The International Steering Group's purpose was slightly different, in that it was intended that this group would serve as a space to make decisions collectively at an international level, however, representatives from respective countries were expected to direct, shape, and lead the delivery of Care Experienced History Month in their own countries, based on the needs of the Care Experienced community there and being sensitive to the current landscape of care.

Having skilled people working alongside Who Cares? Scotland to help with the planning and delivery of the month in Scotland was essential. The Scottish Steering Group was created to provide a space for Care Experienced people, historians and academics to come together to create the outline of Care Experienced History Month across the country, including activities, events and resources which would become available throughout April 2021. This group was made up of five paid consultants bringing with them a variety of skills and experience.

Dr Ian Milligan	Honorary Senior Research Fellow, CELCIS, University of Strathclyde
Dr Christine Whyte	Lecturer in Global History, University of Glasgow
Amy-Beth Miah	Care Experienced Social Sciences Student
David Anderson	Care Experienced, University Lecturer in Social Work, Université de Bretagne Occidentale.
Lorna Goodbrand	Care Experienced Social Sciences Student

Table 1: Members of the Scottish steering group

The key achievements of the Scottish Steering Group include the creation of the lesson plan and teachers' support pack for secondary schools, the HMS Mars' videos, the In Conversation With event, and content featured on the Scottish section of the Care Experienced History Month website. There were also several creative pieces ranging from blogs and poetry to the creation of the symbol for International Care Experienced Day of Remembrance.

Alongside the Scottish Steering Group, an International Steering Group was established, providing a space for Care Experienced people from across the world to come together to share ideas, collaborate on projects and provide additional support for countries that needed it. Like the Scottish Steering Group, the International Steering Group was made up of seven paid consultants, including Care Experienced people from Australia, North America, and Aotearoa New Zealand.

Dr Dee Michell	(Australia) Care Experienced, Lecturer in Sociology, Criminology and Gender Studies, University of Adelaide
Dr Robin Sen	Lecturer in Social Work, University of Dundee
Amanda Gavin	PHD candidate in history, University of Glasgow and visiting researcher, University of Edinburgh
Tupua Urlich	(Aotearo New Zealand) Care Experienced, Advisor, Office of the Children's Commissioner New Zealand
Keri Richmond	(North America) Care Experienced, Manager of Child Welfare Policy at AAP and Executive Director of FosterStrong
Sean Geoghegan	Care Experienced, Writer/Director at Nightfighter Films
Kayt McGeary	(Australia) Care Experienced, Career & Workforce Development Facilitator

Table 2: Members of the international steering group

The key achievements of the International Steering Group include the creation of International Care Experienced Day of Remembrance, a series of 'Untold Stories' from across the world, three of four lectures in our lecture series, the 'History Around the World' webpages on the Care Experienced History Month official website, several events in Australia, social media engagement across countries, and a global reading list for Care Experienced history.

Aims for Care Experienced History Month

The purpose of creating Care Experienced History Month was to provide a platform for Care Experienced people and their allies around the world to come together to remember, celebrate, learn, and connect to Care Experienced people who have been present in our global history and societies since records began and beyond.

To launch and deliver Care Experienced History Month 2021 successfully in countries around the world, and to secure commitment to the project as an annual occurrence, there were four aims we wanted to achieve from the outset.

These aims were:

- Bringing Care Experienced people and their allies together in a safe space to influence the creation and direction of the first-ever Care Experienced History Month. This was to be achieved by the establishment of the three steering groups — the Global, Scottish and 5N1V steering groups — which were to be chaired by Who Cares? Scotland.
- Secure sponsorship to ensure consultants on the Global and Scottish steering groups were paid for their contributions. Sponsorship secured in 2021 would then set a precedent for future years when seeking dedicated funding and/or further sponsorship partnerships.
- Create an online bank of information, content, resources, and a timeline on the history of Care Experienced people across the world which will continue to grow as Care Experienced History Month reaches more countries.
- Create a dedicated day of remembrance, International Care Experienced Day of Remembrance, for Care Experienced people and their allies across the world to pause, reflect on, and remember the legacy of Care Experienced people throughout history.

As plans progressed, the aims for Care Experienced History Month continued to develop, adapt and, at times, shift through various inputs from Care Experienced people, academics and NGOs involved in the steering groups guiding the direction of the month.

When starting the project, an overall aim of mine was to create a digital timeline of the history of care. Time constraints, lack of available funding and staffing meant we were not able to achieve this aim in 2021. However, I remain with the view that this should continue to be a goal that anyone involved in the continuation of Care Experienced History Month should strive to achieve, as ultimately a core purpose of the month is to provide a platform to learn about the history of Care Experienced people.

A key aim that emerged early in the planning stages alongside the steering groups was creating the case for the longevity of the project. Care Experienced History Month 2021, therefore, had to demonstrate the gap in our collective knowledge of Care Experienced people to such an extent that it would be impossible to ignore, thus presenting the case for the commemorations to take place annually.

It became clear that those involved in the delivery of Care Experienced History Month overwhelmingly felt that governments and organisations across the world should seek to continue all year round to look back at their own involvement in the history of care, however challenging this may be. This means being prepared to do the work required to be a true ally to Care Experienced people by allowing our community to come closer to the moments in our history which were caused and perpetuated, exacerbated, and perhaps prevented, by governments and organisations, by acknowledging, remembering, and addressing these moments.

There were several moments in our history that the steering group wanted to explore. However, time restrictions meant that we could only focus on specific moments to achieve the application of rigorous historical research methods to offer a fresh perspective on the events that occurred and the life histories of those who experienced them, debunking myths that previously existed in the context.

As part of the aims of Care Experienced History Month, the steering groups set a goal to explore the history of the Child Migrant Scheme, which on the surface saw the Government, religious organisations and charities sending orphans to imperial colonies for a period spanning more than 300 years. However, below the surface, the Government-induced trafficking scheme as it was named by former Prime Minister, Gordon Brown (ITV News, 2017), was a deeply flawed government policy that was badly implemented by numerous religious organisations and charities, in which 'successive British governments failed to ensure there were sufficient measures in place to protect children from all forms of abuse, including sexual abuse' (Independent Inquiry Child Sexual Abuse, 2018).

Providing context from the perspective of the Care Experienced people affected by moments such as this was central to the inquiry of steering group members and, going forward, should remain a focal point of the work carried out by anyone involved with Care Experienced History Month.

Of course, the aims of Care Experienced History Month will continue to grow as the reach of the campaign broadens. Countries with different care landscapes may find their aims for the month differ to what they are in Scotland. The beauty of Care Experienced History Month, however, is that even with differing aims tailored to the needs of respective countries, as long as the true purpose — to create a platform for Care Experienced people and their allies around the world to come together, to remember, celebrate, learn and connect to the history of Care Experienced people — is preserved, then societies around the world will begin to make strides in understanding the Care Experienced community and our culture, and why care exists the way it does in the present day.

Collaborations

Partnerships

From the beginning there was a need to work in partnership with sponsors, organisations that work with work with Care Experienced people from across the

UK and Ireland. Following the announcement of Care Experienced History Month, several organisations reached out to offer support in making the month a success. We organised a series of meetings with those who had registered their interest to establish a formal partnership for Care Experienced History Month. The organisations involved in this process included:

VOYPIC (www.voypic.org)

Voice from Care Cymru (www.vfcc.org.uk)

EPIC (www.epiconline.ie)

Become (www.becomecharity.org.uk)

Drive Forward Foundation (www.driveforwardfoundation.org)

Coram (www.coram.org.uk)

From November 2020 onwards, representatives of each organisation came together at a monthly meeting to discuss and develop plans for Care Experienced History Month. The group became known as the 5 Nations 1 Voice Care Experienced History Month Steering Group. This provided a space where conversations took place on how to collectively support each other, how to deliver the month across the United Kingdom and Ireland, and to provide updates on planned events and outputs in our respective countries. Discussions on the longevity of the project were also had, including the possibility for joint funding bids in the future to ensure that Care Experienced History Month continues annually for years to come.

International collaborations

The team in charge of delivering Care Experienced History Month for the first time wanted to make sure that the month would stretch further than across countries in the United Kingdom. Once the formal announcement took place, we began extensive mapping of organisations across the world that support Care Experienced people. From August to December 2020, the team reached out to organisations in New Zealand, Australia, Canada, and North America.

Care Experienced History Month in New Zealand was led by our Care Experienced international steering group representative, Tupua, who works for VOYCE — Whakarongo Mai. Extensive research into the history of care in New Zealand was carried out to create a context to understand the impact these moments have had on Care Experienced people in New Zealand today.

Activity in Australia was led by the two representatives on the international steering group from Melbourne and Adelaide. They delivered seven events throughout April, hosted their own 'Untold Stories' series, contributed to the creation of the Care Experienced History Month website and participated in International Care Experienced Day of Remembrance.

Collaborations in North America were led by Keri Richmond, from Fosterstrong. Fosterstrong participated in the International Care Experienced Day of Remembrance and supported the creation of the Care Experienced History Month website — particularly the dedicated United States of America section.

The pandemic meant that a lot of the planned events were unable to happen. However, Care Experienced History Month was able to reach many countries, including securing engagement from India, Zimbabwe, Kenya, France, and Italy. While formal collaborations did not happen with every country approached, we saw that as April 2021 progressed, international interest continued to grow. With more time to plan, more people involved in the delivery of the month, and proper funding streams, I hope that more international collaborations will be formed every year as Care Experienced History Month expands its reach.

Content overview

The global coronavirus pandemic prevented in-person events from taking place in Scotland. This meant that the focus of Care Experienced History Month had to be on digital content. From the start of planning, it was evident there was a desire to create an independent Care Experienced History Month website, which could act as an online wealth of resources all year round. Alongside the website, dedicated social media platforms (@HistoryofCare, @CEHMUK) were key to promoting the content created throughout April 2021.

Every week in April 2021, a live lecture on Zoom was hosted exploring a new topic in relation to the history of care across the world. The lectures followed the schedule detailed below and are all stored on the Care Experienced History website for future viewing.

'The 'Child Migration' Scheme for Care Experienced Children After 1945: What Was it and Why Remember It?' delivered by Dr Robin Sen, University of Dundee

'A History of Everyday Life in Scottish Children's Homes, 1940-1970' delivered by Amanda Gavin, University of Glasgow

'Voices from the Silent Cradles — Life Histories of Romania's Care Experienced Children' delivered by Dr Mariela Neagu, University of Oxford

'African Mission Children in Scotland in the 19th Century' delivered by Dr Christine Graham, University of Glasgow.

As well as the lectures, every day in April the social media accounts shared 'Untold Stories' of Care Experienced people from throughout history to the present day. This project sought to highlight the untold story of a Care Experienced person or of a well-known person whose experience of care has previously been unknown.

In Scotland, we held an online 'In Conversation with' event — also stored on the Care Experienced History Month website — to explore the oral history of the influencing of the Children and Young People (Scotland) Act 2014, hearing from two Care Experienced activists who shared first-hand the process they experienced to see legislative changes introduced.

Perhaps the most poignant moment of Care Experienced History Month was the International Care Experienced Day of Remembrance, which took place on 30 April 2021. A key aim of Care Experienced History Month, the Memorial Day provided a space for Care Experienced people and our allies to pause, reflect, and remember Care Experienced people who lived before us, their legacies, and the Care Experienced people we have lost prematurely. The two steering groups felt it was an incredibly important space to create, particularly with the high rates of premature deaths within our global community. These high rates of premature deaths are detailed in research reports based on studies in England and Wales (Murray, Lacey, Maughan & Sacker, 2020) and Sweden (Vinnerljung & Sallnäs, 2008), as well as a systematic review of research in several countries (Häggman-Laitila, 2018).

The day was marked by sharing the Care Experienced symbol of remembrance, which represents a bridge from the past to present; a bridge to the people; a bridge to the future, and bridging the divide in understanding of the history of Care Experienced people. Throughout the day Care Experienced people and our allies around the world shared reflections on loss, mourning, hope, and of need for change. Just as it is hoped Care Experienced History Month will be celebrated every year, I hope that International Care Experienced Day of Remembrance will long continue and as a result, conversations on accountability progress further than they ever have before.

Conclusion

The history of Care Experienced people is rich and far-reaching. Care Experienced History Month is only the tip of the iceberg. To truly understand a community of people that exists in all societies on this planet, and indeed seek to make changes for people with care experience, we must first look back at the past, remember it, recognise the impact of it, and then learn from it before looking forward to the future.

Care Experienced History Month has a purpose. It is needed. Celebrations in April 2021 have demonstrated that to such an extent it is hard to ignore. The space to acknowledge and commemorate our history should not be underestimated. The COVID-19 pandemic hindered the opportunity to take these commemorations to the streets, to mass grave sites, to former large-scale institutions, but I have hope that Care Experienced History Month will grow into a campaign marked in all corners of the earth, underpinned by the message that Care Experienced people deserve to know their history and culture and that governments and organisations involved in that history have a duty to face, teach, and preserve it.

In my view, Care Experienced History Month presents a new area of historical inquiry that allows Care Experienced people to begin to understand where we come from, our heritage, our culture and the moments in our history that have changed not only us as a community, but changed the systems who intervened in our lives as children.

Care Experienced History Month affords Care Experienced people and our allies the opportunity to learn, be shaped by and grow from our shared history. By reflecting on how we have cared for children of the state throughout history, no matter how challenging this may be, as a society we must force ourselves to confront the role we have had as the oppressor, aggressor and at times enabler of maltreatment of Care Experienced people. This is an uncomfortable reality and no one state can be excused from facing it.

Looking back at history together to create a better future is truly the greatest gift we can give Care Experienced people. Care Experienced History serves as a concrete embodiment of this gift.

I am excited to see how Care Experienced History Month expands. I hope that Care Experienced History Month 2021 will be a pivotal moment in our history. Most importantly, I believe the first-ever Care Experienced History Month marks the beginning of a change in our collective trajectory — a change that is founded on accountability and will see societal shifts for generations of Care Experienced people to come.

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About the author

Charlotte Armitage is a 23-year-old Care Experienced woman who currently studies History and Sociology at the University of Glasgow and is a Public Affairs Officer for an MSP at the Scottish Parliament. Charlotte previously worked for Who Cares? Scotland and was the project lead for Care Experienced History Month 2021.

Scottish Journal of Residential Child Care: An international journal of group and family care experience

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HMS Mars: An industrial school in the late 19th century

Christine Whyte

Abstract

This short reflection on the history of industrial schooling and residential care in Scotland focuses on the ship HMS Mars. Moored close to the city of Dundee, the ship was ‘home’ to thousands of poor, destitute and homeless boys in the late nineteenth century. Designed to fill a perceived need for white British sailors in the Merchant Marine, the ship was largely forgotten after it was scrapped in 1928. This article interrogates some of the ways that the boys on-board had been criminalised, and the imperial context of the training ship.

Keywords

Training ship, residential childcare, care experienced history, industrial school

Corresponding author:

Christine Whyte, Lecturer in Global History, University of Glasgow,

Christine.whyte@glasgow.ac.uk

Introduction

Between 1869 and 1929, over six and a half thousand boys aged between ten and sixteen years old were sent to live on-board the HMS Mars, a 'training ship' and 'industrial school' moored near Dundee. Equipped to house up to 400 boys at a time, the ship was launched as part of a broader movement to establish industrial schools for poor, vagrant and destitute children in Britain.

The first boy to unofficially board the Mars when it was launched in October 1869 was inspired by the possibilities of imperial adventures. As noted above, the first boy was Murdoch McLeod, the adventurous bookbinder's apprentice, who had been inspired by the novel *Swiss Family Robinson* to 'run away to sea'. Two years later, though, Murdoch attempted to escape, by taking a life-buoy and swimming through the night to Tayport, where he was found and returned by a police officer. Much later in life, McLeod was interviewed about his time on the Mars, and recounted how he was 'slung across cannon' and 'lashed with a rope's end' as a boy (Douglas, 2008).

In contrast to the volunteer McLeod, the first boy officially registered was David Petrie, who had been charged under section 14 of the 1866 Industrial Schools Act with being Destitute and Homeless. His mother's address was listed as Dron's Close, while his father's whereabouts were unknown. In theory, industrial schools like the Mars were meant to house and educate the poor, as distinct from the reformatory school for children convicted of crimes. In practice, children were sentenced to time in an industrial school by magistrates for things like begging, to being in the company of reputed thieves. For the children, the experience would have been difficult to distinguish from a criminal proceeding.

On arrival on the ship, the similarity to a prison continued. Children were first stripped and examined by a medical officer. Their hair was cut close to the scalp. Then they were bathed and given a uniform to wear. Their names and details of their families and 'sentence' were noted in a log-book. In a practice very much drawn from prison camp life, each child was assigned a number which replaced their name. From that point on, even just amongst the children themselves, they were only referred to by their assigned number.

Efforts to strip away individual identity from the boys were part of their training for a life at sea, but also greatly reinforced the effects of removal from their homes. Boys were deliberately given little opportunity to maintain connections with family and friends. Parents could apply for discharge of their children but were almost always refused. The notes accompanying one of the very few successful applications for discharge in 1888 emphasised that the committee 'did not wish to encourage applications of this nature' (Quoted in Douglas, 2008, p. 74).

The ship filled its places rapidly. Originally fitted for 300 boys, that number was soon increased to 400. Despite its reputation as a punishment for Dundee's 'bad boys', children were sent from all over Scotland and most had never committed a crime, beyond being very poor and sometimes homeless. In its early years, many came from Edinburgh. The rapid recruitment in the capital was driven by the activities of the Royal Scottish Society for the Prevention of Cruelty to Children (RSSPCC), as well as missionaries. RSSPCC inspectors sought out homeless or vagrant children, who they could take to magistrate's court for committal to industrial schools. Only a few years after the launch of the Mars, this broke out into a scandal with accusations of the agents 'snatching' children from the streets (Kelly, 2019).

The scandal around recruitment in 1874 was also about complaints of physical punishment of the children. In the official register of punishments for 1873, six boys were given between seven and eighteen 'stripes' but the former Baillie Lewis claimed that the official register did not reflect the true extent of violence on the ship, where punishments went unrecorded and far exceeded the permitted caning.

The children of the Mars also were at risk of accidents. Within two months of the launch of the ship, Patrick Foy nearly died in the freezing waters, rescued by Captain Wake. The next year, three children, William McIntosh, William Miln and John Hall, died after being sent to collect mail in a small boat with two other boys.

Fire as well as water was treacherous on-board a ship. At 3am on Saturday 28th of May, 1883, the fire bell rang on the Mars. Three boys, from as far afield as

Fife, Galashiels and Glasgow, were later found guilty of having set the fire which destroyed the Captain's quarters and a large part of the stern. This was only one of many arson or attempted arson incidents on board industrial school or reformatory training ships. Boys attempted to escape, stole food, and hollered and cat-called staff to express their dissatisfaction on-board training ships.

Unlike most industrial schools, *HMS Mars* accepted both Catholic and Protestant boys and so many children were sent from the west coast, with Glasgow becoming the most common hometown of boys on-board. Officers on the ship paid commission to an agent in Glasgow, five shillings per child, to 'do his best to keep up a steady supply of new boys' (Quoted in Douglas, 2008, p. 116-117). One graduate from the ship wrote to Captain Scott in January 1899 and described how he had applied as an orphan to the Glasgow agent, Mr West. The letter emphasises his vivid memories of playing with the other boys, 'The scene just now passes before me. No thought for the morrow. We were happy' (Quoted in Douglas, 2008, p. 118-119). He returned to Glasgow after he left to become a cobbler, using skills he learnt on the ship.

