A Guide to Youth Justice in Scotland: policy, practice and legislation

Residential Childcare

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1. Introduction

This section has been included in ‘A Guide to Youth Justice in Scotland: policy, practice and legislation’ in order to provide information to social workers intending to place or support a young person in residential care to give details of the working methods and issues faced. It is also designed as a resource for those working with young people in residential care.

Each residential unit is required to have a statement of function and purpose that should explain how the particular service delivers the concepts and issues described in this chapter.

Social workers who place young people in residential care, in partnership with other relevant professionals, parents/carers and the young person, will have identified needs and developed strategies to meet them. The young person may have previously had community-based supports and residential care will be considered only where the young person’s needs cannot be met within their home and community. Matching a young person to the residential placement that can best meet their needs is essential and this section is designed to help the social worker consider what questions to ask to ensure the placement will fulfil the requirements.

The Child’s Single Plan should hold detailed assessment information and should have identified the outcomes that need to be met in order for the young person to attain the Getting it Right for Every Child (GIRFEC) wellbeing indicators. It is important that these outcomes are communicated to the residential placement and discussions are held to consider whether or not the placement can achieve the identified outcomes. It is also important to consider how other agencies, families and the young person will contribute to this and how the network of support will be managed. In order to meet the needs of the young person, clear pathways must be identified and an action plan created to include the role of the residential unit. The support that they receive there will help them become more resilient and be successful in the areas determined by the wellbeing indicators. The young person will not live in residential care forever, they may return to their families, live independently or move to adult services and a clear plan to manage this transition needs to be considered.

The social worker’s role is pivotal and in order for the placement to meet the outcomes they must remain involved. This involvement will include the statutory reviewing requirements in the Guidance on the Looked After Children (Scotland) Regulations 2009 and Adoption and Children (Scotland) Act 2007 but should also include the time required to get to know the young person, offer support and communicate with the residential placement.

2. The Role of Residential Childcare (RCC)

Residential childcare should be recognised as being an important, valued and integral part of children’s services that can offer the best possible care and protection for children and young people of all ages, which builds their resilience and prepares them for the future challenges they will face. Good quality residential care provides nurture for children who have had a very difficult start in life and it is the relationships between staff and children, and
amongst children themselves, which are the foundation upon which their future wellbeing will be built. Professionals who are not familiar with modern children’s homes may be surprised that many children, teenagers especially, say they prefer a children’s home to a foster family placement. There is considerable evidence, for this reported over a long period of time.

“Contemporary residential child care does not pretend that it is a ‘family’ and full recognition is always given to children’s heritage and birth family, yet care is intended to be ‘family-like’ in the sense that it aims to provide children with a secure, nurturing and stimulating environment where they experience warm, authentic care relationships with residential workers. Interestingly, some children report that their residential experience has been a family one, or ‘it feels like a family’ (Happer, McCreadie, & Aldgate, 2006, p. 11). For some children, residential care gives them an experience of ‘normal’ family life – doing ordinary things and receiving consistent care from adults – absent from a birth family life marked by extreme stress, dysfunction, or abuse” (Bolger & Miller, 2012).

The crucial factor is the quality and persistence of the caring relationships and the culture of the home rather than the configuration or structure of the household or the building. It should also be noted that many of the children in residential care will have had previous placements, including foster placements, which have not worked out for them. In many parts of the country residential care acts as a ‘safety net’ for the rest of the child care system. This may not be ideal, and certainly poses big challenges to residential teams to provide the necessary level of care and stability, when many children have experienced disruption and may be very suspicious of their latest set of carers.

Many young people will need more than basic care in order to address some of the early psychological, emotional and physical harm which requires support from a range of agencies (NRCCI, 2009). The reparative purpose of RCC sits alongside a concern for the personal growth and wellbeing of the young people requiring to be looked after away from home. This concept of growth has been linked to character development which is promoted by environments in which opportunities where moral choices are made, and staff are important role models (Jones, 2010). Central to the creation and maintenance of these environments are the reciprocal and interdependent relationships of those living and working there (Smith and Steckley, 2011). The concept of wellbeing is central to the national programme for children’s services as part of GIRFEC. Residential staff are key players in the team around the children they look after and are involved in assessing wellbeing next to the SHANARRI indicators (Safe, Healthy, Active, Nurtured, Achieving, Respected, Responsible, Included).

**Range of services**

In 2009 the NRCCI reported on a diverse service providing care to a group of children with increasingly complex needs. There are now a greater number and range of providers looking after children and young people. Generally speaking there are three types: secure services, residential schools and children’s homes/houses/units that can accommodate young people on a full-time basis or as part of both respite and crisis care.

RCC services are all inspected by the Care Inspectorate on an annual basis and inspection reports for all services including grading against quality indicators can be accessed. No two services are the same within and across types, so care standards and inspection regimes
can be seen as a helpful reference point for comparison. The inspection visit is only one part of the process and all services complete an annual return and a comprehensive self-assessment document to inform the overall inspection process – these documents are also available online.

It is worthwhile noting the significant changes that have occurred within the secure estate in the last few years. In 2005/2006 the secure estate increased its beds from 94 to 125 to meet increased demand and to introduce gender specific units. The Good Shepherd Secure Unit was identified as girls only and Kibble and St Phillips were identified as boys only. The other secure establishments remained, providing secure care to mixed gender. In 2011, the number of secure beds was once again reduced to 90 as community based resources and alternatives to secure care funding meant the secure estate experienced a considerable drop in referrals. The secure estate was subject to a tendering process in that began in April 2011 and took effect from July 1, 2011. Scotland Excel managed the tendering process and now has responsibility for managing the existing contracts. St Phillips secure unit was unsuccessful in the tendering process and it closed in August 2011. Contracts were awarded to the remaining secure establishments; however, it was on the basis that they provided mixed gender services.

The secure contract has stipulated clearly the roles and responsibilities for stakeholders as well as service providers and social workers accessing secure care who can expect to be part of an outcome driven process. The contract places responsibility on the secure care providers to have in place an outcomes framework that involves not only the young person but also those who play a key part in their lives. Identifying outcomes should start at the point of admission.

