

A Qualitative Approach to Assessing How the Care System Can Impact on Young People.

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Abstract

The thesis attempted to explore the 'lived experience' of young people who have been through the care system, in order to ascertain what changes could be implemented to improve the psychological wellbeing of young people going into the care system in the future. After a brief introduction (chapter one), an evidence synthesis (chapter two) on young people who have been in residential care was conducted, to examine this phenomenon from an international perspective. A comprehensive search strategy produced fifteen studies, which were selected for final review. A process of data extraction and subsequent data synthesis of the fifteen studies yielded twelve themes. The developed themes included topics such as, for example, the quality of relationships: between the young people, the young people and the care staff and the wider community. The thesis then used an empirical research piece (chapter three) to narrow the focus of the topic to Ireland and to explore the views of young people in conjunction with the views of care workers. For this purpose, a convenience sample of twenty participants (ten residential care workers and ten young people who had been through residential care), completed a care questionnaire and an open-ended interview of one-hour duration. A thematic analysis was performed to comprehend the raw data. The thematic analysis of the dataset elicited fourteen themes; 2 young person themes, 3 care worker themes, and 9 joint themes. The developed themes addressed areas such as: 'fitting in,' 'what makes a care worker' and 'wider connected processes.' The findings were considered in light of other research literature in this area. Since many of the themes related to psychological wellbeing of young people in the care system, the Trauma Symptoms Checklist for Children – Alternate (TSCC-A) was chosen as a psychometric to be critiqued (chapter four). The: properties, normative data, reliability, validity and applicability of the measure were considered. In terms of applicability, how appropriate the measure is for use with young people in the care system was a salient issue. The TSCC-A was used to then assess levels of trauma and psychological wellbeing with the young person in the case study (chapter five). In contrast to the earlier chapters, chapter five looked at the care system in terms of secure institutional care (as opposed to residential care in the earlier chapters), which produced insights into the care establishment as a whole and emphasised aspects such as the importance of therapeutic milieu. D4 who was diagnosed with schizophrenia and committed acts of criminal damage and arson had an individualised care approach adopted with him. He was given pre and post psychometrics to chart the success of his time in care (pre and post intervention). The findings suggested that D4 had shown improvement towards his propensity for negative internalising and externalising behaviours and his psychological wellbeing overall had improved. Chapter six then attempted to consider many of the different insights offered by the preceding chapters and it ends by offering suggestions for how the psychological wellbeing for young people in the care system could be improved, through the amelioration of treatment integrity.

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Statement of authorship

This thesis is submitted to the University of Nottingham in part fulfillment of the Doctorate in Forensic Psychology. The idea for the thesis was the author's own and reflects his interest in the provision of treatment integrity in young people's residential care.

I hereby declare that:

- ~ I am the sole author of this thesis.
- ~ I have fully acknowledged and referenced the ideas and work of others, whether published or unpublished, in my thesis.
- ~ I have prepared my thesis specifically for the degree of Doctor of Forensic Psychology, while under supervision at the University of Nottingham.
- ~ My thesis does not contain work extracted from a thesis, dissertation or research paper previously presented for another degree / diploma at this or any other university.

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CHAPTER ONE

Introduction

The prevalence of young people in care settings

Carter (2005) reports 2002 figures from the non-government organisation Everychild for twenty of the countries in the Former Soviet Union and Eastern Europe. According to the figures, within these twenty countries there were 1.3 million young people between the ages of 0-17 years in social care facilities. In North America, all young people in public care are referred to as 'fostered,' rather than restricting the term for young people placed into professional surrogate families. Even allowing for this, Johnson, Browne and Hamilton-Giachritsis (2006) report that in September 2001, 542,000 young people were in public ('foster') care in America.

Types of care settings

This thesis is concerned primarily with residential care but it is important to understand what different types of care settings and contexts exist and how these compare to one another, indeed institutional care is examined as a contrast to residential care later in this thesis. The most prominent classifications of care settings are: foster care, residential care and institutional care. Each of these subcategories can also be manifested in various ways. The task can be further complicated when some countries (for example the Netherlands) use the term institutional care to label a facility that would ordinarily be classified as a residential care facility in a country such as the United Kingdom.

For the purpose of this thesis the following definitions have been designated to identify the type of care being spoken about. Foster care usually involves a small number of children/young people. The carer receives a stipend to care for these children/young people in his/her own home and the children/young people are free to move between the boundary of the home and the outside world.

Institutional care is associated with negative consequences within young people's development (Johnson, Browne & Hamilton-Giachritsis, 2006; Carter, 2005). Browne (2009) cites that young people in institutional care are at increased risk of: physical underdevelopment, experiencing poor health, developmental delay, a deterioration in brain growth and having emotional attachment disorders.

Institutional care refers to large-scale group care within big institutional facilities; in which the children/young people are detained and are not free to leave the boundary of the facility. In the academic community, institutions are defined as having 11 or more children living without a parent; a large institution is defined as having 25 young people or more, a small institution between 11 and 25, and a small group home as having 10 young people or less (Browne, 2009).

Residential care refers to any group living arrangement where children/young people are looked after by paid staff in a specially designated facility; in which the children/young people are not

detained and can move between the boundary of the facility and the outside world. The distinction between residential care and institutional care is that residential care is not secure.

A residential care home or institution is defined as a group living arrangement, without parents or surrogate parents, in which care is provided by a small number of paid adults (often inadequately trained and/or poorly supervised) (Browne, 2009).

Browne (2009, p.1) maintains that: "Residential care implies an organised, routine and impersonal structure to the living arrangements...and a professional relationship, rather than a parental relationship...it is recognised that this definition would include children admitted to hospital, children in emergency care and those who attend boarding schools and summer camps. Therefore, children who live in an institution without a parent for more than three months are 'institutionalised children' and the focus of our concern."

Residential care context and young people's views towards it

This thesis will refer to children/adolescents as young people as this is an acceptable term to cover both groups. Foster care or substitute family care is the default option in many cases for young people first exposed to the care system in the UK and Ireland. Stanley (2009) maintains that since the Curtis Report of 1946, residential care within United Kingdom can be seen "not as a place for the upbringing of young people but solely as an intervention as in the Children and

Young Person's Act 2009." Higher costs relating to: fostering, poor provision of establishments and some unsavoury abuse scandals have undermined the profile of residential care in a negative way. Furthermore, young people who have been through residential care tend to be over represented in: substance misuse records, mental health statistics and incarceration numbers (SCIE, 2008). As a result of this residential care is usually considered to provide support to young people with more complex needs (Byrne, 2011) and is often viewed as a 'last resort' when selecting where to home young people (Gilligan, 2009).

Contrary to the consensus negative perception of residential care, many young people proclaim to prefer residential care to foster care (for example please see, Emond 2002; Whiteford, 2005). Emond (2002) explains that the young people's feelings about his/her own family are less confusing when in residential care; whilst living in foster care may mean that they are living with the parents 'real' children and they can feel more marginalised as a result (Whiteford, 2005).

From a research perspective in order to understand young people's experiences and views towards the care system and especially residential care, it is qualitative research methods that offer the most opportunity to explore the situation and to access the richness and diversity of the information, which quantitative methods would not allow. According to Polkki et al. (2012) the United Nations Convention

on the Rights of the Child are explicit in emphasising the need to consider young people's views in matters that impact on them and to involve the young people in the process of implementing changes as much as possible.

Using a qualitative approach

When it comes to conducting research and reviews the vast majority tend to be quantitative in nature. While quantitative outcome studies provide a lot of insights, the world remains multifaceted and there are times when a different approach can be more beneficial. Qualitative research illuminates the less tangible meanings and intricacies of our social world (Finlay, 2011). How do young people in care settings experience the care system? How do different types of care settings impact on the young people (for example residential care versus secure institutional care)? How does being 'in care' impact on young people's psychological wellbeing? What do staff relationships mean to them? How do they experience and process societal stigmatisation? What factors do they think make a positive difference to their everyday lives? How can an in-depth understanding of young people's direct experiences be presented in order to provide insights that inform future practice in residential care?

The aim of qualitative research is to be inductive and by its very nature exploratory. It uses measures such as: interviews, focus groups, participant observation, creative techniques, reflection and

first person written narratives (Lindseth & Norberg, 2004; Barnacle, 2004).

The researcher's role is also different in a qualitative study to the role of a quantitative researcher. In a qualitative study the relationship between the dataset and the wider social world is actively acknowledged (Finlay, 2011; Saini & Scholonsky, 2012). The researcher acknowledges playing a role in shaping the interpretation of the data and must then reflexively consider these dynamics. Accordingly, qualitative research findings are often: ambiguous, multi-layered and rather elaborate (Finlay, 2011; Saini & Scholonsky, 2012). Finlay (2011, pp.15-16) surmises how the participants' lived experience should be explored:

- 1) Focus on the participants lived experiences and the meanings of these experiences for the participants.
- 2) With the use of rich and rigorous description which resonates with the participants.
- 3) With a due concern being awarded to existential personal issues.
- 4) With an underlying assumption that body and world are interlinked for the participant.
- 5) With the adoption and application of a 'phenomenological attitude.'
- 6) With a relational approach which has the potential to be transformative.

Chapter two (a qualitative systematic review) and chapter three (empirical qualitative research study) are both thematic analyses (Braun & Clarke, 2006). As Braun and Clarke (2006) purport, choosing to use thematic analysis offers a number of advantages, this lends itself to exploring the lived experience of young people in a holistic manner:

- A rigorous thematic approach can help to produce an insightful analysis that answers specific research questions.
- Results are usually accessible to the educated general public.
- Thematic analysis is a useful method for working within an ethnographic research paradigm, with participants as collaborators and experts in their own fields.
- Thematic analysis allows the researcher to summarise key features of a large data set, and/or to offer an overarching description of the data.
- Thematic analysis demonstrates the similarities and/or differences across the body of data and often allows unanticipated insights to develop.
- Plus, it allows for psychological as well as social interpretations of the data, which is very pertinent to the research area being explored.
- Finally, it can be useful for producing qualitative analyses suitable for informing improvements to policy (Braun & Clarke, 2006). This would be an area the current research thesis would seek to inform.

Structure of the thesis

This thesis is concerned with providing a broad investigation into the impact the care system (mostly the residential care system), can have on young people who go through it, primarily from the viewpoint of the young people themselves. The thesis aims to explore contemporary issues in the field to provide useful and poignant insights into the lived experience for these young people. The thesis encompasses four main chapters: a qualitative systematic review, a piece of empirical research, a critical review of a psychometric measure and a case study. Each chapter seeks to contribute to the understanding of young people's experiences in the care system and what can be done to improve their psychological wellbeing.

Chapter two is a qualitative systematic review, more commonly referred to as an evidence synthesis. The review seeks to examine the views of young people who have been through residential care from a phenomenological perspective and also to look at international comparisons. The review is the first of its kind (evidence synthesis) to examine this topic and yields many different perspectives, for example it illustrates the varied nature of the relationships between care workers and young people and also helps to document wider systemic issues pertinent to the plight of young people in residential care.

Chapter three is an empirical piece of research and it builds on the findings from chapter two. While chapter two explored the views of

young people in residential care in an international context, this chapter focussed on participants living in the Republic of Ireland. This chapter also sought to examine the key role care workers play in helping to shape the context of care in the residential establishment, by exploring their views in tandem with the views of the young people. This piece of research is the first of its kind to systematically compare and evaluate the views of care workers (towards young people in care), with that of the young people themselves.

One of the main findings to arise from chapters two and three related to the psychological wellbeing of young people in the care system. Chapter four evaluates the Trauma Symptom Checklist for Children – Alternate (TSCC-A), which is one of the main psychometric measures for determining psychological wellbeing for children and adolescents. The chapter compares the TSCC-A to comparable psychometric tools and seeks to ascertain its utility in use with a population of young people in the care system.

After, evaluating the TSCC-A in chapter four, chapter five focuses on a case study in which the TSCC-A was used to assess levels of trauma in a young person in secure institutional care. Chapter five seeks to examine the wider care system as a whole by examining secure institutional care for young people (in contrast to the earlier chapters and the focus on residential care). The chapter details the experience of a young adolescent arsonist and charts his progress pre and post intervention over a period of ten months. The chapter offers an

example of how the care system can help to improve psychological wellbeing in young people once the system attempts to be attentive to the individualised needs of the young person. The results of chapter five were presented at the following professional conference: Scott, K., Browne, K., Gargan, I. & Chou, S. (April, 2014). *An examination of the therapeutic progress of an adolescent arsonist who self-harms, when detained in institutional care*. Paper presented at the Northern Irish Branch of the British Psychological Society's Annual Conference: Psychology for a Changing World, La Mon Hotel, Belfast, Northern Ireland. Please see appendix A for a copy of the poster submission.

Finally, chapter six attempts to summarise and assimilate the main findings from the four central chapters to examine what insights they provide into the lived experience of young people in care. The chapter then considers what areas the care system could ameliorate, to improve the psychological wellbeing of young people in care. Suggestions for improving care provision for young people in the future are offered.

Rationale for chapter two

After consultation between the author and his supervisors it was decided that the thesis should begin by focussing on a broad topic and then narrowing this in scope as the thesis progressed. Accordingly, the views of young people in residential care in the existing research literature are explored from a very open-ended holistic perspective

with few parameters implied onto the research topic. The systematic review would also consider a wide international context to understand the experiences of young people in care from many different international perspectives before trying to assimilate how culture impacts on the phenomenon. This general approach would also be very useful into helping to shape the direction the empirical research piece (chapter three) would follow.

CHAPTER TWO

An evidence synthesis documenting the expressed viewpoints of young people who have been through the residential care system.

Abstract

The reviewer set out to explore the self-disclosed consequences and experiences of young people exposed to the residential care system and what the implications are for the young people involved? A broad search strategy was implemented, encompassing four significant databases (PsychINFO; Embase; Medline; Social Care Institute for Excellence [SCIE]). A thorough scoping exercise of the available grey literature (including expert consultation) was also carried out. 3,517 search results were then systematically evaluated resulting in fifteen studies for final review. The fifteen selected studies were subjected to quality assessment using the Qualitative Research Quality Checklist (QRQC). After a process of data extraction and subsequent data synthesis the fifteen studies yielded twelve themes. The twelve developed themes included topics such as the quality of relationships: between the young people, the young people and the care staff and the wider community. These themes were systematically considered across all of the studies and insights and implications for the residential care system and the young people's psychological wellbeing considered in tandem. Then a discussion examined international differences in care provision and the different approaches to residential care adopted in different countries.

Introduction

The purpose of the qualitative review was to examine the lived experiences of young people in residential care (as outlined in chapter one). This would need to occur with respect to: different settings, countries and contexts. While it may be impossible to understand the exact parameters for a given individual, it is important to learn about the impact of aspects such as: culture, religion and political ideology in influencing the care system and a young person's experience of it. In an international context the review wished to examine if there is a vast difference between the experiences of the young people in different countries. What aspects of residential care appear to be endemic regardless of country of origin and which are contingent on the cultural premise in which they operate?

Cultural and systemic factors

There is plenty of research to suggest that young people in residential care are different to 'mainstream' young people or even young people in foster care in a range of ways. 1) The young people live 'outside' the family meaning they are 'outside' the normal societal notions of appropriate child-rearing practices (Ennew, 2005). 2) The young people must navigate between two institutionalised spaces where there are paid staff providing care and surveillance. 3) Young people in residential care tend to struggle in school more than young people in foster care (Francis, 2008). In Ireland for example, these issues are accentuated because the educational system operates separately to the care system (Emond, 2014). While individuals may attempt to

work more closely together on a personal level, on a systemic level the situation is very different to the care/educational systems working in tandem (prevalent in other countries, for example the Scandinavian countries).

Kott (2010) makes the point that when it comes to residential care and young people's welfare, economic difficulties are currently affecting many developed countries. Expensive residential care services focusing on therapeutic intervention can be particularly vulnerable in light of their high running costs (Kott, 2010). Other stakeholders and requisite finances are both likely to be factors pertinent to the current review. Systemic issues related to care provision is something that will be considered throughout the qualitative review and ways to foster cohesion in the care system considered.

International Practice in Residential Care

When the English language literature is examined the consensus seems to be that residential care should only be used for young people with mental health problems or other special needs (Barth, 2005). However, many countries such as Israel, Brazil and South Korea continue to use residential care for less-troubled children. Religion, culture and political ideology have historically played a key role in shaping the residential care that exists today (Courtney, Dolev & Gilligan, 2009).