The *Mars* came under increased scrutiny in 1896, when a committee was established to examine both reformatory and industrial schools throughout the UK. The training ship system had been attacked in 1895 by Admiral Field, who pointed out that the ships were extravagant and wasteful, because so few of the boys went to sea. The ships were defended by Admiral Day Hort Bosanquet, who wrote in 1898 that 'Great Britain is the maritime nation of the world… the calling of seamen is therefore one of the most important, if not the most important, of all careers open to her rescued boys' (1898, p.179). This national pride was tempered with nationalist anxiety. He quoted statistics that 27,765 foreigners were serving on British vessels, alongside 27,911 Lascars, sailors of Asian, Arab, or North African origin, mostly British subjects who served on British ships. He noted an 'alarming' drop in the numbers of 'British sailor lads' joining the Mercantile Marine. This, he argued, showed that there was a strong 'demand for the services of boys in the Mercantile Marine' to replace both foreigners and British subjects of colour in their ranks (Bosanquet, 1898, p.180).

The 1894 report from the Mars revealed that, of 386 children on-board, the ship housed 45 boys under the age of twelve, and 82 between twelve and fourteen years old. They are described as 'orphans, — children of criminal or drunken parents, children deserted by their parents, illegitimate offsprings of unfortunate women, in fact children who only want to be taken from bad surroundings and given a fair chance to become decent members of society' (Quoted in Report to the Secretary of State for the Home Department of the Departmental Committee on Reformatory and Industrial Schools, 1896). The admissions report for 1894 shows that around half the new boys had 'been found wandering', that is seemingly homeless, and a third in 'the company of Thieves, etc' (Ibid.).

The committee's assessment of the advantages of the training ship revolved around its location and isolation, making note of the life in the open air, the surrounding river scenery, and the 'more thorough separation of the boys from the outer world' (Report to the Secretary of State, 1896). Under questioning about the distinction between an industrial school and a reformatory, the committee drew attention to the Mars' own report that stated that 'industrial school children are much the same as other school children' and asked the ship's agent Mr Campbell, 'If the boys are no different from other boys why should they be sent to the 'Mars' to be shut up compulsorily?', his response was 'To take them away from their parents' (Ibid). Boys were only permitted four days at home a year if they had a 'decent home' to return to and requests from the family were almost always refused (Ibid).

The Mars was closed and the ship towed to Inverkeithing in June 1929 to be broken up, after sixty years as a home to boys and staff. The advent of the steam ship, and then the proliferation of destroyers, ended the demand for young boys to work aboard sailing ships. A reporter for the Dundee Courier and Advertiser collected some fond memories from local folk and staff on that day, but nothing from the boys themselves.

Modern retellings of life on the ship focus on the 'opportunity' offered by training at sea, but very little is known about the boys' experiences. The fact that the ship was broken up after decommissioning left no focal point for former residents to remember (Musgrove, 2015). The only written account by a former

'Mars boy' appears to be a manuscript held in the St Andrew's University Archives, by an H. A. Martin. He was active in memorialising the Mars as an adult, described himself as 'sadly disappointed' at the lack of interest shown by official bodies.

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About the author

Christine Whyte is a Lecturer in Global History at the University of Glasgow. Her research focuses the history of slavery and its abolition in West Africa. She is currently a British Academy / Wolfson Foundation Research Fellow, working on a project about state and institutional care for children liberated from the slave trade through the 19th century.

Scottish Journal of Residential Child Care: An international journal of group and family care experience

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Promoting rights: Protecting and respecting children

Melissa Hunt and Elaine Adams

Abstract

This article explores the complex landscape of decision-making for children who are in need of care and protection. It sets out some of the challenges when ascertaining children's views and emphasises the importance of protecting children's rights by involving them meaningfully in all decisions that affect their family life; by recording their views, according these weight and by keeping a written record of what actions were taken and why throughout their involvement with statutory services. It sets out how we currently gather children's views and encourages the use of more creative approaches to ensure that children's voices are heard — and their rights respected — throughout all decision-making that affects them.

Keywords

Children's rights, participation, children's hearings

Corresponding author:

Melissa Hunt, Policy and Public Affairs Manager, SCRA, Melissa.hunt@scra.org.uk

Introduction

Since the inception of the Children's Hearing in 1971 there has been a slow but incremental increase in the extent to which both Scottish society and the systems that have developed to protect children from harm have embraced children's rights and encouraged their meaningful participation in the numerous decision-making processes that impact on their lives. 'The only source of knowledge is experience' applies to all of us — but if our experience is one where we are supported to tell our truth, to engage meaningfully and have those with power listen and take us fully into account — then we will take this with us. If, however, we are side-lined, ignored or patronised — then we take something very different away with us into life. The experience of every child is dynamic and complex and affected in a multitude of ways by a multitude of things. When adults approach any work with children in a rights respecting way from the start of a 'care journey' then perhaps the course of that journey can be altered.

The significance of rights and children's rights in the context of the provision of 'care' by a state is recognised internationally. In Canada on January 1st 2020 the *Act Respecting First Nations, Inuit and Métis children, youth and families* came into force giving the opportunity for indigenous people to choose their own solutions for their children and families (Reducing the number of Indigenous children in care). In New Zealand the Oranga Tamariki Ministry for Children website homepage (When does a child go into care?) indicates clearly the rights based approach that is being taken.

The website offers (amongst other things):

- Support for families
- Working with children
- Children in our care
- Caregiving

In Scotland The Promise reports from the Independent Care Review point us clearly towards a future which uses children's rights as the lens through which we view how we work with children for them to develop into happy, healthy adults: 'We grow up loved, safe, and respected so that we realise our full potential' (Independent Care Review, 2020, p.1). This future will be transformational – and is a world away from where the Children's Hearing began.

In the early days children and their parents were expected to attend Children's Hearings without the reports that provided much of the crucial evidence-base for decision-making being shared with them and with little attention being given to the child's view of the situation they found themselves in. Information was only made available to the Reporter, Social Worker and Panel Members.

It is a surprise to many that practice of this nature was still in operation in the 21st century. In fact, the routine sharing of hearing papers with all children did not become a statutory requirement until the Children's Hearings (Scotland) Act 2011 came into force on 24th June 2013.

Thankfully however, Scottish society has changed since the 1970s and so has the way Scotland views children and takes cognisance of their rights. The Covid-19 global pandemic has shone a light on the impact of adult decision-making on children at a time when legislative changes that impact them directly has quickened. In the past few years Scotland has:

- seen the introduction of Corporate Parenting responsibilities for a host of agencies;
- raised the age of criminal responsibility and is actively considering a further rise;
- outlawed assaults on children by removing the defence of 'reasonable chastisement';
- consulted on raising the age of referral to the Principal Reporter to 17;
- and, most significantly of all, consulted on seeking to incorporate the United Nations Convention on the Rights of the Child (UNCRC) into Scots Law.

Society quite properly places reliance on the family to protect a child from harm, meet the child's needs and ensure that the child's rights are respected and upheld — but some families are not able to meet these expectations. Sometimes care-givers need additional help to meet a child's needs but are unable to accept or actively refuse to engage with supports voluntarily. Some refuse support altogether. Some intentionally or unintentionally place the child at risk of harm. All of the foregoing are potentially detrimental for a child and may require referral to the children's hearing system for proportionate exploration of the child's circumstances and possible statutory intervention.

In practical terms the threshold for referral is clear in section 60 through 66 of the 2011 Act — that a child may be in need of protection, guidance, treatment or control and it might be necessary for a compulsory supervision order to be made in respect of the child. The threshold for the statutory intervention of the Children's Hearing in the 2011 Act, section 66 (2), is also very clear:

> 66 (2) The Principal Reporter must determine –
>
> (a) whether the Principal Reporter considers that a section 67 ground applies in relation to a child, and
>
> (b) if so, whether the Principal Reporter considers that it is necessary for a compulsory supervision order to be made in respect of a child.

If both these conditions are met the Reporter must arrange a children's hearing.

Referral to the Reporter and any subsequent referral to a children's hearing effectively passes the power to take important decisions about the child's life away from a family[1]. These decisions may include where the child will live and with whom the child shall have contact – as well as the responsibility for

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[1] A child or children may become subject to child protection procedures and a child protection planning meeting (previously a case conference) followed by core group meetings and supports. This can happen with or without additional referrals to other public supports (Child and adolescent mental health / family support / parenting supports) 3rd sector support services and referral for consideration of statutory intervention through the children's hearings system if a compulsory supervision order may be required.

ensuring the child's rights are upheld. Currently these decisions are entrusted to an array of decision-makers within the wider children's hearing 'system' in place of the family. These 'layers' of decision-makers include:

- social workers and other professionals in education and health who assess a child's background and current situation and then recommend what action should be taken next.
- independent officials (Reporters) who consider these recommendations in the context of children referred to them and then make their own individual assessment about what further action (if any) should be taken.
- a quasi-legal tribunal (made up of Children's Panel Members sitting in a Children's Hearing) who will be asked to consider assessments and enter into discussions with a child and family before making their own decisions as to what's best for the child.2
- and then a Sheriff in the relevant Sheriff Court, if the reasons for referring a child to a children's hearing need any 'fact finding' or if a child and family do not agree with the decision reached by their children's hearing and they want to appeal it.

At each stage of decision-making the need to protect the child has to be balanced with the need to be proportionate when interfering with the rights enjoyed by the child and their family. Needless to say, this is a delicate balance for professionals to strike, but it is important that the child is heard — which may mean the child's feelings, views, thoughts, understanding, perceptions may all need to be communicated — which can be difficult in a children's hearing when a child's loyalties can be really tested, and people can be under pressure and in some emotional distress. It is also important that opportunities and encouragement to participate meaningfully are provided throughout the decision-making process to ensure the rights of the child are upheld and that this applies to every child; this can be difficult in practice for infants and non-

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[2] Children's Hearings Scotland are the non-departmental public body who oversee the recruitment, training and support of Scotland's volunteer panel member community, which includes the panel members who sit in children's hearings as well as the other volunteers who support them and provide practice advice.

verbal children where professional and other assessment of behaviour has to interpret what cannot be articulated. As it often takes time to build a trusting relationship with a child before they will openly share their views this is an important step in the process of information gathering that must not be rushed or skipped over in the race to complete assessments or to make decisions to meet short timescales.

Our children's hearing has long recognised the importance of ascertaining the child's view. The Children (Scotland) Act 1995 enshrined in law that listening to and taking account of the views of children was to take place when decisions were being made about their family life. This was a position that The Children's Hearings (Scotland) Act 2011 re-stated and expanded upon; Section 27 (modified by the Children (Scotland) Act 2020 Section 3) of the 2011 Act provides that a child has to have the opportunity to give a view; should be able to give their view and that decision makers should consider that view. In addition, Section 121 of the 2011 Act specifies that the chairing member of the children's hearing must ask the child whether the documents before the hearing accurately reflect the view / views the child has expressed. Despite UNCRC and the current legislative framework it is often unclear to what extent — if at all — the views of the child are sought and, if available, the extent to which they are enabled and given due and proper consideration within each stage of the decision-making process.

Dr Robert Porter's study (2019) demonstrated that in both social work assessment and panel decisions:

> children and young people's views are poorly recorded, and that clear views are recorded in only a minority of decision paperwork

and

> when views are absent it is very difficult for those who gave those views to believe that those views were taken seriously, or indeed taken into account by the decision maker at all. (Porter, 2019).

Such decisions may be less likely to be railed against if the child's view (and that of the carers) is respected and recorded and if decision-makers set out clearly to what extent this has been considered as a factor within the decision-making process in a way which does not routinely occur now. Currently social work assessments (and other assessments of children) are required to include the child's view and the children's hearing is required to take that view into account. There is however no requirement to explain how this has fed into their decision-making. The hearing must provide reasons for each decision they make and some of their reasons for decision may include the views of the child — but they are not required to reference these.

Agreement and 'buy-in' to decisions imposed on children and families could also be improved if the information provided as a basis for decision-making was concise and readily understood by everyone involved; for example, by having an easy-to-follow written report that sets out clearly why intervention is necessary and what support mechanisms are in place to work alongside a family to make changes for the child's benefit. It would also be beneficial if the rationale for each decision made was set out clearly; for example, with the reasons for decision of a children's hearing narrating what weight has been given to the multiple factors in a case that justify the making of a Compulsory Supervision Order.

Professionals and decision-makers must build trust in order to work in partnership with children and families; and in order to build trust it is important that the reasons for any interventions in their family life are understood and that solutions are both available and attainable. Families should not be oppressed by the 'system' or set up to fail — and when/if this occurs it should be challenged. Legislation doesn't always alter things quickly either. For example, the 2011 Act included a provision that children should be supported by advocacy workers in the children's hearing, but it took nine years for this to be implemented. The delayed implementation of specific aspects of legislation can mean that the legislation is not fully understood/misinterpreted/may not be as effective as was intended and legislation is not enough to make change happen — the implementation of good intention in legislation is dependent on practical system and cultural shifts for the change to really happen.

Systemic oppression approaches have started to deconstruct the accepted/established apparatus of social systems in their historical context in order to imagine a different future (Brady, 2017). In Scotland a wider recognition of the impact of the social systems and processes in place and the perception of the ways those systems impact on groups of people and on individuals is now very current following the publication of the findings of the Independent Care Review and in the widely reported considerations of the Scottish Child Abuse Inquiry. This recognition and awareness has also been a feature of the learning from significant case reviews across the country (Care Inspectorate, 2019). It is hoped that these findings will lead to the deliberate and careful construction of new national frameworks and systems for future decision-making that are rights respecting and ensure the full participation of children and families at every stage of any future process.

When gathering information professionals should consider how the child is being supported to give their view; the ways in which that view could be best presented to enable the voice of the child to be' heard 'and what can be done to ensure that any view expressed is truly taken account of, given weight to and recorded robustly at each stage of decision-making. The Scottish Government's intention to fully incorporate the United Nations Convention on the Rights of the Child (UNCRC) as well as the ongoing recognition and promotion of children's rights in Scottish domestic legislation[3] squarely places 'fairness' and rights as central to the approach to be taken by decision makers – but this does not necessarily reflect the perception and experience children and young people may have of our current systems and the ways they operate. Incorporation will, however, focus the attention of public services on how they uphold children's rights within existing systems and will hopefully start a process of internal scrutiny and an 'audit' of the services currently provided — this should clearly show the ways in which these services protect, promote and respect children's rights. Such an audit may also result in public services recognising changes

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[3] From the creation of the office of the Scottish Commissioner for Children and Young People in the 2014 Children and Young People (Scotland) Act 2014 to the moves to change the age of criminal responsibility in the Age of Criminal Responsibility (Scotland) Act 2019 and the statutory review of the age at which this should be set

which need to be made in order to prevent systemic oppression — be that actual or perceived oppression.

The 2011 Act gives children the same rights within the hearing process as those enjoyed by adults, whilst recognising that their 'age and maturity' should also be considered. To quote the Scottish Children's Rights Administration (SCRA) statistics, '85% of the 8,875 children and young people subject to a Compulsory Supervision Order as at the 31st March 2020 have only ever been referred on care and protection grounds' (SCRA, 2020 October, p.2). Most of the children who need the intervention of statutory measures of care and protection are placed at risk of harm because early recognition of need or request for support to meet parental responsibilities has not been sought, identified, effective or engaged with; in fact, SCRA Home CSO Research Reports in 2019 indicates throughout the separate reports that support may only be available through a CSO; wasn't available before the CSO; was not fully identified at the right time and therefore actions other than a home CSO may be required to address a child's presenting needs. Children are likely to require a greater level of support than their carers to help them give their views to decision-makers and to enable them to participate fully in a children's hearing. The Children (Scotland) Act 2020 removed 12 years as the age by which children are presumed able to give a view. Section 1 states that 'in considering whether the child is capable of forming a view, the person is to start with the presumption that the child is'. A child who has or is experiencing trauma through unmet need or harm may not be developing according to chronological milestones, so age is an unhelpful determinant of a child's capacity or ability to articulate an authentic view — and there is an ongoing need for adult support for children to enable 'a view' to be developed and delivered.

Currently the following are used to support the child and bring the child's views into decision-making:

Instructing a solicitor / legal representative

But many children coming to a children's hearing are too young to instruct a legal representative and most legal representatives attend to represent adults.

Appointment of a Safeguarder

This must be considered by the panel members at every hearing. Safeguarders will ascertain the child's views and make their own independent recommendations for action to a children's hearing. Safeguarders can also be appointed in associated children's hearing court proceedings.

Use of technology

The use of Virtual Hearings during the Covid19 pandemic has provided an opportunity for children to attend hearings remotely. The use of technology in and of itself however gives rise to additional concerns around fairness and participation (SCRA, 2020 June and , SCRA, 2020, July).

Use of advocacy workers

The Scottish Government has now enacted section 122 of the 2011 Act so there is a duty on each and every Children's Hearing to make children aware of the availability of children's advocacy services (Hearings Advocacy) to support them before, during and after their Children's Hearing (age and maturity being taken into account).

A further step to empower children to give their views is Section 14 of the Children (Scotland) Act 2020 which puts a new duty on local authorities to seek the views of children in relation to contact with any brother or sister relationships and sets clear criteria for determining ‵individuals with participation rights' in the children's hearing. This will allow brothers and sisters, as well as others who have brother/sister ‵type' relationships with children to give their views in decision making and have decisions reviewed for the first time in relation to ‵contact'.

Before the pandemic children's hearings were moving tentatively towards providing children with more freedom of choice about the ways in which they could present their views to decision-makers; accepting that filling in a form ‵All about me' was not helpful for many and embracing, for example, the use of avatars and digital devices. The pandemic has also permitted children for the first time to really have an element of choice about whether or not they attend a hearing/part of a hearing — it is much easier to 'switch off' a virtual hearing than it is to leave a room full of people (for example), although further consideration of this is required (including consideration of whether children are under any undue pressure when using technology to access their hearing and the impact of the digital divide on children at the hearing and the response of children to virtual hearings is not at all a 'uniform' response — as detailed in the Our Hearing Our Voice views on returning to face to face hearings which can be read here). The pandemic has of necessity shown that radical changes to systems can take place in a short timeframe where there is the collective will to make this happen.

The use of more creative approaches to help children give their views on current systems and practice has been driven by the work of Our Hearings, Our Voice (OHOV) – the Independent Board of Children and Young People for the Children's Hearings System. OHOV has worked closely in its first year with the Verbatim Formula, with Napier University School of Computing and John Morrison to develop ways of effective storytelling / digital storytelling; to share with a wider audience what it feels like to be a child caught up in the current system, to begin to challenge existing practice and to begin imagining what the child protection landscape could look like if children's rights were truly at its heart.

Our Hearings, Our Voice members are saying profound, moving and eloquent things about the experiences they have had; the impact of this on them and on their engagement with the Children's Hearing. Their experiences along with the findings of the Independent Care Review challenge us to change our systems, develop new ways to engage with children of all ages and to provide the supports they tell us they need to ensure their rights are upheld and their views are properly considered at every stage where decisions are made that affect them.