3. Key concepts

Group Living Environment

The extra familial living environment is one of the key psychosocial processes central to understanding RCC (Anglin, 2002). Groups of unrelated young people (requiring to be looked after away from home) living together gives us the unique dynamic of nearly all RCC services. Whilst this dynamic, if problematised, may appear to contribute to the persisting application of the last resort principle, others view group living as a “positive, developmentally appropriate, growth producing experience” (Barnes, 1991).

The young people living in residential care must manage, in addition to often complex familial relationships, usually four or five close living relationships with other young people. Much is made of the negative impact of peers but there are alternative narratives to the relationships formed in RCC. Young people can form close relationships with their fellow residents and these can be a powerful source of support (Emond, 2002). Regrettably, influences are not always positive and there are concerns that peer connections formed in residential care can, among other things, increase the likelihood of offending behaviours (Barry et al, 2008; TACT, 2008). A last-resort approach to residential care can mean that decisions to place young people in residential units do not always consider the potential of relationships between young people and how these will be monitored (Hayden, 2010).
Relationship as a therapeutic process is a basic and well defined concept in child care: it is the forming of human bonds via trust, empathy, and communication skills and the using of these bonds to facilitate behaviour change (Brendtro, 1969).

Although not necessarily unique to RCC, young people also have to manage relationships with multiple adults – usually between ten and 20. What is unique to RCC is the intensity, and sometimes the intimacy, of the relationships (Kohlstaedt, 2010). This is related to the length and quality of time young people will spend with these adults. The encounters are not time-limited sessions within benign neutral environments. The RCC environment is the life space of the young person: where they eat, sleep, wash, relax, express emotions, have fun and test boundaries.

The group living dynamic presents challenges to all working with young people in RCC. Risk management and control must be balanced with conscious positive use of the social encounters. Equally staff must respond to pain based behaviour (Anglin, 2003) recognising the existence of deep seated and long standing pain carried by the young people and the manifestation of this internalised pain. It is important that when staff are dealing with young people in crisis, they must take into consideration the impact their response may have on the young person.

RCC is a 24-hour service and staff work across all hours on a rota basis. The rota can include sleep-ins and night shifts which enable staff to have care responsibility at all times during the week. Rotas can be seen as mechanistic and not sufficiently focussed on the needs of children (Burton, 1993). It is a difficult balance to get a rota, which serves the best interests of the young people and the needs of staff. Rotas will also affect the availability of key staff not only for the young people but also for those working in partnership with them.

The key worker system is almost universally adopted across the RCC estate and in its best form it will be guided by the principle of ensuring that the young people’s individual needs are championed within the service and beyond. Key workers usually need to be identified before young people are accommodated but it is good practice to review this and consider who is the right person to take on this role. Having a named person within the RCC team can be helpful for establishing good working relationships with other agencies, families and the young person themselves.

The role of other staff in the group living environment is often overlooked; however, cleaners, cooks, admin workers and other ancillary staff all have a significant role in the daily lives of the children and young people who are looked after.

Life space intervention

Life space intervention stems from the work of Fritz Redl in the 1950s. He developed specific interview techniques which recognised the need “to act when it is opportune to do so”, in recognition of the inadequacy of interview by appointment (Redl, 1957). Redl’s ‘Life Space Interview’ has been further developed by others as a technique for dealing with crisis situations. This is generally seen as an alternative to over-controlling lecture type interventions and involves the selection of a specific incident, getting the young person’s perspective, clarifying the distortions and coming up with a plan of action (Brendtro et al, 1992).
Almost unique to RCC, practitioners are based and conduct most of their work with young people in the space where they live. The life space is the “total physical, social, psychological and cultural space surrounding an individual at any point in time” (Whittaker, 1981).

Life space intervention sees the group living environment as providing a context for opportunity led work which is distinguished from planned or structured interventions (Ward, 2002). Actively and thoughtfully engaging with young people where they live can be seen as removed from the real social work intervention using planned interventions and structured programmes (Smith, 2008).

In RCC the concept of life space intervention helps us to consider the possibility of RCC work and the role and characteristics of residential staff required to create developmental group care. The use of daily life events requires an understanding of the importance of staff being able to develop and maintain positive relationships. The ability to use daily and routine events as interventive moments requires that staff are noticing behaviours, understanding the context of these behaviours by making meaning and using insight and self-awareness to decide the best way to intervene (Garfat, 2002). Of equal importance is the need for self-reflection to ensure that staff learn from the intervention experience and are able to use what is learned to apply to future situations (Smith, 2005).

The conscious use of everyday events for therapeutic purposes is of course not new, but applied to RCC it helps us consider the contribution the placement can make to build on the strengths of young people as well as meeting their needs.

**The therapeutic role of Residential Childcare**

*Children and young people in residential care have – almost without exception – had very troubled pasts. The majority of looked-after children are removed from the care of their birth parents because of physical abuse, neglect, emotional abuse and sexual abuse. Most have experienced more than one form of maltreatment, often over many years. Some young people find themselves in residential care after a series of placements with foster carers – and sometimes other residential care homes – have broken down. Those working in residential care have to help minimise the damaging consequences of such traumatic pasts. Amongst other things, they need to help young people overcome their difficulties, regain or develop a sense of self-worth and self-efficacy, and help them to develop the skills and competence to negotiate and maintain interpersonal relationships and other adult roles. It is no easy task. Arguably, it is not something that can (or should) be done “intuitively”. It is in this broader sense that residential care is inherently therapeutic – or should be (Macdonald et al, 2012).*

RCC practitioners will develop close relationships with the young people they care for. As well as using this relationship to affect change they will also help them make sense of their life, have new experiences of adults and manage relationships with those closest to them. Staff working with these aims in mind and within an agreed model of practice will certainly be working with therapeutic intent (Milligan, 2007).

While there does appear to be a trend to services describing themselves as therapeutic there is no shared definition. A national definition has been developed in Australia, which offers a helpful guidance:
Therapeutic Residential Care is intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs. (McLean et al, 2011)

Evidence on outcomes for therapeutic residential care is very limited. Where study of therapeutic approaches has been undertaken there has been evidence of improved morale of staff and short term outcomes including less confrontational environments and fewer serious incidents (MacDonald et al, 2012).

MacDonald et al 2012 conclude that RCC is inherently therapeutic and notes: “if we are to improve outcomes for looked-after children in residential care, the task has to be essentially therapeutic, and we have to make sure that staff can approach their work in this way” (ibid p53).

