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

Section 8: Residential Child Care

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Contents

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 those working with young people in residential child care (RCC). This includes those working within establishments, social workers intending to place or support a young person in RCC and the wider team around the child. This section explores the role of RCC as a vital part of the continuum of care and the key concepts, models and programmes, and practice challenges in RCC, which should be referred to alongside the statement of function and purpose that each residential unit is required to have. When reading this, it should be borne in mind that in October 2016, the Scottish First Minister announced a "root and branch" review which will explore the underpinning legislation, practices, culture and ethos of the care system, including in RCC. This will be driven and shaped by the evidence of care experienced young people and propose changes to the care system to improve the quality of life and outcomes of young people in care.

The Children and Young People (Scotland) Act 2014

As detailed in section one, commencement of Parts 4 and 5 of the Children and Young People (Scotland) Act 2014, referred to as the 2014 Act, has been delayed. Further guidance on these sections of the Act is awaited but it is important that residential workers understand the role of all professionals involved with a child and particularly the role of the Lead Professional.

The Lead Professional has a range of roles and responsibilities, which include:

- Ensuring that the Child's Plan is implemented, managed and reviewed properly and to co-ordinate the support described in the plan. This includes updating and sharing the plan after each review; ensuring any other plans for the young person are informed by, and incorporated into, the Child's Plan; and reviews are integrated as far as possible
- Maintaining contact with and ensuring the child or young person and family understand what is happening at each point so that they can be involved in the decisions that affect them
- Promoting partnership working between agencies and with the child and family

The Child's Plan should hold detailed assessment information and identify 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, which the young person and their family should contribute to. It is important that these outcomes are communicated to the residential placement and discussions are held to consider how the placement can support the achievement of the identified outcomes. Moreover, consideration should be afforded to the role of other agencies and how the network of support will be coordinated and managed. 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 (for more information please see the Reintegration and Transitions Section 6 of this guidance).

2. The Role of Residential Child Care (RCC)

Children who require support and intervention present a range of needs, meaning a range of possible services and types of care placements must be available. RCC 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 those children and young people who need intensive care and support, whatever their age, and which builds their resilience and prepares them for the future. There are now a greater number and range of RCC providers looking after and accommodating children and young people on a full-time basis or as part of respite and crisis care. Generally speaking there are three types: children's houses/units; residential schools; and secure units. Children's houses provide accommodation and support for children, in small units, usually not accommodating more than six children. These establishments differ from residential schools, where education is also provided on site. Most children's houses and residential schools are run by local authorities, although some are provided by the voluntary and independent sector. Currently, secure care, accommodation and education in Scotland can be provided for 84 young people aged 10-18 through four independent charitable services and Edinburgh City Council (see Secure Accommodation Network Scotland and Youth and Criminal Justice in Scotland: the young person's journey for more information). "Secure care is the most intensive and restrictive form of alternative care in Scotland" (Gough, 2016, p.3), with the secure care national project having recently presented a number of key messages and recommendations (see Gough (2016) for more information). The secure care contract stipulates clearly the roles and responsibilities of stakeholders as well as service providers and social workers accessing secure care. Many RCC services and all secure care providers have in place an outcome framework to support the identification and meeting of outcomes for young people in their care.

All RCC services are inspected by the Care Inspectorate on an annual basis and inspection reports, including grading against quality indicators, can be accessed. No two services are the same, 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 services complete an annual return and a comprehensive self-assessment document to inform the overall inspection process.

RCC has been the subject of various inquiries and investigations into concerns about the role of RCC and abuse in care (the Scottish Child Abuse Inquiry is ongoing) with this form of care often being perceived as the 'last resort' for children whom other placements have not worked out for and/or as the 'safety net' for the rest of the child care system (Skinner, 1992; NRCCI, 2009). However, numerous national enquires have reached the conclusion that RCC is a "positive choice" for some young people (Kent; Utting; Shaw, as cited by Kendrick, 2013). The critical factor is the quality and persistence of the caring relationships and the culture of the establishment rather than the configuration or structure of the household or the building:

"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).
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 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, with a number of the key concepts in RCC discussed below (Smith and Steckley, 2011).