Across a wide range of children's services there is now a recognition that approaches designed specifically for children and young people to help them articulate their experiences and feelings are valuable. A good example of this occurred as part of the London Borough of Culture 2019 in Waltham Forest -the

East Side Story pulled together young people from across the community to articulate their experiences and their hopes for the future – and to write and perform their story. East Side Story was broadcast on the BBC and as a production is now an entity in and of itself.

Across Scotland, champions' boards and Our Hearings Our Voice are also working with the creative arts to develop ways in which children can express their genuine feelings about the often emotionally challenging situations they find themselves in; about the futures they want to see for themselves and their families and about changes that they recognise are needed to improve the experience of any relevant proceedings for other children who will need such supports in the future. Working alongside those with lived experience should help us reshape and improve our future child protection/youth justice systems and help eradicate any real or perceived oppression.

As we move towards life post pandemic and 2022 it is important that practitioners who support children and families and legal decision-makers in the children's hearing devote time and resources to examining how they currently engage with children and in considering what extra approaches could be tested to support, co-develop and implement creative and innovative solutions that protect children's rights, ensure their voices are heard and increase their meaningful participation in all decision-making that affects their lives.

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About the authors

Melissa and Elaine have between them over 40 years of experience working in child protection with the Scottish Children's Reporter Administration (SCRA) in addition to earlier experience in the education (Melissa) and legal (Elaine) sectors. Both have an interest in promoting children’s rights.

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The other side of the wall

Laurence Wareing and Paul Gilroy

Abstract

The closure of CrossReach's last remaining residential school, Ballikinrain, marks an important stage in the evolution of the charity's care for young people. CrossReach (the operating name for The Church of Scotland's Social Care Council) began opening large residential schools following World War II. It has now moved to family-style living in local communities for its children and young people, a process in which Scotland's changing legislation and CrossReach's own knowledge and experience have interacted to underpin a nuanced understanding of child centred care. Changes in practice at Ballikinrain, informed by academic and psychological consultation, legislative changes and recommendations from Scottish Government reports are described, together with a growing understanding of the local community's role in supporting cared for young people and necessary collaboration in the elimination of stigmatisation. This evolution is illustrated by statements from former pupils, and the particular example of one boy and his key worker, whose metaphor of driver and navigator suggests a fruitful way of viewing relationships at every level of the residential care system. We argue that the trajectory towards child-centred practice and legislation, exemplified by The Promise, supports the residential childcare system to enable our children and young people to influence national policy.

Keywords

Child-centred, family-style, local, legislation

Corresponding author:

Laurence Wareing, Freelance writer, lw@laurencew.org

When Ballikinrain, CrossReach's residential school north of Glasgow, closed its doors for the final time earlier this year, in one way it felt like the end of an era. At the same time, the decision represented a decisive affirmation of the direction of travel CrossReach has been following for the past couple of decades.

CrossReach, which is the operating name for The Church of Scotland's Social Care Council, has been providing residential care and education for young people since opening its first List D ('special') school for girls after the close of World War II. For the next 60 years, we held to the model of gathering children and young people together in large, residential school campuses located across central Scotland.

From the turn of the millennium, however, the combined influence of government legislation and our own evolving understanding of effective practice has underpinned a move away from the residential school model to providing a range of houses located in communities, supported by a separate school. The first of these houses, Millmuir Farm in Gargunnock, opened in 2007 and marked the beginning of a shift to family-style living in local communities. Its success, and that of other houses that followed, led to a service-wide restructuring in 2014 and – ultimately – to the closing of Ballikinrain's doors at the start of 2021.

We no longer have large groups of young people living together in imposing buildings with extensive grounds. In the case of Ballikinrain, quite literally we've walked beyond the estate – rather remote and set apart – into local towns and villages. Here, our young people can connect more immediately with the world around them. Two to five children live in each of our houses that look and feel a good deal more like ordinary family homes. Nevertheless, while we may 'look' different, it's the same ethos, the same value base, informing our work that has driven CrossReach's evolving strategy since the opening of Millmuir.

Relational model

That ethos is built on a relational model. Like many others in our field, we believe in the maxim that children who have been harmed through relationships can be healed through relationships. It is a way of being that we worked on at

Ballikinrain with the help of Dr Dan Hughes, who developed his Dyadic Developmental Psychotherapy approach in the late 1980s. This approach encourages connection with children and young people using playfulness, acceptance, curiosity and empathy (P.A.C.E.).

However, with the best will in the world, it's hard to build homely, therapeutic environments in a castle. There is no denying that good relationships were built at Ballikinrain. One former pupil, now a priest and coffee entrepreneur in Derby, has written about 'the seeds of love planted' here, whose lasting impact finally emerged after 15 years of a chaotic lifestyle. In emphasising his memory of love and care, Darren – who was part of the care-experienced system in the 1980s and early '90s – is using language that pre-echoes a key thrust of the Independent Care Review: *The Promise*.[i]

Yet, how can you build equally important relationships with peers or members of the surrounding community when, as another former pupil said, you have to walk 200 yards just to get to the end of your driveway? Claymore says that the difference it made to him when he moved to Millmuir Farm was immediate. A 200-yard walk would now get him to the local shop. And when he began high school, he added, 'I was allowed to get the bus every day, there and back. That was me taking the bus myself.'

Claymore vividly describes this transition from the castle environment, living with six boys within a much larger group of staff and young people, to having just one other housemate and someone looking after them. Millmuir became his home for four years. Before, he says, he had only been interacting with 'the same people in the same situation' as himself, and had felt like he was 'avoided by the public'. Now, however, he integrated into the local community with far greater ease. This was even a place where he could invite his friends to after school.

Emphasising otherness

At Ballikinrain, despite the best efforts of loving staff well-versed in supporting trauma-experienced children, the 'avoidance' Claymore speaks about was a dominant feature of a broader understanding of being stigmatised. He surprised us when he identified the isolation that he had felt there, despite having been part of a lively, nurturing community. Yet, Professor Andrew Kendrick, Emeritus Professor, University of Strathclyde, has argued that one of the worst results of stigma is precisely this sense of isolation.[ii]

When Pineau, Kendall-Taylor, L'Hôte and Busso (2018) ask what care-experienced children and young people need, at the head of their responses is a requirement to 'engage local communities to help support the care system to reduce stigma and marginalisation':

> According to experts, building connections between people in the wider community and care-experienced young people can reduce the 'othering' that care-experienced individuals may feel. Connections with community can also build informal networks of support for both carers and children.[iii]

In residential child care organisations, we often find ourselves unwittingly 'othering' the young people we seek to help precisely because we are naming their issues, saying we're good at supporting and helping them to change, in order to bid to local authorities and other funders who want us to resolve those issues.

There is a real sense in which the system of which we are a part perpetuates an unspoken requirement to label our young people to argue for, and justify the allocation of, resources, thus underpinning the process of 'othering' and the very stigmatisation we wish to eliminate. Residential care organisations find themselves with no choice but to adhere to language that is itself damaging.

Moreover, in the case of Ballikinrain, the relative isolation inherent in the building's physical environment could only ever result in a reinforcement of otherness and the experience of living with stigma.

Context and community

In the decades since we began opening our residential schools, we have supported over 5,000 children and young people at CrossReach. But it was precisely the kind of transformative experiences Claymore describes, because of his move to Millmuir Farm, that inspired us in 2014 to move towards closure of our large institutions and extend our delivery of care and support in local communities, alongside the opening of a new school campus in Erskine.

At a time when society's values often seem to weight towards a desire for 'bigger and more', we have confirmed that what benefits our young people best is 'local and less'. Family-style living enables them to experience love and nurture in a more homely context, and to build relationships with their carers that have the potential to be sustained in a mature way after they have moved on to the next stages of their lives.

More than that, by bringing young people in CrossReach's care close to local communities, in more intimate settings, we are endeavouring to minimise the experience of 'othering' that Claymore has identified. The point is to support young people to connect more effectively with society and the world at large. Going 'local and less' helps build their resilience.

For this to be at its most effective, engagement with the surrounding community needs to be intentional, on both sides of the relationship. The term 'corporate parenting' may sound bureaucratic, but as defined in the 2008 Scottish Government report *These are our Bairns*, it is something akin to the more homely notion that it takes a village to raise a child. The report quotes Sir William Utting:

> You may feel that 'corporate responsibility' and 'corporate parenting' are . . . concepts that bear little relation to activities in the real world. However, the fact is that children's lives are directly and profoundly affected by the quality of corporate parenting offered to them! ...This is not to replace or replicate the selfless character of parental love; but it does imply a warmth and personal concern which goes beyond the traditional expectations of institutions.[iv]

Former pupil Darren likens this approach to the process of roasting coffee beans. He caught the coffee bug after a period of prison and rehabilitation and insists that making good coffee is about giving the bean the right treatment and ‘putting it in the right context. The journey that you go on, how you nurture it, how you discover and release the potential within it. . . that’s rather like people.’ Drawing that comparison led Darren to upscale his belief into something organisational, developing a social enterprise business that teaches coffee making skills to help others step out of institutions into society, as he did.

> What is needed for someone coming from a traumatic background – who hasn’t even been shown how to live in a community in a healthy way – is a sense of shared responsibility. A sense that we can all change our community. If we’re transforming others, we’re all being changed. When I discovered that I can contribute to society, it’s that which keeps me away from the chaos.[v]

For CrossReach as an organisation, our own journey to establish homes for our young people in the right contexts and communities has been a long one, but one that has run in parallel with Scotland’s evolving legislation and aspirations. Back in 1992, Angus Skinner’s report, *Another Kind of Home*, highlighted that for some children, residential care should be considered a positive option.[vi] Reports that followed, while challenging, have also supported us in what we were trying to do. These, through to the findings of the Independent Care Review: *The Promise* (2020), coupled with GIRFEC, A Curriculum for Excellence, The Children and Young People (Scotland) Act (2014) and, most recently, the Scottish Parliament’s unanimous support for the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Bill, have all challenged us to think, do and behave differently.

In particular, *The Promise* states: ‘There must be no barriers for children to have regular, positive childhood experiences and Scotland must create an approach to care where maintaining, sustaining and protecting loving relationships is possible and much more probable.’[vii] So, it’s heartening to get feedback from another former pupil who lived at Ballikinrain long before we began instituting our move to home-style living: ‘It never felt like staff, more like family, with father figures mother figures, uncles, aunts, the type of structure a kid needs in any situation, that was given wholeheartedly.'[viii]

The rally car principle

From the perspective of Claymore's own key worker, Craig Faller, to be 'more like family' requires patience and an eye on the end goal:

> When I first started key working Claymore, I told him that we would be a two-man team, that we would work together to get the best possible outcomes for him. I assured him that we would go through his journey together, the good times and the bad times, and we would come out the other side stronger people with us both having learned something. I never made promises that I couldn't keep. Importantly, we never set targets that were outwith his reach.
>
> I used to look at it like being in a rally car. Claymore was the driver and I was his support /co-driver. I just gave him directions and he negotiated the road that would get us to our destination. Sometimes we got there unscathed and sometimes we crashed on route. But we would stop, assess the situation, make some repairs and then carry on our journey to the finish line.[ix]

Craig recognises that Claymore 'had a resilience about him and a determination to succeed and that is the ultimate reason he has got to where he is today'. Nevertheless, we would argue that the rally car principle was instrumental in establishing mutual respect and a strong bond over the years that has been maintained between these two men now that Claymore has moved on. From Claymore's perspective: 'I always had someone in my corner all the time. If you don't have someone who believes in you, what's the point?'

We would also suggest that this metaphor, which reflects the impact of trust and journeying alongside the young person in care, is one that can resonate at all levels of the residential care sector. It embodies the idea of partnership and mutual respect, ideally also to be found between a care organisation and the community within which its young people live (thus creating the 'right context' to release potential that Darren spoke about). It can, and should, also be fostered between legislators and care organisations, and legislators and care experienced young people themselves.

The confidence Claymore developed by being part of a smaller family-style environment was one factor that allowed him to get fully involved with Who Cares? Scotland, a national voluntary organisation that supports care experienced people to have their voice heard. He discovered they wanted to hear his ideas and what he had to say. He shared with others who'd had similar experiences and, together, they went to the Scottish Parliament and made their views known there as well. In such ways, our national duty of care for young people can prove its commitment to child centred responses – by listening to the information and guidance young people themselves present. If we want to get to a successful conclusion in the rally, we'll listen to what those with the knowledge have to tell us.

It's an approach exemplified by *The Promise*. We would argue that *The Promise* holds a level of credibility not because much of what it says is new (as our own organisational experience and the impact of earlier reports have demonstrated) but because it has heard and amplified the voice of care-experienced young people currently in the system and those who have come through the system in recent years. Their voices now have the potential to speak not only to the residential care sector but, crucially, also to the communities within which we operate.

Legislators, care deliverers and communities alike can be navigators, offering direction but from the passenger seat, allowing our young people to negotiate the road that will get us all to our destination.

> Looked After children and young people need continuity and stability and essentially they need listening to. In my opinion we need to improve the communication between local authority workers, from social, residential and education workers, to foster carers and senior officers, to make sure their roles and responsibilities are having a positive impact. Putting the young people at the centre of all they do will, I believe, improve the future of many.

(Young care leaver, quoted in Scottish Government, 2008[x])

For the children and young people and adults who have made that final step from Ballikinrain into local communities, the impact in just a few short months has been incredible. Young people are going to the local park and making new friends, neighbours arrive with home baking to welcome us, and one social worker described the atmosphere in one house as 'much more nurturing'. They added, 'J is more relaxed and happy'.

Positive, healthy and caring relationships have always been at the heart of what CrossReach does. Sometimes these relationships are with the place, sometimes with the people we have met and known, but for most of us, former pupils and staff members alike, it will be a mixture of both. So, we're certainly feeling some nostalgia around saying goodbye to Ballikinrain. Its grand entrance, elaborately carved staircases, and huge play spaces all contributed to the school's unique character.

But if we are aspiring (as the Scottish Government is) for Scotland to be 'the best place for children and young people to grow up', then isn't it important for them to be living within Scotland's diverse and vibrant communities and not set apart from them – 200 yards behind an estate wall?

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About the authors

Laurence Wareing is a freelance writer and editor, with wide experience across third sector organisations, including residential child care charities.

Paul Gilroy has worked in the Children and Young People's residential care sector for 35 years, most of them with CrossReach. Since 2007, he has been the charity's Head of Service, Residential Care & Education.

Notes

[i] '"We grow up loved, safe, and respected so that we realise our full potential." Scotland's ambition for children and young people', Independent Care Review: *The Promise* (2020: www.carereview.scot/wp-content/uploads/2020/02/The-Promise.pdf), p.1.

[ii] Stigma in Childhood project seminar, August 2017, University of Strathclyde, Glasgow.

[iii] Pineau, M. Gerstein, Kendall-Taylor, N., L'Hôte, E., & Busso, D. *Seeing and Shifting the Roots of Opinion: mapping the gaps between expert and public understandings of care experience and the care system in Scotland* (2018: Washington, DC., FrameWorks Institute), p.10.

[iv] Utting, W., cited in Scottish Government *These are Our Bairns: a guide for community planning partnerships on being a good corporate parent* (2008: www.gov.scot/publications), p.v.

[v] Howie, D., interview with authors, 14 July 2021.

[vi] Social Work Services Inspectorate for Scotland (1992) *Another kind of home: a review of residential child care (1992:* Edinburgh, Her Majesty's Stationery Office).

[vii] Independent Care Review: *The Promise* (2020) *op.cit.,* p.22.

[viii] Former pupil (anon), private Ballikinrain Facebook page, 13 June 2021.

[ix] Faller, C., personal email to authors, 15 May 2021.

[x] Young care leaver (anon), cited in Scottish Government (2008) *op.cit.,* p.v.

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Why engaging on children's rights internationally matters at the local level: 2021 Days of General Discussion on Children's Rights and Alternative Care

Miriana Giraldi

Abstract

With the forthcoming Days of General Discussion (DGD) on the Rights of the Child scheduled to take place in September 2021 to consider children's rights and alternative care, this article reflects on the opportunities provided by this initiative to engage with the UN Committee on the Rights of the Child as a global community. Looking at the role of the Committee and considering all the progress and achievement that has been possible since the 2005 Day of General Discussion, the article explains the purpose and ambition of the 2021 DGD, and makes the case for active participation and involvement in international policy and legal work in order to support the work at the local level, and in countries and communities around the world.

Keywords

Children's rights, human rights, UN Committee on the rights of the child, alternative care, quality care, prevention

Corresponding author:

Miriana Giraldi, International Associate, CELCIS, miriana.giraldi@strath.ac.uk

Introduction

The UN Nations Committee on the Rights of the Child — the body of eighteen independent child rights experts tasked with monitoring implementation of the Convention on the Rights of the Child (the CRC) and its 'Optional Protocols' by its State Parties — will hold 'Days of General Discussion' (DGD) in September 2021.

State Parties are all the countries that have signed and ratified the UN Convention on the Rights of the Child — currently the entire global community except from the United States — and have therefore made a commitment to protect and promote children's rights, for ALL children. This is a tremendous achievement, and one that requires ongoing commitment, dedication and perseverance from Governments at all levels, organisations working with and for children, and each and every one of us, if we really want all children, everywhere, to enjoy their rights.

The primary way in which the Committee carries out its monitoring role is through a process of reporting and dialogue with State Parties, which allows for assessing progress in each country and providing tailored recommendations. While Governments are the main interlocutors in this process, there is also scope for children and civil society organisations to contribute by providing information so that the Committee can gain a rounded understanding of the state of children's rights in any given country.

There are other tools and activities at the disposal of the Committee for the fulfilment of its role, which includes explaining the rights contained in the Convention and the Optional Protocols, and providing guidance on particular issues. This is exactly where the DGD fit — they are opportunities to foster a deeper understanding on specific issues or aspects of the CRC, and this year, the focus will be on Children's Rights and Alternative Care.

Originally scheduled to take place in September 2020 but postponed due to the COVID-19 pandemic, the DGD will be held online on 16th and 17th September

2021, over two half days, to enable participation from people and organisations from across the globe.

Why do we need to focus on the rights of children in alternative care?

The overall purpose of the DGD is to examine the current situation regarding alternative care worldwide, to identify and discuss particular areas of concern with regard to the unnecessary separation of children from their families, and to identify appropriate ways to respond to family and child separation in cases where it is unavoidable.

The specific objectives include acknowledging the harms that care can cause and the abuse of some children in care and exploring measures that can be taken to ensure prevention, intervention and access to justice, accountability and suitable reparation. Additionally, the DGD will provide an opportunity to explore efforts towards the development or strengthening of child protection and alternative care systems, grounded in a multi-sectoral approach; and encouraging rigorous research to identify the outcomes and impacts of alternative care provision in different settings, and follow-up mechanisms for children leaving care.

This will not be the first time that a DGD is dedicated to the rights of children who are in or at the edges of care. In 2005, the focus was on children without parental care, a topic that was chosen by the Committee because of growing concerns about the rights of children who were growing up without the primary protection of their parents or caregivers. These concerns were rooted in the large numbers of children across the world who were coming into care, the quality and conditions of alternative care provided, and the low priority afforded to responding appropriately to these children. All this had transpired through the Committee's monitoring work on the implementation of the Convention.