This research evaluated some of the models described in the next section and defined the term 'therapeutic approaches' as ways to help staff understand how trauma effects children and young people, how and why their ways of coping with this trauma might be maladaptive, how and why agencies and staff respond in the ways they do, how some of these ways are not adaptive; and how they might change.

While services in other parts of the world are comfortable with the concept, RCC services in the UK have been reticent in the past decades to use therapeutic to describe the service they give to young people (Milligan, 2007). This reticence may be linked to an anxiety about the greater skills or knowledge required to provide therapeutic care (Clough et al, 2006). However, there is a growing confidence about the therapeutic possibilities of the RCC environment supported by the adoption of specific models of care or intervention.

4. Models and programmes

Models of intervention in RCC, although often developed from clinical models, are very seldom strict clinical programmes but are likely to permeate all aspects of the group living environment. They are as likely to be shared frameworks of understanding hung on core principles, sometimes supported by toolkits or manuals. They are invariably consistent with the opportunities provided by the group living environment and life space intervention.

Currently ‘Trauma Informed’, ‘Attachment Promoting’, ‘Strengths Based,’ and ‘Social Pedagogy’ are terms used to describe models of intervention or ways of working.

There are also specific programmes for crisis intervention, which provide a context for physical interventions, including restraint or safe holding.

There is not enough space to discuss each in full so below is a brief outline of these models and relevant references to further reading. In addition to this it is important to note that these terms are often transposed to practice in different ways. Individual services are normally more than happy to direct others to their own reference materials.

a) Trauma Informed
The development of trauma informed practice over the last two decades has been informed by advances in understanding the impact of neglect and abuse on the developing brain (CWIG, 2009) and a concern about the retraumatising of children in care services (Ososky and Lieberman, 2011). Trauma informed models emphasise the importance of establishing and maintaining a safe, non-violent culture in which children can learn adaptive ways of coping with stress (McDonald and Millen, 2011).

“It is easy for caregivers to see these children as bad, mean, sick or crazy in response to their troubling behaviour. What is often missed, especially under stress, is that injured children repeatedly re-enact yesterday’s traumatic experiences with today’s caregivers. It is easy for staff who are inadequately trained, often overworked and thoroughly stressed to get pulled into these re-enactments. When we allow ourselves to be pulled into this recurring play, and we successfully act out our assigned role, we risk retraumatizing the children we have pledged to help” (Farragher and Yanosy, 2005).

Trauma informed models establish cultures of practice which recognise not only the impact of trauma on the individual but also the impact on staff and the organisations caring for these young people (Farragher and Yannosy, 2005; Rich et al, 2009). It is seen as a whole approach and developed by agreeing core principles and tasks. Bloom (2005) describes the principles as: dominant characteristics, cultures of nonviolence, emotional intelligence, inquiry and social learning, shared governance, open communication, social responsibility, growth and change (p70).

The Core Principles are referred to as:

- **A Commitment to Nonviolence** – helping to build safety skills and a commitment to higher purpose
- **A Commitment to Emotional Intelligence** – helping to teach emotional management skills
- **A Commitment to Social Learning** – helping to build cognitive skills
- **A Commitment to Open Communication** – helping to overcoming barriers to healthy communication, learn conflict management, reduce acting-out, enhance self-protective and self-correcting skills, teach healthy boundaries
- **A Commitment to Democracy** – helping to create civic skills of self-control, self-discipline, and administration of healthy authority
- **A Commitment to Social Responsibility** – helping to rebuild social connection skills, establish healthy attachment relationships, establish sense of fair play and justice
- **Commitment to Growth and Change** – helping to work through loss and prepare for the future
  (Bloom, 1997)

b) Attachment Promoting

Attachment promoting models are based on an understanding of the early attachment experiences of the young people you are looking after and an awareness of the influence of your own experiences. There is an acceptance that, while family remains of prime
importance as a source of enduring attachment figures, young people can form special relationships with caregivers (Furnivall, 2011). Staff need to recognise the importance of the enduring attachment figures and work to maintain these relationships throughout placements. They also recognise the healing potential of their own relationship with the young person and how this can promote healthy development (ibid.p11).

It is difficult to separate an attachment promoting model from one that is trauma informed but those working from attachment promoting basis are specifically interested in avoiding controlling practices and promoting connections with young people (Moore et al, 1992). Understanding the early attachment experiences of young people is integral in influencing the young person’s internal working model and their way of maintaining relationships with others. This increased understanding of the young person positively affects the way caregivers frame and respond to their behaviours, encouraging more pro-social responses to stress and anxiety and helping young people make sense of interactions. Relationships are seen as the foundation for all interactions and interventions and it is impossible and undesirable to maintain the role of unaffected, uninvolved professional (Leaf, 1995).

There is a particular emphasis on not reacting to difficult behaviour and managing situations without resorting to punitive measures. However, this does not provide an excuse for inappropriate or unacceptable behaviours and the development of a permissive culture.

*It’s extremely difficult not to get bowled over by behaviour. When a teen is oppositional or aggressive we fear that even if we considered what the needs might be behind the behavior, we are implicitly condoning the behaviour and inviting more of the same. It is important to understand that we are not suggesting that anyone accept or condone behaviour which puts anyone at risk*  
(Maples Adolescent Treatment Centre Website, 2007)

While most staff will have received some input on attachment theory in their qualifying training, using attachment theory to inform practice requires greater understanding of the complexities of attachment styles and the development of an Internal Working Model. Applying this knowledge in the residential child care environment is equally complex and staff members require support from supervisory staff and external consultancy to ensure that they have opportunities individually and collectively to reflect and learn. In addition to making greater sense of young people’s stories, attachment theories, combined with research on brain development, recognise adolescence as an opportunity to provide new relational experiences which have a chance of influencing the young person’s Internal Working Model, even if there is the recognition that earlier experiences cannot be erased (Moore et al, 1992).

Principles underpinning trauma informed approach:

- All behaviour has meaning
- Attachment is for life
- Conflict is part of attachment
- Secure attachment: A balance between connection and independence
- Growth involves moving forward while understanding the past
- Understanding, growth and change begins with empathy
- Relationships include being connected and independent: Maintaining balance is key.
- Attachment brings joy and pain
- Attachment allows trusting the relationship even during turbulent times
c) Strengths-based

Strength-based practice is an approach to guiding at-risk youth and their families that is exceptionally positive and inspiring. It begins with the belief that all individuals have or can develop strengths and utilise past successes to mitigate problem behaviour and enhance functioning and happiness. Its focus is on what people do right (Applestein, 2012).