In Europe and the United States, the growth of young people's care establishments partly reflected the changing nature of religious charity. Facilities were seen to offer the possibility that religious values could be imparted onto the residents. Political ideology has also been significant. For example, the influence of the Catholic Church on political debates in Ireland had consequences for child welfare (through lifestyle choices such as divorce and abortion) (Courtney, Dolev & Gilligan, 2009). Culture appears to exert its greatest influence on the evolution of residential attitudes toward the relationship between children and adults. In the developed world the way children are expected to respond to adults can be very different and this can shape how the young residents are socialised. Residential homes in European colonies generally attempted to educate the indigenous children in the language and cultural norms of the coloniser (Courtney, Dolev & Gilligan, 2009). More recent trends in residential care have seen an altering of the typical Western values around residential care as a means of last resort. This trend has been most notable in Scandinavia. In Sweden, the "new therapeutic" context emerged in the 1960s and 1970s and saw the development of smaller group care settings, located in neighbourhoods and involving the child's entire family in the treatment process (Emond, 2002).

Planning the review

Initial scoping was conducted in March 2016. There was found to be a terminology issue with 'residential care' and 'institutional care,' as different countries can use these terms interchangeably. Accordingly,

it was decided that secure care would constitute institutional care, as understood in the UK and Ireland. Therefore, studies other countries would cite as institutional care will be examined to see if they are referring to secure care or residential care. Most of the returned studies from the scoping exercise were returned from the fields of social work and childcare, so it was felt that the choice of databases should reflect these fields as well as psychology domains. Previous reviews in this area were searched for in the Campbell collaboration and the Cochrane library as well as through various web searches.

Appraisal of previous reviews

The reviewer was not able to find any previous literature reviews conducted in a systematic manner dealing with the topic of young people's lived experience in residential care. However, two comprehensive pieces of research had included the topic of young people's experiences in residential care within the confines of a larger subject matter.

Hart, La Valle and Holmes (2015) carried out a piece of research aimed at informing policy around how young people in residential care in the United Kingdom cope in the educational system, for the Department of Education in England and Wales. The research examined many different concepts including: 1) is there a national/local care strategy for young people in care; 2) are there types of care different to the English model that bridge the gap between fostering/residential placements/secure care; 3) How do

residential care establishments operate in terms of: parental access, educational provision, staffing levels and having the children as active participants in their own care pathway.

Hart et al.'s (2015) research did contain a section on young people's experience of residential care. This provided useful insights for the current review. Compared to policy makers and staff, young people were found to place greater emphasis on relationships between the young people in the residential establishments. Hart et al. (2015) noted that young people can feel threatened by their peers or like they are in competition with them. Hart et al. (2015) also reported ample evidence to suggest that young people often feel they cannot talk to staff since they will not be listened to and tend to 'act out' instead to try to instigate change, for example running away.

The closest piece of research to the current review was a literature review carried out at the Hadley Centre on young people's views on care, conducted in 2015 by Coram and the University of Bristol. Selwyn (2015) authored the piece but it was a standard literature review including residential care and foster care and included references to many policy documents and expert accounts on the subject. This is in contrast to the current review, which only examines empirical studies citing the young people directly as the experts and only deals with residential care. Selwyn's (2015) research is phenomenological in nature and highlighted a range of key themes that could be pertinent to the current review. These themes included:

1) relationships with: birth parents/ carers/ with trusted adults/ siblings/ social workers/ friends/ teachers, support at times of transition, 2) respect as an individual, 3) opportunities and understanding, 4) negative labelling and stigma, 5) choice and control, 6) being given second chances and 7) having a place in the world. Overall the current review hopes to evoke the meanings to young people Selwyn's (2015) research managed to achieve but to narrow this to residential care and to use only first-person accounts from the young people themselves. These themes may emerge in the current review and would be elaborated upon if appropriate.

Aims and Objectives

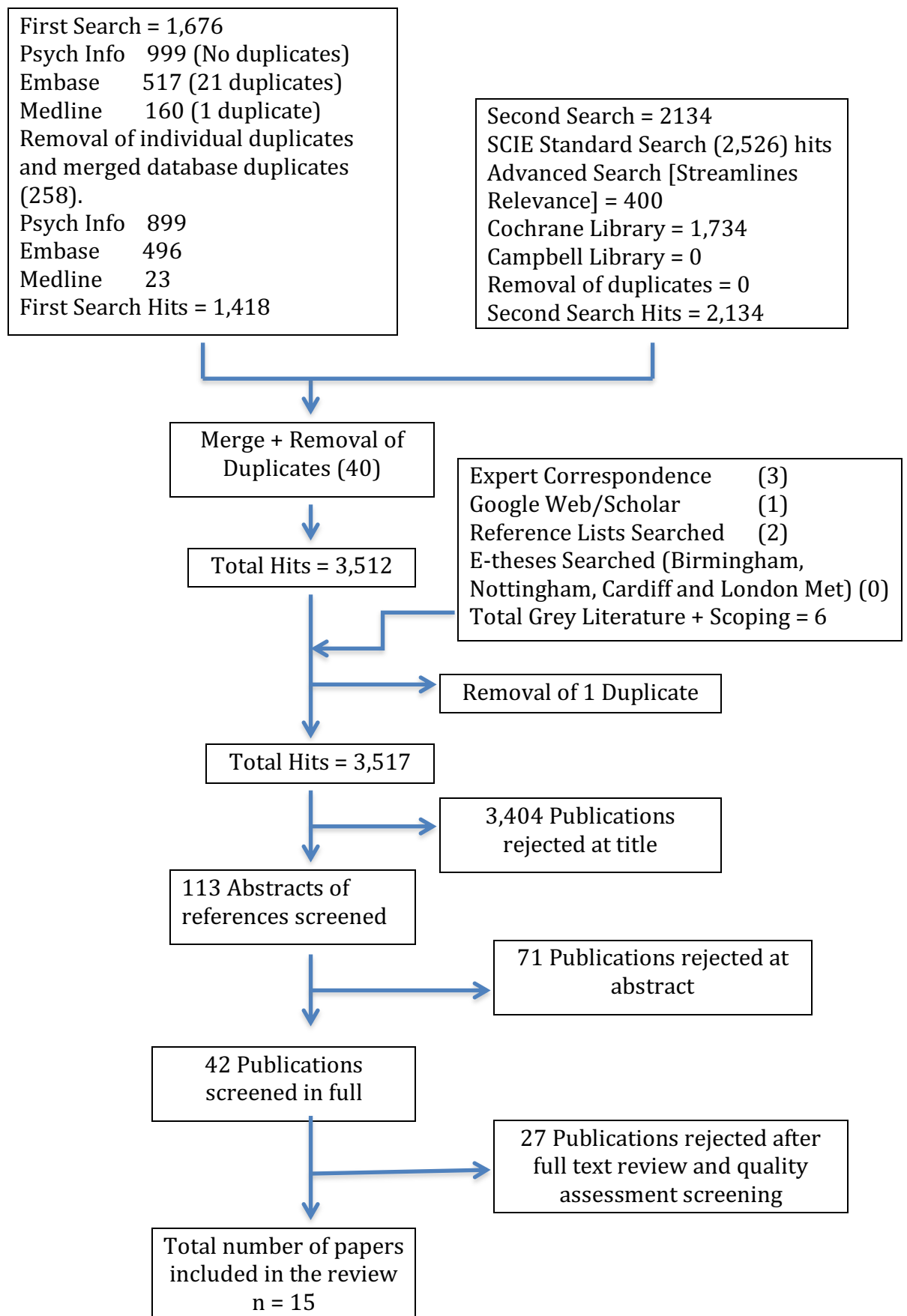
This review wanted to examine all studies that have been carried out to date (16/05/16); that explore young people's views of residential care and their associated experiences of being in residential care. This process aimed to encompass manifestations of experiential symptomatology and the psychological components it entails. The review also aimed to explore this issue from an international perspective and to compare and contrast the views of young people in different countries who have experienced residential care. The review hoped to develop insights into what aspects of the care process are desirable and which aspects could be improved by probing the very population who are most impacted by it.

Method

Search Strategy: Sources of Literature

A structured review to capture as many relevant studies as possible was conducted. This was made up of a first database search on the 13th of May 2016; a second database search on the 16th of May 2016; and a search of the grey literature was finalised on the 28th of June 2016. Please see figure 1 (next page) for a flow chart overview of the following procedure.

Figure 1. Flow chart comprising the current review's search strategy



The first database search covered: PsychINFO (1806 to May week 19, 2016), Embase (1980 to May week 19, 2016) and Medline (1946 to May week 19, 2016), all accessed via OVID SP. The second database search covered: the Campbell collaboration, Cochrane central and the SCIE database. The SCIE produced 2,526 hits in the standard search. The reviewer sought permission from the SCIE online for membership, this was granted and it allowed the reviewer to: "accurately streamline the results by relevance," which reduced 2,526 hits down to 400 hits. The results of the two database searches were merged together and duplicates removed; this was supplemented with a thorough scan of the grey literature. The grey literature searched encompassed: 1) the first 100 hits in Google under 'web' and 'scholar.' 2) Then the electronic theses pages for: Cardiff University, London Metropolitan University, University of Birmingham and University of Nottingham were searched (these were chosen as they all run doctorates in forensic psychology). 3) The reference lists for the studies from the database search that fit the PICO were checked for other potentially significant studies. 4) Finally, a number of experts in the field were contacted to see if they had any other studies to recommend for the review. This correspondence offered from the experts was very helpful and was provided by: Prof. David Berridge (Bristol University), Dr. Bernard Gallagher (Huddersfield University), Prof. Andrew Kendrick (Strathclyde University), Dr. Rosaleen McElvaney (Dublin City University), Prof. Julie Selwyn (Bristol University) and Dr. Mimi Tatlow-Golden (Trinity College Dublin). These experts were identified firstly as being prominent

authors in the field (based on publications examined); and secondly some individuals were recommended for consultation from having contacted an initial list of experts.

Search Strategy: Search Terms

The search terms were devised to capture an open-ended view of the young people's experiences. Therefore, very little parameters were applied to the search terms to allow as many potential studies as possible to be considered. This approach is considered more appropriate with qualitative research where the studies generally have to be hand examined to process the meaning of the study (Saini & Schlonsky, 2012). The titles of qualitative studies also tend to be based on a general subject area and are less specific in nature than quantitative studies. This approach also allowed the search terms to be identical across all of the databases utilised which makes future replication of the review easier to conduct. It should be noted that Boolean operators and Medical Subject Heading terms (MeSH) were used in the search strategy. The MeSH terms are a pre-determined set of classification systems for each topic, applied to all articles in each database. The following syntax were applied to all databases (title and abstract search only) (as per appendix B):

(Young people) OR (Children) OR (Adolescents) OR (People)

AND

(Care) OR (Residential care) OR (Institutional care**)

AND

(Experien*) (To allow for derivatives such as – experience / experiences / experiential).

**As outlined in chapter one, some international countries refer to what would be classed as residential care in the UK/Ireland as institutional care.

Search Strategy: Reference Management Software

The results from the first and second database searches were uploaded into EndNote. The duplicates from single database searches (in brackets in the flowchart) were removed. Further duplicates from when the different database searches were merged together were removed. The grey literature searches produced 6 studies and one of these was removed, as it was a duplicate. Then the 3,517 overall hits [3,512 database hits; 5 grey literature hits] went through a two-stage screening process (PICO review and quality assessment review).

Search Strategy: Inclusion/Exclusion Stage

The reviewer firstly examined the 3,517 studies under the following PICO (table 1, below).

Table 1. Inclusion and exclusion criteria

<i>Inclusion</i>	<i>Exclusion</i>
P* – Young people who have experienced residential care before the age of 18.	Young people who have not experienced residential care before the age of 18.
E – Experienced residential care for a period of at least three months.	Did not experience residential care for a period of at least three months*
C – N/A	C – N/A
O – Consequences of exposure to residential care for young people less than 18 years when in care, as expressed by the young people	N/A

themselves. Encompasses manifestations of experiential symptomatology and psychological components.	
S – Thematic synthesis studies – citing young people as the experts.	Expert Opinion Papers.

** A residency period of less than three months was deemed to be insufficient for a young person to have developed a strong phenomenological experience of residential care when being compared to other residents who could have been resident in his/her residential establishment for a period of several years.*

Studies were eligible for inclusion in the review provided: (1) the study described young people's experiences of residential care. They had been in care before the age of 18 and had spent at least three months in the care establishment. (2) The study used qualitative methods of data collection and analysis, the data analysis does not all have to have been qualitative (could be mixed methods) but it must have been a central component and it must have been utilised from a narrative perspective. (3) The study must have been empirical and the data must have come from the young person's own first-hand account of their experiences. No search restrictions were placed on publication date, language or country of origin. Indeed, international perspectives were welcomed for inclusion in the hope that they could add to the overall body of information on the topic and highlight different considerations within different jurisdictions. Studies that did not adhere to this protocol were rejected prior to the quality analysis stage.

The titles of the 3,517 studies were assessed under the PICO and based on these, 113 studies were deemed fit to progress to the next stage. The primary reviewer then examined the 113 studies against

the PICO based upon their abstracts. The 113 studies were also independently examined against the PICO by a secondary reviewer, which enables a more rigorous assessment prior to the dedicated quality assessment stage. The secondary reviewer was Mr. Garrett Kennedy (psychologist / lecturer in counselling psychology at the University of Wolverhampton), he was chosen due to his familiarity with qualitative methods and person-centred approaches, both in practice and research. Based on consultation between the primary and secondary reviewer 113 studies were narrowed down to 42 studies (71 studies rejected at the abstract stage). The remaining 42 were subjected to a full text review and 27 of these studies were subsequently rejected, while the remaining 15 studies were put forward to the quality assessment stage.

The 27 studies rejected at the full text review stage were rejected for a variety of reasons: 1) the study related to secure care instead of residential care (N=7). 2) The participants in the study were from a mixture of residential care and foster care and there was not a clear separation between the two (N=4). 3) The population had a learning disability / autistic spectrum disorder and the methodology had been adapted accordingly, it was fundamentally different to the chosen studies (N=2). 4) The methods chosen were mixed method but focused more on quantitative aspects than qualitative ones; not comparable to chosen studies, for example drawing conclusions statistically based on questionnaires (N=7). 5) Studies interviewed residents along with other stakeholders (staff/social workers/policy

related individuals), sometimes there was not a clear differentiation between the two and they treated the combined population as a whole, (N=3). 6) The emphasis of the study was too narrow and instead of encompassing an overall experiential outlook of the residents it was purely associated with one narrow topic, for example play conditions in residential care homes (N=4).

Again, please refer to figure 1 (page 20) for the flow chart that illustrates the inclusion/exclusion process.

Search Strategy: Quality Assessment Stage

The Qualitative Research Quality Checklist (QRQC) by Saini and Scholonsky (2012) was used to complete this stage (please see appendix C to examine the form) (and Saini & Scholonsky, 2012, for more detailed information on the QRQC). The QRQC was developed based on existing research regarding standards for measuring qualitative designs and consultation with experts in qualitative research. The QRQC is a 25-item quality appraisal form designed to critically assess: “credibility, dependability, confirmability, transferability, authenticity, and relevance of qualitative studies” (Saini & Schlonsky, 2012, p.173). It examines qualitative research based on: 1) epistemological and theoretical frameworks, 2) study design, 3) study setting, 4) data collection, 5) sampling procedures, 6) reflexivity of the researcher, 7) data analysis, 8) ethical issues, and 9) dissemination of the findings.

The appraisal tool is not a means of excluding studies based on “quality,” but it provides the opportunity to evaluate the quality of studies based on dimensions that have been agreed on by the scientific community. Discretion, reflection, and flexibility remain central, and this provides “guideposts” for evaluating the quality of studies. As such, the interpretation of “quality” becomes part of the reviewer’s interpretation of the studies (Saini & Schlonsky, 2012, p.174).

Rather than excluding studies based on flaws in the study designs as is the case in most quantitative reviews, (for example: small sample size or limited reporting of procedures); reasons for possible exclusion were based on the theoretical sensitivity of studies to the overall aims of the qualitative synthesis. The reviewer attempted to question whether the narrative of the story was clear and reflected the experiential situation for its participants. Obviously, reviewer bias is a limitation of this approach and is a significant consideration when conducting a qualitative synthesis. The beliefs and assumptions of the researcher can influence how the data is identified and evaluated (Yardley, 2000). The reviewer tried to be mindful of this when assessing the studies. The reviewer’s personal background is in psychology. This does not represent or reflect the disciplines most closely involved with the residential care system (social care and social work) and as a result the reflexive nature of the data synthesis process could have yielded different perspectives to the viewpoints typically associated in the social care/social work domain (Tatlow-Golden & McElvaney, 2015). Please see table 2 (next page) to see how the reviewer assessed the quality of the studies chosen to be shortlisted for the review.