A lot of progress has happened in the intervening years, building on the outcomes of that DGD, when the Committee recommended the development and adoption of 'a set of international standards for the protection and alternative care of children without parental care' (Committee on the Rights of the Child, 2006). This was based on the written contributions that had been submitted in preparation for the DGD, and on the discussions that took place. The United Nations Guidelines for the Alternative Care of Children were developed and subsequently welcomed by the UN General Assembly, unanimously, in 2009. Their drafting, and development, was possible because of a concerted effort made by Governmental and Non-Governmental actors alike — and their implementation is also dependent on all relevant stakeholders working together. Several tools were created to promote awareness, understanding and use of these Guidelines: ‘Moving Forward: Implementing the Guidelines for the Alternative Care of Children’, a manual offering practical guidance as well as promising practice examples from across the world; ‘Getting Care Right for All Children’, a massive open online course (MOOC) aimed at policy makers, practitioners, and all those involved in providing services around children’s care; ‘Tracking Progress’, an online tool to support those involved in strengthening care systems in measuring progress in the implementation of the Guidelines in their countries; and the ‘Alternative Care in Emergencies Toolkit’.

The aspiration of the 2021 Days of General Discussion

In spite of all these developments, more remains to be done to ensure that all children without, or at risk of losing, parental care can have their rights respected and actively promoted. Child protection and care systems need strengthening, and forms of unsuitable alternative care must be phased out. This year, there is the intention to recognise the impact of the Covid-19 pandemic and lockdown measures that were adopted, to ensure we learn from experience and build better, and more resilient, systems of care. There is also an ambition to focus on addressing the needs and rights of children who are separated, unaccompanied, or without care; and to discuss access to justice and accountability for children, their families, and adults who grew up in care. Finally, there is the motivation to consider how to strengthen families and communities to avoid all unnecessary separation, how to deliver quality, appropriate care services and to transform systems towards family and community-based care.

The ambition of those working to prepare and organise the DGD is to make it a forward-looking and solutions-oriented one. And also, most important of all, to ensure that it is fully participatory, and a platform for all those with lived experience, or direct experience of working in child protection and alternative care systems, to participate and share information, from as many different regions and contexts as possible. This is what will allow us all to share and learn and consider solutions that can deliver the change that is needed. This commitment is already reflected in all the preparatory work.

The UN Committee on the Rights of the Child has received many submissions through its open call, and high numbers of children and young people have engaged through a global consultation. All of this information will be read and analysed, and will form the basis of the proceedings during the DGD itself. Active participation will continue to ensure that the focus is where it needs to be, and that DGD outcomes will help us, as a global community, to continue to make progress. As the 2005 Day of General Discussion demonstrates, this activity can lead to much learning and progress, and to the development of tools that can be used by Governments and authorities at all levels, and also by civil society, service providers, and NGOs. The work of international bodies can feel very remote for individuals, or those working at the local level. Ultimately, the aim is really to understand what happens at the grassroots, and to facilitate positive change and advances locally — wherever that may be. This can only happen if we all play our part. Indeed, international standards and guidance are useful in promoting positive change on the ground if relevant stakeholders know them and use them, for example, to develop and promote better services and systems, or to hold authorities to account. Though they are great accomplishments in themselves, it can be more helpful to think of them as tools that we can use to make progress on the ground, in our communities in countries all over the world.

So, let’s engage, participate and share — so we can all move forward together.

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About the author

Miriana Giraldi is International Associate at CELCIS and has a background in European and international policy. She is interested in strengthening the evidence base to inform policy and practice.

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Stability in residential care in NSW, Australia: The role of the workforce

Jenna Bolinger, Philip Mendes, & Catherine Flynn

Abstract

Stability in residential care has, to date, been operationalised by fundamentally counting placements and equating these with varying levels of stability. In so doing, it has been found that having many placements (i.e., indicative of instability) is associated with diverse problematic outcomes including increased criminalisation, increased mental health difficulties and ongoing placement instability. On the other hand, however, stability has not been found to provide repair. This paper examines staff's roles and needs required for providing stability. Thirteen staff who worked in residential care in New South Wales participated in semi-structured interviews regarding their thoughts on what brings stability to a residential care placement and the impact of stability on a young person's outcomes. Analysis was conducted using thematic analysis and QSR NVivo. Findings suggested that staff were required to provide consistency and work within a therapeutic lens when delivering residential care to young people. To do so, they required support from the organisation in terms of training and supervision. The findings suggest that stability can be achieved in residential care largely via consistent relationships with staff who are well supported by their organisations

Keywords

Residential care, stability, youth work, out-of-home care, Australia

Corresponding author:

Jenna Bolinger, PhD candidate, Monash University,

jenna.bolinger@monashedu.au

Residential care in Australia

Residential care forms part of child protection and child welfare systems in most developed countries (Ainsworth & Thoburn, 2014). Within Australia, out of home care (OOHC) is governed by the individual states and territories, with non-government organisations (NGOs) responsible for the day-to-day management of the young people in their care. Most young people in the broader OOHC system live in foster care or kinship care, with only about 6% of young people in residential care; according to recent 2019 data, this equates to 2,876 children in residential care across Australia (Australian Institute of Health and Welfare [AIHW], 2020). Residential care facilities typically look after children and young people aged 10 to 18 years (82% are aged over 10 years according to AIHW, 2016).

Stability in residential care

Stability has historically been measured using a ‘placements-over-time’ paradigm, meaning that an individual’s experience of stability has been determined by the number of placements they have experienced over their time in care (Unrau, 2007). Stability has been examined in foster care settings, rather than residential care settings, wherein the counting of placements can be extrapolated to indicate consistent carers and, to an extent, consistency of residents within the house. Within residential care, however, the ongoing nature of a single placement does not, in and of itself, indicate any consistency within that placement. Staff may change, residents may change, management structures may change, all while a young person remains within the placement.

Outcomes associated with instability

Placement instability, as measured by a placements-over-time paradigm, has been found to lead to a host of negative outcomes for young people, particularly in the areas of mental health, attachment difficulties, behavioural problems, sexual and general offending, and executive functioning difficulties, which includes the abilities to plan, set goals and inhibit behaviours.

Placement instability has been found to be linked to greater use of mental health and psychiatric facilities (Fawley-King & Snowden, 2013) and increases in anxiety and depression (Pritchett, Gillerg & Minnis, 2013). According to Newton, Litrownik and Landsverk (2000), placement instability can lead to externalising behaviour difficulties, such as aggressive behaviour or property damage. The authors found that over a study period of 18 months, behaviour problems increased as placements increased. Further, multiple placements have been found to reduce executive control, which relates to the ability to self-regulate emotions and behaviour (Lewis et al., 2007), while other researchers found that as unique foster placements increase, a child's ability for inhibitory control decreases (Pears et a., 2010). Therefore, as placement numbers rise, it appears that young people become more behaviourally dysregulated, and have less capacity to inhibit problematic behaviours or regulate their emotions.

Given that counting placements only provides detail about the number of placements a young person experiences, rather than the quality of the placements or the quality of the connections, what appears to be stability may rather equate more to a time in which a young person has not changed placements. Therefore, an examination of what constitutes stability, and how that can impact on outcomes for young people, is necessary. Tarren-Sweeney (2017) stated that for many very complex young people, a positive outcome may simply be a lack of deterioration. Therefore, the provision of stability may not lead to overtly positive outcomes, rather it may provide a buffer against negative outcomes. This supposition, however, is likely to be based on an operationalisation of stability that does not include a focus on connection and therefore may underestimate the power of stable connections.

This paper will address the elements that are key for staff to be able to provide a stable environment for the youth in their care; what supports do they need; how do staff create stability and what is their experience of stability for the young people they care for?

Methodology

This paper will seek to answer the research question, ‘How do residential care workers define, understand and explain placement stability’? This question interrogates what has not previously been explored in the literature, i.e., what actually constitutes stability in a complex, multifaceted environment with many moving parts, including a rotating roster of staff, co-residents and a management system including team leaders, managers, caseworkers and psychologists. The research question is inherently exploratory as stability has not, to date, been examined as a construct as part of the literature and secondly has not been considered within residential care. Therefore, a qualitative approach was taken to undertake in-depth interviews with key personnel involved in residential care. To do so, 13 interviews with residential care staff were conducted, including youth workers, managers, clinicians, and senior management staff.

Staff participants had a mean age of 44.4 years (min 20.0; max 51.0), with eight males and five females participating. As is evident, there is a wide range of experience held by the participants, with a mean number of years as 10.8 years. Most participants have a degree (either undergraduate or post-graduate) from a range of disciplinary backgrounds including psychology, social work, and youth work. It is notable that the sample is highly educated, with nine out of 13 (69.2%) staff participants holding at least an undergraduate degree, with 23% holding postgraduate degrees. Those that hold lower qualifications, such as a Technical and Further Education (TAFE) qualification or high school degree, dominated the youth work/floor staff demographic. According to a Victorian state survey undertaken by The Centre for Excellence in Child and Family Welfare Inc (2015), who examined statistics about the residential care workforce from over 20 organisations with 1,597 staff members, of whom 37% were male and 63% female, and 62% held post-secondary school qualifications, 14% of whom had university qualifications. This finding suggests that the current sample is more highly educated, with a greater proportion of male staff than is typically found in residential care. Regarding the positions held by the staff, many participants have previously or currently held roles in management at co-ordinator or manager level. Two participants worked in upper-level management, two held clinical roles and the remaining participants had the majority of their experience working ‘on the floor’ in residential houses. This sample provides a wide range of voices of those who have worked in residential care including understandings of how stability has been enacted, how it has failed and the consequences of both.

Purposive and snowball sampling was used to identify suitable individuals to interview, and participants were subsequently asked if they were aware of any other individuals who may be suitable to participate. The researcher’s details were then passed to those potential participants for them to contact the researcher.

Semi-structured interviews were undertaken with participants that sought to identify the elements of stability that were perceived as significant. Questions were asked in relation to positive and negative placement experiences, the impact of stability and instability, the impact of co-resident changes and the impact of positive and negative matching. The data were analysed using thematic analysis (Clarke et al., 2019) and QSR Nvivo.

Results

Staff members identified several elements that contributed to stability, many of which were also identified by the young people. Staff particularly identified that consistency within the staff team was necessary, that they required support, supervision, and training to be able to do their jobs well, they needed the agency to be able to ‘push back’ against the funding body to reject inappropriate referrals and that a trauma informed approach was particularly necessary. These will be discussed in turn. The staff’s experiences of the impact of stability on the young people in their care will also be examined.

Consistency

Stability for young people requires the external experience of consistent, strong staff members who are known to the young people and each other; working in consistent and predictable ways.

> …for me a stable placement means that there is not frequent changes in the staffing and other young people coming and going and their case worker and clinician and other people around them, I think that stability is the people that are involved in their life or constantly there even if they stay in the house is just as unsettling for them as moving frequently which is a worst case scenario. (KI, co-ordinator)

Without consistent staffing and a consistent routine, young people cannot experience a placement as being stable. Therefore, of fundamental importance is that consistency of attachment figures and predictability in the day-to-day experience of the placement is prioritised.

Organisational scaffolding

The way the organisation functions is an important element of stability, according to staff participants. The organisation provides the scaffolding for staff to be able to do their jobs, by providing training and support, ensuring that the staff feel listened to and empowered to do their work well. When this does not occur, however, staff are more likely to burn out and create instability within the team and the house by using their leave allowances.

> I've got a good manager who makes me feel supported because she's always working hard to keep the team together and she's always working with the team and she has the same goals we have - trying to make it like a family environment as best we can. So, my manager is really good like and the rest of my team are really good but it's a hard struggle sometimes for the team. (AB, youth worker)

> Training is helpful as well, of course, like psycho-education for staff to be able to understand, I suppose, that what they're seeing in the behaviours that they're observing and trying to manage, that's actually coming from a place and that's not that a child's just defiant that there are underlying causes for that behaviour which I suppose in a way it helps other staff develop

> more empathy and more understanding so that they are a little bit more patient, nurturing, those sorts of things instead of just being reactive to the behaviours that they're trying to deal with. (SH, co-ordinator)

The need for the organisation to scaffold the staff to be able to do their job is highlighted by staff. Staff at different levels of employment, from floor staff to high level management, noted that managerial support, in terms of providing support, supervision and training, was integral to ensuring the staff were able to remain in their roles. In developing an understanding of stability, if consistent staffing were a key element, then organisational support, and scaffolding form the bedrock beneath the consistent staff teams.

Push-back

Further, those in higher level management and clinical roles described the need to manage relationships with the funding bodies to ensure that the funded obligations are met, without jeopardising the day-to-day running of the organisation itself. Some participants indicated that the ability to 'push back' against the funding bodies provided greater ability to ensure more appropriate matching of residents in the houses.

> But in terms of how much of influence you have is relative when you think about you are contractually obliged to have certain places and if there's a vacancy then you are contractually obliged to take whatever is remotely applicable. So even if that matching is not entirely workable, you still have to do it and then consider what the risk is and then ameliorate against the risks. We were always addressing it from a position of risk, of best interest, because you don't have it. If you only have 10 houses and you only have a vacancy in 1 of those houses, then the referral can only go there, otherwise what you're doing is moving other young people to create spaces. (SJ, area manager)

The difficulty of managing these relationships with funding bodies was highlighted by these individuals who noted that, while there is some possibility of push-back, this is limited by the contracts and by the need to be able to pay staff when agencies are funded for beds to be filled. This forces a difficult balancing act of managing those relationships, managing less-than-perfect placement options or the possibility of destabilising otherwise stable placements to make a better match for the referred young person.

Trauma informed care

Staff participants identified the need for an understanding of, and need to implement, trauma informed care. Within this context, staff identified that when they can understand the impact of trauma on the developing brain and attachment systems, they are better equipped to respond in helpful ways to the young people and maintain a positive and stable placement. With the knowledge about the impact of trauma, staff were able to understand the dynamics within the house better and make informed choices about how to respond, rather than reacting to problematic behaviours and interactions.

> …a lot of the time we see staff entering into power struggles, conflict cycles with young people and allow ego and power to dominate the conversation as opposed to the development of the child so there was a lot of that that we saw. But once staff get a really good understanding of trauma informed practice then things tend to change. (WC, manager)

In seeking to understand stability, a trauma informed workforce is more likely to focus on the development of the young person, understand the dynamics at play and work with that young person, rather than against them in times of crisis and be able to repair any ruptures that occur. Thus, promoting a stable placement requires staff to be able to manage difficult interactions in helpful ways and this is, according to staff, facilitated by an understanding of trauma informed care.

Stability as reparative

Staff noted that when stability was present, they observed reductions in problematic behaviours and increases in prosocial behaviour.

> …young people getting into employment, finding their own accommodation, family restorations, young people starting their own businesses, getting their licenses, going on to live independently. You know we've seen young people that have grown up and had their own children, being good mums and dads, basically breaking generational curses. (JA, manager)

> I've seen kids go on to basically, once they've had stability, they've been able to resolve their trauma. And when they've been able to do that, I've seen an increase in their educational functioning, I've seen an increase in their health functioning, I've seen an increase in their social functioning. (WF, clinician)

Discussion

Consistent staffing

Staff identified the need for externally stable elements for a placement to be considered stable. Consistency applied to both the staff members and constancy within the house including staff interpretation and enacting of the rules, and routines, and how the staff managed various situations, such as maintaining routines or addressing behavioural difficulties like property damage or self-harm. It was noted by one of the senior management staff members that staff who are struggling may have a tendency to take advantage of their leave allowances, or call in sick, which increases instability for young people. When this occurs, young people cannot predict who will be caring for them, which contributes to inconsistency and unpredictability within the house.

This finding has not previously been found in the extant literature on stability; however, this can be explained by the previous literature being based in foster care. The key difference between foster care and residential care is that foster care is a family-based model, in which the young person resides with the family, as part of the family. Therefore, for a placement to be consistent, the caregivers also, by definition, are consistent and known to each other and those in the placement. This difference between the placement types highlights the need for research examining stability specifically in residential care.

Organisational scaffolding

Training and supervision were identified by staff as being important. Staff noted that training allowed them to understand what was occurring with the young people and develop strategies to assist the young people more effectively. Further, ongoing supervision provided support to the staff, and they noted that in the absence of support, staff would have a tendency towards burnout and may take advantage of their leave entitlements which, in turn, creates greater instability for the young people. Youth work staff identified that the presence of good managers can make a significant difference to morale when there are day-to-day challenges to cope with. Management staff, however, spoke of the need to provide support to their staff to assist when there are challenges, to reduce burnout. The outcome studies regarding young people in residential care do not typically refer to the training undertaken by the staff looking after the children and this has not been a feature of any analysis to date. The provision of training and supervision, while not a direct component of stability, does provide a buffering for staff against the challenges of their work, thus providing a greater likelihood of stable and consistent staffing and approaches to their work.

Push-back

Some staff, specifically those in upper management and one clinician, were able to identify the need to push-back against the funding body where possible to ensure that appropriate matching can be done. The issue of ‘push back’ fundamentally relates to advocacy and the expertise the managers have regarding the individual young people, the houses, and the staff’s capabilities. Being able to argue against inappropriate referrals would facilitate the matching process, making it more likely that positive matching can occur for both staff teams and the other young people in the placement, which would increase the likelihood of stable placements. The inability to do this, however, creates a fundamental flaw in the ability to plan for stable placements.

Trauma informed care

The staff described how awareness of the influence of trauma on the developing brain and attachment systems altered the way they interacted with the young people, particularly during difficult periods, such as when the young people were acting out towards the staff. It was notable that there were differences in which staff spoke explicitly of trauma informed care, with the youth work staff using the language less frequently than the management staff. This may be because the staff spoke about how they work with young people, rather than the overarching principles of what they are doing. It is notable that at least two of the youth workers involved referred young people to be interviewed, meaning that, between two- and six-years post-leaving care, the young people have ongoing meaningful relationships with those staff members. Therefore, while they did not use the language of trauma informed care, they have naturally engaged in it.

Stability as reparative

The staff participants were able to identify positive elements of healing associated with stable placements, including improvements in connections to the house and the staff, increased school engagement, improved communicationand an ability to heal from their past trauma. This finding is particularly significant given that it is contradictory to all previous findings. Tarren-Sweeney (2017) hypothesised that, at best, stability could provide a buffering against negative outcomes. The staff members were unanimously able to identify positive outcomes resulting from stability for their young people. To make sense of this finding, we must consider the initial proposal that in operationalising stability by measuring the number of placements a young person experiences over a time frame, the important elements of what make a stable placement get missed, such as consistency and quality of relationships.

Conclusion

The significant findings of the current research include the need for ongoing stable and consistent relationships with safe adults who genuinely care about the young people. The staff that provide those supportive relationships, equally need to be supported by the organisations that they work for, through management, training, and supervision. Furthermore, the findings challenged the assumption that remaining in a single placement was sufficient for an experience of stability, through the need for consistent caregivers and the difficulties associated with casual staffing.

Staff participants were able to identify positive elements of healing associated with stable placements, including improvements in connections to the house and the staff, increased school engagement, improved communication, and an ability to heal from their past trauma. Staff have a crucial and key role to play in the provision of stability and the organisations have a crucial role to play in providing an environment in which staff can provide such stability.

The experience of stability has little to do with an ongoing placement, however, this is a necessary condition of stability. A felt sense of stability within a placement appears to be related more strongly to a consistent placement with whom the young people can forge and maintain genuinely caring relationships that are supported by the management of the organisation.