As it suggests, this is a collaborative approach focussed on harnessing the strengths and capacities of young people and their families so they are co-producers of support (Pattoni, 2012) or partners in their own healing (Brendtro, 2004). It is consistent with resilience based approaches which more specifically focus on the talents and interests of young people to build self-esteem, improve mental health, and open up new social networks (Gilligan, 1999).

Similar to the development of attachment promoting models in the past two decades, strengths-based approaches have developed as an alternative to what were seen as coercive models of intervention (Brendtro, 2004). Coercion is seen as a failure of the caring environment and significantly, incidents of physical restraint are seen as sentinel events. Equally the approach recognises the importance of maintaining family relationships or restoring belonging (Brendtro, 2004).

In very simple terms the role of the practitioner is to identify and build on the strengths, interests and talents of young people with the expectation that these successes can be used to build esteem and help efficacy in the future. The family is also attributed strengths and the worker must proactively seek to create opportunities for positive interactions with family. As well as building the resilience and improving the mental health of the young person the approach increases positive attitudes towards young people and benefits practitioners’ mental health and job satisfaction (Racco, 2009).

One element of the model is also the positive reframing of behaviours wherever possible, the ability to reframe thinking being important to promoting positive feelings towards young people and enabling the healing process (Brendtro et al 1992). The table below offers a brief example of reframing:

<table>
<thead>
<tr>
<th>Decoding Problem Behaviour</th>
<th>Positive, Hope- Based Reframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obnoxious</td>
<td>Good at pushing people away</td>
</tr>
<tr>
<td>Rude, arrogant</td>
<td>Good at affecting people, expressive</td>
</tr>
<tr>
<td>Resistant</td>
<td>Cautious</td>
</tr>
<tr>
<td>Lazy, un-invested</td>
<td>Good at protecting yourself from further harms</td>
</tr>
<tr>
<td>Manipulative</td>
<td>Good at getting needs met</td>
</tr>
<tr>
<td>Just looking for attention</td>
<td>Good at caring about and loving yourself</td>
</tr>
<tr>
<td>Close-mouthed</td>
<td>Loyal to family or friends</td>
</tr>
<tr>
<td>Different, odd</td>
<td>Under appreciated</td>
</tr>
<tr>
<td>Stubborn and defiant</td>
<td>Good at standing up for yourself</td>
</tr>
</tbody>
</table>
Principles of strength based practice:

- Goal orientation: Strengths-based practice is goal orientated. The central and most crucial element of any approach is the extent to which people themselves set goals they would like to achieve in their lives.

- Strengths assessment: The primary focus is not on problems or deficits, and the individual is supported to recognise the inherent resources they have at their disposal, which they can use to counteract any difficulty or condition.

- Resources from the environment: Strengths proponents believe that in every environment there are individuals, associations, groups and institutions who have something to give that others may find useful, and that it may be the practitioner’s role to enable links to these resources.

- Explicit methods are used for identifying client and environmental strengths for goal attainment: These methods will be different for each of the strengths-based approaches. For example, in solution-focused therapy clients will be assisted to set goals before the identification of strengths, whilst in strengths-based case management, individuals will go through a specific strengths assessment.

- The relationship is hope-inducing: A strengths-based approach aims to increase the hopefulness of the client. Further, hope can be realised through strengthened relationships with people, communities and culture.

- Meaningful choice: Strengths proponents highlight a collaborative stance where people are experts in their own lives and the practitioner’s role is to increase and explain choices and encourage people to make positive choices. (Pattoni, 2012).

d) Social Pedagogy

Social pedagogy (Smith, 2011) is more a way of thinking than a set of practices. Expert, supervisory or counselling type relationships give way to socio-educational approaches. Workers and those they work with become co-constructors of meaning or ‘fellow travellers’ in journeys of growth. PETRIE ET AL (2006) identify features of a social pedagogical approach. These exist within a general rubric of promoting individual and community wellbeing and happiness; the thrust is to use and develop people’s resourcefulness.

The articulation and expression of an ethical stance is foundational. Knowledge and skills are both informed by and feed into a practitioner’s developing ethical stance. This notion is encapsulated in the concept of ‘haltung’, which is broadly translated as ethos, mindset or attitude and describes the extent to which one’s actions are congruent with one’s values and
fundamental beliefs (Eichsteller and Holthoff, 2010). This might be thought of as ‘first practice’ from which all else follows.

Practitioners utilise a combination of intellectual, practical and emotional qualities. Social pedagogues study a range of academic subjects but their training also involves learning recreational and cultural skills. The ‘heart’ aspect of the task underpins all of this work. Social pedagogy recognises the importance and inevitability of close personal/professional relationships between pedagogues and those they work with and the negotiation of appropriate boundaries within these. This requires practitioners who are self-aware and reflective.

Social pedagogy identifies three ‘selves’ - the professional, the personal and the private. It is only the private self that is kept apart from those we work with. The professional and personal ‘selves’ combine to support the self in action endeavour at the heart of direct work with people.

Most social pedagogical practice does not take place in the one-to-one meeting or in a counselling session but through shared activity. Social pedagogues come together with those they work with around shared activities. This practice reality is encapsulated in the concept of the common third. The pedagogue and the client share and have a joint claim on an activity in all of its different stages, from idea to execution. This makes for greater equality and authenticity in relationships where professional hierarchies become dissipated through joint involvement in an activity within which expert and novice roles might be reversed, or at least rendered less pronounced.

Every situation and the actors within it are inevitably different and therefore not amenable to any notion of a single best practice. What is best will be determined in the particular circumstances that pertain in any situation.

Rights perspectives are central to social pedagogy. The kind of rights deemed to be important in social pedagogical traditions are broad social and cultural rights. Such rights are rarely stand-alone or absolute but are negotiated and become realisable within respectful relationships.

Summary: Models and programmes

Longitudinal studies examining the effectiveness of models and programs in RCC is lacking but what we do know is that regardless of the model there are a number of elements which influence quality of care; the manager has a vision and is able to articulate it; the team have a shared sense of purpose and any model is orientated in the best interests of the young people (Sinclair and Gibbs, 1998; Anglin, 2003). It appears that the model of care is only significant if these measures are met. For those involved in making decisions about best resources or working in partnership with RCC staff it is essential that you know what model of intervention they are using and the underpinning theory.