Table 2. Breakdown of how the shortlisted studies performed on the QRQC

Study 1	Barter (2003).
Study 2	Johansson & Anderson (2006).
Study 3	Stokholm (2009).
Study 4	Schjellerup Nielsen (2010).
Study 5	Carter (2011).
Study 6	Gallagher & Green (2012).
Study 7	Arthur, et al. (2013).
Study 8	Leichtentritt (2013).
Study 9	Bejenaru & Tucker (2014).
Study 10	Chama & Ramirez (2014).
Study 11	Emond (2014).
Study 12	Tatlow-Golden & McElvaney (2015).
Study 13	Khoo, et al. (2015).
Study 14	Magor-Blatch & Ingham (2015).
Study 15	Nourian, et al. (2016).

Table 2 Scoring System for each QRQC Questionnaire Item:

Applicable:

1=Yes

2=No

3=Unclear

Addressed:

1=Yes

2=No

3=Unclear

For Example, a score of 2,3 would indicate that the question was not applicable and whether it had been addressed or not was unclear.

Table 2. Breakdown of how the shortlisted studies performed on the QRQ

Qualitative Research Quality Checklist																
Study Number:																
Q No.	Question	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Q1.	Is the purpose and research question(s) stated clearly?	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q2.	Is a qualitative approach appropriate to answer the research question (e.g., exploratory vs. explanatory)?	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q3.	Is the setting of the study appropriate and specific for exploring the research question?	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q4.	Is there prolonged engagement to render the inquirer open to multiple influences?	1,1	1,1	1,1	1,3	1,1	1,1	1,3	1,1	1,3	1,3	1,1	1,1	1,1	1,3	1,3
Q5.	Is there persistent observation in the setting to focus on the issues relevant to the research question?	1,1	1,3	1,1	1,3	1,1	1,1	1,3	1,1	1,3	1,3	1,1	1,3	1,1	1,3	1,3
Q6.	Is the research design appropriate for the research question?	1,1	1,1	1,1	1,3	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q7.	Is the process of sample selection adequately described and consistent with the research design/ research question?	1,1	1,1	1,1	1,1	1,1	1,1	1,3	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1

Q8.	Is the sample size and composition justified and appropriate for the research design/ research question?	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q9.	Are the methods for data collection adequately described?	1,1	1,1	1,1	1,2	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q10.	Are the methods for data collection consistent with the research question?	1,1	1,1	1,1	1,3	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q11.	Is a range of methods used for triangulation?	1,1	1,1	1,1	1,2	1,1	1,2	1,1	1,2	1,2	1,2	1,1	1,1	1,1	1,1	1,2
Q12.	Is there an articulation of who collected the data, when the data was collected and who analysed the data?	1,1	1,1	1,1	1,3	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q13.	Is there an audit trail regarding data collection including tapes, memos, and note taking of decisions made in the study?	1,3	1,1	1,3	1,2	1,1	1,3	1,1	1,1	1,1	1,1	1,3	1,1	1,1	1,3	1,1
Q14.	Is there adequate consideration for ethical issues, such as informed consent, privacy, and confidentiality and protection from harm?	1,1	1,1	1,1	1,3	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q15.	Has the researcher identified potential and actual biases (both as researcher and in the research design)?	1,3	1,3	1,1	1,2	1,1	1,1	1,2	1,1	1,1	1,3	1,1	1,1	1,1	1,1	1,1
Q16.	Did the researcher integrate the use of a reflexive journal in the data analysis and interpretation?	1,3	1,1	1,3	1,3	1,1	1,3	1,3	1,1	1,1	1,3	1,3	1,3	1,3	1,1	1,1

Q17.	Is the process of data analysis presented with sufficient detail and depth to provide insight into the meanings and perceptions of the sample?	1,2	1,1	1,2	1,2	1,1	1,1	1,2	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q18.	Are quotes used to match concepts and themes derived from the raw data?	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q19.	Do the findings emerge from the experiences/ subjective interpretations of the sample?	1,1	1,1	1,3	1,1	1,1	1,1	1,3	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1
Q20.	Was member checking employed?	1,3	1,1	1,3	1,3	1,3	1,3	1,1	1,3	1,1	1,3	1,1	1,3	1,1	1,1	1,1
Q21.	Does the researcher provide "thick description" of the sample and results to appraise transferability?	1,2	1,1	1,1	1,3	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,1	1,3	1,1	1,3
Q22.	Were stakeholders involved in the project?	1,1	2,2	1,1	1,1	1,3	1,3	1,1	1,1	1,2	1,2	1,2	1,2	1,3	1,2	1,2
Q23.	Did all stakeholders have equal access to the research process and benefits?	1,1	3,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3
Q24.	Did all stakeholders enhance their understanding of their own reality due to the research process and results?	1,3	3,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3
Q25.	Are the stakeholders empowered to act as a result of the research process?	1,1	3,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3

Search Strategy: Data Extraction Stage

Due to the variability of qualitative designs the extraction process is often seen as being an iterative process. However, because of the subjective nature of qualitative research and indeed qualitative research tools it is seen to be best practice to assess the studies from more than one standpoint. This is challenging, as there are very few qualitative research extraction templates available. In order to comply with this, each study was subjected to a pro-forma qualitative data extraction form developed by the British Psychological Society (2007) along NICE guidelines, to glean relevant data and to ensure that the same data had been extracted from each study (see appendix D).

Findings

Description of studies

The 15 studies deemed suitable for the review all adhered to a phenomenological approach of exploration over explanation of the subject matter. Ten of the studies were based solely on qualitative interviewing. Five of the studies had mixed method designs, primarily interview based but supplemented with other quantitative techniques (studies 3, 11, 13, 14, 15).

The final 15 studies came from the following sources: study 1 (SCIE), study 2 (PsychINFO), study 3 (expert consultation, Prof. Andrew Kendrick), study 4 (expert consultation, Prof. Andrew Kendrick), study 5 (SCIE & PsychINFO; 1 duplicate copy removed), study 6 (PsychINFO), study 7 (expert consultation, Prof. Julie Selwyn), study

8 (PsychINFO), study 9 (PsychINFO), study 10 (PsychINFO), study 11 (PsychINFO), study 12 (Reference check on SCIE website), study 13 (PsychINFO), study 14 (Embase), study 15 (Google Scholar; article retrieved from Sciencedirect database). The main characteristics of the 15 included studies are illustrated in table 3 (page 37).

Characteristics of included studies

The included studies were published between 2003 and 2016, with 60% of studies published in the last three years. Wide ranges of countries were represented: England, Scotland, Ireland, Denmark, Sweden, U.S.A., Israel, Romania, Mexico, Australia and Iran. All of the studies reviewed were written in English but two had originally been written in another language and then translated into English; Khoo, et al.'s (2015) study was originally in Spanish and Schjellerup Nielsen's (2010) study was originally written in Danish as part of a larger study. The total population sample across the studies was 249 participants not including Stockholm's (2009) study in which it was unclear how many participants took part. Again, most of the studies did not differentiate by ethnicity or gender, but all of the studies noted whether the participants were: residents (N=8), ex-residents (N=4), or a mixture of both (N=3). The length of time in residential care ranged from an average of 3 months (Magor-Blatch and Ingham's [2015] Australian study) to 5 years 4 months (Khoo, et al.'s [2015] Mexican study). Some of the included studies examined residential care from the perspective of multiple stakeholders,' not just young people; they formally interviewed/informally spoke with

personnel such as: care staff, social workers and managers in the residential care establishments (N=4) (Barter, 2003; Stokholm, 2009; Schjellerup Nielsen, 2010; Arthur, et al., 2013). These studies were included as oppose to the others which were rejected because there was a very clear differentiation between the views of the young people and the other people formally interviewed/conversed with. Only the views of the young people in these studies were considered for the purpose of this review.

Two of the studies selected explored the views of young people in residential care in an establishment operating on therapeutic community principles: Carter (2011) and Gallagher and Green (2012). These were included because the way the studies were conducted was closely aligned to the rest of the studies selected. Similarly, two studies with populations with a mental health diagnosis were included: Tatlow-Golden and McElvaney (2015), and Magor-Blatch and Ingham (2015). The participants in these studies appeared to suffer from many of the issues facing any other young person population in residential care: problematic behaviours, psychological vulnerabilities and issues associated with psychological wellbeing. Interestingly, Nourian, et al.'s (2016) study specifically targeted young people in residential care known to have a high level of resilience to see if they could determine what helped these young people to cope more adequately than their peers in residential care. This study was included because it could be useful in identifying some

key factors related to young people in residential care and improving their psychological wellbeing.

When it came to the methodological measures employed by the included studies there was quite a bit of variation. All of the studies used individual qualitative interviews apart from Khoo, et al. (2015). Khoo, et al. (2015) used a mixed methods approach incorporating: focus groups, adapted Photovoice and Mapping. Some other studies also availed of mixed method designs to supplement their qualitative interviews: Barter (2003) included vignettes on violence; Stockholm (2009) had paired interviews and also used systematic observation. Arthur, et al. (2013) utilised the young Scottish care leavers personal reflections on their observations from their trip to Danish residential care establishments. Emond (2014) incorporated the most triangulation to the methodological approach with: focus groups, life snakes (outlining the person's life on a chronologically sequenced chart), looking at drawings and even playing a board game being used in tandem with the individual interviews. Other studies tried to incorporate quantitative measures into their research designs, Magor-Blatch and Ingham (2015) used self-report questionnaires along with further psychometrics; whilst Nourian, et al. (2016) used a psychometric (Persian version of the Wagnild & Young Resilience Scale, 1993) at the outset of their assessment procedure to establish a population with high resilience levels.

Blatch and Ingham's (2015) study, whilst not being representative of young people in residential care as a whole (due to the small sample size) did show trends in the quantitative data. The participants completed the self-report questionnaires when they first entered the residential care service and again after being resident for three months. There was an upward trend for participants on the Children's Hope Scale (Snyder et al., 1997) and the General Self-Efficacy Scale (Schwarzer & Jerusalem, 1995), whilst there was a downward trend for the participants on the Kessler Psychological Distress Scale (Kessler et al., 2002). Again, it is important to reiterate that this review is focused on qualitative data and the quantitative data from this study was not focused on for the qualitative synthesis (only the qualitative data).

Overall, the participants in five studies reported predominantly positive experiences in residential care (studies 5, 7, 13, 14, 15), the participants in three studies reported mainly negative experiences (studies 3, 9, 10) and the participants in seven studies reported mixed experiences while in residential care (studies 1, 2, 4, 6, 8, 11, 12). For example, study 2 had participants who held contrasting viewpoints on whether a structured environment is helpful for young people in care. (Please refer to the table 2 study numbering on page 28 to familiarise oneself with the study numbers). Table 3 on the next page gives a breakdown of the 15 studies included in the qualitative review.

Table 3. Characteristics of included studies

Summary of reviewed studies, in order of year of publication. The Study number is also listed below the year.						
Author and year	Topical focus/Purpose	Location	Methodology	Sample Description	Type of Data Analysed	Main Emergent Themes
Barter (2003). Study 1.	To look at the context in which residents experienced peer violence, in the hope of underpinning the structures/practices /cultures which allowed peer violence to occur.	England	Qualitative summary of interviews	71 residents between the ages of 8-17. Boys (45) and girls (27).	Abstract discussions about violence through the use of vignettes (case examples of actual situations with different forms of peer violence). And Semi-structured interviews.	Residents experienced four types of violence: direct physical attacks, non-contact attacks, verbal attacks and unwelcome sexual behaviours.
Johansson & Andersson (2006). Study 2.	Examining residential care institutions in Sweden due to its topical nature since numbers in care continue to rise. How can different individual experiences in an establishment be understood?	Sweden	Qualitative case study with an idiographic approach.	6 adolescents, 3 girls and 3 boys. 15-18 years of age.	Retrospective pre-structured interview schedules used.	Emergent themes included: key workers and staff, structure, the first day of the stay, the other residents, parent's contact with the establishment, termination and discharge.

<p>Stokholm (2009). Study 3.</p>	<p>Examining identity formation for young residents by examining their social interactions.</p>	<p>Denmark</p>	<p>Phenomenological in orientation – contains aspects of grounded theory.</p>	<p>Child residents between the ages of 6 and 15.</p>	<p>17 individual interviews, 6 interviews with children in pairs. Ages 6-15. Systematic observation consisting of: 5.5 months in establishment A and 3 months in establishment B.</p>	<p>The significant influence of peer groups on young people's development and identity formation in residential care was the central theme. This was split between being yourself and becoming part of a peer group and how an individual reconciles these two to form their sense of identity.</p>
<p>Schjellerup Nielsen (2010). Study 4.</p>	<p>Based on a study of relationships within a community-based residential establishment in Denmark. Calls for greater integration between residential care establishments and outside societal establishments (for example local schooling).</p>	<p>Denmark</p>	<p>Qualitative narrative approach.</p>	<p>11 young people were interviewed. 2 young people, aged 14 and over, still lived in the residential unit and the others now lived independently</p>	<p>Interview based. However, it is unclear what measures or protocols were implemented.</p>	<p>Themes from the research highlighted: 1) everyday life in social arenas, 2) family involvement and cooperation, 3) to feel at home, 4) schooling and leisure time, 5) friendships and the residential groups, 6) from ideal to reality.</p>

Carter (2011). Study 5.	Examines a TC youth home (Thornby Hall) from the perspective of residents to see if their insights offer valuable information to help create an environment in which young people who have endured trauma in their early lives can be best cared for.	England	Thematic Analysis	3 ex-residents and 5 current residents. Ages not listed.	Individual interviews and a group interview. Semi-structured interviews utilised a set interview protocol of questions. 'What works' in participant's own words.	Focused on: belonging and feeling connected, the staff, the peer group, the environment, how being in the residential establishment changed them and would their life be different if they had not gone to the residential establishment.
Gallagher & Green (2012). Study 6.	To add to the pool of data on the process adopted in therapeutic children's homes (The Orchards) and how good these establishments are at meeting the residents' emotional and behavioural needs.	England	Template analysis. This technique is useful when a few of the themes in the data are known prior to researching, it enables the themes in the dataset to be illuminated and structured.	16 former residents, aged between 16-21 years when interviewed.	Semi-structured intensive interview schedules used, with questions on the participants' experiences. Average interview duration was 135 minutes.	Emergent themes included: life outside the establishment, life after the establishment, therapy, relationships, school, friendship, leisure, life story work, preparation for changing placement and contact with staff.

Arthur et al. (2013). Study 7.	This study compares the differences and the similarities in care provisions between Denmark and Scotland.	Scotland / Denmark	Qualitative approach founded on personal narratives was used.	4 Scottish Care leavers. 12 Danish care leavers.	Interviews with set protocols used with the Danish respondents and personal reflections on their visit to Denmark offered by the Scottish care leavers. Each caregiver had different protocol questions.	Common themes of: stigma, loss, and support in transitioning into adulthood existed. Danish respondents reported that the quality of their relationships with staff was usually better.
Leichtentritt (2013). Study 8.	The study examined putting siblings together in residential care and sought to see if the siblings benefitted from this practice in their views.	Israel	The hermeneutic phenomenology method. Hermeneutics is the "art and science of interpretation" and phenomenology is the study of "a phenomenon as it presents itself in lived experience."	12 children. Ages ranged from 7–14 years, time in the current residential establishment was between 1–6 years, and their siblings' history in care was between 1–7 years.	In-depth semi-structured interviews of approximately 90 minutes duration.	Four themes emerged related to having a sibling present with them in care. 1) comforting/discomforting, 2) togetherness/separateness, 3) openness/restraint, and 4) expect more/allow less.