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About the author

Jenna Bollinger has a master's in forensic psychology from UNSW and is currently completing her PhD at Monash University, investigating stability in residential out of home care in NSW, Australia. She has worked in out of home care in different capacities since 2012 and is currently the director of psychology and clinical services for Knightlamp, which consults on assessment and implementation of therapeutic programmes in out of home care across Australia.

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Reflections on lifespace intervention in social work

Kathy Grant

Abstract

This article is a reflective piece about my own personal experience of frontline social work practice during this surreal time that we continue to live through. The response to the pandemic has brought challenge but has also created positive opportunities for reflection, change, motivation and for me personally, created a re-energising for the parts of the 'job' I had forgotten just how much I missed. By 'job' I mean not my job as a social worker or residential child care worker, but the job of building relationships and connecting with people by just spending time with them.

Keywords

Relationships, lifespace, social work, residential child care

Corresponding author:

Kathy Grant, Social Worker, Falkirk Council, Kathy.grant@falkirk.gov.uk

Introduction

This article is a reflective piece about my own personal experience of frontline social work practice during this surreal time that we continue to live through. When I was a student there was a strong focus on prioritising time to critically analyse and reflect on our practice and what impacts on our work in quite a formal way. Remember the reflective logs during placement? As we become more experienced and workloads increase, our capacity to explore and put our reflections down on paper becomes more difficult to prioritise. However, engaging in the process of critical reflection is an important part of the social worker role in terms of identifying challenges and successes.

Critical reflection is defined in various ways in research. However, Fook (2012) highlights the agreeable view that developing our skills around reflection increases our ability to be transformative, in terms of the capacity to positively impact our practice and 'to involve and lead to some fundamental change in perspective' (Cranton, 1996, pp. 79–80).

The process of writing this piece has allowed me to meaningfully reflect on areas of my practice, especially around relationship-based practice and consider how social workers can perhaps be enabled to work in more reflective and relationship-based ways.

Reflections

The experience of the last 18 months has been a very surreal one. I did not imagine that I would live through a global pandemic, and I wonder what the long-term implications will be on the world, our life and what happens now and next. Me and my colleagues are also wondering what work life will be like when there is still a need to protect each other from the virus whilst also protecting the needs of the children, young people and families we work with as best we can.

As a significant part of the workforce was required to shield, myself and my social worker colleagues in Scotland, the UK and the rest of the world have faced many challenges. However, we have continued to go the extra mile, worked even more extra hours, worked extra days, and taken on additional duties to help each other to support the workforce and most importantly the families, children and young people who have continued to need us. Ferguson, Kelly and Pink's (2021) recent research highlights just how complex the moral and practical dilemmas are that services have faced when responding to complex child protection needs. We have also realised how important we are to each other as teams, colleagues and friends. We have missed the informal peer support we gave each other, which we perhaps didn't know we needed until the effects of the pandemic took away these valuable moments of being there for each other. The fears about home working, 'bubbles' and hot desking that are around as we tell the people within strategic roles that we must protect the relational security of our vocation — and we want and need our teams back together soon.

However, the response to the pandemic has also created positive opportunities for reflection, change, motivation and for me personally, created a re-energising for the parts of the 'job' I had forgotten just how much I missed. By 'job' I mean not my job as a social worker or residential child care worker, but the job of building relationships and connecting with people by just spending time with them. As a residential child care worker I used to do this every day: the walking to the shop; the watching TV; the playing football; the doing homework; the having fun; the brushing their hair; the being there during the rhythm and routine of the day. These are the activities that may be questioned as not being a good use of a social worker's time in a profession that is increasingly saturated by the demands of child protection, report writing, case recording and assessment. However, I would argue that engaging in these sorts of opportunities are sometimes the best use of our time given the theories behind relationship-based practice and the view that the task of assessment takes place within the context of a relationship. Relationships are universally acknowledged as crucial to our practice; 'the heart of social work' (Trevithick, 2003) and the thing that 'underpins social work practice in all its forms' (Ruch, Bryan & Hingley-Jones, 2016). Much of the literature which discusses child and youth care cites the words of Uri Bronfenbrenner who argues that 'every child needs at least one adult who's crazy about them' (1977, p. 5). Gilligan (2008) also advocates for the necessity for children and young people to experience an 'emotional connection' to another human to influence 'healthy human development (2008, p. 46). An attachment perspective recognises that 'relationships are generally the place where things can go wrong in the first place, but equally relationships are generally the place where things are eventually put right' (Howe, 2005, p. 204). This strengthens the argument that creating environments within social work that encourage young people and their social worker to establish and build positive, genuine connections which value the therapeutic benefit of spending time together is vital… challenging, but vital.

When reflecting on the opportunity I have had during the pandemic to support the residential services within the local authority I work in, I found this to be an enriching, positive, fun time. This has enabled me to remember the value that both young people and adults can gain by spending time together doing what may appear to be nothing but is in fact an important therapeutic exchange in terms of that relationship. I have missed working in the 'lifespace' with young people and I will use this as a reminder of how valuable this approach is to social work practice.

Steckley (2013) discusses that the term 'lifespace' was first coined by Kurt Lewin in relation to residential child care to help illustrate to care workers the 'totality of the care task' that they undertake (p.24). Steckley discusses the potential of the residential milieu and the opportunities that arise to nurture the therapeutic relationships that exist, and how these can be embraced. Literature would suggest that residential child care workers have a huge advantage over statutory social work professionals in terms of relationships given their position and opportunity to engage in work within the 'lifespace' (Ward, 2007, p. 17). What a worker does in response to a particular behaviour or event is sometimes called 'lifespace intervention' (Smith, 2005). For me, in my role as a residential care worker, terms such as 'lifespace intervention' and 'opportunity-led work' provided a conceptual and theoretical framework from which to make sense of and describe my role. In relation to residential child care, Ainsworth (1981) stated that 'practitioners take the theatre for their work the actual living situation as shared and experienced by the child' (p. 234). When embracing a lifespace intervention approach to our practice we should remain mindful of the benefit that the conscious use of everyday opportunities can have for children and young people. A skilled, self-aware practitioner will have the ability to engage with a young person meaningfully in a therapeutic way about their lived experience using these everyday opportunities. Lifespace interventions should have a purpose or goal and have the potential to reinforce the actions that are identified in the Child's Plan. For example, if what we want to happen is for the child to be safe and protected from the exposure from parental domestic abuse then we should play alongside the child when he or she begins to play with Lego and recreate violent scenarios between mum and dad, as these may be memories from the child's own lived experience and create opportunities to provide a therapeutic response. Or if what we want to happen is for the child's emotional wellbeing and mental health to be supported then we need to create opportunities for learning and conversation around this. For example, choose a movie to watch with a relevant theme that can encourage a chat about feelings and how this may relate to the child. By doing this the adult can connect with the child in a way that makes sense to them in a purposeful but therapeutic way. Although, this way of engaging with a young person can sound simplistic, it is a skilful task and requires practice and an awareness of our use of self to enable us to spot the opportunities for communication and engagement that may arise during interactions, and then decide how to best respond (Ward, 2002). Allsopp (2007) discusses the complex nature of lifespace work and highlights the risk that some professionals can be in the lifespace of a child but are unable or unaware of how to engage in the opportunities that are being provided to them by that child.

In considering how social workers can embrace a lifespace approach to practice it is important to remain mindful that unlike a residential child care worker social workers may not care for young people in the same way, but we do care about the young people we work alongside. Therefore, when considering the framework of lifespace intervention, our lifespace with the young person will be our relationship. It can be argued that we will have more potential to strengthen these relationships when interactions do not only take place within 'planned sessions' that have a specific focus usually determined by us. In my experience the having fun and co-creating memory making moments can have a tremendous impact on the quality of a relationship with a young person. I am not naïve to the fact that social workers usually become involved with a young person following some sort of crisis and our interactions may not always feel positive at those times. Research carried out by Hill (1997) argues that children and young people who have a social worker have experienced the abuse of adult power. He suggests that being mindful of how we engage with young people has the potential to help redress the impact of abuse of power if they are enabled to feel they have influence and some degree of control over their lives and how they engage with us. His research also found that the young people spoke most positively about the relationship with their social worker that was established through spending time with each other.

Conclusion

So, to reflect on what I have learned during the pandemic and my time supporting the residential services, I have realised that I have missed the relational focus, therapeutic potential and fun of the lifespace.

Social workers should be enabled and supported by their employer to challenge cultures that maintain barriers which do not fulfil the aims of The Promise and nurture the workforce to feel ‘supported to listen’ to children and young people creatively when they need it, not only how and when the needs of the business dictate (Independent Care Review, 2020). Listening to children and young people is enshrined in law and policy and it can be argued that when we are unable to listen as well as we want to it is usually the result of the bureaucratic pressure that is placed on the workforce. The recently published English Government commissioned children’s social care review’s The Case for Change report simply stated that ‘the greatest value of social work is the interaction between social workers, children and families’ (The Independent Review of Children's Social Care, 2021, p 77). However, the Report of the 21st Century Social Work Review, Changing Lives (Scottish Executive, 2006) documented similar findings, stating that the quality of the therapeutic relationship between social worker and individual or family is critical to achieving successful outcomes.

Therefore my colleagues and I feel deflated that despite historic call for change little appears to have shifted in terms of providing the workforce with the space and time to focus on relationships given that the same messages continue to come out from significant case reviews, research and government reviews of our systems. (Munro Review, 2011; Morrison, 2016)

Messages from research and discussions with my colleagues and managers suggest social workers want the decision makers and influencers who operate at a strategic level to better understand that the task of establishing, building and maintaining relationships with children, young people and their families is an essential yet complex, skilful, emotional process. It is a process that requires us to invest our time in order to maximise the therapeutic potential that our relationship-based interventions can have.

As social workers we are aware that for a therapeutic intervention to be as successful as it can, it must be engaged with within a genuine, meaningful relationship. We want to invest more of our time in these relationships and in my experience our managers want to help us to do this more, too.

This can be challenging for social workers especially in the current climate and pressure faced by the workforce. However, I am optimistic when considering The Promise and the drive for Scotland to 'build a country that cares, made up of services that work to meet the needs of children' (Independent Care Review, 2020, p. 9). Social workers already do care enormously and the call for 'strategic, needs based planning for children so they are provided with warm, relational, therapeutic, safe, loving environments when they are required' would suggest an understanding that the workforce is not the issue, and it is the structures around the workforce need to change (Independent Care Review, 2020, p. 112).

Social work will always be underpinned by legislative frameworks and policy to guide the basis of our intervention and assessments, and reports will always be required from us to evidence the impact of these interventions. However, if the social work profession can be mindful of the benefit of adopting a lifespace approach to practice in the same way that the residential child care profession are, I think that is that can only be a good thing for the workforce and the young people in terms of relationship based practice.

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About the author

Kathy Grant is a children and families social worker. Before that she worked in residential child care for a number of years.

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A personal reflection: In for the long haul

Frank Ainsworth

Abstract

In the early 1970s Frank Ainsworth was appointed to a lectureship in social work at the University of Dundee. Shortly after, he met Leon Fulcher, an American, at a conference in Aberdeen. Fulcher was at that time a lecturer in social work at the University of Stirling. Their mutual interest was residential care for children and youth, and this is what they were hired to teach. This article documents their scholarship that commenced in Scotland. In some measure it also documents the relationship and careers of Ainsworth and Fulcher that have both coincided and diverged across the years. They met at a time when the education of residential workers was moving away from specialist courses and was being merged with mainstream social work education, the responsibility of the former Central Council for Education and Training in Social Work. For some this was seen as less than successful as far as the professionalisation of residential services for children and youth was concerned, at least in England. Ainsworth and Fulcher made important moves in career and country of residence in the mid-1980s: Fulcher to New Zealand as Professor of Social Work at the Victoria University of Wellington; Ainsworth to Australia as Head of School of Social Work at the Philip Institute of Technology in Melbourne. Both have retained an active scholarly role, together or with others, in relation to residential services for children and youth. Even after 40 years this continues. This article is a personal reflection on Ainsworth's and Fulcher's personal and professional journeys.

Keywords

Reflection, group care, residential child and youth care, global perspectives, formative experiences, witnessing change

Corresponding author:

Dr Frank Ainsworth, Senior Principal Research Fellow (Adjunct), School of Social Work and Human Services, James Cook University, frankainsworth@hotmail.com

Getting started

Starting in 1981, Fulcher and Ainsworth produced three edited books about the residential care of children and youth (Ainsworth & Fulcher,1981; Fulcher & Ainsworth, 1985; Fulcher & Ainsworth, 2006). The books included contributions from key residential services professionals from the USA and from the UK. In the first book, the field of group care was set out as embracing institutional care, residential group living and day care services that are found in all four major human service resource systems: health, education, social welfare, and justice (Ainsworth & Fulcher, 1981, p. 8). All of these were defined as group focused services, where practice is in the life space rather than in an office environment. In particular, the focus is on how residential childcare staff practise in a public arena where they are constantly under the gaze of fellow workers, hence the life space conceptualisation.

More recently, the group care field has been expanded to include, for example, university halls of residence (Islam & Fulcher, 2021, p. 14). In doing this the authors draw on the concept of group care as a field of practice, from the first Ainsworth and Fulcher book (1981).

Global perspectives

Leon Fulcher and Tuhinul Islam from Bangladesh have published four books since 1986 that document the use of residential services for children and youth in 71 of the world’s less developed countries (Islam & Fulcher, 2021). This major achievement shows the extent to which residential services for children and youth continue to be a major source of care. Since the Stockholm Declaration (Stockholm, 2003) the push in Europe and North America has been to spread a policy of deinstitutionalisation. More recently Eurochild (2010) has promoted this concept in European and Eastern European countries, and Flagotheir on behalf SOS Villages is promoting deinstitutionalisation in Asia (Flagotheir, 2016). This is even though deinstitutionalisation is primarily a northern hemisphere concept.

Formative international experiences

In 1975-76, Ainsworth was awarded a Nuffield Social Science Fellowship, which enabled him to spend sabbatical time at the School of Social Work, University of Washington, Seattle. This gave him the opportunity to meet Henry Maier and Jim Whittaker, both stalwarts of residential care of children and youth. In 1987 Henry published Developmental Group Care of Children and Youth that many would regard as a monumental contribution to the field.

Whittaker remains active and was instrumental along with Jorge del Valle and Lisa Holmes in publishing Therapeutic Residential Care with Children and Youth: Developing Evidenced Based International Practice (2015). In 2022, Whittaker, with Jorge del Valle, Sigrid James and Lisa Holmes, will steer the publication of Revitalizing Residential Care for Children and Youth: Cross-National Trends and Challenges. These two books make a substantial contribution to the international literature on residential care for children and youth.

Whittaker also organised an invitation only International Working Group on Therapeutic Residential Care that had a first meeting in Loughborough, England in April 2016, attended by 32 participants from eleven countries. This meeting produced a Consensus Statement about Therapeutic Residential Care for Children and Youth. The statement was widely circulated and was published in Australia, UK, Holland (in Dutch), Israel (in Hebrew), Japan, Spain, and the USA. This working group continues to meet albeit in a virtual format due to Covid-19.

The sabbatical year exposed Ainsworth to American residential programmes, and to other American scholars with an interest in residential services for children and youth. One such person was Anthony (Tony) Maluccio from the University of Connecticut, who was later to move to Boston College as the head of the doctoral program. In the 1990s Maluccio, recognised by his peers as an outstanding child welfare scholar, supervised Ainsworth's PhD and the required 1996 thesis titled *Family-Centered Group Care: Model Building.*

Subsequent to the 1970s sabbatical, international travel to conferences — in Canada, many European countries, Israel, North America, South Africa, and Australia — in the search for more knowledge about residential services for children and youth, became an on-going mission. This continues today with an active research relationship with Boys Town, Omaha, an important American child and youth serving agency (Huefner & Ainsworth, 2020; 2021).

Fulcher made another international move in 2004, to an academic position and a period of residence in the United Arab Emirates as Dean of Students, before returning to New Zealand. This was an important formative period as he regards student halls of residence as forming part of the field of group care settings.

As can be seen, international experience and residence has, for Ainsworth and Fulcher, provided diverse experiences that led to a rich international perspective on residential care of children and youth. This perspective is now being taken up by others (Whittaker, del Valle & Holmes, 2015; Whittaker, del Valle, James & Holmes, forthcoming).

Witnessing change

Ainsworth's doctoral thesis was about putting the family of a child in residential care centre-stage, even when a child or young person was unlikely to return to live with their birth family because of child protection concerns. It emphasised the lifelong importance of family relationships and sought to maintain these as much as possible, rather than have them fragment though neglect. In that respect the concept of family-centred group care was a forerunner of the present-day emphasis by residential programmes on parental engagement (Small, Bellonci & Ramsey, 2015). It was also a move away from the then common house-parent model of residential care for children and youth, where a married couple tried to create an illusionary sense of family by claiming substitute status, when most children and youth in residential care at that time already had a very much alive, real family (Hansen & Ainsworth, 1983). Family-centred group care was, and is, an improvement from an earlier era when children and youth in care were encouraged to forget about their family of origin, even to the extent of being told that their parents had died. To forget about your family of origin, no matter how difficult that family may have been, was of course an unrealistic and cruel expectation.

The next improvement, which began in the 1970s, involved moving from large campus-based institutions to small community-based group homes with rostered staff as the preferred residential setting for children and youth, albeit primarily for an adolescent population. This move also meant that small group homes offered a less restrictive residential care environment, as residents of these homes invariably attended community-based schools. Under the older campus style institution there usually was a campus-based school only attended by children in care, which was increasingly viewed as undesirable. Group homes have however been increasingly criticised due to their lack of safety and pronounced instability (Clark, 1997; Ainsworth, 2017; Ainsworth & Bath, forthcoming). What the move to small group homes also allowed for was a growing conviction that the length of time children and young people spent in residential care should be keep to a minimum, although the research evidence to support this conviction is rather slim.

A final thought

Ainsworth and Fulcher have made numerous scholarly contributions to the worldwide literature about the theory and practice of residential care for children and youth. This has taken place while many social service organisations, in a wide range of countries, have tried, and continue to try, to reduce their reliance on residential care for children and youth. The recent Canadian scandal about Indian Residential Schools (Mackrael, 2021) will no doubt be used, by some, to further argue this position, even though the last of these schools closed in 1997, six years before the Stockholm Declaration (2003) on children and residential care. This policy is often supported by dubious comparisons between the outcomes of home-based and group care programmes (Huefner & Ainsworth, 2020).

Since the first Ainsworth and Fulcher publication in 1981 it has been necessary to hold fast to the view that residential care for children and youth is a necessary part of a continuum of services that a mature child welfare system must have.

Importantly, the firm view of Ainsworth and Fulcher is that ’no child or young person should be placed *unnecessarily* in residential care’ (Islam & Fulcher, 2021, p. 10). But the companion view is that some children and youth can benefit from a period in a safe, well designed, professionally staffed and managed residential care programme. This should be for the few with behavioural and emotional issues, not the many. Empirical efforts to demonstrate this fact continue (Mastronardi, Ainsworth, & Huefner, 2020).

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About the author

Dr Frank Ainsworth is Senior Principal Research Fellow (Adjunct), School of Social Work and Human Services, James Cook University, Australia. He is also in a Guardian Ad Litem in the NSW justice system, with an emphasis on child protection cases.