Some models have prescriptive structures and systems to support the programme but equally all residential services work within organisations, which direct, through policy and procedure, the day-to-day running of the service. Young people systems and structures include routines, house rules and key working while those for staff include staff meetings, supervision, changeovers, rotas, recording and shift planning. The challenge for the service
is to ensure that all systems are oriented in the best interests of the young people while at the same time ensuring that staff feel valued and supported. The challenge to those professionals working in partnership with residential colleagues is making best use of these systems to support work with individual young people.

5. Practice issues in Residential Childcare

Managing challenging behaviour

“It is only staff who are able to demonstrate a clear commitment to young people, listen to them and understand and respect them, who are able to build relationships and who can therefore manage challenging situations and effectively defuse potentially disruptive behaviours” (SCIE, 2006)

Many young people in residential care have developed a repertoire of behaviours as a result of the trauma they have been exposed to, that the adults who care for them may find challenging. These behaviours can include:

- Violence and aggression
- Problematic drug and alcohol use
- Self-harming
- Absconding
- Offending
- Withdrawal

Effectively managing challenging behaviour is an integral part of the care that should be provided to children and young people in RCC. In this respect, what follows must be viewed in the context of the key concepts discussed above and in particular in the context of the applicable model or programme. Equally the organisational policy and preferred crisis intervention training given to staff will have an important influence on practice.

If we are serious about developing good practice in managing difficult behaviour, we must be clear about what we expect from staff when they are faced with it, how this fits in with the ethos and culture of the home and how this can be supported and monitored through effective supervision, guidance and training.

Ethos

Good practice in any aspect of residential childcare should begin with agreeing an ethos or philosophy. Bringing a staff team together on a philosophy, which in some cases may challenge personal values and perspectives, is a demanding process. When agreeing an approach to managing all aspects of challenging behaviour, it is important that staff are given the opportunity to reflect on their views on punishment or consequences for behaviour, how their behaviour was dealt with when they were adolescents and individual's experiences/views of the police. There should be a clear policy of how offending behaviour will be viewed and dealt with. Offending behaviour can occur within the residential units such as assaults on staff or other young people or within the community. In the past there has been evidence of young people admitted to residential care increasing the number of
charges they receive by being prosecuted for their display of pain based behaviours. The social worker and residential service should consider how offending behaviour will be dealt with both in a preventive and reactive sense, and this should be recorded in the action plan.

There must also be recognition that approaches which question established practice can be viewed with suspicion. Staff teams need to agree approaches to dealing with challenging behaviour and police involvement – these approaches must be based on a non-punitive approach within the context of trying to understand pain based behaviour and the most effective ways of managing these without recourse to Police. Managers and supervisors must then be aware that staff might feel as if they are relinquishing control leading to a sense of helplessness.

A shared philosophy helps homes/units to develop a shared understanding of pain-based behaviours within teams and establish cultures of practice which reflect this philosophical commitment. This, in turn, will have an effect on how behaviour is managed.

*Cultures of practice*

*Effective management of difficult behaviours is dependent on a number of factors including the structures and systems which exist to guide and direct staff but it is inextricably linked to the ethos and culture of individual services (Home Office, 2004).*

Research on cultures has shown that the development of delinquent cultures can be directly linked to inadequate or discordant staff responses. Effective practice requires the establishment of positive staff and young people cultures, which complement each other (Brown et al, 1998).

Cultural responses specific to offending behaviour must be developed. Responding to verbal abuse, physical threats, intimidation, violence, destructive behaviour and self-harming, staff responses must:

- Be consistent with a philosophy which aims to understand pain-based behaviours
- Be proportional, appropriate and not reactionary
- Where possible be discussed with colleagues on duty before acting
- Be fully reflected on – learning from incidents is imperative

Cultures of practice require systems which embed regular opportunity to discuss approaches and reflect on events. Staff meetings are a valuable forum for thinking creatively both about how to manage behaviour. It is in a forum such as this where you establish a shared philosophy, as well as consider how this is applied in working with the group and specific individuals. Incident evaluation and debriefing are also essential elements of developing good practice and are desired cultural responses to significant events. Debriefing is a core element of the training provided to staff for managing difficult and challenging behaviour. Informal opportunities for discussion are helpful but formal recognition of the significance of an event is somewhat more powerful. What we actually do, what happens in reality, before during and after significant events such as those involving the police, will either reinforce or undermine any cultures of practice.
The young person’s family and social worker should be informed of incidents of challenging behaviour and be involved in discussions about how they were managed, and how to use the learning from the incident to shape future practice.

Physical Restraint

Physical restraint is defined in Holding Safely (Scottish Government 2005) as “an intervention in which staff hold a child to restrict his or her movement and should only be used to prevent harm.” This definition implies the use of force as it is a restraining hold which is being described. There has been a degree of confusion over the distinction between physical intervention and physical restraint. This may have arisen because some training organisations include a number of physical interventions, such as sitting beside a child, or placing a hand on their shoulder, within their training courses on physical restraint. Physical restraint is the most serious of physical interventions.

Physical restraint should be seen as a significant event, only being used when absolutely necessary and when in the best interests of the child. There are exceptional situations in residential establishments when physically restraining a child is necessary and the most appropriate action to take.

National Care Standards for Care Homes for Children and Young People must also be followed. It is essential that the parent and social worker contributes to the individual plan which needs to be in place before a physical restraint is used and that they are informed when a restraint has been used and are included in discussions with regard to how best prevent the need for restraint in the future.

Involvement of the Police

There are some behaviours where, due to organisational policy and/or existing protocol, involving the police is largely non-negotiable e.g. child protection, missing persons, drugs, and offending in the community. However, RCC staff can exercise discretion over many other behaviours which would be deemed offences in other contexts e.g. violence towards others, threat of violence or harm, damage to property, theft of property and disorder offences. This latter group are the behaviours referred to in this section.