3. Key concepts

Group Living Environment

The extra familial living environment is one of the key psychosocial processes central to understanding RCC and groups of unrelated young people living together, away from home, gives a unique dynamic to RCC services (Anglin, 2002). Relationships 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). 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, including that these can increase the likelihood of offending, but there are alternative narratives to the relationships formed in RCC (Barry, 2008; TACT, 2008). Young people can form close relationships with their fellow residents which can be a powerful source of support and such group living a "positive, developmentally appropriate, growth producing experience" (Barnes, 1991, p.123; Emond, 2002). Regrettably, placement decisions do not always consider the potential of relationships between young people and how these will be monitored (Hayden, 2010).

Although not necessarily unique to RCC, young people also have to manage relationships with multiple adults – usually between 10 and 20. These relationships include those with the staff team, with RCC a 24-hour service and staff work across all hours on a rota basis. Rotas can be seen as mechanistic and it is important the needs of staff and the best interests of the child are balanced as far as possible (Burton, 1993). Young people will almost always be allocated a keyworker. In its best form keyworking will be guided by the principle of ensuring that 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 after admission. Having a named worker 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, administrative workers and other ancillary staff often have a significant role in the daily lives of the children and young people who are looked after. What is unique to RCC is the intensity, and sometimes the intimacy, of each of these relationships related to the length and quality of time young people will spend with these adults (Kohlstaedt, 2010).

The group living dynamic presents challenges to all who work 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 take into consideration the impact their response may have on the young person and other children residing in the establishment.

Life space intervention

The RCC environment is the life space of the young person: where they eat, sleep, relax, express emotions, have fun, test boundaries and learn. Moreover, 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 stems from the work of 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 and Wineman, 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).

Life space intervention sees the group living environment as providing a context for opportunity led work by actively and thoughtfully engaging with young people, which is distinguished from planned or structured interventions, for example as is typical in social work practice (Ward, 2002; Smith, 2008). Such use of daily life and routine events requires an understanding of the importance of staff being able to develop and maintain positive relationships, noticing behaviours, understanding the context of these behaviours by making meaning and using insight and self-awareness in deciding 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. Arguably, alongside relationships, the potential and ability to consciously harness the everyday care and experiences to enhance development and promote healing is one of the most fundamental and powerful things that RCC can uniquely provide (Steckley, 2016).

The therapeutic role of Residential Child Care

Children and young people in residential care have - almost without exception - experienced trauma and loss, with previous experiences of maltreatment and placement breakdown common. Those working in residential care have to help minimise the damaging consequences of such traumatic pasts and support young people to regain or develop a sense of self-worth and self-efficacy, and develop the skills and competence to negotiate

and maintain interpersonal relationships and future roles and responsibilities. It is no easy task and is not something that can (or should) be done "intuitively" but is crucial:

> *"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"* (Macdonald et al., 2012, p53).

Therapeutic RCC 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, pg. 2)

'Therapeutic approaches' are defined as ways to help staff understand how trauma affects 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; and how they might change. While services in some other parts of the world are comfortable with the concept, RCC services in the UK have been reticent in the past decades to describe the service they give to young people as therapeutic (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). Moreover, while evidence on outcomes for therapeutic residential care is limited, that which has been undertaken has found evidence of improved morale of staff and short term outcomes including less confrontational environments and fewer serious incidents (MacDonald et al, 2012). As a result, 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 strictly clinical programmes. They are likely to permeate all aspects of the group living environment and provide 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 commonly used to describe models of intervention or ways of working. There are also various specific programmes for intervention that may be available within each establishment. 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, it is important to note that these terms are often transposed to practice in different ways. Individual services should be able 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 concern about the re-traumatising of children in care services (Osofsky 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 pg.3).