Bejenaru & Tucker (2014). Study 9.	The study explored perceptions of risk commonly held by residents in care system in Romania.	Romania	Thematic Analysis	35 young people were involved; aged between 14 and 26 years old when interviewed.	Retrospective narrative inquiry (NI) interviews. NI was utilised to focus on the participants' experiences of risk. Interview duration, 45-135 minutes.	Forms of risk identified included: care system policy and practice, external perceptions and beliefs, young people's fears for future risks and risks arising out of peer and staff relationships.
Chama & Ramirez (2014). Study 10.	In the US many residential care establishments do not provide the services required to instigate meaningful change in young people. This study sought to contribute to this area by asking young people what works for them.	USA	Qualitative approach founded on personal narratives was used. Qualitative coding software utilised.	30 young people participated. Ages not listed.	Open-ended interviews based off a protocol. The duration of the interviews ranged from 90 minutes to 180 minutes.	Important themes in improving residential care included: staff, establishment atmosphere, counselling, punishment practices, re-entry issues and spiritual development.
Emond (2014). Study 11.	This study explores peer relationships for young people in residential care. What experiences did they have and what was the meaning of these experiences?	Ireland	Firstly, narrative analysis. Secondly thematic analysis.	16 children (five girls and eleven boys). Ages ranged from 8-18 years.	Data was gathered using: interviews, a focus group, the use of a life snake, looking at drawings and through playing a board game.	The results suggest that the children were very conscious of being "in care" and this impacted on their sense of identity. They would use coping strategies to protect this identity when attending school.

<p>Tatlow-Golden & McElvaney (2015).</p> <p>Study 12.</p>	<p>To explore the viewpoints of young people in care towards mental health services, as many of these young people would have mental health needs.</p>	<p>Ireland</p>	<p>Informed by principles of Consensual Qualitative Research (CQR). CQR draws on principles of: grounded theory, phenomenology and comprehensive process analysis.</p>	<p>8 young adults (7 women and 1 man) aged 18 to 27 years. Interviews were between 70-90 minutes in duration.</p>	<p>Retrospective semi-structured interviews implementing open-ended questions.</p>	<p>The themes discovered fell under the following headings: 1) Views of mental health and of mental health services, 2) emotional wellbeing and 3) Young adults' advice: what mental health services could improve upon.</p>
<p>Khoo et al. (2015).</p> <p>Study 13.</p>	<p>The study aimed to explore young people's descriptions of their lived experience in a residential care establishment in Mexico, focussing on their relationships to significant others and their daily activities.</p>	<p>Mexico</p>	<p>Phenomenological in nature - focussing on the children's lived experiences.</p>	<p>6 young residents (4 girls & 2 boys) participated in the study. They were aged between 14-16 years old. 8 were initially selected but 2 refused to take part.</p>	<p>Mapping, adapted Photovoice and focus groups.</p>	<p>Recurrent themes included: stigma, adequate support and feeling cared for, having a sense of normality and comfort in the establishment and having emotional bonds to the other young people and the staff they reside with.</p>

Magor-Blatch & Ingham (2015). Study 14.	The study wanted to examine the "lived experience" of young people in residential care who were receiving treatment for mental health conditions (stepped care services).	Australia	Phenomenological approach to thematic analysis.	6 ex-residents aged between 14-18 years. 1 male and 5 females took part.	Semi-structured interviews and self-report questionnaire and further psychometrics.	There were two main themes that emerged from the data: (1) 'Relationships' and (2) 'Life engagement.'
Nourian et al. (2016). Study 15.	The study aimed to understand what resilience means in the lived experiences of young people residing in residential care establishments.	Iran	Hermeneutic phenomenological method with Van Manen's (2001) six-step approach. Wagnild & Young Resilience Scale.	8 adolescents (5 male & 3 female) living in residential care, ages ranged from 13-17 years.	Semi-structured interviews of between 38-63 minutes duration. The researcher recorded the participants' non-verbal cues after the interview sessions.	Themes emerging in the study included: 1) 'aspiring for achievement,' 2) 'self-protection,' 3) 'going through life's hardships,' 4) 'spirituality' and 5) 'self-reliance.'

Data Synthesis of included studies

The reviewer read each of the fifteen studies a number of times to enable a familiarisation and understanding of the dataset. The reviewer then followed an interpretive integrative technique. This provides interpretations of themes across studies by integrating findings from all studies where findings are reframed to create a new understanding of an event or phenomena (Sandelowski & Barroso, 2007). This helped to crystallise the dataset into a thematic analysis (as proposed by Braun & Clarke, 2006). The overarching themes across the fifteen studies were developed (for example *relationships with staff*), while also including the more salient themes to only appear in limited studies (for example *Psychological outlook*). What follows is a thematic analysis of the dataset (which elicited twelve themes) and how it related to the lived experiences of young people in residential care.

1 - Structured environment versus personal autonomy

When it comes to entering residential care first impressions matter for the young people: "*from walking in the front door the sense of a family setting was very obvious, the warmth and the love that I felt was overwhelming*" (Arthur, et al., 2013, p.31). Carter (2011) noted that young people were impressed with the facilities at Thornby Hall (in the United Kingdom) and the welcome they were given, which helped to foster a sense of ownership in the young people. Schjellerup Nielsen's (2010) study outlined how important it was for the physical environment to feel like 'home' for the residents.

Contrastingly, the participants in Chama and Ramirez's (2014) study described the residential establishment as being like a 'prison' and said more consideration should be given to doing things that the young people want to do.

In Johansson and Andersson's (2006) study some of the participants liked how structured the environment was, while others felt it gave them very little control over their lives. Interestingly, the young people that felt this lack of control came from backgrounds characterised by uncertainty and negative controlling influences (however, this was in contrast to Magor-Blatch and Ingham's [2015] study where participants claimed it would have been preferable if the establishment was run in a more structured way).

The participants in Khoo et al.'s (2015) study had been residents of the establishment for an average of over five years and spoke about the establishment as being highly structured, which was supportive of their educational and psychosocial needs. Indeed, the young people thought of the residential establishment as 'home' to such an extent that they were often apprehensive about leaving the 'safety' of the establishment. However, they did not elaborate on the features of the environment that made them feel this way.

2 - Peer support more important to young people than adult support

Emond's (2014) study makes the point that in residential care, there is a difference between the adult/young person relationships and the

young person/peer relationships. The adults are required to interact with the young people, however, the young people choose to interact with one another, since these relationships are chosen they are more valuable. The participants in a number of studies spoke about relying on their peers in the establishment for emotional support more than the staff. Fellow peers are people in the same situation, with similar experiences, so they can understand each other and they live there while staff come and go (Barter, 2003; Stockholm, 2009; Carter, 2011; Nourian et al., 2016).

The participants in Schjellerup Nielsen's (2010) study described the peer dynamic as being: "*somewhat like a family or sibling relationship*" (p.6). This is interesting as Leichtentritt's (2013) study (on siblings placed together in residential care) describes the dynamic as having all the same attributes as a non-sibling peer dynamic in residential care, with just more extreme forms of highs and lows. Certainly, for many of the participants in these studies the peer relationship was characterised by the importance of understanding for young people in residential care. Emond's (2014) study notes that the participants in her study felt that adults in their lives (both inside the care establishment and outside, for example teachers), had little sense of how the young people were in their interactions with: the peer group, friends, or adversarial relationships.

3 - The Social hierarchy & impression management amongst young people

When it comes to social hierarchies in residential care establishments it is clear that they operate based on: "*understanding of unspoken rules of the resident group*" (Schjellerup Nielsen, 2010, p.6). Johansson and Andersson's (2006) study maintains that when 'acting out' occurs amongst other residents in the establishment, some young people feel bullied into being involved in the situation whether they want to be or not. When it comes to status amongst the residents, young people (in studies 1, 2, 3, 4 & 9) report a hierarchy and those of lower status can often feel intimidated or exploited, with most participants reporting being subjected to peer violence (Barter, 2003). Bejenaru and Tucker's (2014) participants noted that there can be psychological or physical abuse, many of the residents feared having their possessions stolen. Most worryingly, since the smaller ones (in terms of age / physical stature) are usually exploited they themselves will usually grow up to then become the higher status residents exploiting those of a perceived 'lower status.' In this study peer abuse (or bullying) was viewed as being 'necessary' and it served as a form of 'education' for the participants (Bejenaru & Tucker, 2014). Stokholm (2009) purports that a resident's: age and duration of enrolment can play a role in a young person's status with: "*the latest to arrive becom[ing] the punching ball*" (p.562).

Stokholm's (2009) study argues that interacting socially with peers provides significant sources for self-perception and self-management

for the individual young person and as a result of this plays a key role in his/her identity formation. Young people placed a lot of emphasis on fitting into the social hierarchy and would often shape their behaviour accordingly, *"there's a big difference between who I am here and who I am at home. I have to act more tougher at home"* Emond (2014, p.198).

Stokholm (2009) argues that it is only when a young person has moved up the hierarchical ladder that he/she feels comfortable enough to concentrate on aspects relating to being released from residential care. This can make arrival in the residential care establishment particularly problematic. Due to the young person not having enough behavioural interactions with the other residents to know where he/she fits amongst them. How they see their own position in the young people's hierarchy and his/her subsequent identity is effected as a result (Emond, 2014; Tatlow-Golden & McElvaney, 2015).

4 - Sense of belonging

This seemed to relate closely to the theme of identity and how the young people see themselves (see Emond, 2014). As previously mentioned, Carter's (2011) study noted how participants strived to be understood by peers and wanted by adults and when both of these things occur it equates to a sense of belonging. This sense of belonging was less tangible in Johansson and Andersson's (2006) study, in which the participants lived in the same care establishment

but had radically different experiential outcomes. Johansson and Andersson (2006) postulate that: *"the most important effects on development come from the nonshared environment. Siblings perceive and interact with their environment in different ways, and parents treat their children in different ways"* (pp.315). Leichtentritt's (2013) study on siblings in care found that sense of belonging was an even stronger theme and that having a sibling near you offered another strong connection to your familial ties while in care. Finally, on this theme, Stokholm (2009) concludes that young people in care form friendships and alliances with other young people in care in order to belong, which in turn positions him/her to gain recognition and acceptance from the young people's hierarchy as a whole.

5 – Relationships with staff

A number of studies cited staff inconsistency as a central theme. This ranged from inconsistency around rules: "one of them might say 'aw go on out there for half an hour'...another one will tell you...'sure go you off for the day'" (Tatlow-Golden & McElvaney, 2015, p.3). Inconsistency around disciplinary responses towards various behaviours was common (physical attacks/verbal attacks/unwelcome sexual behaviour). Barter (2003) notes that the most consistent staff disciplinary response occurred towards physical violence, with verbal attacks showing the most inconsistent staff response. Leichtentritt's (2013) study with siblings said that the staff expected more togetherness from the siblings than they did from the other young people, but conversely would allow them less time together and kept

trying to emphasize their individuality. This resulted in feelings of disillusionment for the participants.

Participants in Johansson and Andersson's (2006) study stated that work was purely a job (instead of a vocation) for some care staff and they were only there to collect a paycheck, while other staff members made a significant effort to help the young people. In Bejenaru and Tucker's (2014) Romanian study the care staff members were seen as: *"remote, often uncaring, authoritarian and aggressive"* (p.299). There were also issues around the staff maintaining confidentiality (Bejenaru & Tucker, 2014). Chama and Ramirez's (2014) American study was even more alarming, one staff member was described as: *"very controlling. He was verbally abusive"* (p.124). The establishment as a whole was described as: *"withholding food as punishment, using humiliating methods, and exerting punitive actions,"* (Chama & Ramirez, 2014, p.125). For example, one deterrent was to hide the clothes of children who had run away, so the children were forced to walk around in their underwear when they returned.

The participants in Bejenaru and Tucker's (2014) study wanted to form close relationships with the staff but were restricted by the establishment's relational practices and procedural practices, in which meaningful interaction between care staff and young people was shunned in favour of a more detached approach. In Gallagher and Green's (2012) study the participants spoke about wanting to feel

loved by the care staff and how that influenced their behaviour: *"the one thing you need most is to feel genuinely loved. You never quite got that. That is why we used to play up, so that we could get some attention for us"* (p.440).

Affection was very apparent in a number of studies in which the participants spoke about the care staff as if they were family (Arthur et al., 2013; Khoo, et al., 2015). This support helped to improve the young people's psychological wellbeing. Furthermore, the care staff acted as positive role models for young people, this taught them to improve their general relationships with other adults in their lives: *"my relationship with my Dad has improved just because we can communicate more"* (Magor-Blatch & Ingham, 2015, p.342). From an attachment theory perspective (Bowlby, 1969), the participants in Carter's (2011) study best surmise the positive impact care staff can provide for young people in residential care. Due to the care staff's patience, the young people felt forgiven and wanted even after they had misbehaved, this helped build the young people's: self-esteem, ability to trust others, resilience and their sense of self-worth.

6 - Stigma in society

Many of the negative assumptions young people in residential care feel is harboured against them is excellently described in Emond's (2014) study. These assumptions include: their parents do not love them, their parents suffer from addiction to alcohol or narcotics, they are in the residential home because of criminality, they are socio-

economically disadvantaged and/or they had been abandoned. Gallagher and Green's (2012) participants noted that stigmatisation could come from other professionals (such as teachers being insensitive), or from the peers in their class: "*not many people wanted to be friends with children from children's homes*" (pp.444). Emond (2014) notes that some participants saw being in residential care as being part of their identity; while for others it was a great source of shame. This concept of shame was echoed in Tatlow-Golden and McElvaney (2015) participants, in which they spoke about the double stigma they felt in being in residential care and having a mental health diagnosis. It can be difficult for the young people to not internalise negative messages about themselves at times and they can feel like they are in some way responsible: "*residential care? Oh my God, what did you do?...but it's not always you who has done something bad*" (Tatlow-Golden & McElvaney, 2015, p.4). In Khoo et al.'s (2015) study the participants also felt a lot of stigma about how people outside of the residential establishment viewed them but they had psychologically assimilated this in a different way. They spoke about how their 'otherness' united them together, while feeling a sense of alienation from the rest of the world. This aspect of the rest of the world is important because it appeared to be a societal issue as oppose to a schooling one in Bejenaru and Tucker's (2014) study. Bejenaru and Tucker's (2014) participants spoke of the risk of being labelled as a young person in residential care: "*I am also revolted because of clothes. If we have the same clothes, the same shoes, the*

same track-suits, it is normal they realise that you come from the institution, as if we are numbered" (p.1301).

7 - Systemic issues

Schjellerup Nielsen (2010) raised concerns around the inclusiveness of societal services for young people outside of their residential care establishment. In the study they noted how important it is for different social arenas to interact with one another (for example the care system and the educational system), but they argue it is difficult for the care system to form these closer links and thus the young people who need the services more than most young people in society end up becoming increasingly marginalised (Schjellerup Nielsen, 2010). Tatlow-Golden and McElvaney (2015) looked at systemic issues within the confines of the care system and point out that the young people interact with so many professionals, for example people like: care staff, social workers and psychologists. Therefore, there is no benefit to forming close relationships with these people since the relationship can often end abruptly. Furthermore, they cite the lack of communication between these professionals meaning young people are often forced to repeatedly reveal personal and potentially traumatic information to a series of virtual strangers (Tatlow-Golden & McElvaney, 2015). Carter (2011) emphasised the influence of systemic factors within the residential establishment itself, since the care staff can only interact with the young people to the best of their ability if they are supported within their role, from the top down at an

organisational level, which is often not the case within the residential care system.

8 - Spirituality

Spirituality as a construct might be tied closely to culture, whilst many studies did not mention religion; it was a key consideration in two studies. In Khoo et al.'s (2015) Mexican study there was a statue of the Virgin Mary in the residential establishment, the *"youth often went to in order to get strength, feel motivated and to pray"* (p.5). Similarly, spirituality was a positive coping mechanism for the participants in Nourian et al.'s (2016) Iranian study: *"when there is a problem and you call on Imam Ali, you find a peace that helps you not make decisions in anger"* (p.7). Chama and Ramirez's (2014) American study highlighted how spirituality should be personally determined and the residential establishment should not try to be too coercive in its approach to spirituality with young people: *"I don't think they should try to force religion down your throat"* (p.127).

9 - Parental contact

The Scottish care leavers in Arthur et al.'s (2013) study were impressed with how much family connections were prioritised in Denmark compared to the residential care system in Scotland. Parental contact with the residential care home fell into three categories for the participants in Johansson and Andersson's (2006) study. They maintain that contact with the residential care establishment for families can be: 1) a source of support for families,

2) a source of anxiety for families, or 3) a source of anxiety for the young people in care. While familial contact is generally viewed as a positive aspect for young people in care, there are times when this may not always be the case. A couple of the studies in the review cited the participants as recognising that family contact might be impeding their progress or that their parents may not always be as reliable as they would like them to be (Tatlow-Golden & McElvaney, 2015; Magor-Blatch & Ingham, 2015). Khoo et al.'s (2015) participants spoke about feeling out of control when it came to family contact and often viewed care staff as being closer to them, however, as one individual noted family: *"are important and leave an emptiness and will always be in my heart"* (p.5).