The criminalisation of young people in residential care has periodically raised concerns. Young people who are looked after away from home are three times more likely to be charged with offences than those in the general population (NACRO, 2003; Taylor, 2006). From the middle of the last decade research has highlighted the correlation between persistent offending and being accommodated in residential care (Bradshaw, 2005; Evans, 2007). However more recent research has emphasised that the correlation between care and offending is largely a result of shared risk factors (Schofield et al, 2012). Furthermore additional risk factors associated with the concentration of risky young people in residential care and the lack of control over placements are equally influential (Hayden, 2010).

Police have been used where staff feel that they are unable to keep people safe. They may be asked to attend a unit where a group of young people are intimidating other residents and staff and there are real concerns that the environment makes safety impossible. Having
police attend who have no knowledge of the young people or the staff can often lead to avoidable charges or, on occasion, escalation of incidents.

It is clear that the relationship between RCC staff and the police is seen as central to avoiding the criminalisation of young people (Schofield et al, 2012; Taylor, 2006). This relationship is often formalised through protocols and guidance (Hayden, 2010). One report has concluded that joined-up work was one of four key measures to be taken to ensure that being looked after and accommodated was not an accelerant into criminalisation (Tact, 2008).

One of the other key measures was improving the quality of residential care (specifically staff) and introducing more use of restorative approaches. This recommendation resonates across other research with a particular emphasis, not on the formal restorative interviews or conferences but more on the application of restorative principals in the informal interactions. Restorative approaches are widely used in children’s homes throughout England and individual councils, and Norfolk, Durham report at least a 50% reduction in the involvement of police in children’s homes. Other local research also reaffirms the possibilities of restorative approaches redefining the culture of practice within individual homes (Mirsky, 2005).

The nature of positive experiences of policing strategies is characterised by:

- a pro-active effort to establish links with the police (or vice versa)
- the development of a strong relationship with a core team of officers
- predominant involvement of the police in the home would be carried out by two or three key officers
- they would follow up on absconders as well as deal with any other issues in the unit, and they were often available at moments of crisis
- link officers would be clearly skilled in communicating with young people and this has a knock-on effect on the young people’s perception of the police
- relationships between the officers, staff and residents can better develop through informal contacts
- involvement of this core group of officers is predictable and there is a good mutual awareness of roles
- the police recognise that units are homes for the young people (Gentleman, 2008)

Joint working relationships and cultures of practice should be well supported by clear practice guidance. Guidance for staff should:

- aim to improve outcomes for young people
- aim to improve joint working between care staff and the police.
- acknowledge the particular context of residential care and young people (guidance for office-based staff may be different)
- guide and advise staff about when and whether to involve the police. Outlining circumstances where it may be necessary, desirable and effective - using examples can help
- be as short as possible and be accessible to all staff
• highlight the importance of understanding and the challenges of responding to pain based behaviour

In practice residential child care staff know that they will have to deal with emotional, and sometimes violent or disturbing behaviour, given the background of the young people in their care. Staff are trained to manage this behaviour and will negotiate, redirect anger, use humour, challenge, and even physically restrain. If the final decision is to call the police there are five key considerations to ensure this is done thoughtfully:

• Timing of police intervention: would it be better to wait?

  ➢ RCC staff must consider whether the arrival of the police be conducive to effective management of the environment, if they will have the time to discuss the situation fully with the police when they arrive and if it could potentially exacerbate the situation. Sometimes, especially where incidents have been well managed, it can wait until tomorrow.

• Initial phone call with senior colleagues to discuss the situation and how best to proceed:

  ➢ In most RCC environments staff on duty, regardless of position, will be expected to manage most situations and make the right decisions. However, it is perfectly understandable that there may be occasions where running the situation by a colleague and especially a senior member of staff may help decide whether involving the police is the best course of action.

• Let the police know the story:

  ➢ Attending officers can often walk into incidents as they are developing – if at all practical take time to outline the facts to attending officers when they arrive.

• Discussion between staff and police about charges. This needs to be open and honest, agreeing what is the best way forward.

  ➢ Whether about charges or any other action this discussion is essential not only to take the best decisions but to also develop positive relationships.

• Post incident support and reflection must include an examination of why the police were called and what was learned from the experience.

  ➢ This would be part of normal incident debriefing but this should allow for an open discussion about the incident and consideration about whether the decisions made were in the best interests of the young person and consistent with the philosophy of the service.
Family work

Working with the families of young people accommodated in residential care is an inherent part of the role of residential staff. How this work is carried out and types of work involved will be guided by legislation, guidance and policy but will often come down to the philosophy of the service, and usually the head of home (Bullock, 2008; Gibbs & Sinclair, 1999). This is evidenced in the wide variation in practice (Brown et al, 1998). While it is important for residential staff to create connections with young people it is of course essential to remember that these children already have families (Burstein, 2006) and that child and family are irrevocably linked (Ainsworth, 1997).

In practice, family work includes a range of activities from phone contact to keeping them updated on formal parenting programmes. The focus of all family work is supporting the relationships with the people most important to the young person. Often these are families who have rejected the intervention of other services and there is also an additional quality to residential staff which is often important to families in that they are not social workers.

Similar to the anxieties of residential staff about the therapeutic role is a historical nervousness about those undertaking family work requiring specialist or additional training, leaving practitioners feeling neither confident nor competent (Kelsom and McCullogh, 1988). Residential staff tend to downplay their role with families which is contrary to the wider view of the role they can play in assessment and intervention during and beyond placement (NRCCI, 2009).

As much as the life space creates opportunities for direct work with the young person, the residential child care environment is seen as a place of particular opportunity for engaging with families (Kelsal and McCullogh, 1988). Being a 24 hour service, staff are an accessible source of support and guidance throughout the week. It is during these moments when residential staff can establish significant relationships with family members, usually parents.

Even where family difficulties may have contributed to accommodation, there is little argument about the importance of family contact to the young people looked after away from home. It is also increasingly apparent that good outcomes for young people living in residential care can be affected by the ability to focus on family (Landsman et al, 2001; Knorth et al, 2012). More specifically, maintaining good contact and ensuring that families are involved in decision making processes are seen as important factors associated with successful services (Clough et al, 2006). In a review of comparative studies, residential care which was family centred was seen as the more promising model of group care and one specific study reported better outcomes than other interventions, including treatment foster care (Lee et al, 2011).