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; Barton, Gonzalez and Tomlinson, 2012). It is seen as a whole approach and developed by agreeing core principles and tasks 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 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, 2005)

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 practitioner's 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 and can describe these experiences as similar to being in a family, even using kin terms to describe these relationships (Furnivall, 2011; Kendrick, 2013). Staff need to recognise the importance of the enduring attachment figures and work to maintain these relationships throughout placements (Furnivall, 2011). They should also recognise the healing potential of their own relationship with the young person and how this can promote healthy development (Furnivall, 2011).

It is difficult to separate an attachment promoting model from one that is trauma informed but those working from an attachment promoting basis are specifically interested in avoiding unnecessarily controlling practices and promoting connections with young people (Moore et al., 1992; Barton, Gonzalez and Tomlinson, 2012). Understanding the early attachment experiences of young people is integral in influencing the young person's internal working model and their way of developing and 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).

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, learned through early relationships, which is a set of expectations and beliefs about the self, others and the relationship between the self and others. Applying this knowledge in the RCC environment is equally complex and staff members require support from colleagues, 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). In the face of long-term difficulties and negative experiences and well established coping strategies, the pace of change can be slow, requiring patience, persistence, perseverance, the recognition of small steps, and repeated exposure to positive experiences.

Principles underpinning a trauma informed/attachment promoting approach are:

- All behaviour has meaning
- Attachment is for life
- Conflict is part of attachment and attachment allows trust in the relationship even during turbulent times
- Secure attachment: A balance between connection and independence
- Growth involves moving forward while understanding the past
- Understanding, growth and change begins with empathy
- Attachment brings joy and pain (Obsuth et al., 1992)

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, assets, competencies and resources and can utilise past successes to mitigate problem behaviour and enhance functioning and happiness (Saleebey, 2000; Appelstein, 2008).

As it suggests, this is a collaborative approach focussed on helping individuals, families and communities to recognise and harness their strengths and capacities so they are co-producers of support, partners in their own healing, and in improving their outcomes and quality of life (Pattoni, 2012; Brendtro, 2004; Saleebey, 2000). 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).

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 strengths, capabilities and resources of the family are also actively identified 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, which is important in promoting positive feelings towards young people and enabling the healing process (Brendtro et al., 1992). The table below offers a brief example of reframing:

Decoding Problem Behaviour	
Pejorative Label	**Positive, Hope- Based Reframe**
Obnoxious	Good at pushing people away
Rude, arrogant	Good at affecting people, expressive
Resistant	Cautious
Lazy, un-invested	Good at protecting yourself from further hurts
Manipulative	Good at getting needs met
Just looking for attention	Good at caring about and loving yourself
Close-mouthed	Loyal to family or friends
Different, odd	Under appreciated
Stubborn and defiant	Good at standing up for yourself
Tantrum, fit, outburst	Big message
Learning disability	Road block

(Appelstein, 2008).

Principles of strengts-based practice:

- **Goal orientation:** 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 in the face of any difficulty or condition.
- **Resources from the environment:** 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.

- **The relationship is hope-inducing:** A strengths-based approach aims to increase the hopefulness and hope can be realised through strengthened relationships with people and communities.
- **Meaningful choice:** 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 is more a way of thinking than a set of practices (Smith, 2011). 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 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, mind-set 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 in the everyday and 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 are 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. The models are complementary in nature and often more than one model will be drawn upon to inform policy and practice. What is important is that these models meaningfully support and inform practice rather than being tokenistic.

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's 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 members 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 challenges in Residential Child Care

Working within the life space of RCC is inherently challenging and complex. This section will explore briefly some of these challenges, including managing pain-based behaviour, physical restraint and police involvement, family work, mental health and gender, as well as what can support staff and young people in such situations.