10 - Pros and cons of therapy

In Gallagher and Green's (2012) study the participants had mixed emotions on their experiences of the therapy offered. Some participants thought it helped them to process their emotions whilst others thought it was a pointless exercise and the time could have been better utilised. The two primary concerns were: 1) the therapist misinterpreting their remarks/actions or overreacting, 2) the therapist not adhering to confidentiality in the participant's view, by discussing session content with the residential care staff. Furthermore, the young people emphasised how challenging and potentially damaging it can be for young people to re-visit the sources of their trauma(s) if not in a psychological state to do so. Chama and Ramirez's (2014) participants were of the opinion that there was a big difference in the

quality of the counsellors in the care establishment, with the counsellors with more experience and training being more attentive to the young people's needs.

11 – Termination of care

Johansson and Andersson (2006) maintain that disruptive residential care placements can foster negative perceptions of residential care. The potential for placement breakdown should be foremost in the minds of professionals when choosing where to send the young people. There can be a failure to involve the young people in this process and they can be moved from one residential care placement to another, with little notification and/or little transition period being afforded (Bejenaru & Tucker, 2014). This can have negative implications for the young person's education and self-esteem (Schjellerup Nielsen, 2010).

Leaving residential care can also be a traumatic time for young people and needs to be carefully managed so young people are not left feeling "*deserted*" and "*thrown out*" and may not even be given a chance to say goodbye, as described in one study (Johansson & Andersson, 2006, p.313).

This is an issue that is handled in some countries with more sensitivity than in others. In Arthur et al.'s (2013) study looking at the differences between Danish and Scottish care systems, one participant, a Scottish care leaver called Murray, recalled the

reactions of the Danish young people to his experiences: *"they had not heard of young people moving placement more than once and were shocked at my experience"* (p.36).

Gallagher and Green (2012) argued that placement termination should be: planned, incremental, involve prior preparation and if focused on independent living have an emphasis on practical skills acquisition. The participants noted that they could often feel guilty towards their peers because they are leaving them.

Once young people leave they face into a life of unknowns according to the participants in Bejenaru and Tucker's (2014) Romanian study: *"their future lives were seen as being subject to a high level of risk. They saw themselves leaving a care system that offers little support: in counselling, in finding a job and in identification of a house to rent"* (p.1302). Arthur et al.'s (2013) Danish cohort is faced with a different situation, with an educational system setup to help them with free fees and *"they will get support from a social worker at least once a week"* (p.37). Carter's (2011) study suggests that this societal investment in disadvantaged vulnerable young people through affection and responsive care is likely to have long-term lasting benefits both for the individual and society as a whole. Three of the well looked after participants in the study went on to become: a policeman, a social worker and a foster carer.

12 - Psychological outlook

In Nourian et al.'s (2016) study with participants with high resiliency scores there were a number of factors which had shaped the young people's psychological outlook, to allow them to cope better with adverse experiences. Firstly, they practiced self-encouragement. Secondly, they were goal oriented and this helped them to achieve their targets. Thirdly, they viewed early negative experiences as a positive, which had made them more resilient and meant they were less affected when negative situations arose in the residential establishment. They spoke about avoiding conflict and dealing with the problems under their control, while not dwelling on the ones that they could not alter. This study raised the question of whether the young people's experience had improved their ability to deal with conflict, or if this resiliency was also culturally ingrained, since Iranian culture centres on publications bestowing the virtue of "tempered steel" (Nourian et al., 2016, p.7). Either way, it demonstrates that vulnerable young people in residential care do not need to be defined by their past experiences and they are capable of progressing in society just like their peers who are not in residential care.

Please see table 4 (next page) for a breakdown of each of the emergent themes outlined in the findings section and how each theme relates to each individual review study.

Table 4. Identified themes from evidence synthesis review studies

Theme (n)	Number of studies (n) which positively identified theme	Positive studies (Study number)	Number of studies (n) which negatively identified theme	Negative studies (Study number)	Number of studies (n) for which the theme was not highly significant or the theme was not even mentioned
1 - Structured environment versus personal autonomy	5	2, 4, 5, 7, 13.	3	2, 10, 14.	5
2 - Peer support more important to young people than adult support	7	1, 3, 4, 5, 8, 11, 15.	0	-	5
3 - The Social hierarchy & impression management amongst young people	2	3, 4.	6	1, 2, 3, 9, 11, 12.	5
4 - Sense of belonging	5	2, 3, 5, 8, 11.	1	2.	7
5 - Relationships with staff	5	5, 6, 7, 13, 14.	6	1, 2, 8, 9, 10, 12.	1
6 - Stigma in society	1	13.	5	6, 9, 11, 12, 13.	7
7 - Systemic issues	0	-	3	4, 5, 12.	9
8 - Spirituality	2	13, 15.	1	10.	9
9 - Parental contact	3	2, 7, 13.	5	2, 7, 12, 13, 14.	7
10 - Pros and cons of therapy	2	6, 10.	2	6, 10.	10
11 - Termination of Care	3	5, 6, 7.	5	2, 4, 6, 7, 9.	6
12 - Psychological outlook	1	15.	0	-	11

Discussion

The review provided a number of insights across the twelve themes that the fifteen studies produced. Within the thematic analysis, the participants in certain countries had a better opinion on residential care than the participants in other countries. The Scandinavian countries in the study appeared to have the highest approval rating among the participants, while the Romanian care system was not well regarded by participants from there. It should be noted that the participants in the Mexican study had a very high opinion of their residential care establishment, but from their responses it sounded like their care establishment was very good, and not symptomatic of a typical residential care establishment in Mexico. Participants in countries such as Australia and Ireland produced largely mixed opinions on the quality of the care system in their respective countries.

Sweden and Denmark demonstrated that when it comes to living with other children in residential care smaller groups are better for young people, as the staff can devote more attention to them. Furthermore, they may need to be protected from other young people (like the participants in Romania and England), and care from staff can help to counteract a societal view of young people in residential care as being damaged from abuse or neglect (as evidenced in the Mexican study).

The physical environment and the mood perpetuated within the care establishment are also very important to the psychological wellbeing

of the young people. In the studies in: Denmark, Sweden, Mexico and England the participants spoke about the care establishment feeling like a 'home' and feeling welcome there. In other countries (for example Romania), the participants did not feel comfortable in the care establishment, indeed in the American study one participant characterised the residential establishment as being like a 'prison.'

From an international perspective social hierarchy among young people within the care establishment appears to be universal. Emond (2002) maintains that based on her own ethnographic research, young people place significant emphasis on their peers in residential establishments and the group dynamics they all form as a whole. Young people appeared to rely on the support from these peer relationships more than adult relationships. However, like family contact, peer relationships can be a source of positivity or negativity and should be closely monitored by care staff. Family contact in most cases is viewed as a positive, indeed in countries like Denmark positive family interaction plays a key component in treatment integrity. Familial contact is a multi-faceted issue though and it needs an individualised approach as some participants spoke about how they regressed when they spent time with family (like in the study in Australia). In Israel the approach of keeping siblings in care together as much as possible was viewed to be a positive concept for the participants.

Interactions with staff was also an area that was highly emotive for the young people and the quality of the staff/young person dynamic was evidenced in Denmark and Mexico, where the participants thought of certain care staff as being like 'family' to them. On the other hand, in America, Romania and Israel the care staff could be described as detached and the participants felt that the care staff put pressure on them. In Iran, the participants actually used negative experiences and their mistrust of staff as a positive to strengthen their resilience and psychological outlook.

A cause for concern arising from the research was the consequences for young people when the time arises to change placement or when the time comes to leave the care system. A great deal of care was taken in Sweden and Denmark in allocating young people to specific placements in order to minimise the possibility of placement breakdown. This was in stark contrast to countries such as: England, Scotland and Ireland where placement breakdowns are unfortunately commonplace. The level of support afforded to young people when leaving residential care is also radically different in different countries. Systemically, Swedish and Danish care leavers transitioning into independent living were supported financially and educationally, however, in Romania young people leaving care were actually fearful about becoming embroiled in poverty and possible criminality.

Courtney, Dolev and Gilligan (2009) emphasised how spirituality, culture and political ideology could be important in residential care.

The current review illustrated in the American study that spirituality could shape how the whole residential care establishment operates. When it comes to political ideology the Mexican study operated on a political ideology consistent with its background as a Spanish colony, the participants viewing the religious iconography in their residential establishment as a source of strength. The role of culture was highly significant in the Iranian study, where the participants viewed their difficult backgrounds as a source of pride in helping to build their resilience (as oppose to Romania for example, where their problematic backgrounds were seen as a source of shame). The current review also showed how the “new therapeutic” context which emerged in Sweden in the 1960s and 1970s appears to be working for young people in residential care in Sweden today and it could be a template for other countries to follow in the future.

However, it should still be noted that: residential peer group dynamics, young people and staff dynamics, quality of care services, systemic issues and the quality of post-care services are all areas that remain under researched; further study is required to combat the dearth of literature currently available in this area.

Limitations

It should be noted that while the review strategy attempted to include as many relevant studies as possible within the confines of the PICO parameters, there will inevitably have been some studies that would

have been eligible for inclusion that the reviewer did not manage to successfully identify.

Conclusion

The review yielded twelve themes and eleven of these were prominent in at least two studies in the review. This suggests that the constructs developed into themes by the reviewer were pertinent to the experiences of the young people across the fifteen studies. The review also helped to illustrate several different international approaches to residential care and how from a sociological perspective these could be improved, which would positively impact on society as a whole. Lastly, this review was focusing on the lived experience of young people in care and the reviewer believes a qualitative approach was required to obtain the rich descriptive findings that this review produced.

Rationale for chapter three

The review highlighted a number of factors that are important to the experiences of young people in residential care and their associated psychological wellbeing. It also suggested that many young people in care do not feel like the care staff members understood what was going on in their lives. Whilst a few of the studies mentioned the care workers opinions on some matters, the emphasis was primarily on the viewpoints of the young people. The reviewer did not encounter any study placing equal weighting on the views of the young people and the care workers and trying to objectively consider these views in an

impartial way. Based on this finding the reviewer decided it would be an interesting direction to take the dissertation. To try to empirically evaluate if the care workers views on meaningful residential care for young people was the same as that of the young people themselves. Chapter three seeks to narrow the focus from an international perspective to the Republic of Ireland. The aim being to examine how many of the twelve themes identified through the international research literature will be evident in a sample of Irish young people and care workers who have experienced the residential care system.

CHAPTER THREE

An exploratory examination of the comparative views of residential care services held by care workers and young people who have been through the residential care system.

Abstract

The research sought to explore the quality of care services for young people in residential care in Ireland and how successfully they transition into aftercare services. The aim was to examine this topic from the viewpoint of young people who have been through the residential care system but also from the perspective of the care workers who are responsible for the quality of young people's care. For this purpose, a convenience sample of twenty participants (ten residential care workers and ten young people who had been through residential care), completed a care questionnaire and an open-ended interview of one-hour duration. A thematic analysis was performed to evaluate the raw data. It was evident that what constitutes quality of care was similar for the care workers and the young people involved. However, the care workers constituted a more homogenous group and the young people held more varied opinions. The thematic analysis of the dataset elicited fourteen themes; 2 young person themes, 3 care worker themes, and 9 joint themes. The developed themes addressed areas such as: 'fitting in,' 'what makes a care worker' and 'wider connected processes.' The findings were considered in light of other research literature in this area, suggestions for future research offered and conclusions made about what the findings mean in the context of Irish residential care.

Introduction

Considering young people's views on residential care in light of the chapter two findings

As noted in chapter two, in the main, the young people were positive in their views on: the relationships they formed with care workers (Carter, 2011; Gallagher & Green, 2012), their schooling experiences and the preparations that were made for them for when they would leave their care placements (Arthur, et al. 2013; Schjellerup Nielsen, 2010). One issue the research literature has highlighted is that there has been a considerable focus on young people in care developing relationships with staff, but that less thought is given towards continuing these relationships after the young people leave the care placement (Bostock et al., 2009). Some young people in the qualitative review noted that they had found therapy challenging (Chama & Ramirez, 2014), had difficulties making friends (Bejenaru & Tucker, 2014) and felt that the care placement had not done enough preparation work with them before they left the placement (Gallagher & Green, 2012). Overall the qualitative review (like the research literature) illustrated that residential care establishments can provide a good standard of care and they usually do (Pazaratz, 1999). The current research will consider if the Irish residential care context is similar to the international residential care context.

The Interpersonal dynamics between the young people in residential care and the social care workers

De Swart et al. (2012) discovered that many residential care studies did not report on characteristics of care workers. This raises a lot of questions in light of the findings from chapter two, as characteristics of care workers is an area highlighted as being instrumental to the young people's treatment outcome (Duncan, Miller, Wampold & Hubble, 2009; Bickman et al., 2004). This raises an important question. Is the role care workers play in facilitating young people's progress sufficiently valued? Characteristics of care workers found to be significant include: level of education and training, the individual's personal professionalism and his/her relationship building skills (Duncan et al., 2009; Van der Helm, Boekee, Stams & Van der Laan, 2011).

Within the residential care research literature, care workers systemically integrating their work with the young people's family members can often be referred to as '*wraparound*' care (Grundle, 2002). Wraparound care is based on using the young person's strengths and their family members strengths, in the care planning process and utilising community services and other supports as much as possible, to achieve a positive outcome (Grundle, 2002). The difficulty in achieving this was highlighted in the systemic issues theme in chapter two (for example Schjellerup Nielsen's [2010] study).

Knorth et al. (2008) found that care workers appear to be much more critical in evaluating young people's behavioural progress than the young people themselves and the young people's parents. The reasons why care workers are more critical in their views of young people's progress is unclear, but this is an area that the current research seeks to explore. Furthermore, if the care workers are more critical in their views on the progress of the young people in residential care; then does this impact on how they carry out their role or does this lead to further considerations/implications?

The care worker's perspective

Morgan (2009) draws attention to a number of the factors care workers have to contend with and how conflicting responsibilities can make it difficult for them to best care for the needs of young people in residential care. Firstly, on one hand care workers need to form a relationship based on trust with the young people but they also have to share sensitive information about those same young people with their colleagues. Secondly, they have to facilitate leisure activities and other pursuits for the young people, while trying to ensure that no harm comes to anyone involved (physical, emotional or psychological). Thirdly, the needs of the young people vary widely and the care workers have to be attentive to this while maintaining a balance to try to maintain fairness among how the young people are treated (Morgan, 2009). Kiraly (2001) argues that appropriate staff training and supervision is crucial in allowing care workers to best meet the needs of the young people they care for.

A large-scale study examining the challenges faced by care workers was carried out in 2015, in which ninety-three care workers were interviewed (Molepo, Sophia & Delport, 2015). The most prominent challenges that the respondents listed as impacting on their ability to carry out their jobs were: dealing with the young people's behaviours, a lack of tangible and immediate results, poor stakeholder relations, a lack of recognition, a lack of clarity on their role, inconsistent job requirements, a lack of professional growth and development opportunities and inadequate working conditions (Molepo, Sophia & Delport, 2015). Little and Kelly (1995) also found that the quality of life for young people in care is not only influenced by staff but a number of other groups such as teachers and social workers.

The research objectives for the current research were:

- 1) To add to the findings from chapter two and to explore the views of young people who have been through residential care.
- 2) To explore the views of care workers and see what they think is required to help the young people they care for.
- 3) To consider the young people's views and the care workers' views together, to explore how similar the two viewpoints are.

The empirical research aims to examine if the young people's views of what young people in care need is the same as that of the care workers. Furthermore, what do both groups think could be done to improve the treatment integrity of residential care for young people in the future? There has been no prior research attempt to give equal

weighting to the views of young people and care workers (on residential care) in any of the research literature assessed for the current piece of research.

Method

Organisational Overview

The research took place in conjunction with Fresh Start Residential Services. Fresh Start Residential Services offer intense supervision to young people whose needs could otherwise mean the possibility of secure care settings being required. The multi-disciplinary staff team allows Fresh Start to work with most levels of need, primarily behavioural difficulties. Upon arrival at the care unit a care plan is developed for each young person during his/her placement, attempting to address the person's individual needs. The placement plan determines the level of supervision and therapeutic intervention required for each young person. The young people receive 24-hour supervision, 7 days a week, by experienced and skilled staff. Psychotherapy or psychological input is provided, if requested, by a qualified psychotherapist or psychologist. Occupational therapy, speech and language therapy and psychiatric support are also available to the young people if applicable.