Family centred residential services are defined as a philosophy or model of working which (similar to strength-based models) emphasise the partnership between staff and families and take an ecological view of the young person in the context of their family and community (Knorth et al, 2012). Ainsworth (1997) suggests the three areas of program function which will evidence the family centeredness of services:

- Service availability (including cost of transportation for visits/contacts, parenting programmes)
• Parental involvement (including accessibility for parents and full participation in decision making processes affecting the young person)
• Staff attitudes and expectations (especially related to contact, parental rights and reunification)

Essentially residential services should evidence commitment in all three areas to ensure they are family centred. However, the responsibility of other members of the team around the child cannot be understated. For example, post-placement support is a significant part of family support and while there is recognition that residential staff should be seen as major players in providing this support (ibid), local practice often precludes this role. The placing social worker has a key role in determining roles and responsibilities in this area of work.

Mental Health

A study noted that:

• Looked after and accommodated children have both a greater number and also more complex mental health problems than their peers
• There is a highly committed and passionate workforce caring for our looked-after children
• There are a plethora of policies and agencies involved in a very complex picture and a lack of joined-up working
• The complex funding arrangements of the services providing care can cause barriers preventing the needs of these vulnerable children and young people being met in an appropriate and timely manner
• There is no formal involvement by the NHS in placing and moving children (Lachlan et al, 2011)

The reasons for the complex mental health problems of young people living in residential care include their early childhood experience of poor parenting, loss separation, bereavement, parental illness and impact of the environment (poverty, deprivation, social exclusion) (Scott and Hill, 2009).

There are a number of studies outlining the mental health needs of children and young people in residential care. These are well presented in a paper produced by the Social Work Inspection Agency (Scott and Hill, 2009), which concludes that “many children who are looked after and accommodated do not receive the health assessments and treatments they need from conventional health services. The reasons include: frequent moves disrupting communication and records; professionals’ low level of awareness of the particular circumstances of looked after children; stigma and fears associated with standardised examinations or visits to clinics; and the reluctance of some children and young people to engage with health professionals” (ibid p32).

The NRCCI recommended, “building on best practice, it is important that multi-agency services are provided to support the mental health and well-being of children and young people in residential child care. CAMHS teams have a crucial role in offering direct help. All residential services should have access to specialist consultancies to find the best approaches to help individual young people. Residential staff should be equipped and supported to identify and assist with common, nonpsychotic mental health problems such as depression and anxiety, as well as addictions.”
There is some evidence of good practice in supporting the emotional well-being of young people in residential care as recommended above (Mindful Care (Moray); Springfield Project (Fife); Edinburgh Connect (Edinburgh). As well as offering direct work to young people in residential care, they also offer training and consultancy to residential child care staff.

The role of residential staff in improving the emotional well-being of the young people they look after is embedded in therapeutic interventions (see above) and linked to establishing relationships which support the emotional development of young people (Smart, 2008) but other initiatives have also provided a more systematic approach to promoting good health: “positive role modelling can be used to develop the idea of the health promoting unit where staff and young people pull together to make their lifestyles as healthy and enjoyable as possible (Scott and Hill, 2009). Health Promoting Units have been developed in some areas along the lines of the similar schemes targeted at schools.

One Scottish Study (Minnis and Del Priore, 2001) focussed on the prevalence of attachment disorders in children and young people living in residential care, commenting on the potential implications of these disorders on longer term development. The knowledge of residential staff in understanding these disorders and receiving the support they need to best look after the young person was also studied with a positive recognition of staff working in residential care (Miliward et al, 2006). The recognition of attachment disorders is seen as important not only for understanding behaviour and managing care but also because if they are not addressed placement breakdowns are more likely, linked to the inability to form attachments. In turn this has potential lasting implications for forming relationships in the future (Minnis and Del Priore, 2001).

**Gender**

Throughout this section, reference should be made to the Good Principles and Practice: Vulnerable Girls and Young Women. This section looks at some of the literature and research relating to gender differences and gender sensitive practice, and defines good practice principles in working with girls and young women, as distinct from boys and young men, across a range of services.

**Key Principles**

For both girls and boys there are some key principles outlined in literature which are considered to be essential in supporting young people and helping them make relevant behaviour changes. These include:

- Positive working relationships based on trust and mutually agreed goals
- Staff who demonstrate genuine empathy and interest
- A safe and secure environment, both physically and emotionally
- Clear, consistent boundaries and consistency of approach by staff
- A strengths-based approach

However, differences between boys and girls suggest that therapeutic approaches may be improved if further consideration is given to relationships, the expression of emotions, the structure offered and learning styles.
Relationships with Staff

Girls prefer smaller numbers of staff delivering direct interventions as this allows them to develop closer working relationships based on trust and respect and access to female staff, with relevant training is important. Training should include understanding of issues regarding gender identity and development, and staff should be skilled at managing sensitive emotional issues.

Boys also need the opportunity to be able to express their feelings in an environment which is safe and supportive and in a mixed gender environment it will be important to provide each young person with opportunities to socialise with peers and staff of the same gender. It may be advantageous to provide allocated, structured time to ensure that these opportunities are provided.

Relationships with Peers

Girls emphasise the importance of the opportunity to spend time with other female peers which is positive, supportive, safe and non-stressful. This provides opportunities for girls to express themselves, explore their feelings and reflect on experiences. The importance of relationships is also evident in respect of how relationships are formed with peers. Boys tend to focus on dominance and social status, and engage in more competitive activities, whilst girls tend to gather for social contact and place more importance on the relationships themselves rather than the activities.

Intimate Relationships

To date adolescent relationships have received limited research attention because of the difficulties associated with this research. Young people can be reluctant to discuss their relationships, as generally they are considered to be private and that these relationships are often transitory.

One study provides some understanding about the particular difficulties for girls where Banister and Jakubee (2004) interviewed female students aged 15 and 16 years. They found that girls blamed themselves for their boyfriends’ abuse and lack of commitment, and that the girls were reluctant to affirm their own needs and interests within the relationship. The girls felt they were faced with a decision about whether to compromise their values and needs to maintain the relationship, or whether to risk the relationship in order to maintain their true self and beliefs. For looked after and accommodated young people, who are likely to have experienced family difficulties and therefore less belonging and connection to family members, romantic relationships may become more significant. A sense of self-worth, and the development of a positive personal identity allows individuals to develop healthy relationships, express their own needs within a relationship and reduce the likelihood of abuse or exploitation. Services need to consider how they can support the relationships of young people in residential care including exploring acceptable and unacceptable behaviours within relationships and how to remain safe in relationships.