Dr Leon Fulcher is an international child and youth care consultant based in New Zealand. In addition, he is a member of the Board of Governors of CYC-Net, the online residential child and youth care information and training website that originates from South Africa.

Dr Fulcher read this article prior to publication.

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Voices of young women leaving care: 'I did not have anywhere to go…so I went with a man'

Petra Roberts

Abstract

Transitioning into adulthood can be difficult for many young people but transitioning from residential care comes with challenges to those who have grown up away from parents and family. This paper will present the voices of young women in Trinidad and Tobago and the challenges they faced transitioning from residential care. Their voices highlight the need to think in more gendered terms when contemplating effective strategies for facilitating transitions from out of home care.

Keywords

Residential care, transition, women, developing country, Trinidad and Tobago

Corresponding author:

Petra Roberts, Assistant Professor, Ryerson University,
petra2.roberts@ryerson.ca

Introduction

Transitions out of child welfare residential services and into various forms of independence or semi-independent living arrangements have been studied for years. In this paper, I want to focus in particular on the unique challenges facing young women. There is a large body of literature on young people transitioning out of care, with poor outcomes being documented worldwide (such as Hedin, 2017; Rome & Raskin, 2019; Haggman-Laitila, Salokekkila & Karki, 2019; Perez & Ramo, 2011). Most studies do not specifically focus on the experiences of young women, despite very clear evidence that their social circumstances differ substantially from those of young men. Policy recommendations are often gender blind. For example, a recent report from the Scottish parliament (Hall, 2019) provides information for support for young people transitioning to adult life and then proceeds to make no further reference to gender. Similar silence on gender can be seen in, for example, the Youth Leaving Care Working Group in Ontario, Canada (2013) and Childtrends in the United States (2017).

Over the course of the past five years, I have focused my research on residential care in the Caribbean nation of Trinidad and Tobago, my original home. I quickly realised that there is an untold story about young women transitioning out of these facilities. In addition to a lack of transition planning and programs to ensure preparedness to support themselves and live independently, the young women's transition challenges may be compounded by gendered expectations that women will become attached to a man who will support her.

When I consulted the international research literature, I quickly realised that we rarely hear the voices of young women themselves. To contribute to a global discussion about the unique aspects of young women transitioning out of residential care, I present here the stories of transition which four women shared with me. The women generally reported stable, happy childhoods in the residential care homes. It was upon departure that they faced the greatest problems. They told me about lack of preparation for the transition, homelessness, trading sex for a place to stay and for basic survival, unemployment, no financial supports and substance abuse.

Context

There are three main sources of out-of-home care for children and youth in Trinidad and Tobago: 1) state-supported former orphanages, now called children's homes; 2) community homes run by local community members; and 3) faith-based homes run by various religious groups. The state-supported homes accommodate most children. These homes were established in the mid to late 1800s to care for orphans of deceased indentured workers or former enslaved workers. Today, the children in the homes are generally not orphans but rather children taken in from the community because of neglect or abuse.

There are no hostels for girls aging out of the homes. Instead, young women leaving residential care without family or community support can access an adult woman's shelter, attempt to reconnect with family, or temporarily seek to board with staff members from their residential programme who offer this option in exchange for low rent and/or domestic work. Another survival tactic is to develop a sexual relationship with a man, not for money but for a place to stay.

Below, I describe my conversations with four women: two grew up in the larger children's homes, one in a faith-based home and the other in a community group home.

Veronica

As with most alumni from the state homes, Veronica and her brother were admitted to the home as toddlers. Veronica was allowed to stay in the home until age eighteen. The siblings had lost contact with their parents; however, recently, Veronica had seen her mother in the city. *'She was with another man. We walked face to face and she ended up passing me straight!'* Veronica's brother arranged room and board with a staff member for himself. In contrast, her transition out of the home was traumatic as she was sent to a facility that she felt was completely inappropriate:

> I went to Esther House. That home is for abandoned women. They didn't even tell me that and I was so upset. I am not abandoned. And it is for

> pregnant women who had been getting licks [physical assault] from their boyfriend. They told me the day before, ‘You going to a place’ but…you know when somebody telling you something they would make it sound alright, all okay. So, I end up going with it until I see what it is. I saw one person who was pregnant and I saw one who was very mad. She would be always trying to take your stuff. She lies, because the last time she stole my wallet, my ID, everything.
>
> One time, I returned to the home around 11 o’clock and she [the manager] locked me out the house. So, I had to jump the gate. I didn’t eat, bathe or anything. She did that to me about twice and around Friday she told me I no longer could stay here. She was like, ‘By Saturday you have to leave.’ So, I left. I went to work the morning. It had a woman at work who [asked], ‘Where you going to go?’ and I was like, ‘I don’t know’.

Veronica was late because she played for a professional football club and had to attend practice. Because so few women play professional football, this excuse may not have been as acceptable to the manager of the home as it would have been for a young man. In addition, staying out late could have been viewed as Veronica being involved in a sexual relationship, which was against the rules of the home. Her co-worker took Veronica to a community home owned by a woman called ‘Auntie’. Auntie could make a decision without the approval of a board or any formal authorities, and it was easier for her to accommodate a young homeless woman than a young man. The worker at Esther House could have encouraged Veronica to contact the welfare officer or the manager of the state home but based on her experience, Veronica believed that might not have helped. The assumption was that the state home discharged her to a safe place and it was her choice not to follow the rules of Esther House.

Beverly

Beverly was also placed at a home as a toddler with a twin sister. However, at age sixteen, she was transferred to a residential training centre. Beverly may have been displaying behaviours which the staff felt were disruptive to the home’s functioning.

> I was transferred to a training centre, which was like a boarding school. There was this man who was working as a supervisor in the boys’ department. He used to buy stuff for me like chocolate, etc. At the age of 18 I ran away because he bought a phone for me and they took it. I couldn’t take it any more…the frustration just got to me and I just run away and never looked back. He [the supervisor] took me in. When I moved in with him, he told everybody that I would be his daughter. In the outside I am his daughter, in the inside I am his wife… because he used to turn and say, ‘If you ain’t do what I say I will put you out and you will have nowhere to go’. So, you have nowhere to go, you have to do what you have to do.

Beverly’s experience illustrates the vulnerability of young women to sexual exploitation when leaving care.

Kelly

Kelly and her two siblings lived in one of the faith-based homes, operated by the Catholic Church.

> Initially, I left when I was 19 because we met our dad then. He supposedly wasn’t well and my sister wanted to go and my brother and I decided that all of us will go. It did not work out with our father. I end up homeless after that. He had put me out so I had nowhere to go. I end up sleeping not on the street but I found a little makeshift something to stay in. And it was probably one of the most down periods in my life.

Kelly found it humiliating to return to the home and ask for shelter. Yet,

> I eventually went back. I had to beg. They had a board meeting to decide because they were concerned [that while] I was out I was exposed. They did not want me to influence the other children. Returning was much harder than before. It was like I had to work to stay to earn my keep. In addition, I had to give them my tithe [one-tenth of one’s salary].

Kelly eventually moved into an apartment with her siblings who had moved out of their father’s home when conflict developed.

Liz

Liz and her brother were placed in a small community home. Liz could not recall how the decision was made for her discharge from the home. She went to live with a staff member when she was 10 years old. She remembered the transition being quite challenging for both her and the staff member.

> I think the staff took me because she felt sorry for me that nobody wanted me and you know she kind ah really force herself to be there for me. She kept reinforcing that when I was 18, I had to leave because she is only my foster parent until I was 18. When I was in form 4 or 5 [levels of schooling], I turned 18 and I did not have anywhere to go…so I went with a man. He showed me love and cared for me and I moved in with him.

The man Liz moved in with was 12 years older than her. The relationship became abusive. She left after the birth of her second child. Once again, the vulnerability to sexual exploitation is clear.

Discussion

For decades in Trinidad and Tobago, boys have been placed in transition group homes after the age of 18 while girls were expected to find their own homes or return to unstable, and often unsafe, family situations. There are twice as many boys as girls in residential care. It may be that girls are easier to control in single female-headed households (Children’s Authority of Trinidad and Tobago, 2012, p. 62), thus leaving boys to be caught up in criminal behaviour or be abandoned to the streets. Concern about boys’ criminal behaviour could have been a reason for the establishment of the transition centres for boys. This would be similar to the development of child welfare systems in the United States, Canada and some European jurisdictions to respond to increasing male youth deviance and criminality.

Recognising the negative effects of lack of transition planning and support, the two large state-funded homes recently developed transition units which serve both young women and men. The topics in the units’ training manuals include self-esteem, relationship building, financial planning, human sexuality and family planning. There is a large section on 'home economics' which includes meal preparation, housekeeping and laundry. But career goals and economic independence are absent. Without such training, young women are left vulnerable to sexual exploitation and abuse and disadvantaged in the workplace in a way that young men are not. Indeed, responses to transition challenges appear to draw very heavily on a male-centred view of the world. Preparing young women for sexual health while at the same time exposing them to sexual exploitation because of homelessness and economic dependence appears less than ideal. I suspect that young women everywhere, even in European, American and Canadian contexts, face different challenges than young men as they transition out of residential care. It is time to listen to their voices and consider a more gendered approach to thinking about such transitions.

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About the author

Petra Roberts is a social worker with years of practical and clinical experience from working in Canada (northern, rural and urban) and international practice. Petra is currently employed at Ryerson University in the Faculty of Community Services, School of Child and Youth Care. Prior to her appointment at Ryerson, Petra taught in the Department of Social Work at Algoma University in northern Ontario. Her research interests are in the area of children and families, mental health, child welfare and out-of-home care for children in Canada and the Caribbean.

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The 18th Kilbrandon Lecture (University of Strathclyde, 18 February 2021): Labours of Love: The Crisis of Care

Madeleine Bunting

Abstract

This lecture was arranged during the COVID-19 pandemic and during a period of government-imposed restrictions to normal life. Only essential shops were open. Schools, colleges and universities were mostly closed, and learning moved online. The lecture itself was live-streamed, as a webinar, to an audience of around 500 watching from their own homes. The lecture was based on Ms Bunting's research for her 2020 book, 'Labours of Love: The Crisis of Care'. She spoke about how care has been marginalised and the skills required to perform it widely undervalued, even by carers themselves. The pandemic brought the work of carers to centre-stage. While health and social care services had been underfunded for decades, a war-chest was found to fight the virus and its consequences. Ms Bunting pointed out that the vast amount of caring work, paid and unpaid, falls to women. 'Care is the feminist issue; it profoundly shapes women's lives at home and at work.' The lecture was followed by commentaries by University of Strathclyde academics Dr Graham Connelly and Dr Laura Steckley, and a vote of thanks by Minister for Children and Early Years in the Scottish Government, Ms Maree Todd MSP.

Keywords

Crisis of care, social care, consumerism, language of care, welfare state

Thank you so much for that lovely warm welcome. I can't tell you how honoured I am to be here and to be speaking to you, for several reasons – one, as Jennifer mentioned, I have a very, very great fondness for Scotland and so regret not being with you in person, and that we are doing this by 'Zoom' when it would have been such a wonderful occasion. But still we press on and I am very honoured that I'm walking in the footsteps of so many of your past lecturers in the Kilbrandon lecture series who had been a personal great inspiration to me, and I include people like Guy Standing, Frank Cottrell-Boyce, Harry Burns, and most recently I've been looking at the work of Dame Alexis Jay. So I'm honoured, and I have to also add that it gives me great satisfaction to be following Donald Dewar, because as a very young cub reporter aged 24 I turned up in Glasgow to do some research and bless him Donald Dewar took me seriously. I probably didn't have a clue what I was asking him about, but he was patient and graceful.

I'm also honoured, because I think Kilbrandon did something really rather remarkable, which as a writer I'm really, really interested in, because he managed to make redundant a word. Now I'm somebody who spends a lot of time thinking about words. When I was a teenager and child, the word 'delinquent' was commonly used of troublesome teenage boys, largely boys. And it's interesting that my children wouldn't ever use that term, they wouldn't even know what I meant by it – delinquent is not a time now used, and I think in many ways Kilbrandon played a key role in shifting the focus from deeds to needs and I'm putting out that word to pasture.

I'm going to take another word tonight, and I want to take you through various questions and investigations that took me the best part of four years around the word 'care'. It's such a short word, it's only four letters and yet if you begin to think about it, it covers such an enormous range of human activities and is threaded into so many different forms of relationships. So, in some contexts it's professionalised, in others it's industrialised, we talk about the care industry, it gets commodified. And yet it's also absolutely part and parcel of our most important intimate relationships: we provide care for our partners, our parents, our children, and so it is deeply personal.

So I described care really as a form of empire, because it is so vast, and because it has so many multiple meanings and is used in so many ways. But the curious thing about this empire is that it is often overlooked, it is often misunderstood or not understood at all. And so I would say, if people ask me - what was the purpose of your book? what is the kind of overarching aim of what you were trying to do in your four years of research? - I would say it's this, and it's really quite small, quite simple, I want to provoke curiosity into what care really is: a word that we bandy about all the time, it's ubiquitous, it has become sort of hollow of real substance because we're using it so often. Take care, we say, take care, it's become a form of goodbye.

But actually, when you drill down into what exactly happens when one person is providing care for another, when someone is receiving care: what are they receiving? And it's that complexity that I think is the most important thing, that if we can shift across society, cross cultural curiosity into care. And one of the things that I think makes it so deceptively complex is that it straddles so many dualisms. It's both ethical and practical: who do I care about? who do I care for? - and very practical - how do I care? So it's about an emotion, the sense of empathy or connection, of resonance between people, but it's also absolutely about actions, lots of very important small actions. It's both creative and routine. We all know occasions when we've had responsibilities for somebody which constitute care, which have become tedious and exhausting and a draining experience. And similarly, we've had experiences where it's almost like an Epiphany, this sudden moment where there's a shift and that moment of care becomes profoundly meaningful and our understanding of who we are as human beings, how we relate to another human being, is suddenly evident.

It's also scientific. A nurse providing care is drawing from a great reserve of scientific knowledge. I shadowed GPs[1] and I was constantly aware of how they were relating this huge body of training and expertise to the person that was in front of them. There was a personal relational element and also this scientific knowledge.

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[1] General Medical Practitioners

I think care because of its complexity gets organised in very different ways, it gets understood in very different ways, and we don't normally connect the intimate personal care of a partner, or a parent and child, as essentially sharing many characteristics with the professional care of perhaps a nurse, or a GP, or a social care worker. And it was a great interest of mine to find those commonalities right across all sorts of different forms of care.

But first let me just briefly start a word on timing. I started researching this project in 2015 for, in fact, a BBC Radio series, a series of essays that I wrote for BBC Radio 3. And over the following four years, people would ask me, what are you working on? and I would explain, and their eyebrows would go up, slightly puzzled because, of course, my previous book had been about the Hebrides, so they were thinking, Well, this is a bit of a jump into a new direction Madeline. And then they were, like, don't you find it depressing? And I'd be, like, sorry? And they made a number of very quick leaps. They leapt from care to the elderly - instantly -so everyone assumed I was writing about the elderly, which took me back completely because that was not the intention of my book at all, although of course that's an important dimension to it. And then they said, it's a bit boring, isn't it? And it was that response that I encountered frequently. And I'll be really honest, hand on a heart, I'll say I began to doubt myself: what am I doing? why am I spending four years on a subject that so many people find boring? am I even going to find any readers?

And I think what I will try and show in the course of this lecture is that there is a cultural undervaluing of care, which is so extensive, so pervasive, and in many respects so subtle that we are all involved and compromised by it. We are all caught in a value system which does not actually accord care with the significance that it rightly deserves.

Now that was my position four years ago and over the following few years. In April 2020, I'm putting the final proofs to bed on the book and of course everything has been upended and I'm standing on my doorstep clapping for carers with a cacophony of noise in East London - as you can imagine, trumpets, horns, we're all battling saucepans, it was fireworks going off in the street, and I just was completely astonished that our value system could be so dramatically turned upside down. And people could be recognising that actually they were totally dependent at that moment on the undervalued work of hundreds of thousands of carers and key workers. Was this the beginning of a new era? Was this the paradigm shift that I was calling for in the book? Or was this some brief emotional moment that might just pass? We'll come on to that.

So I'm delighted really to be speaking in Scotland, at this particular moment, because in the middle of a pandemic I think we've been thinking very, very deeply about care. I think that the recent review into the adult social care in Scotland[2] was fascinating and when Derek Feeley, the Chair, rightly said, if not now, when? I couldn't agree with him more and I was punching the air. And then he also said, we need a new narrative, we need to shift the paradigm, and I also couldn't agree with him more, and that is what my book is all about. Because the crisis of care is not just about budgets and financing and demographics, about an ageing population. Those are all the buckets that care gets stuffed into. It's something far, far more profound which goes to this point that I'm making, about a structural, systemic undervaluing of care across our culture.

The subtitle of my book is The Crisis of Care and as a journalist and commentator on The Guardian I had of course been writing about the crises of care, of the multiple crises of care continually. And just briefly remind you, I want to make sure that we have this landscape in front of us to remind you – of endemic low pay. I have various figures in front of me, and each of them still shocks me when I look back at them. Forty percent of child-care staff are underpaid. The Low Pay Commission describes this sector as by far the worst problem for low pay. And social care workers, many of whom are on contracts that don't give them a proper wage - something like 220,000 are believed to be affected by low pay. But what this leads to is persistent retention and recruitment problems across the care sector. And enormous resources going into this constant churn which so badly compromises quality. And that's true in even

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[2] Independent Review of Adult Social Care (Feeley report, February 2021) https://www.gov.scot/groups/independent-review-of-adult-social-care/

relatively well-paid areas of the care workforce such as nurses. But is obviously particularly problematic in places like child-care and social care.

And then I've been curious about how the problems associated with care move into better paid, high status forms of care work - care professions where there's a constant concern about burnout, stress. Care professionals such as GPs talking of heavy workloads, standardisation, the audit culture, a form of work intensification, which has provoked a recruitment crisis in GPs. And then of course the care home sector: deeply precarious long before COVID, uneven provision, areas of the country where there are too few places, the loading of debt onto private care home chains such that they risk going under, some indeed have done so. And domiciliary care, stripped to a minimum; inhumane 15-minute visits, no pay for travel time, and the tightening criteria which have seen something like one and a half million elderly people who once would have received support at home no longer do, a skeletal system.

And then this bizarre phenomenon which we're all familiar with, a sort of repetitive cycle of commissions and inquiries, and outrage and rhetoric from politicians - this has got to be tackled, that the care particularly of the elderly needs to be addressed. And repeatedly nothing results, nothing effective results; we limp on to the next Commission, the next inquiry.

And then under austerity certain aspects of care have been hollowed out in a way that is chilling. So the number, for example, just to give you a specific example, the number of disability nurses, such a key expertise, dropped by 41% in seven years between 2009 and 2016 - a shocking statistic. And equally troubling is the decline in mental health nurses of 10% at a time of soaring need.

One of my objectives really when I set out to write a book about this subject was to try and understand why I've been writing about this for 20 years, these repeated crises. What was the bigger framing that would perhaps explain why we seemed to be constantly lurching from crisis to crisis? And that's why I decided that I would criss-cross the country, length and breadth, north-south, east-west. I would shadow care professionals, people working in care. I would interview carers in all kinds of different contexts, charity workers, nurses, doctors. Go onto wards, sit at the back of GPs' surgeries, go into care homes, talk to people working in palliative care, in hospices and hospitals. And I decided I wanted to hear what they had to say, what was their explanation, what did they understand by this short four-letter word care.