Access

Ethical approval for the study was sought and obtained through the University of Nottingham's Faculty of Medicine and Health Sciences Research Ethics Committee (see appendix E).

After consultation with various care professionals in Ireland, Fresh Start Residential Services was deemed to be the most appropriate residential service to examine residential care in the Republic of

Ireland and how people progress after being through the system. After further liaison with the appropriate senior management, permission to carry out the research within the organisation was granted.

Due to the transient nature of this population and probable high rate of attrition, all thirty-young people who had left Fresh Start services in the last three years were invited to participate in the research (with the aim of achieving 10 respondents). The researcher liaised with social workers (see appendix F) about obtaining contact details (applicable address and/or telephone number) for the young people and then would approach these young people directly (see appendix G). The care workers were approached directly. All house managers and service managers in the organisation were written to and provided with a care worker information sheet (see appendix H) and then the 10 care workers selected based on trying to include different locations from around the country.

Selection Criteria

All the existing clinical files for the thirty-young people who had left the organisation in the preceding three years were examined to understand their overall experience and to isolate salient points that were repeatedly mentioned in clinician reports (for example difficulty with peers). Each individual in Fresh Start must complete a needs assessment and, in all likelihood, will also have a social worker report and clinician reports written about their progress whilst in care (for

example occupational therapist or psychologist). Common issues highlighted by clinicians were noted and these issues were instrumental in forming an interview schedule and questionnaire about the quality of care services (for example: educational/behavioural/interpersonal/physical aspects). From this the interview schedule was formalised and a questionnaire for equivalent use between young people and care workers was developed.

Background Information

Since research often highlights certain background characteristics and demographic factors of young people who are less likely to progress satisfactorily in residential care, demographic information was collected for each young person involved in the research study. Only the data for participants who had agreed to take part in the study was examined. This information related to: age, gender, ethnicity, length of stay and current living situation (salient demographics such as 'current living situation' were returned to with participants at the time of the interview).

Participants & Demographic Information

A convenience sample of 10 young people who had left Fresh Start residential care within the last three years took part in the research. The young people in the study were in care at some duration between the age of 13 and 18 years. They were aged between 18 and 21 years at the time of the interview. Six male participants and four female

participants took part. Nine of the participants were designated as being white Irish and one of the participants was designated as being black Irish. Six of the 10 participants identified as heterosexual (3 males; 3 females) and four of the participants identified as homosexual (3 males; 1 female). The length of time in residential care for participants ranged from 1-year duration to 5 years duration. All 10 of the participants had transitioned to independent living at the time of the interview (none lived with family, all lived with housemates [n=8], or on their own [n=2]). In the interview when the 'reason for entering residential care' was discussed, the young people cited a dysfunctional familial background [n=7], or his/her own problematic behaviour [n=3].

Ten Fresh Start care workers were also involved in the research. There were eight females and two males; all were designated white Irish. They were aged between 27 and 54 years at the time of the interview. Fresh Start's organisation is spread around the whole of the Republic of Ireland and the care workers were from a range of different locations including: Westmeath, Cork and Dublin. The least experienced care worker had been employed as a social care worker for 7 years duration (still a significant amount of time), while the most experienced admitted to having 19 years of experience. At the time of the interview, they were all working in small residential units, which would house between one and three young people at any one time.

Materials

Raw data in the young people's clinical files helped to formulate the semi-structured interview schedule (see appendix I) and the questionnaire (see appendix J). For example, the researcher noted that mental health and physical health needs were consistently mentioned in clinician reports. Hence informing the researcher to include these factors in the interview schedule and the questionnaire.

This interview schedule (see appendix K) and the questionnaire (see appendix L) were replicated with the care workers to be as equivalent as possible, in order to capture the nuances between what the young people were saying in comparison to how the care workers view the topic of young people in residential care. The questionnaire used key items that were coded with numerical Likert scales value (for example "The house was a clean and safe environment" - 1 *strongly disagree* to 7 *strongly agree*, 4 meaning no opinion or the question is not applicable to him/her). The number 4 option was added to the questionnaire because when the questionnaire was piloted a few of the test participants felt that certain questionnaire items were not applicable to him/her.

Location of study

All of the questionnaires and interviews were completed with the young people in the closest Fresh Start office to where they were living at the time. This helped to ensure a safe environment for the young person and the researcher and also ensured that suitable

professionals were available (outside the private room), to provide support if required. Similarly, the questionnaires and interviews with the care workers also took place in a private room in the residential care home. Since this is where they worked, this approach provided the least amount of disruption to their daily lives.

Procedure

When each participant arrived, the researcher went through the consent form with him/her and explained about the electronic recording of the session (see appendix M and N). After giving his or her consent to take part in the research, each participant was required to complete a short questionnaire followed by an interview of approximately one-hour duration. They were given ample time for breaks, if required, while doing so. Concentration levels and intellectual ability varied among participants, but the researcher adopted a patient and individualised approach (for example reading out questionnaire items if appropriate). Questions from the semi-structured interview schedule were kept open-ended (or Socratic) in design, to allow time for the participants to share their views and experiences (Heslop & Macaulay, 2009). Focused personal questions were handled with sensitivity and were primarily an elaboration on a subject raised by the individual participant. The topic and pace of the discussion was altered in response to elicited non-verbal cues of participants, with the researcher noting some non-verbal cues with a piece of paper and a pen (Corey, 2001). For example, if a participant was visibly struggling to articulate his/her experiences in care, then

the researcher would focus in on particular parts of the experiences the participant mentioned, in order to simplify the interview for the participant.

Data Analysis

The completed questionnaires were examined for descriptive data such as frequencies of different scores on various items. The researcher was interested in questionnaire items that showed a convergence/divergence of opinion between the care workers and the young people. Attention was also paid to specific questionnaire items that showed a large divergence of opinion within one of the populations (for example the young people).

Once the interviews were completed they were transcribed and anonymised prior to the thematic analysis being performed. The transcripts were read and re-read to develop familiarity with the dataset. Initially, low level coding was performed in Microsoft Word on each individual interview transcript by noting relevant quotations. Once this was completed, high level coding consisted of collating the coded extracts and exploring how different codes combine and/or inter-relate to create patterns (or more commonly referred to as themes, as per Braun & Clarke, 2006). The emergent themes were listed and clusters of related themes were developed (super-ordinate themes). These super-ordinate themes were created through a number of processes: abstraction (putting similar findings together and adopting a theme name for the related cluster), subsumption

(where a theme brings other related themes to it), polarisation (examines differing relationships in the dataset), contextuation (identifying the contextual elements within an analysis), numeration (the frequency at which the theme appears in the data), and function (the purpose the theme conveys) (Smith, Flowers & Larkin, 2009).

NVivo for Mac qualitative analysis software was used to limit (not remove) the role of researcher bias in the exploration of the identified themes. The researcher was able to identify how often a theme was sourced (participant number) and referred to (times mentioned) across the different interview transcripts, to build up an understanding of its potential significance. This software allows the researcher to: sort, classify and arrange data. To explore relationships in the data. It also allows the researcher to combine analysis with: searching, shaping, linking and modelling. Using this software, observations can be made and a body of evidence constructed, to explore the relevant research question.

Reflexivity

As previously mentioned in chapter two, reflexivity is about reflecting on the role of the researcher in impacting (and possibly biasing) the research process; this is especially prevalent in qualitative research (Yardley, 2000). The beliefs and assumptions of the researcher can influence how data is collected and analysed. The researcher needs to be mindful of his/her own values and existing views through reflective

practice and how this may impact on the potential for bias in the overall research (Yardley, 2000).

The researcher in the current study worked in residential care as a practitioner (trainee forensic psychologist), for approximately 18 months duration. During this time the researcher was exposed to young people and care workers raising issues such as: staff/young people dynamics, the level of parental contact afforded to residents and the physical environment of the residential establishments. Accordingly, the researcher would have been more sensitive to perceived issues in these areas when analysing the interview transcripts. Therefore, researcher bias would have been more likely to occur when addressing these themes.

Findings

Examining the Questionnaire Dataset*

(*Please see appendix O for the Tables of the Young People & Care Worker Questionnaire scores).

The results of the questionnaire data were considered from both a within groups and a between groups perspective. These results provide the context in the thematic analysis for a more detailed and varied presentation of young people and care staff perspectives.

The research objectives for the current research were:

- 1) To add to the findings from chapter two and to explore the views of young people who have been through residential care.

The questionnaire items for young people that showed the largest range of fluctuation (with participants answering very low [1] or very high [7] on the same items), are listed below:

Q3	The house was made to feel like my home.
Q6	There were helpful review meetings with staff to let me know how I was getting on.
Q14	I was taught life skills to help prepare me for independent living.
Q18	I was taught life-skills such as how to manage my own shopping.
Q20	I was taught about things such as substance misuse.
Q21	I was taught about things such as sex and sexuality.
Q24	I was able to spend enough time with my family.
Q29	I could see a psychologist if I wanted to.
Q34	At times I felt like there were too many members of staff around.
Q35	At times I felt like there were too few members of staff around.
Q36	I felt comfortable and accepted by the other residents.
Q37	I felt comfortable and accepted in the community when I was in care.
Q44	My behaviour improved and became less extreme while I was in care.
Q45	I felt prepared when the time came to leave residential care.

The fluctuation in scores on items Q3 and Q37 might be explained due to the care establishments being based in different geographical locations; the care establishments themselves are also physically different buildings to one another.

It is to be expected that the young people had a wide variation of opinions on different residents (Q36), as interpersonal dynamics among the residents can be a great source of support or aggravation for young people in care, and indeed it can even be tied to their own sense of identity (as illustrated in the social hierarchy and impression management theme in chapter two).

Q34 and Q35 could be related to varying care team numbers in different care establishments and the care rota can sometimes be imbalanced. When it comes to care team meetings (Q6) and a young person's willingness to receive feedback, the young people gravitate more to some of the care workers than others, (some care workers being perceived as more personable). This point closely ties into items: Q14, Q18, Q20 and Q21 as young people view some care workers as being more approachable and willing to impart knowledge than others.

Meeting with a psychologist (Q29) to talk about his/her life seems to be a multifaceted issue for the young people. Some think it is beneficial, some do not see the point in talking to a stranger and some think it is something which young people are not equipped to deal with at the time. They believe young people would benefit greatly from it later in life (when the provision is usually no longer available to them).

With regard to Q24, family contact time can be contingent on how much interaction the family want to have with the young person in care and whether the care staff team believe the family members to be a positive influence on the young person.

Q44 producing such different opinions is worrying, as improving a young person's behaviour during his/her time in care is one of the main ideals behind the care system in the first place. Hopefully, some insights into this area will be forthcoming in the thematic analysis findings. Finally, Q45 can be related to the care establishment's motivation to impart relevant knowledge on the young person, or the young person's own motivation to consider his/her future.

2) To explore the views of care workers and see what they think is required to help the young people they care for.

Care workers were a lot more consistent in their responses on the questionnaire and their scores showed a very small range of fluctuation compared to the young people. This could be down to the young people evaluating residential care from their own personal lived experiences. On the other hand, care workers are more likely to approach the topic from a generalised perspective, as they would have worked in a care establishment for a period of years and would have witnessed several young residents enter and leave care within that time frame. The questionnaire items for care workers that

showed the largest range of fluctuation (again examining scores of 1 and 7) were:

Q30	The young people can see an occupational therapist if I they want to.
Q36	The young people feel comfortable and accepted by the other residents.
Q41	The young peoples' social needs are met.

The contrasting scores by care workers on item Q30 probably relates to resourcing. Fresh Start supply occupational therapists to the care establishments, but in urban areas because of the increased demand (most care establishments are based there), it can be more difficult to avail of an occupational therapist's services. Conversely, care establishments in rural areas can find it more difficult to cater for young people's social needs (Q41), due to the lower population density and fewer available amenities for young people to frequent. It is unsurprising that item Q36 also produced such mixed opinions among care workers, since they view the interpersonal dynamics at play between the residents on a daily basis.

3) To consider the young people's views and the care workers' views together, to explore how similar the two viewpoints are.

When it came to comparing the range of fluctuation on questionnaire item scores between the young people and the care workers, three items showed the largest range of fluctuation (above 3 Likert scale points).

Q3	The house is made to feel like home for the young people.	YP = 6*	CW = 2*	Diff = +4
Q32	The young people are encouraged and rewarded by staff when they do well.	YP = 4*	CW = 1*	Diff = +3
Q40	The young peoples' educational / occupational needs are met.	YP = 2*	CW = 5*	Diff = -3

** Relates to the number of points difference between the lowest score someone in the group gave on the questionnaire item and the highest score someone in the group gave on the questionnaire item.*

The young people had varying opinions (between 1 and 7) on whether they felt the residential establishment was made to feel like 'home' (Q3). The care workers gave consistently high scores (between 5 and 7) and obviously felt that the care establishments they were working in endeavoured to make it feel like 'home' for the young people. The young people psychologically understood that it was not their home and this may have been influencing their response to this item. The care workers were more concerned with the materialistic efforts that were made to improve the care establishment.

Item Q32 followed a similar pattern with the young people having vastly different opinions (scores between 1 and 7) and the care workers showing a lot of homogeneity (scores between 6 and 7). The young people may have felt there was a big difference between how much the care workers praise them; the different young people must have had very different experiences in their relationships with staff. For the care workers this was quite an emotive item, as they would naturally want to believe that they were making an effort to help the young people (therefore the high scores they gave here is perhaps to be expected).

In Q40 the young people actually felt their educational/occupational needs were met (scores between 5 and 7), whilst the care workers felt otherwise (with scores between 2 and 7). With this item, the young people may not have had something to gauge what they were

receiving compared to what other young people not in residential care might receive. The care workers are acutely aware of this and they can become disillusioned with the inability to provide certain services to the young residents due to issues such as: finance, geographical location and educational politics (for example a school not wishing to take a student from a residential care establishment).

Examining the Interview Dataset*

*(*Please see appendix P for NVivo Mind Maps of: 1) Emerging Themes, and 2) how many participants referenced the themes and how many times the theme was mentioned throughout the twenty interview transcripts. The pages after the NVivo mind maps detail how the final thematic analysis headings were decided upon.)*

After reading and re-reading the twenty interview transcripts (supplemented with the use of NVivo for Mac qualitative software) a thematic analysis (as proposed by Braun & Clarke, 2006) was developed. What follows is a thematic analysis of the dataset (which elicited fourteen themes; 2 young person themes, 3 care worker themes, and 9 joint themes) and how it related to the three stated research objectives above. Participant quotations appear in italics (YP represents a young person quote and CW represents a care worker quote).

1 - Previous Care Experience (Young People Theme)

Most of the participants had experienced foster care and residential care and were keen to highlight the differences. The first point mentioned was how they initially experienced the change in environment. *"If you've come from a foster family into a residential you'd be stoned by the differences. Like there's kids running riot. In*

foster families you don't see that. Kids throwing tantrums, kids throwing food out the fridge, kids getting up in staff's face, spitting on people, fighting people, arguing, smashing TVs, smashing, terrorising" (YP - P14 P12 L11-16).

The participants who favoured foster care emphasised the difference in the care approaches with respect to policy and procedures. *"Foster care straight up [is better] because...there is no child protection act, there is no log books"* (YP - P11 P3 L9-14). Another participant thought the setup in foster care was more realistic in preparing young people for future life: *"I needed it because being in residential care I was wrapped up in cotton wool. You are protected and you have policies and procedures so you can't – I had to get a job when I was in foster care, I had to do things for myself"* (YP - P19 P7 L4-7).

In contrast the young people who favoured residential care did so for relational reasons and felt they did not fit in or they were treated differently to their foster parents' biological children. *"I think foster care is...quite unfair. Because you had to go into someone else's home and play by their rules...It was always around the family's timetable and like their routine, and you had to adapt to that but I like, for me, I always felt like the black sheep, like I was never solely someone's daughter or a part of the family"* (YP - P17 P8 L38-44). Other participants gave explicit examples of how they felt they were treated differently: *"If we asked for pocket money, she'd be like 'oh, I don't*

have it.' But if her kids came in and said 'oh, mummy, can I have money?' - 'oh, yes, there you go'" (YP - P15 P4 L27-29).

2 - Psychological Imprint (Young People Theme)

A key theme for the young people was what being in care meant to them in terms of their own sense of identity. Firstly, the participants spoke about being put into care and how that impacted on them psychologically. *"Depression or insecurities and stuff, for me a big thing was finding who I was. I always felt lost, because my parents, they barely came to visit, they didn't give a shit, so I always felt misplaced, I didn't know who I was, where I belonged"* (YP - P16 P6 L22-25).