Identity

Early explanations about the stages of development (Erikson, 1995) theorised that the development of self-identity occurred in adolescence and was resolved through autonomy,
and in determining how one is different from others. Young people will develop their identity around strengths, weaknesses, goals, occupations, sexual identity and gender roles. Adolescents will also "try on" different identities, using their friends to reflect and feed back to them.

Erikson’s theory of development noted that the development of self-identity occurred before intimate relationships are explored. Gilligan (1979) suggested, however, that this sequence of development occurred in boys and not girls. She reported that for girls, these two stages occur simultaneously, because girls develop their self-identity through their intimate relationships with others. This suggests the importance of intimate relationships within the development of girls’ self-identity, and why these relationships can be problematic for girls.

Coping

There are also differences in the way in which girls and boys process experiences, with girls being more likely to internalise problem behaviours and boys to act out externally. For example boys are more likely to engage in overt criminal activity, physical aggression and behaviour difficulties compared to girls who present higher rates of depression, suicide ideation, self-harm, hopelessness, negative self-evaluation and eating disorders (Handwerk et al, 2006).

Expressing Emotions

Research has noted that girls will more readily express their emotions, show signs of depression and anxiety and attempt suicide, compared to boys who are less likely to report negative feelings but are more likely to commit suicide (Eisenberg, Martin, & Fabes, 1996; Kindlon and Thompson, 2000). This research suggested that boys learn to bear their negative feelings alone, but fail to manage these feelings. Those providing residential care need to become adept at recognising when boys may be in crisis, and in supporting boys to express and manage their feelings in a safe and supportive environment. There is evidence that girls self-disclose abuse more readily than boys and that self-disclosure can be a protective factor for wellbeing, social relationships and development (Leman and Tenenbaum, 2011).

Aggression

Evidence indicates that girls’ use of aggression is usually within the context of relationships, and they will seek to hurt others through relational aggression. This can take many forms and includes name calling, bullying and the deliberate exclusion of another individual from the group or activity. Boys’ use of aggression is generally more reactive, and they tend to respond impulsively with physical aggression or violence (Bjorkqvist, Lagerspetz and Kaukiainen, 1992; GPG and Underwood, 2003). Relational aggression can be equally as damaging as physical aggression and should be addressed with equal regard.

Relational aggression is also significant due to findings that young people who are relationally aggressive have an additional increased risk of adjustment difficulties, such as rejection, loneliness and depression (Crick and Grotpete, 1995; Rys and Bear, 1997).
A further example of the differences in girls and boys aggression is evident in their attempts to influence others. Boys are more likely to use overt threats and physical force, whereas girls will use verbal and more covert means (Serbin, Moller, Gulko, Powlishta, & Colburne, 1994).

**Learning styles**

Research has noted gender differences in approaches and learning styles for girls and boys. Studies have indicated that boys' brains have more areas for spatial-mechanical functioning, than for verbal-emotional functioning in comparison to girls, and that they will experience words and feelings differently (Blum, 1997; Moir & Jessel, 1989).

Boys are more linear in their approach to learning and respond more positively to clear structure and learning objectives in comparison to girls, who prefer a less formal and more flexible approach to their learning, with time and space for thinking and reflection.

Another noted difference is girls' preference for real life context when learning and that providing background information about the history of a particular subject increases girls' interest. Boys seem to show less interest in this additional information and can quickly become restless. Boys prefer shorter instructions and problem focused learning (Chadwell, 1997).

Within the context of formal education, there is evidence that girls tend to have higher aspirations than boys (Feingold, 1994) and that they can be excessively critical in evaluating their own academic performance (Pomerantz, Altermatt and Saxon, 2002).

Evidence also suggests that girls are often more concerned about pleasing teachers (Pomerantz Altermatt, and Saxon, 2002), compared to boys who may be more focused on whether a subject is of interest to them. Girls are more likely to drop out of formal education and their interpretations of failure can be that they have disappointed relevant adults and therefore they are of little worth. Girls also tend to generalise such experiences to other areas of their lives.

**Response to restrictions**

Girls are less responsive and less likely to comply with physical restrictions placed upon them. Research has shown that girls are more likely to abscond (12% versus 8% of boys) or breach the restrictions of an electronic tag or conditions of a Drug Treatment and Testing Order (Commission on Women Offenders, April 2012). One study found 60% of girls compared to 40% of boys absconded from residential schools (Clarke and Martin, 1972), and another study of runaways noted that the majority of their sample (55.9%) was girls (Thompson and Pillai, 2006). In both studies the researchers highlighted the importance of the environment, and how this needed to be addressed in order to reduce absconding rates, rather than too much focus on the individual. Specific factors noted were stress, lack of structure, the opportunity to abscond and if behaviour is left unchallenged.

**Environment**
A high standard of physical environment is important and girls should also have access to relevant materials such as books, magazines, DVDs, and images which promote positive and healthy images of women. Contributing to the physical environment, for example choosing décor and furnishings, also increases feelings of security, safety and ownership. Girls are also noted to respond better in a safe, comfortable, welcoming space - ‘think bean bags over plastic chairs’ (Chadwell, 2007).

Within a mixed gender environment thought is needed in order to provide physical space that is suitable for both male and female residents, given that boys are more focused on activities and girls on the importance of their relationships.

6. Conclusion

This section has considered working methods and issues that are particularly relevant to social workers who are placing or supporting young people who have offended in residential care, and to those supporting young people in residential care.

The issues of family work, mental health and gender are examined and the importance of residential care in being able to address pain based behaviours skilfully is discussed. This discussion includes the use of physical restraint and the police.

It emphasises the need for the social worker, the residential staff, the family and the child to work together in order to ensure that the outcomes selected for the young person are met.

These outcomes are more likely to be met if the young person is matched to the placement that is most likely to meet their needs. This chapter aims to give information that will help the social worker ask the questions needed to identify whether this is the right place for their young person, and then to consider how best the placement can be supported.
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Residential Child Care (RCC) has an interesting history in Scotland. Reviews and critical incidents have shaped the service, as it is today its legislation and practice and contributed to several relevant policies http://www.scotland.gov.uk/Topics/People/Young-People/protecting/lac/residentialcare.