Managing pain-based 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, 2008, p.ix).*

Many young people in residential care have developed a repertoire of behaviours, often as a means of surviving and having their needs met in the face of the adversity and 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
- “Disgust” behaviours (such as spitting, smearing, urinating, or poor self-care)
- Frequent and unsubstantiated complaints against staff

Effectively understanding and managing pain-based 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 the organisational policy and preferred crisis intervention training given to staff.

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 acknowledge the challenges, tensions and dilemmas commonly faced in doing so (Moodie and Nolan, 2016). In addition, organisations need to reflect on how staff can be supported to respond to such behaviour, but also to understand why children behave in the way they do and what needs are being expressed and met through such behaviours.

Ethos and policies

Good practice in any aspect of residential child care 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 behavior, including in respect of police involvement, 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 children or adolescents and individual’s experiences/views of the police. There must also be recognition that approaches which question established practice can be viewed with suspicion.

Having policies or procedures to guide staff practice in responding to challenging behaviour, both generally and specifically, can be useful. However, specifically in respect of offending behaviour, Moodie and Nolan (2016) found the existence of such policies across Scotland and the familiarity of staff with them when in existence varied. Furthermore, this research highlighted that policies and procedures can only ever provide guidance and responses require to be individualised, depending on the circumstances of the incident, and a matter of professional judgement (Moodie and Nolan, 2016). It is however crucial such judgment is situated within and shaped by a positive, shared, supportive and respectful organisational culture and ethos, which has been developed through open debate, challenge and negotiation (Moodie and Nolan, 2016).

Cultures of practice

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 challenging and offending behaviour must be developed, which should be:

- Consistent with a philosophy which aims to understand pain-based behaviours
- Proportional, appropriate, non-punitive and responsive, not reactionary
- Discussed with colleagues on duty before acting, where possible
- Ensure police contact is the option of last resort
- Fully reflected on – learning from incidents is imperative

It is also crucial that recognition is given to the impact on staff of exposure, and responding, to pain-based behaviour. For example, Moodie and Nolan (2016) highlighted the complexity, dilemmas and tensions that residential workers grappled with in their decision-making in responding to offending. In supporting staff to manage this, 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 about how to manage behaviour, establishing a shared philosophy and considering 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 a desired cultural response to significant events but it is important debriefing is undertaken in a manner that feels useful and supportive to staff (Moodie and Nolan, 2016). Informal opportunities for discussion and colleague support are helpful but should be available alongside managerial support and formal recognition of the significance of an event. Similarly, it is crucial that the organisational culture invests in and prioritises staff induction, training and professional development to enable staff to understand behaviour; provide a range of strategies and a toolbox of resources that can be drawn upon in responding appropriately to behaviour; and promotes self-awareness (Moodie and Nolan, 2016). 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.

A relationship-based, partnership approach to managing behaviour should also be adopted. The young person's family and lead professional 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. This should be reflected and recorded in the Child's Plan.

Physical Restraint

Physical restraint is defined in Holding Safely (Davidson et al., 2013, p.viii) 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 which is the most serious of physical interventions.

Physical restraint should be seen as a significant event, only being used in situations of serious, imminent harm and when no other less intrusive means for ensuring or re-establishing safety are practicable. Each individual establishment will have an organisational policy on the use (or otherwise) of physical restraint, which all staff should be familiar with and be trained in the particular approach adopted. National Care Standards for Care Homes for Children and Young People (2005) 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 included in discussions with regard to how best prevent the need for restraint in the future.

Police involvement

The vast majority of looked after children do not come to the attention of the police and in RCC when they do this can be for a range of reasons, including absconding, victimization, offending within the residential units such as assaults on staff or other young people, vandalism, breach of the peace/threatening behavior, or offending within the community (Moodie and Nolan, 2016). The data that is available in England and Wales suggests that looked after children come into contact with the youth justice system at a higher rate than the general population (NACRO, 2012; Department for Education, 2011; Zayed and Harker, 2015). The Howard League for Penal Reform (2016) found 13 to 14 year old looked after children in England and Wales were nearly 20 times more likely to be criminalised (convicted or subject to a final warning or reprimand) than a non-looked after peer. In Scotland, there is a lack of available data on offending but the small-scale study by Moodie and Nolan (2016) highlighted concerns, particularly regarding the high number of offences committed by the same young people and number of charges for breach of bail and vandalism. As a result it has been stated that multi-agency data gathering and monitoring on a local and national basis is essential, with RCC workers and social workers having a key role in clearly recording and capturing specific details of any police contact and subsequent charges or convictions (Moodie and Nolan, 2016).