And it was fascinating: again, and again I would sit down with somebody in an interview - a health care assistant, or a social care worker - and they would be very awkward, and they would say to me: I really don't think I've got anything to tell you, I don't know what to say - you know, I do my job, that's all. And I would say, well, perhaps I could just ask you a few questions and I'm sure we'll find something to talk about. And slowly the hesitancy and the shyness would wear off and an hour later we would still be chatting and there'd be still more to say. And then there were these extraordinary moments when a social care worker turned to me and she said: I had no idea of all the things I've just said. And it was one of those wonderful moments, because you could see the pride in her as she got up and left the interview. And what was so moving to me, and so humbling for me, was the number of people that said to me at the end of the interview: thank you for listening. And I was like well, thank you, thank you because you've been so extraordinary as an interviewee.

But there was some process of affirmation going on that I wasn't fully aware of. One person explicitly said it to me - she'd worked in home care, a very luxury end of home care where she'd gone to live in people's houses. And I listened to her describe those experiences, and then she emailed me afterwards and she said: thank you so much for listening, you're the first person who's asked me about it and listened to what my experiences have been, and it has just been so powerful to be affirmed in that way.

So then I got to thinking, well what is all this about, what is it that people are not being comfortable to talk about? One care worker said to me: I don't really like confessing what I do; at the school gates people look down on me when I say on a social care worker. And I realised that there was a sense of shame she was carrying, that this is not high-status work, it's not valued. One very feisty 21-year-old, wonderful character with long braids and lots of piercings and tattoos and a wonderful warm heart. She said to me: I don't care if my friends think my job's rubbish and is wiping bums, because I know it is so much more; I know that I make a difference to people's day, and when they are just trimming nails or sorting out suntans in a beauty parlour, they're not making someone's day, I am. And I loved her attitude.

But it was true even of a couple of friends of mine who had done care work in their 20s. Both of them had several degrees each. And they said to me: no one has ever asked about that chapter of my life. It was two separate friends, different ends of the country, they didn't know each other. But both of them shared the same thing - they had worked very hard, one in a care home and the other as a health care assistant in a hospital. And they said nobody had shown any interest in the work, and they'd never had an opportunity to talk about it before, despite them both acknowledging that it had had a profound impact on their lives, that it had given them a perspective on what it is to be human that they had deeply valued.

So I felt as if there was some sort of invisibility that masks so much of care and that silences so many of the experiences of care and indeed that was an issue that I came back to again and again in the course of the book. The way in which care as an activity, as a relationship, as a labour, as an ethical imperative - in all these ways it gets edged out of the conversation; it's a subtle form of silencing. And I think there's so much wider kind of fear about our frailty as human beings, about our dependence ultimately at the vulnerable moments of our lives, particularly when we're sick or ill, dying or elderly. It's almost as if we want to keep such experiences at arm's length. I think there's a deep cultural aversion to the reality of our lives, which is our dependence at key moments: we will be dependent on the kindness of strangers. And as that’s so, surely, we all owe it to ourselves, and each other, that whatever cultural resources we can mobilise to sustain that kindness of strangers is critical, and I think the pandemic has really helped make that point to us.

So I came up with a working definition of care, and I propose in the book some ways of thinking about what care is in its commonalities right across the board, and how it then gets interpreted in very different ways, and I started with three foundational elements, if you like. The first is presence, the second attention and the third is touch. Now I found the literature on care within the nursing discipline one of the most rich and fascinating. And I think that nursing, and in particular Anne Marie Rafferty, a Scot herself, who is the current President of the Royal College of Nursing, told me: Madeleine, care is dark matter, it's everywhere and yet we still can't quite pin it down; there's something that's so elusive and difficult to define about it. But one of the quotes that is often used in nursing literature is the quote by Simone Weil, the French philosopher, that the purest form of generosity is attention, to give someone your attention.

And I was very struck by this when I was interviewing the mother of a child with disabilities, who said to me that when her daughter was in intensive care, she could recognise the person and the quality of their care by the way they opened and shut the door and moved across the room. We communicate through every part of our body language, particularly at acute moments of vulnerability. And speaking for myself, I recognised this immediately when I was in labour and the midwife was giving me so much emotional support. I held her hand so tightly - please, please come back from your break as fast as possible! And my gratitude to her was enormous and that's the curious thing that any carer will tell you, is they get so much back from their gestures of care. So many nurses and doctors and care workers said, this is a reciprocal relationship - I get so much back from those I care for, their gratitude, that affirmation of the value of my labour.

So, going back to this working definition, I found the work of an American philosopher Maurice Hamington very, very beautiful. He has thought and written a lot about care and he has a wonderful article in which he talks about his thinking about care through the experience of washing his daughter's hair. And he talks about how so much of our experience of care starts with an experience of touch as small children, as babies, and in the touching care becomes an embodied knowledge of tenderness and empathy. And also, he describes humour, that as he's washing his daughter's hair they chat, they giggle, they share jokes, and at all times she's feeling his tenderness, his attentiveness - don't get water in her eyes - any parent who's ever washed their children's hair knows you have to be very careful not to get any soap in the eyes, otherwise it all falls apart.

So care is like a muscle memory, we remember it, and of course our last moments in life will similarly be about touch. I held my father's hand: he'd been in a coma for two weeks, and the nurses said to me, hold his hand, and I have to trust that something in that touch reached him as he slipped away.

So to just emphasise this aspect of the relationality, because I think it's been deeply problematic, but it gets lost, it gets neglected, it gets forgotten. One of the things that really alarms me is when you're talking to people working in the in the care sector how often they use the word 'delivery'. I hope my audience doesn't include anybody that uses that word in speeches, but I suspect you may do. I've heard a lot of people talking about the delivery of care packages. It sounds like an Amazon parcel. And I think it's really, really misleading - dangerously so, because it indicates the ways in which the values of the consumer culture have been infiltrated into care. The point about delivery - as all of us are discovering in lockdown; the parcels that arrive on our doorstep, we say thank you to the delivery man, if we have a chance, but usually he's heading down the garden path before we've even had a chance to say that - it's a very short, one-off interaction, if that at all, it's a transaction. But the point about so much of care is it's not discrete, it's not packaged it's unpredictable and it's extremely hard to work out where it stops and starts, or indeed what its constituent elements will be at any one time. The care worker who turns up in a home to maybe wash or feed somebody with dementia may well struggle to leave on time as the elderly person may drop their cup of tea, may struggle that particular morning getting dressed, slip in the shower, any number of things - we know how often suddenly something happens, you didn't expect it.

So there's a flexibility that needs to be built into the system; you can't turn care into a sort of Taylorised[3] production line. That's what another professor of

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[3] A reference to Frederick Winslow Taylor (1856 – 1915), and American mechanical engineer and management consultant, associated with the 'efficiency movement' in the study of manufacturing processes.

nursing was passionate about - you can't do the breaking up of the process, the management theory that Taylor proposed and apply that to the tasks of care - which has been done repeatedly - and those type of market models of competition and productivity imported into care can be disastrous. One of the ways in which they are disastrous, which I thought was particularly interesting in my research: a very, very interesting psychologist, Paqueta de Zuleta (2013) at Imperial College, produced a paper looking at how neuroscience shows us that our brains work either in competitive mode or in compassionate mode. In competitive mode it triggers the fight-flight responses - but those will crowd out our capacity for compassion. It's either one or the other; it's very hard to do both at the same time, so introduce competitive pressures into care environments, such as targets, such as trying to meet financial disciplines and the result will be a decline in care, an obscuring of it; it sort of fades out from the picture. And I think that's what happened in the Mid Staffordshire Foundation Trust crisis in the 2000s when the Inquiry found a catalogue of catastrophic quality of care - tragically so - and efficiency and productivity and the emphasis on the bottom line had meant that basic patient care, the dignity and respect of the patients, had been ignored.[4]

I was very interested by one person who pointed out to me that there are two areas of human endeavour in which efficiency cannot be the priority. It plays a role, but it cannot be the priority: and that's war and care. And actually, we've discovered exactly that in the pandemic. Huge amounts of money have had to be spent; we can't quibble about who needs a test - we have to ensure that the tests are there. So perhaps we're learning some of some of that, but there's a long way to go.

When I was shadowing a ward in a hospital: every morning when I went through the main entrance to the hospital there was a massive advert beside the main entrance for a care services' company - care, the way you want it, where you want it - and sure enough, there was a picture of a smiling, very pretty, elderly

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[4] Mid Staffordshire NHS Foundation Trust Public Inquiry 2013 https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

lady with a very smiley care assistant and a bunch of flowers. Now ‘care, the way you want it, where you want it’: care is not about consumer sovereignty, this kind of principle of the consumer society. It doesn't, it cannot fit easily with priorities of convenience and speed, so the GPs who said to me that the priority to ensure seven-day surgeries was entirely misplaced; in their view it compromised their ability to provide continuity of care which they believed was absolutely essential to the care provided by a GP.

And another part of the definition of care which I think gets obscured, and it's really important, is that there is a part of care which is always a gift - a gift of self. And I have recently got very interested in the way we talk about vocation: often in the context of medicine or healthcare, people will talk about a vocation, and a sense that their commitment and dedication to their work is such that they go beyond the call of duty. But we wouldn't so often probably talk about vocation in terms of a social care worker, and I wonder why not, because they are often just as dedicated, just as prepared to go beyond the call of duty, and they understand they're giving of themselves.

When I shadowed healthcare assistants on a ward: the healthcare assistants absolutely had me amazed to be frank; their sense of humour, their sense of how they brought their own personality into every day, every minute of their day; the jokes, the humouring, lots of humouring elderly confused, disorientated patients; how they would coax them into eating, how they might suggest washing and getting dressed, and how they managed to do this with a sort of lightness of touch so that nobody was quite aware of what they were doing. Again, and again, I noticed this: a nurse practitioner did the same thing in a GP surgery; in the general chat about - where are you going on your holidays this year, and I've just come back from my holiday - there was a process of observation of the patient going on, which was deeply skilled, a kind of humanity, but also being prepared to bring yourself to work.

So I felt that, given the complexity, given the significance of this form of work, why on earth is it so disregarded, so marginalised? And that took me into the rich body of theory and feminist economics and feminist philosophy that has accumulated in the last 30 years: the work of people like Joan Tronto (1993), Nancy Folbre (2001), Virginia Held (2005) have pioneered a fabulous challenge to 300 years of intellectual tradition. ‘Who cooked Adam Smith's dinner, and why don't we know?’ That was the witty title of a Swedish journalist’s book (Marçal, 2016). It was his mother, and he couldn't have written his magnificent works without the support and care of his mother.

What troubles me is that this considerable and deeply inspiring body of academic work - and I draw on it extensively in my book - seems to have failed to shift the political and economic assumptions in the public sphere. In public debate these academics have not made much headway to be honest. And what persists is a cultural value system in which care must be free or cheap. That is how it's been structured under industrialisation. Indeed, Nancy Folbre says patriarchy was designed to make care cheap or free. So we're looking at a massive cultural edifice, if you like, and how do we challenge that? How do we help these academics with their pioneering work really begin to punch through into the public debate?

Now I'm describing a long running invisible crisis there of perception. But I think what's bringing this to a head, and was doing so before the pandemic, is where three trends are now colliding. One is a rise in the need for care as the population ages. But also, the unresolved issue of child-care: we've done it on the cheap. And we have now unprecedented levels of female employment. Household incomes rely on two incomes and yet we've never worked out: what does childcare, quality well-funded childcare, really look like? The UK has dragged its feet for decades.

The social trend whereby more and more women have gone into the labour market since the 1980s means that patriarchy solution to care, largely free, done by women, is no longer possible. So women in their 50s and 60s, which is a peak moment for the demands for care, they are often now looking after elderly parents and still looking after young adults. And yet they are themselves in work; you no longer have an army of available women to cope with neighbours in crisis, or elderly aunts, or relatives. If you look at novels of the 20th century: the role of a woman, once she had raised her own children, was to largely look after the extended members of the family in one way or another, or members of the community. That's no longer an option, and yet we haven't thought through the implications of that.

There are a number of ways of thinking about the future and I will just draw very briefly attention to a couple of them, as I come to the end of my lecture.

I think we're at a turning point; we can go in several different directions at this moment in history. Interestingly, Japan with its aging population has decided the future is probably robots and in investment in technology. And there's a lot to be said for technology. I don't want to be caught in some Luddite-type refusal of the role of technology. It clearly has a role. It's fascinating how AI is providing incredibly accurate diagnostic techniques, but will this really make the GP or the doctor redundant? No, I would firmly argue we will still need relationship. But some say, no, we can sort all this out with more and more technology: robots in care homes; more and more remote surveillance of the elderly in their homes; more and more tech aids in environments built to support the elderly.

That's one future, but I'm going to suggest there's another future. And I’ve got an interesting ally. The chief economist at the Bank of England gave a very, very interesting speech a year or so ago, and it turns out he's a surprising ally. Because what he said is with automation great swathes of employment are going to be made redundant, but care is a growing employment sector that cannot be automated: it's too unpredictable, it requires too much flexibility and too much human judgment. And care will continue to grow, the demand for care in multiple ways will continue to grow. It's a worthwhile, useful human activity. It can be deeply rewarding and generate great sense of purpose. So the chief economist of the Bank of England said the future could be high tech and high touch economy.

Care is a service worth investing in. It's a form of wealth creation. And we could in fact envisage a future in which care, both for relationships and people, but also a care ethic embedded in how we bring up our children, applies to our environment as well, because of course that's the other parallel crisis of care: fundamentally, the environmental crisis is a crisis of care. So, having had an industrial revolution which enforced a work ethic, with all the cultural resources of church and state to enforce that, I would suggest our challenge now is a care ethic. How do we embed that in our children?

Thank you.

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Response by Graham Connelly

Thank you so much, Madeleine, for such a thought-provoking and enjoyable lecture. You've challenged us to think about this small word 'care' in so many different ways. Your book 'Labours of Love: The Crisis of Care' makes disturbing reading, but it also shows us what we need to do to value care better. The book is thoroughly researched and beautifully written – over four years you listened, you shadowed, and you volunteered. My own professional and voluntary life has been intimately connected with the care experience of children and young people, so I homed in easily on the questions you've raised – but I've also got a very personal take on your observations.

My 98-year-old mother was in hospital when the pandemic struck. She couldn't return to her sheltered flat and is now in a nursing home. Like so many families, we've experienced frustration and guilt - caught in the liminal space care homes currently inhabit between avoiding residents' deaths at all cost - and actively supporting real people to live decent, meaningful lives. We scrabble between having no control and trying to claw back bits of control.

Madeleine, I'm going to name-check your earlier book, 'Love of Country: A Hebridean Journey' (2016), not just because you applied the same sound journalistic values to that research – the interconnections with literature, particularly poetry, the intelligent voices of the people you talked to on your journey and the revealing glimpses of the personal – but also because of some other observations which resonated with me. For example, you point out that the island 'Iona's history can be easily misunderstood.' You say that writers have homed in on the island's remoteness, and yet, as you say, at several times in its history, the island has been very well connected. That loss of awareness of connectedness seems to me to be an apt metaphor for how care has become marginalised. In 'Labours of Love,' you present several forms of evidence for that.

- The way in which unpaid care is taken for granted.
- Your observation that capitalism was built on ignoring and marginalising the care work of women.
- The spread of consumerism through public services.
- The valuing of paperwork and systems over relationships, captured perfectly in the words of the home-care worker who told you 'the work is both closely supervised and yet lonely'.
- Endemic low pay.
- Finally, what you call 'obfuscating language' – 'words bankrupted of meaning' – such as 'delivery' of services and glossy brochures which drop the word 'care' – rather carelessly into every other paragraph.

As you say in your foreword to the book, because of the current pandemic, care 'has suddenly taken centre stage'. I like to think that's one of the more positive things to come out of the present crisis. So, I want to mention some things which your book and lecture have helped me to think more deeply about.

The connecting word in the titles of the two books is 'love'. When the First Minister commissioned the Independent Care Review in 2016, she made a commitment that 'Scotland would come together and *love* its most vulnerable children and give them the childhood they deserve.' As in your own research journey, the Care Review said the most important task of caring is to listen – and it heard the voices of more than 5,500 people involved with the care system, more than half of these care experienced. I can't possibly do justice to the review in this short time, but I want briefly to highlight just a few things:

- The fact that people with care experience themselves drove the review, including the Chair.
- The emphasis in its findings on providing adequate support for families to stay together, and on keeping siblings together in care.
- Actively helping children in care to develop meaningful relationships with caregivers and the wider community.

We may have been better in Scotland at keeping the values of the market at bay in the children's sector, though not in the adult care sector. There's legislative protection in Scotland against privatisation of children's services. But austerity has impacted universal provision. On the positive side, there's still widespread support for universal no fees for undergraduate study, the nursing and midwifery bursary has been retained in Scotland, a substantial care experienced bursary has been provided, and its initial age cap of 25 removed, and there is a summer vacation grant.

The journalist and care experienced campaigner Kenneth Murray has pointed out how articulate people with care experience have skilfully harnessed the media to speak publicly. He asked recently: 'how much might have changed, sooner, if people had a platform for their voice much earlier in our history?'

There's strong and effective support for the advocacy of human rights in the children's sector which has led to the UN Convention on the Rights of the Child (Incorporation) Bill currently at Stage 3 in the parliamentary process.

Most of us have missed out in the past year on regular dental health screening and routine treatment. A very high proportion of care experienced adults have poor dental health, including high rates of childhood extractions. Some rather neat big data research by partners led by Glasgow University's Dental School, and research and campaigning work by Who Cares? Scotland highlighted the inequalities. The upper age for free treatment for adults with care experience has been raised to 25. But poor dental health, effectively caused by a failure of the state to provide adequate care in childhood, has lifelong consequences, and many who are older have found they can't afford the cost of expensive treatment.

Lastly, I think it's relevant to highlight the positive contribution of this University's two research and policy centres devoted to children's care and protection and justice (CELCIS and CYCJ). Their work has been possible because of continuing support of our principal and senior officers, and ministers and civil servants who have demonstrated the belief that children in adversity have the right to have the things that they care about respectfully researched.

Thank you again Madeleine for your lecture.

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Response by Laura Steckley

Thank you, Madeline. I too really very much enjoyed your book and your lecture, and I would add to what Graham has already said about your book. Another dimension of it that I really enjoyed was the presence or gift of, as you mentioned earlier, of yourself - very strongly through the book and your own experiences of giving and receiving care. I just wanted to mention that, before I kind of shifted to a sort of a focused response. At the beginning, you talked about carers being both ethical and practical, and by the end I think you were also speaking about care as political and that was kind of where I wanted to go with my response, and maybe as a springboard to your discussion that follows or your response that follows. Joan Tronto - whom you draw on, and that gorgeous tapestry of thinkers, researchers and practitioners of care in your book - she highlighted in 2013 what she then called democratic and care deficits and she argued that they were two sides of the same coin. She even went so far as to say that nothing will get better until societies figure out how to put responsibilities for caring at the centre of their democratic political agendas.