The psychological imprint of being in residential care was not just a purely internalised construct either and many of the young people felt they were harshly judged or stigmatised within wider society. *"I find that there is a horrible judgement in society around people in care. I find that they think that you're scruffy, you're going to rob them, you're crap. You're no use. Like they. Like they just think you're so disadvantaged, and it's not fair. Because you know like, I've worked hard for my junior, my leaving and all my college exams and because of people's kind of perception of people in care or whatever they're gotten the idea from, it's not fair to generalise everyone"* (YP - P17 P9 L42-49). However, for other participants they had assimilated being in care as a positive aspect of who they are and reflected on it positively. *"Well there is something that makes you want to [go back*

to the care home to visit]...good to do it and I always went back because it was my house, it was my home, that is why I went back. I am sure you do it, you go back to your parents every now and again. It was my home, I went back and I didn't care who was there. You are sat in my seat, get off it, that is mine" (YP - P19 P12 L45-50).

Finally, what it means to be in care was: a personal consideration, societal consideration but also played a key dynamic among the peer relationships in the care establishments and their connections to their families. *"You have a huge respect for your family when you are in care, no matter what your parents do on you, you have a huge respect and your family is number one. So, dissing somebody's family is not okay and I think a lot of people felt that if they said they were in care they were bringing their family down. Because who wants to think that their parents can't look after a child and the kids doesn't want to accept that until they have to" (YP - P19 P18 L2-8).*

3 - What makes a Care worker (Care Worker Theme)

All of the care workers spoke about training prior to when they started working in residential care. The general consensus was: *"one would need to be in college having studied social studies for the equivalent of at least a year anyway, so at least you've got the basics and the foundations" (CW - P2 P2 L30-32).*

The main discussion on this theme focused on personality and whether a certain type of person is drawn to becoming a care worker.

Aspects such as humour were listed as being essential but one participant gave a nice overview of what type of personality she felt was needed to be a care worker. *"I think problem solving, being empathetic, knowing yourself you know, understanding yourself, understanding the job, understanding the limitations of what we can do and what we can't do and how far we can want something for another young person, it doesn't mean that they are going to take it, so sometimes we feel like we're banging our head against a wall so, perseverance is something"* (CW - P3 P7 L1-6).

Several care workers mentioned a sense of fallibility and ownership over oneself and not letting that impinge on the young people as being important. They also spoke about the hardship the job can take on the person themselves: *"care workers you know, they miss out on significant things because they're working and they're providing a difference for other young people so they miss out on family, so I think that's quite difficult"* (CW - P2 P17 L34-37).

While the care workers acknowledged the difficulties of their job, they also strongly emphasised how much they enjoyed the work, how rewarding it was and how this was fundamental in what makes a care worker; deriving satisfaction from seeing the young people progress. *"One of the most positive experiences I've had is where I've had we'll just say one young person return to me after they've left and speak to me about the positive experience they had while they were in care, and being able to understand some of the structure and boundaries*

that we put in place and explaining that they understood that it was difficult at the time and they rebelled against it, but they understood long term why it actually was necessary and it benefited them" (CW - P2 P16 L34-41).

4 - The Care Work Team (Care Worker Theme)

All of the care workers in the study had been in the job for a long period of time and cited the support of their immediate teams as being instrumental in their longevity in the role: *"Emotional support generally with teams is just brilliant"* (CW - P1 P18 L10-11). The hallmark of the most successful care teams according to the care workers is communication. *"Good team, good supports, good supervision. Just being able to interact with your colleagues and say look that, you know we can try this out and try this approach, whatever it is that kind of thing. Good communication, like even knowing where people are and what they are doing, and all those kinds of things are vital"* (CW - P1 P2 15-19).

Being a care worker is a demanding job and often the validation they receive from their fellow care workers (who understand the role) can be a stronger motivator than any monetary rewards. *"Peer supervision...that's how we still have child care workers to stay working in Fresh Start and residential care despite being assaulted and abused and, I was cut and pay cut and, blah, blah, blah, is because of their colleagues and their peers and the children"* (CW - P8 P16 L1-4).

The issue of support within the care team is also a rather nuanced dynamic and what happens to one member of staff is often felt throughout the whole care team. *"A couple of staff...if they are having a bad day or if a kid is targeting them, you know, it's very hard for me to work with that kid who has been targeting my colleague and for me to be the carer now, I'm not going to neglect him in any way but if he is coming to me for his needs but he has been very aggressive and abusive towards another staff member, it throws the dynamics a little but then again it comes back to the team, it comes back to having a good strong team and we all know why we do things and how we work"* (CW - P4 P10 L41-48).

This highlights the wider systemic issue of the care team and how the organisation must look after every care team member, not just because of how situations impact on them but it can also affect how the whole care team and organisation functions. *"A happy staff team is a happy house leads to happy young people and it's not being selfish or anything but I think sometimes the staff are forgotten about and they are kind of the ones that take the first cut or the first brunt of any financial difficulty and then that trickles down through their self motivation, motivation as a team, motivation as a company and also a happy house leads from a happy team, so any small thing that we can do to boost the staff will always boost the house and boost the young people"* (CW - P2 P9 L11-18).

The young people also notice the dynamics within a care team, be it in a positive or negative way. *"They were all in sync with each other. They were always good at not getting swindled by the kids or outsmarted in any way"* (YP - P16 P4 L13-14). *"There will be a moment one will disagree with the other, and then the other one rolls her eyes up to the back of her head and walks off and goes out for a cigarette or what not, that kind of stuff we do know what staff bounce off each other and what staff get on well"* (YP - P18 P7 L11-15).

5 - Organisational Support (Care Worker Theme)

There were a lot of different areas raised by care workers under this particular theme. Firstly, they disagreed with how organisational decisions were made. They cited many aspects, for example, which residential establishment to place a young person in, and argued that senior management (who do not have interactions with the young people directly) could communicate with them more. *"I think one of the major things with care workers is that they don't get a great say in what goes on with the kids...they are working with kids all of the time, and then its completely taken out of their hands...I just don't think it makes sense"* (CW - P1 P9 L01-09).

Almost all of the care workers felt that the work they carryout was not recognised by senior management within the organisation. *"I think the person that signs the cheques has no idea of the daily struggles that we have with young people...with one young person getting him out of bed in the morning and going to school...for the person signing*

the cheques up on top of the HSE [Health Service Executive] they're going to school every day, they're fine...But there are a lot more needs for that young person than just getting up and going to school so there's a big disconnect and I think we would find it difficult to even explain it to them" (CW - P2 P13 L31-44).

Some of the care workers went further and actually felt they had been treated disrespectfully by the organisation or even coerced during their time in the organisation. *"I would have been told, look at you, you're faffing around the place, what are you doing? What are you stre - what are you stressed out about?"* (CW - P9 P27 L23-25). *"I think one of the things that I don't really like about the assaults and when it does happen, some of the senior management are quite adamant that we need to press charges on the young person. Although it's a staff decision, it can be influenced by senior management"* (CW - P7 P22 L21-25).

Apart from this there were some very practical considerations, which care workers felt impacted on their ability to perform their role to the best of their ability. These included things such as where they were assigned: *"[A care worker is] made to work in different places which can be very draining and daunting like you know, so you might have a house but they are short staffed, 50 miles away and you have to go and you don't know what you are walking into"* (CW - P4 P20 L26-29). And the fiscal limitations imposed upon them: *"It's about the bottom line and it's about the pennies and the purse strings and it really is*

that. And I think in fact [the company director] would actually tell you that. It might just start and do a good job but at the end of the day, it's a business" (CW - P8 P15 L24-27).

However not all of the feedback about organisational support was negative and the participants spoke about how useful they found: therapeutic crisis intervention training, team debriefing sessions and clinical support; all of which is supplemented by the organisation. *"I think that the clinicians and the service that we did have...that having access to a clinical team that can give the team the supervision that they need, I think that's critical"* (CW - P3 P7 L26-29).

6 - Care Environment (Joint Theme)

Some of the participants viewed the residential care establishment favourably and as their 'home,' however, this viewpoint was highly contentious among the young people. *"I loved my house which is probably rare to say. A lot of people say I hate this and I hate that and they would moan about where they were living but I actually genuinely loved where I lived. It was my home"* (YP - P19 P5 L23-26).

In contrast, other participants said they did not feel safe in the residential establishment: *"I found very hard because it was supposed to be our home, and all these people coming and going. And sometimes we didn't feel safe. That was the hardest. Like you're supposed to feel safe in your own home"* (YP - P17 P4 L9-12). When it came to the care workers most spoke about attempting to create a 'homely' environment for the young people, but there were dissenting

voices also. *"I think the accommodation for residential care can often mirror that of a very dysfunctional challenging family and you walk along the street, I can walk along any street and say there is a residential unit because it will have odd curtains on the windows, or they will be pulled down, it will be a bit un-kept and stuff like that and that is because of the continuous damages"* (CW - P5 P16 L35-40).

The most important aspect of creating a 'homely' environment was down to the little details that show consideration. *"Like as soon as they come in, they are given their own personal space, we try to encourage them to pick their duvet covers, put posters up on the walls, whatever they like, then when their friends come over, we welcome them in"* (CW - P4 P6-7 L49-01). This approach was also endorsed by the young people: *"The staff members made me feel welcome, they'd buy me posters, they'd buy me anything really for my room, anything to make me feel like home"* (YP - P13 P2 L19-21).

One aspect of the physical environment, which garnered a lot of attention, was the office in which the young people's notes are recorded. *"[With the office]...I think you just wonder what happens. Because they'd go mad, 'you can't go into this place,' that's when you actually think it's massive and you're more intrigued to know what goes on"* (YP - P14 P12 L48-50). Other young people were more understanding of the care establishment's procedural requirements and argued for as relaxed an approach as possible. *"If, where possible, allow the young people to go into any room. Obviously, I*

can understand the office there's private files in here, that I can understand, and we were allowed in every other room. Which was good, I like that" (YP - P12 P6-7 L49-02). One care worker also spoke about the office and how it can create a barrier against meaningful bonding with the young people. *"It's very natural for a young person to want to come in and talk to you in private...but if you are a young person and you walk in and you close that door and I say just a second there...and I go and open the door, what is that saying to a young person, is it saying that I don't actually trust you or my own safety or you are not safe with me"* (CW - P5 P4 L14-19).

7 - Level of Agency (Joint Theme)

Maintaining boundaries and structure for the young people was viewed as being fundamental in allowing the care workers to do their jobs. *"It takes a while for them to learn the predictability of the house because that predictability is important for the kids because they probably haven't had any predictability at home so once they have settled into that then you can start to see that you can actually do a bit of work with them"* (CW - P6 P9 L5-8). Some of the young people rebelled against the rules while others accepted them: *"I think someone would fight against the staff and the other residents instead of cooperating. I think it would take longer time to find out that it is easier to go with the rules and to follow the staff's orders, not to fight against them"* (YP - P11 P6 L27-32).

However, nearly all of the young people felt the rules were inconsistent among staff members and this was a source of great frustration for them. *"The only problem I ever had with that home was because there were certain people coming in and there's was rules really that I-- not rules but stuff that we agreed with certain people...so that one particular day, this evil little, conniving little yob came into the place and had a problem with it and then brought it up in the meeting and that's when it got stopped"* (YP - P14 P9 L4-18). Even the care workers acknowledged that although the residential establishments had the same policies, different people interpreted them differently. *"The boundaries are different with everybody although we can say you know, this is black and white, these are the guidelines, how you respond is always very different, whereas if you have the same person all the time, giving you a yes or a no answer, it becomes more real I think and just less fight in it"* (CW - P4 P4 L6-10).

Some of the participants were more defiant on the topic of rules and structure though and spoke about it as if it was some kind of power struggle between the staff and the young people. *"The nuclear family of mam and dad and there's only the two of them...whereas here...we're more rigid sometimes, it's like mam would be willing to, a mam would be willing to say, 'Jesus, just go on, go on, do it.' Whereas, we won't because at the end of the day, we're not there tomorrow. And I don't have to deal with you all the time so, you can't wear me down in all this. So yeah, I suppose we're probably more*

strict than parents” (CW - P9 P15 L03-11). One of the young people was adamant that she would eventually get the outcome she wanted because she could manipulate staff: “if I didn't do something I wouldn't be allowed out, but I'd be stubborn, and I'd walk, and they'd give in then, and they'd come and pick me up halfway along the road, like, and then drop me off” (YP - P20 P8 L23-26).

8 - Peers (Joint Theme)

Similar to the findings of chapter two, social dynamics and hierarchy among the residents in the residential establishments was a multifaceted phenomenon. One care worker gave an interesting synopsis: *“they definitely know right from wrong more...but still [they] can be influenced...sometimes you have younger kids and older kids and you might have...say two younger kids who are fairly well behaved for the majority of the time, and then you might have another kid that moves in and that the kids that are good will act up to show ‘we’re cool’...or they might be afraid of being bullied because they’ve been in the care system and sometimes you get kids that are fairly easy going and easy to work with and you can have another kids that comes in who could be very abusive. So, they have to kind of stand their ground as well, so its difficult for them definitely, so whoever they are actually living with, its going to impact greatly on how they behave and reacting to their peers” (CW - P1 P14-15 L49-09).*

A number of the young people had good experiences with their peers in the residential establishments. They saw the relationship as being similar to that of siblings. *"Like sisters, we'd take each other's clothes, take each other's make up, whatever. And then, like the young fellas, we'd be kind of killing each other [unclear - 00:07:37], you know? But I just found that it was like a family environment. I still talk to them, today even"* (YP - P15 P3 L11-14). Many of the young people felt it was their shared similar experiences which helped to unite them: *"the young people were great, like we all had - the great thing about residential is that the people you are living with we are all in the same boat, so we all know each one's - no one is different"* (YP - P18 P2 L10-12). The care workers also acknowledged how some residents could be a very positive influence on others. *"He noticed that another resident was having some difficulties, and he spoke to her in quite a mature manner and it was almost like he was a staff member that he was able to - he was able to voice it quite well. He was able to - he was quite [unclear 00:50:09] in how he approached the issue. He was kind, he was caring, he showed empathy and he could show understanding"* (CW - P7 P20 L25-30).

Other participants reported very different experiences of interacting with their peers and felt this stemmed from the backgrounds of some of the young people they were living with. *"You could have a kid that gets abused or something like that, and they might try that with another kid or something like that, and they don't know they're doing anything wrong, because that's what they know, that's what they've*

experienced" (YP - P16 P13 L47-51). This view was echoed by many of the care workers: *"the bullying factor...a young person's history and...difficulties and challenges that they've faced, that gives them a certain outlook and a certain approach to other kids. And...you put a highly intelligent young person who has been abused or used or I suppose, exploited all of their lives, they'll want to transfer that onto a vulnerable young person"* (CW - P8 P8 L34-41).

The young people who had negative experiences with peers became quite emotional talking about it: *"no I wouldn't say they were siblings at all to be honest. They are people who are living with you and you try to keep yourself distant from them but you don't get involved in their business... 'oh what's up?' - 'Fuck off.' That is what they say to you. 'Mind your own business, get the hell away,' that type of thing"* (YP - P11 P10 L30-36). One girl began to cry as she said how isolated she felt in care because the louder young people tended to receive the care workers attention. *"I just kind of bottled everything up. So, like everything that happens to one person has an affect on everyone else and I don't think the staff and their workers in the house actually realise that. They can go home within a few hours, they can go home to their own family but we have to put up with it. We have to put up with all the screaming and the shouting...whatever's going on we have to witness it"* (YP - P17 P4 L41-46).

9 - Staff (Joint Theme)

There can often be a disconnect between what the young people want for themselves and what the care workers feel they are trying to achieve for the young people, this can be a source of discontent. *"I think our expectations are always higher than what young people would strive for themselves. I think that it's good to set those expectations but sometimes maybe we can set them too high, that the young people will fail before they succeed because they know they can't succeed...I suppose young people often find that there's too much expected out of them and think they have to do too much to prove themselves or to get to the level that we would find acceptable"* (CW - P2 P3 L32-42). A couple of the care workers felt that the young people can end up viewing them as the enemy and felt the young people did not want to listen to them. *"I think they find that if we're here in the office that we're talking about them and it's all staff were in cahoots against young people"* (CW - P7 P21 L21-23). *"They're always going to go with what their families and friends say before us"* (CW- P7 P11 L41-42). Indeed, some of the young people did feel this way but they still showed a grudging acceptance of certain things the care workers said to them. *"I think it was the social interaction with my friends, the social interaction with my sports club and all that. It wasn't the staff but the staff would say right you can't do this and you can't do that in life and you take that on board. There is only some information that the staff give you that is useful but a lot of it is shite"* (YP - P11 P9 L23-27).