There are some behaviours where, due to legislation and/or organisational policy, involving the police is largely non-negotiable e.g. child protection, missing persons, and drugs. 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. Police contact will often be made where staff feel they are unable to maintain the safety of those present (young people and staff) or to control the type or the severity of the behaviour being displayed (Moodie and Nolan, 2016). 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. Therefore, efforts to build and maintain relationships between the police, RCC staff and young people are key in avoiding the criminalisation of young people (Schofield et al., 2012; Taylor, 2006; Moodie and Nolan, 2016). These relationships are often formalised through protocols and guidance but equally informal visits by the police to the establishment, outwith times of crisis, can have a crucial role (Hayden, 2010; Moodie and Nolan, 2016). Tact (2008) 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, with other factors improving the quality of RCC and the knowledge-base and skills of residential staff, as well as introducing more use of restorative approaches (Tact, 2008; Mirsky, 2005).

Police involvement should be the option of last resort. However, where this is deemed necessary a number of factors should be considered to ensure this is done thoughtfully:

- What can the police bring to this situation that cannot otherwise be provided?
- What will the likely impact of police contact be (i.e. will it help to de-escalate the situation or not)?
- Should I discuss with colleagues, on or off shift, how best to proceed?
- Let the police know the story when they arrive as far as the situation permits

- Whether about charges or any other action, discussion between RCC and the police is essential, not only to take the best decisions but also in terms of developing and sustaining positive relationships.

- If a young person is charged, it is crucial this information is recorded as per organisational policy, shared with the Lead Professional and the young person is provided with accurate information about the implications of such a charge, as well as supported on any subsequent journey through the youth and criminal justice system (where this is the outcome).

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

Family work

Working with the families of young people accommodated in RCC is an inherent part of the role of residential staff. The types of work and how this is undertaken will be guided by legislation and policy, as well as the Child's Plan, but will often come down to the ethos of the service (Bullock, 2008; Gibbs and Sinclair, 1999). This work is crucial as the child and family are irrevocably linked, the child will often be having contact with their family and may well return to reside with them on leaving the establishment (Ainsworth, 1997). Moreover, the 2014 Act clearly states that wellbeing assessments should be completed in partnership with the child and parent and that seeking and considering the views of the child and parent should be a key part of the process. Practice however markedly varies, with Malloch (2013) finding that at times the needs of family members can often be overlooked (Brown et al., 1998).

Similar to the anxieties of residential staff about their therapeutic role, there 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). Moreover, 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). Working effectively with families can be challenging and workers would benefit from training and support that will develop their confidence and skills in this area of intervention.

In practice, as much as the life space creates opportunities for direct work with the young person, the RCC 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 at all times, and this can be conducive to the establishment of significant relationships with family members, usually parents. The range of activities undertaken as family work varies, necessary given the variation in need of the families involved, but can include the provision of practical and emotional support, phone contact, information sharing about the establishment and processes, keeping parents updated on their child's progress, involvement in programmes and interventions, and transition planning (Malloch, 2013).

Contact is a further area where staff will often be involved with families. 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). This should however be based on robust assessment of the impact of such contact on young people's wellbeing and the views of the child, with it being crucial that decisions about contact are reflected in the Child's Plan.