Now, since then we've seen those trends escalate to what you rightly call a care crisis, and I think it's also arguable that we are witnessing a democratic crisis as well, especially with the events of the last several weeks in my home country of the United States. Her assertions that we have misunderstood politics as if it were part of the world of economics, rather than the other way around, and that we need to rethink the relationship of the market to the democratic state - those seem to chime with your arguments that the eclipsing way and economic discourse around care is unproductive. I was also struck by the degree to which some of the people that you interviewed in your book did really seem to have their citizenship and capacity to participate in democratic society significantly constricted by the way care is currently conceived and organised. You talked about a structural and systemic way that care is devalued and how their experiences are silenced, and I wonder about how this fits into a wider conceptualisation of care as being intimately connected with democracy. I also wonder at the way that care is so devalued - how that has affected the very fabric of our social relations, and some of the ways in which we see that kind of happening with COVID, the rise of the far right, that sort of thing. If we add the climate crisis to the mix, it seems that we might be approaching some sort of pivotal moment - or you mentioned a turning point earlier - where it's no longer viable to keep care-related concerns in the shadows and the margins, especially if we start to accept care as a broader species of activity beyond like health and social care to include all of the ways that the labour of care is central to human life, including like parcel delivery, as you mentioned earlier in your discussion, but also the care of the planet. And, just over a year ago, the late David Graeber[5] wrote of the beginnings of a global revolt of what he termed the caring

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[5] David Rolfe Graeber (1961-2020), American anthropologist.

classes, pointing out that our most dramatic struggles of labour activity of recent years have involved cleaners, teachers, nursing, home workers, junior doctors and university workers.

And so, I just kind of wanted to ask about your thoughts about this. Tronto argues for what she calls 'caring with', and she defines us as a face of caring that requires like caring needs, and the way in which those needs are met, how they need to be consistent with our democratic commitment to justice, equality and freedom for all people in an inclusive society. And so I just wondered your thoughts about that just in terms of this potential turning point.

Reply by Madeleine Bunting

Thank you very much to both Graham and Laura for such rich and stimulating responses - and there's a very wide range of subjects raised here, and I can't possibly do them all justice, so I'm sorry about that, and I suspect we could have continued this conversation long into this evening if I was in Glasgow now - and wouldn't I love to be, but there we go. I'm glad Graham mentioned his 98-year-old mother because I think bringing this kind of personal experience, as Laura says, is a form of gift of self, and I think it comes more easily to a lot of women and I'm glad that men can join a conversation - I'm sure lots of men do - but it's to be welcomed. I think we're dismantling a sort of boundary, a border between the personal and the public, and care was always tightly within the personal and therefore people felt it wasn't appropriate to bring it in - but that's why I brought my own personal experiences into the book. Because I feel is actually at that level of sort of universality, whereby we all recognise we're in the same boat, that we offer care, we struggle sometimes to offer care, we would like to offer more care, like Graham. This pandemic experience has been an excruciating experience of not being able to look after my mother and not being able to provide her with more care. So I'm very appreciative of Graham on that and very much appreciate the descriptions that he was giving about the efforts of children in care in Scotland and that fascinating Inquiry which I'm familiar with.

And Laura raises a raft of really interesting points which I hope the audience will take away with them and think deeply about. Care is used to reflect power structures, and I think Tronto's insights on that are really, really helpful. You know, I live in London, where a large proportion of the care workforce in its lowest paid is BAME, black ethnic minority, and the low pay and the way in which they have often not being unionised is reflecting a deep structural imbalance around power. Care has a fascinating relationship with power, and we don't have time to get into it tonight, but of course power is in all sorts of care relationships, in all sorts of ways, and we didn't talk this evening about the abuse of care, which is a terrible reality, and all care has to be organised and thought about in ways that reduce that possibility for abuse, and I would argue that we've implemented an audit culture which is not actually very effective at reducing abuse. What reduces abuse is strong team working, strong cultures of care. No individual cares on their own, they're always supported by others who care for them. So it's this reciprocality of care that constantly needs to be emphasised; my care of others is only possible because of the way others are caring for me.

I’d like to end on just one point, briefly - unfortunately there’s not time to get into it further - just about pedagogy and the and the model of pedagogy that I came across in Denmark and how inspiring, it was. Because there was a system of education where students did a three-year degree which was about how you nurture human potential in another human being and that pedagogy degree might mean that they ended up in a kindergarten, or they might end up in a care home, or indeed they might end up caring for children in care. The same principles applied: develop their own humanity so that they could develop others’ humanity, and the way they did that was through creativity. So I thought I'd landed up in an art school; I was, like, hang on, why is this place full of props for the theatre and artworks. And they said that's how we develop our own understanding of who we are, through the songs we sing, the plays we put on, the paintings, the sculpture. And that's why I was so fascinated by the relationship between care and creativity and drew on that extensively in my book. And I think it's that kind of inspirational perspective about care as a profoundly creative act akin to poetry and music, and song and dance, and indeed needing to include all of those in its life enhancing, life enriching capacities.

One final word. Einstein said the world, as we have created it, is a process of our thinking: it cannot be changed without changing our thinking. And I would add, but it can be changed if we change our thinking. So if you've understood that, terrific.

Thank you so much.

Vote of thanks by Maree Todd, MSP

Oh thank you so much. What an absolute pleasure it is to be with you this evening. Ladies and gentlemen, Professor Davidson and distinguished guests, it is my pleasure to thank Madeline Bunting for this year's Kilbrandon lecture. With my own Hebridean connections I wish we had another hour to chat about the Hebrides because for me the leap from the Hebrides to care is not such a big leap at all. Island life is defined by empathy; to survive life on an island you have to be attuned to what's happening with your neighbours. It's a survival thing. And, of course, in the Gaelic culture we talk at least as often about who are your people, as we do ask the question: Where are you from? It's who are you from and where are you from? So I can see absolutely clearly why your journey to the Hebrides would have inspired you to look more closely at care.

We're very grateful for the generous way in which you've shared the central arguments in 'Labours of Love and the Crisis of Care' and your lecture this evening has been challenging. You've highlighted the need for all of us to form a deeper understanding of care and a richer appreciation of the skills and the knowledge involved, and you've emphasised the centrality of empathy and trust and, just as importantly, the need for our public institutions, especially in light of the pandemic, to look a freshly at the value that we place on care.

Here in Scotland, as you've heard, we are absolutely determined, committed and resolute that we will put love at the very heart of care for our children. You certainly though provoked our curiosity into care as you set out to do. And I laughed at your description of care, I mean it really resonated with me, just a couple of the words you choose - as a mum of three - you mentioned care being both exhausting and profoundly meaningful. I also love the way that you talked about touch and I think that each and every one of us have touched upon the sense at the moment, at this very moment in time, where we all have to stay apart, how we are all yearning for touch more than ever before, and I think that is an uncomfortable thing for us to consider, but it's a vitally important one.

I'm very happy to join you in making the word ‘delivery’ redundant. Care is anything but passive; it is a dynamic relationship, and I am probably not the only woman in the room who will have railed at the substitution of the word ‘delivery’ for birth, literally giving the mother a passive role in this significant event in their family's life, and of course handing the starring role to a doctor. Well, what can I say!

During this lecture – I’m a politician and I'm afraid I cannot stay off Twitter - so slap bang in the middle of this lecture one of our wonderful early learning and child-care practitioners tweeted me. We're having a bit of a day, celebrating going back to early learning and child-care, and we have a little campaign going about thumbs up for early years. And she tweeted me this quote from Gordon Neufeld[6]: ‘We were never meant to care for children whose heart we do not have’, and I just thought that was so profoundly perfect for the lecture that you gave us tonight, but I felt it was worth admitting that I had been tweeting.

So all of your audience this evening from many professions will be grateful to you for the insights that you have presented. Your insights will also inform how the Scottish Government responds to Derek Feeley’s independent review of adult social care. You've heard how we're listening to you at a very pivotal point in Scotland. Pivotal, not just because of the Feeley review –I think Graham mentioned the revolution in children's rights that we have happening with the incorporation of the UNCRC. I am personally determined to ensure that every child and adult in Scotland receives the care and the support that they need to

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[6] Dr Gordon Neufeld, Canadian developmental psychologist.

live full and active and flourishing lives. The Scottish Government will work in coming years with local authorities and health and social care and education sectors to promote a rights-based approach to wellbeing an independent living.

On the fifth of February this year, we celebrated the first anniversary of The Promise.[7] And, as you know, The Promise came out of the Independent Review of Care[8], which was one of the most substantial, ambitious and necessary reviews in the history of the Scottish Parliament. The Scottish Government is fully committed to delivering the recommendations set out within The Promise. The promise demands change right across the system in Scotland that will involve practical change at every level, but more fundamentally, it will require a transformation in the culture of care. Now that will take time, but the process of change started immediately, and it is continuing apace. It actually began as the review went on. Just this month, the Government launched The Promise Partnership Fund, an investment of 4 million pounds from the Scottish Government, administered by the Cora Foundation.[9]

The Fund will help support early intervention and prevention work across Scotland and it will help organisations create capacity, adapt approaches, work towards cultural shifts and collaboration to improve holistic family support. We aim to create for the new normal for sector wide collaboration which listens to families when they speak, supporting them when they need it. When they need it, where they need it, and for as long as they need it. It's about making a difference to how we work with care experience children, young families, young people and families and, most importantly, as you've heard these changes must reflect what matters most to them as laid out in The Promise. We are, of course, mindful for the need for immediate support during the pandemic and lockdown, and that includes exploring what direct actions can be taken to mitigate the potential risk to vulnerable care leavers as a result of isolation in lockdown. We aim to develop and implement proposals within the next two to three months. I

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[7] https://thepromise.scot

[8] https://www.carereview.scot

[9] https://www.corra.scot

would also add that this month Regulations[10] were passed in the Scottish Parliament which allows siblings to have a greater input into children's hearings. These bring an opportunity for brothers and sisters to attend and to take a full part in the matters being considered that concern them. This is very much meeting The Promise findings and it will add to protecting family relationships and ensuring that contact is maintained.

So, to conclude I would like to take this opportunity to thank Principal Sir Jim McDonald for his introduction and Professor Jennifer Davidson who has chaired tonight's slightly different lecture with such skill, and I really appreciated the contribution of Dr Graham Connelly and Dr Laura Steckley. On behalf of the Scottish Government, I want to convey my thanks for the continuing support that the School of Social Work and Social Policy and the wider University gives this lecture series. I'm so pleased to hear that the University of Strathclyde's *Scottish Journal of Residential Child Care*, which has a growing international audience, is producing an edition that will contain a published version of tonight's lecture. I want to thank Mr Raymond Taylor from the University for organising tonight's lecture and also for our appreciation for the meticulous work of Peg Rourke and Fiona Lynn and thank you also to Alan McCleave for ensuring that the proceedings have run so smoothly this evening.

And finally, I want to convey my appreciation to all of you who have come here to hear the Kilbrandon lecture, particularly those of you who are directly involved in the hearing system as panel members, reporters, social workers and teachers. The valuable work of children's panel members, children's reporters, social workers, teachers and other child-care professionals has since the inception of the children's hearing system made an enormous difference to the lives of thousands of children and their families. Scotland's children's hearing system is an institution which reflects our distinctive Scottish values and culture, and it is an important means of ensuring that Kilbrandon's vision of an effective and integrated justice and welfare system for children and young people is

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[10] The Children's Hearings (Scotland) Act 2011 (Rules of Procedure in Children's Hearings) Amendment Rules 2021
https://www.legislation.gov.uk/ssi/2021/68/contents/made

passed on to future generations, updated and strengthened and refined to meet our future needs.

Madeleine, you encouraged us to be ambitious, braver and hopeful. We are immensely grateful to you for the unique perspective that you have brought to the 18th Kilbrandon lecture.

About the Kilbrandon lecturer

Ms Madeleine Bunting is an English journalist and author and honorary fellow of the University of Cardiff. She read history at Cambridge University and studied politics at Harvard University. Ms Bunting was formerly an associate editor and columnist at *The Guardian* and is a regular broadcaster for the BBC. She has won awards for her writing on global inequality and international development. Closer to home she has been recognised by the Commission for Racial Equality for drawing new voices into the media from the British Muslim community.

About the respondents

Dr Graham Connelly is a chartered psychologist and an honorary senior research fellow in CELCIS (the Centre of Excellence for Children’s Care and Protection). Prior to retirement in 2018, he held various academic appointments in the University of Strathclyde over 26 years. His research interests relate to the education and wellbeing of care experienced children, young people, and adults. He is a non-executive director of Kibble Education and Care Centre and a trustee of the MCR Pathways school-based mentoring programme. He is also the editor of the Scottish Journal of Residential Child Care.

Dr Laura Steckley is a senior lecturer at the University of Strathclyde and a member of the School of Social Work & Social Policy and CELCIS. Her professional child-care background is in direct practice, management and training in residential care and treatment for adolescents in the United States and in Scotland. She leads the MSc in Advanced Residential Child Care and is Vice Convener of the University's research ethics committee. Her teaching and research primarily focuses on residential child care, and in particular, developmentally-enhancing and relationship-based practice and its related complexities.

Ms Maree Todd[11] was appointed Minister for Childcare and Early Years in 2017. In this role, she supports the Cabinet Secretary for Education and Skills and her portfolio of responsibilities includes children's hearings, children's rights, children's services and children's workforce. Maree Todd grew up in the West Highlands, attending Ullapool High School and then studying pharmacy and prescribing at Robert Gordon University and the University of Strathclyde, as well as taking an ante-natal teaching diploma at the University of Bedfordshire. A pharmacist by profession, Ms Todd worked in NHS Highland for 20 years, mainly as a mental health pharmacist in a psychiatric hospital. She also contributed to SIGN guidance on perinatal mental health.

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[11] Ms Todd was subsequently appointed as minister for Public, Health, Women's Health and Sport in May 2021.

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Book review

Book Title

Child Poverty: Aspiring to Survive

by Morag C Treanor

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Corresponding author:

Kate Mackinnon, Policy Associate, CELCIS, kate.mackinnon@strath.ac.uk

Rosie Moore, Policy & Participation Advisor, CELCIS,
rosanna.moore@strath.ac.uk

Aspiring to Survive was published in February of 2020, at the precipice of the Covid-19 pandemic which has impacted every aspect of our lives and shone a harsh light on the inequalities in our society, as well as exacerbating them. In *Aspiring to Survive,* Treanor asserts that child poverty is never inevitable, and that even in times of financial scarcity the right government decisions can prevent it.

Few could be more qualified than Professor Morag Treanor to speak to child poverty in Scotland. With an extensive research career in this area, she has been a member of the Child Poverty Action Group's advisory board, is a commissioner of the Scottish Government's Poverty and Inequality Commission and is a member of The Promise Scotland's oversight board. Furthermore, the personal reflections she offers on her own experiences and motivations to carry out this research are poignant and ensure that readers understand this book not just in terms of abstract policy decisions, but in the context of real lives of children and their families.

The core message and approach of this book is that child poverty is not inevitable, and it is what governments choose to do (or not do) that can either exacerbate or eradicate child poverty. This leads to a critical exploration of the myths and stigma around poverty, especially where these shift the blame for poverty on to the individuals experiencing it rather than the systems that cause it. *Aspiring to Survive* takes an approach of shedding light on these myths and stigma by presenting the reader with a comprehensive evidence base to challenge them, inviting us to 'flip' our thinking and make up our minds on what policy decisions are needed.

This evidence is made up of findings from longitudinal research that Treanor has carried out with families since 2013, alongside analysis of wider quantitative datasets to ensure these findings are representative of all families across Scotland and the UK. This approach is helpful for supporting her arguments around policy, and also means that *Aspiring to Survive* is an excellent resource and reference point for anyone working to understand child poverty.

Aspiring to Survive also provides detailed context around policy on child poverty internationally. There is particular attention to policy across the U.K. where reserved matters, as well as the myriad of ways that economics, culture and media interact across the border, make what happens in Westminster relevant to Scotland. However, if one of the aims of this book is to 'shed the light' on how the myths around poverty mutually enforce and inform policy decisions that exacerbate poverty, this raises a question about what this means in a Scottish context, where there are several notable differences in policy around child poverty, such as the Child Poverty (Scotland) Act 2017, or the Scottish Child Payment. Whilst these differences in legislation and policy initiatives are raised in Aspiring to Survive, what would be especially useful to see in future publications would be a more in-depth examination of the implementation of policies seeking to reduce child poverty in Scotland, as we know that there can often be a stark difference between the *intention* of a policy and the effect it has on people's day to day lives.

Changes to legislation to incorporate the United Nations Convention on the Rights of the Child (UNCRC) into Scots law is one example of where we need to pay attention to how policy change makes a difference in the lives of children and families. Upholding the economic rights of children, which are interdependent and indivisible from all other rights under the convention such as play, good health, or being able to grow up safely with one's family, is an integral part of UNCRC incorporation. The action needed to uphold these rights may bring up challenges that are distinct from work to uphold other rights, and so *Aspiring to Survive* will be invaluable to those working in policy or practice to ensuring all aspects of UNCRC incorporation are successful.

Aspiring to Survive was published at the same time as the culmination of Scotland's Independent Care Review. Driven by children, adults and families with experience of the 'care system', it was a root and branch review seeking to understand how to love and care for Scotland's children with care experience. Amongst other reports produced by the review, *The Money*, written by Katharine Trebeck, argued that the cost of poor financial and other policy decisions to the wellbeing of the people in and around the 'care system' was too high, and set out the argument for planning an economy based on improving people's wellbeing, a 'wellbeing economy'. Since then, there has been a commitment from across Scotland, including by the Scottish Government, to 'Keep The Promise' to children and families to make the changes urged by the review, of which addressing poverty and is a core priority. There is a swell of ambition and momentum to make changes, which are not shy about challenging deeply engrained systems and structures, when necessary, but there is work to do to enable it to translate into real change in the lives of children and their families experiencing poverty.

The aims of *Aspiring to Survive* are tightly connected to many of the recommendations of the Independent Care Review as set out in The Promise. As Scotland begins to undertake the work needed to meet these recommendations, we will be using the rigorous and evidenced based policy analysis in Aspiring to Survive to play our part in this work and would welcome any development that further aligns Aspiring to Survive to ongoing work to upholding The Promise and the UNCRC. This work is all the more urgent in the context of the Covid-19 pandemic and its aftermath, which risks further entrenching inequality and poverty. The accessible and evidenced based approach in Aspiring to Survive will be an integral part of the toolkit for anyone who is interested in, or working to ensure that Scottish policy not only alleviates poverty and inequality but eradicates it.

References

Trebeck, K. (2020) *The Money*. Independent Care Review.

About the authors

Kate Mackinnon is a Policy Associate at CELCIS. She supports CELCIS to influence, shape and set policy that centres the needs and voice of children and young people in need of care and protection. Within this role she leads work at CELCIS on improving experiences when accessing care records. Her background is in supporting children and adults who are experiencing domestic abuse, sexual violence or abuse.

Rosie Moore is the Policy & Participation Advisor at CELCIS. She supports CELCIS to embed participation in both an operational and strategic manner, that champions the voice of children and young people in all areas of work. Within this role she leads on several pieces of participation work at CELCIS, most recently around the recruitment of new CELCIS Strategic Board members with lived experience. Her background is in supporting children and adults who have lived experience of care, predominantly through her work at the Independent Care Review and her Board roles at STAF and Each and Every Child.