Family work should be situated within a wider organisational ethos that is family centred, with such establishments found in comparative studies to be the more promising model of group care and provide better outcomes than other interventions, including treatment foster care (Lee et al., 2011). Family centred RCC services 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 which evidence the family centeredness of services are:

- 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, local practice often precludes this role (Ainsworth, 1997). The placing social worker has a key role in determining roles and responsibilities in this area of work.

Mental Health

Looked after and accommodated children were found in a study by Lachlan and colleagues (2011) to have both a greater number and also more complex mental health problems than their non-looked after peers. The reasons for the complex mental health problems of young people living in RCC include their early childhood experiences, which often includes poor parenting, loss, separation, bereavement, parental illness and impact of the environment (poverty, deprivation, social exclusion) (Scott and Hill, 2009). Research in this area is summarised by Scott and Hill (2009), who concluded 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"* (p.32).

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"* (National Residential Child Care Initiative, 2009, pg.24)

Some progress has been made in this area, with various examples of good practice evident. The role of residential staff in improving the emotional wellbeing 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). Other initiatives have also provided a more systematic approach to promoting good health such as role modelling and Health Promoting Units (Scott and Hill, 2009). Alongside this it is important that staff member's knowledge, understanding and skills continues to be developed and that they receive the necessary support to best look after the young people in their care (Millward et al., 2006). Further information on the mental health needs of young people can be found in the Section 10 of this guidance on Mental Health.

Gender

This section should be read in conjunction with the section of this guidance on Girls and Young Women. While many of the key principles of good quality RCC detailed elsewhere in this section are essential to supporting and promoting the development of all young people, differences between boys and girls suggest that therapeutic approaches may be improved if further consideration is given to relationships; identity; coping and expressing emotions; learning style; and the structure offered based on the gender of the particular young person. It should however be recognised these are general differences and each child will be different.

Relationships with staff

Girls generally prefer smaller numbers of staff delivering direct interventions as this allows them to develop closer working relationships based on trust and respect, often preferring access to female staff. 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, reflect on experiences and learn about 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

Research on adolescent relationships is more limited due to the difficulties associated with this research and that young people can be reluctant to discuss their relationships. Banister and Jakubee (2004) provided some understanding about the particular difficulties for girls based on interviews with 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. Work focusing on healthy and unhealthy relationships should be incorporated into the day to day living experience of young people in residential care, with a range of tools available to support this.

Identity

Early explanations about the stages of development theorised that the development of self-identity occurred in adolescence and was resolved through an acceptance of self, and in determining how one is different from others (Erickson, 1995). Young people will develop their identity around strengths, weaknesses, goals, occupations, sexual identity, gender roles and through relationships. 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. Training to staff should include understanding of issues regarding gender identity and development.

Coping and expressing emotions

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). However, 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, and Fabes, 1996; Kindlon and Thompson, 2000). This research suggested that boys learn to bear their negative feelings alone, but fail to manage these feelings. 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). 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.

Whilst boys' use of aggression is generally more reactive, overt and they tend to respond impulsively with physical aggression or violence, for girls this is usually within the context of relationships, more covert and verbal, and they will seek to hurt others through relational aggression (Bjorkqvist, Lagerspetz and Kaukiainen, 1992; Serbin et al., 1994). Relational aggression can take many forms and includes name calling, bullying and the deliberate exclusion of another individual from the group or activity, which can be as damaging as physical aggression and should be addressed with the same degree of seriousness (Crick and Grotpeter, 1995). 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 Grotpeter, 1995; Rys and Bear, 1997*).* It is important staff are trained and supported in understanding and managing different types of aggression.

Learning styles

Research has 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 and 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, preferring 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.

Responses to restrictions and the environment

In terms of 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, with stress, lack of structure, opportunity and whether behaviour is left unchallenged identified as features in this (Clarke and Martin, 1972; Thompson and Pillai, 2006).

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, with girls noted to respond better in a safe, comfortable, welcoming space (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. It emphasises the need for partnership working between the lead professional, the residential staff, the family and the child to ensure that the desired outcomes 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 section aimed to give information that will help the social worker consider 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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