One of the prominent subthemes for young people who did not form meaningful relationships with the staff was trust. *"I think young people should be able to trust the people they are around every day...I wasn't given that chance. Because...I didn't feel like I trusted them because I didn't know anything about them, I didn't even know their surname. So why should I talk to you about everything that's going on in my life when I don't even know your surname?"* (YP - P17 P10 L29-36). The young people felt that more was required of them in the relationship with care workers, than the other way around. *"The staff don't like telling the lads where they live or telling them about their own history even though they know all my history, but the staff don't want us to know about theirs"* (YP - P18 P18 L46-49). The young people on many levels interpret how the care worker interacts with them and this is an area the care system could improve. *"Some people talk down to you because they don't understand that you know half the stuff that they know, so you feel this small and they are feeling this tall, and you don't understand what they are saying, or else they are speaking too technical"* (YP - P18 P5 L9-12). Ultimately, some young people felt they had been disrespected: *"they just need to feel comfortable and feel respected – it is all about respect. If you are going to give respect you are going to get respect"* (YP - P19 P11 L15-17).

The young people were very much in favour of diversity among the staff members. *"Well I've been in lots of...units and there's been African people and there's been a couple of gay people working with*

the young ones so I think that's great" (YP - P13 P20 L48-50). However, one young person commented on how he felt care workers could adopt a different persona in work to how they are in their personal lives. *"There was a staff member at one of the houses...and I met him on a night out, and he said to me 'please don't tell the lads that I'm gay' and I was kind of like thinking but what happens if a gay lad comes up to you and he wants to talk about sexuality and stuff, I found that very strange"* (YP - P13 P21 L3-8).

The young people and the care workers thought forming one close relationship (preferably with the young person's key worker) could have an incredibly positive impact for the young people in care. *"And we try to identify someone on the team who's into similar things and can strike up that relationship with them that at least they have one person so they can say okay I'll answer the phone to that one-person, ill talk to that one person when I leave"* (CW - P2 P6 L4-8). *"There was this one care worker, I've got a very close relationship with her, And I'm still in contact with her now. And I'd see her as quite a mother figure...I don't really have that relationship with my mother and it's nice that I can have that relationship with that one person that I can talk to if I need"* (YP - P12 P13 L30-38). Essentially this significant connection came down to communication. The way care workers frame their interactions with the young people can impact on the young person's self-esteem. *"Don't say 'yeah, do you want to go,' like, just say like, 'we have the money there if you want to go and get your hair or your nails done,' I'd be like, 'yeah, come on.'* Like one of

the females that go with them, they can make a day of it, like, and they feel special then, you feel, oh yeah, someone does actually care about me like, and want to do stuff with me" (YP - P20 P29 L9-14).

The main problem with many care teams according to a number of the young people was the gender breakdown of the staff members. *"One of the main flaws of the care system is that there's not enough male influence...most of the people in care are young boys...And it's not bad to have a female role model, but when all your role models are female...I think they should have both, just to have an equal understanding of life"* (YP - P12 P12-13 L45-16). The young people felt this way about social role modelling for a number of reasons; some believed men discipline differently, while others cited how it can be easier to talk to men/women about different things. *"A girl isn't going to say 'something around my privates' to a fella, they would get embarrassed, and vice-versa. It's understandable, obviously. I think just having a male presence in their life...It's always good to have balance"* (YP - P16 P7 L14-19). *"Half the kids in care generally don't have a father figure in their life so therefore they end up being bad because they haven't got that male discipline. That is why a lot of people are out doing drugs because the male discipline is just not there"* (YP - P11 P14 L35-38).

A word many of the young people repeated when speaking about care workers was 'human,' to behave as 'humanly' as possible with the young people (this is what distinguished the more relatable care

workers). They felt some care workers could behave in an overly 'textbook' manner and said that young people really just want the care workers attention. *"If it was a man I wouldn't touch him, you know in his area, I wouldn't touch a woman in her area, but it would be more like...hugging people without asking their permission...To them it was seen as wrong, not that 'he just needs extra attention' or that 'he needs to be, needs to feel loved or wanted'. But they were thinking about it like 'he's touching me inappropriately'...They could have said to me, 'you can't do that' instead of saying 'ok you need to go and spend a couple of hours by yourself now' and you know what I mean, I felt punished more than told 'this is not ok'"* (YP - P13 P6-7 L37-34).

10 - Wider Connected Processes (Joint Theme)

Many of the care workers stated that one of their most important goals was to try and help the young people to receive a good education. They felt that the educational resources were often unobtainable though. *"85 or not higher per cent of the children in residential care services, are children who present challenging behaviour and the general school system is not capable of managing them"* (CW - P8 P6 L15-17). *"An awful lot of schools in the locality will not touch us with a barge pole. They'll not go near us especially if they know kids are in residential care...I feel that, our young people here are victims of...prejudice and stuff like that by schools and people out there"* (CW - P9 P10-11 L48-37). Interestingly, some of the young people did report great experiences in school and said that

their teachers had really helped them. *"It was great. I was put into a class that was too advanced for me, because I'm dyslexic. So, it was that little bit harder for me. So, I was put downstairs to a teacher that knew how to deal with kids who had dyslexia...I always had one to one, when I was in school"* (YP - P15 P3 L28-35).

When it came to systemic issues outside of the home, there were many other factions apart from the education system for the young people to navigate. *"The guards [police] are a red flag to them...usually they're at battle with them or get used to being charged or followed by the guards or in trouble, and having negative experiences of that"* (CW - P3 P5 L33-36). *"You throw in the social workers, social acting leader, guardian...the juvenile liaison officer, all these different people and generally, they don't have a clue who is what and what they're about"* (CW - P7 P6 L48-50).

The role of the social worker was viewed by both the care workers and the young people as being instrumental in how successfully the young person copes in the care environment. *"The social worker was saying, 'well you see, this is not a HSE house.' And he's 12. It's...abusive to sit down and say, 'so don't make...yourself at home now, I want you to make this your room and paint it and whatever and then in two months time, you need to come and live here now because this bed is free and it's cheaper.' And that's what's happening. And the child does not understand nor will they ever understand"* (CW - P8 P22 L34-40). The young people also had strong

opinions on how professionals such as social workers communicate with the young people in care. *"I went through eight or nine different social workers...like fuck this, I am not dealing with this crap anymore. I had to tell her what's going on in my case because they haven't read up properly or you give one question to another one, but she leaves...I always find professionals like social workers and...psychiatrists that work with kids, they are always dressed like...suits and stuff like that, you are...talking to young kids...with a suit and a tie and suit pants and you are sitting there like you are God's gift like with the legs crossed, arms folded, 'oh yes and how are you feeling today?' It's too professional for the young people"* (YP - P18 P21-22 L34-37).

There was one particular issue that many of the young people wanted to speak about. They felt there were unreasonable parameters placed upon them (because they were in care), which other young people in the community would never even have to consider. *"Used to drive me mad. If you wanted to stay over in [a friend's] house, their parents would have to get clearance. That's the most embarrassing thing in my whole life. There was one friend that I had and her mum went and got it done. I was like 'you don't have to get this done, I'm not forcing you to get this done.' She was like 'no, no, no, if they want proof that I'm not a criminal, I'll go and do it'"* (YP - P15 P7 L4-9).

11 - Familial Ties (Joint Theme)

Some of the care workers recognised that at times familial contact was not in the young people's best interests and spoke about the importance of child protection within their role. *"These kids are in here because they've been neglected and abused a lot of the time, so there's a lot of the time that they are not really, its not really that great of an idea to have them have too much access...need to think of child protection"* (CW - P1 P3 L36-43). However, the young people said that many of the care workers are extremely supportive in helping to facilitate positive family contact. *"If I wasn't in care, I wouldn't have met my father...Because I was, one day I was just like, no, I'm going to go out, find him. I made it my mission. And the staff were very supportive"* (YP - P12 P8 L29-34).

One young person got particularly angry on the topic of young people going into residential care in the first place and felt this was punitive for the young people. *"Well to be honest a young person shouldn't be brought into care full stop. I think that a programme should be set up for the parents. A parent improvement scheme, instead of taking it out on the child. So, if the parent does drugs, get a court order into rehab, if the father is an alcoholic get the court to put [him] into rehab"* (YP - P11 P18 L1-5). A number of care workers spoke about how they try to incorporate systemic familial work into their role where possible and this has produced positive results in the past. *"We have met with mums and done some TCI [therapeutic crisis management] training, shown her how to handle conflict when things*

kick off, she was so open to being helped, you know" (CW - P4 P5 L28-30).

Who is responsible for a young person being housed in residential care was a contentious issue; some of the young people believed it was the parents' responsibility and others disagreed. *"A lot of the time...it's the HSE fault. It doesn't matter if mam's an alcoholic and she can't look after me and I've had [unclear 00:06:56] or, I've been abandoned or this or that. It's always HSE"* (CW - P9 P4 L8-13). *"A lot of times the young people are very resentful of their parents for allowing them to be taken away, or for being the cause of them being taken away"* (CW - P3 P17 L20-22). When a young person holds their parents responsible, this is something that can impact them many years after leaving residential care. *"The relationship with my mother, it isn't really there...Because I feel anyway, even though I know I shouldn't, I still hold a grudge against her, for making me go into care"* (YP - P12 P11 L35-41).

The care workers did not speak about wider family beyond the young people's parents, but the young people felt this was an area that is badly neglected. In regard to siblings and their relationships: *"me and my sister, we were together, but my brothers are twins and they got split up. I think that's the craziest thing, splitting up twins. I'm glad we were kept together"* (YP - P16 P3 L9-12). Wider family were also spoken about: *"there is huge stuff done with the mother, they try and get the mother to get back in contact with her kids but it's always*

forgotten about like our aunties and our uncles, our grannies or grandparents and the extended family is always forgotten about" (YP - P18 P3 L12-15).

The issue of familial contact and how this impacts on the young people's psychological wellbeing was addressed from a range of different standpoints. For example, one peer having family around could be demoralising for another young person in the care establishment. *"I think it is lovely to come and show the family where you live...but it can be hard then when they are sitting there all having dinner and laughing and you have another resident...sitting thinking...my mother doesn't want me"* (CW - P4 P17 L34-37).

Generally, though the young people thought care staff are very responsive to the issue of familial contact and do try to make family contact as positive an experience as possible for the young people. At the same time, they can show ingenuity when required: *"one of the greatest things I always found that if your family...if they ever let you down [the staff] were always great at creating something on the spot that we can do instead...like going to the cinema or taking something to eat or something like that. They always tried to take our minds off...it...I thought it was brilliant"* (YP - P18 P19 L23-28). One young person suggested being as transparent as possible about the process when the care workers are speaking to the young people. *"Like say sometimes my visits weren't able to happen because my Ma was pissed, tell me that, instead of saying 'oh she wasn't able to make it'*

because it looks bad - obviously it's bad on my Mum but it looks bad on them as well because they are kind of bullshitting for my Mum - I just think be honest more" (YP - P18 P23 L1-6).

12 - Fitting in (Joint Theme)

Ideologically 'fitting in' within the care system can be culturally very difficult for the young people and the care workers. *"I think the care system is very middle class and...no matter how much we try and [7.55 unclear] children in terms of education and getting a job and achieving holidays and cars, that's not the world they come from, you know a lot of the kids may not know any significant adult with a job or has ever had a job because that is just not where they come from so they look at us like we have two heads"* (CW - P6 P3 L44-49).

Some young people spoke about the anger they were feeling when they first moved into residential care and how this made it difficult for them to adapt. *"I mainly just played my PlayStation. When I moved to [5:18 unclear] I became very angry because I had been moved away from my friends and family so I took it out on the staff and the people who tried to become my friends who are now my enemy's and yeah, I was very angry"* (YP - P11 P3 L18-22). Once in the residential care system many young people can be subjected to placement moves and breakdowns. A couple of the young people spoke about how young people needed 'stability' so they knew where they 'fitted in' in life. *"You can kind of understand why they go off the rails for a while as well, because there is no one showing them the sensibility,*

the sense of belonging, because they are moving them left right and centre and they can't settle in one place because they know - like one lad that I used to live with...used to leave his bags packed and leave them under his bed because he thought he was going to get moved left right and centre" (YP - P18 P11 L25-31).

When it came to the young people 'fitting in,' one of the most significant considerations was how many friends the young people could make in the community. *"I'm a firm believer that if a child has friends, the child is happy because that's all you really want when you're a teenager, is friends. The ones who have friends or have a school placement where they have a network of kids who are around every day and they have that consistent network of other kid peers that they can trust...kids talk to each other then"* (CW - P8 P6 L39-46). The young people spoke about how they felt they had to be different people in the care establishment compared to the outside world in order to 'fit in.' *"You act different when you're with your friends...It was subconsciously. Especially when I went into secondary school, I kind of became...Very outspoken. If I had something to say, I'd say it, I wouldn't worry about someone if they liked it or not. It got me into trouble, but I was never dissing anyone around, I was always making fun of myself or something. That was just my way of fitting in. It definitely helped, because I was one of the most popular people, with many friends"* (YP - P16 P5 L3-11).

Unfortunately for some of the young people, the wider community was difficult for them to transition into and they felt stigmatised. *"They found out that I was in care, and they started calling me an orphan, all this crap, because...I think they kind of felt like oh they should pick on the one who has least"* (YP - P17 P15 L23-28). *"I got bullied every day at school. But I was a strong person so I was very able to just zone out and just let them say whatever they wanted to"* (YP - P13 P10 L20-22).

The care workers and the young people had mixed opinions on whether being in the residential care system affected their ability to adapt to daily life. *"I have...worked with a kid who...did not want his friends to know that we were care workers picking him up, we were an aunt or we were a sister, so obviously he felt different but I worked with other kids who would meet a friend in the street and say this is my carer"* (CW - P4 P6 L33-37).

13 - Psychological Wellbeing (Joint Theme)

"Like when I got stressed out, or angry or anything, I wouldn't eat, I'd either smoke weed or I'd self harm, or I'd overdose, or, like, my appetite is brutal like, even to this day, it's still brutal like" (YP - P20 P27 L5-8). The young people highlighted a range of issues that impacted on them while they were living in residential care. The care workers were equally gregarious in noting how quickly the young people's mood can change in residential care. *"Healthy relationships, self-esteem, body issues...And they change quite quickly so, today*

could be that the young person feels that they're overweight and tomorrow they don't like their hair and then the next day, they don't like their skin. So you're managing it all the time" (CW - P7 P10 L41-47). Two of the care workers mentioned how positive reinforcement had a profound affect on the young people and their sense of wellbeing. *"A lot of them haven't had praise, they haven't had recognition...that's something very different for them. I think its good for them to experience a lot of rewards because they probably would have had a lot of things sanctioned even when they were not possibly doing anything wrong in the first place"* (CW - P1 P16 L6-12).

One of the care workers became very emotional as she said that sometimes no matter how much effort they put into helping the young people, sometimes residential care could not meet the young people's needs. *"We have gone into court and said to the judge like look we really need you to make the decision here because we really feel this child is so at risk from others and from society and from himself and they have all of these crimes behind them and actually prison might be the safest place for them, and we have had to do that in the past"* (CW - P6 P15 L24-29). The care workers spoke about having a range of services available to help the vulnerable young people, but the difficulty in encouraging the young people to avail of the services. *"Get them settled and get them back to some type of baseline before you can get in there with therapeutic stuff because if you try and do the therapeutic stuff with the behaviour they completely spiral and they just cannot contain themselves at all...they*

often end up criminalised so I think it is better to focus on their behaviour first" (CW - P6 P9 L19-28).

The young people were divided on whether mental health and counselling services were helpful for young people in residential care. *"They tried to send me to anger management sometimes but it didn't work because I just let them know what they wanted to hear I didn't actually tell them the truth per se"* (YP - P11 P11 L24-26). Perhaps services like counselling need to be conveyed to the young people in a more relaxed manner. A participant who spoke highly of counselling commented: *"I think you need to explain to young people that you are not going because you are in care, you need to go because everybody goes to counselling. Make them watch a few American movies, they go for fucking shite over there...it is something that everybody needs, it is not just because you have been through a lot and yes that would come out in counselling...A young person...would go, 'no, no, no' – [but] everybody needs counselling. It is a normal thing"* (YP - P19 P15 L11-19).

When it comes to the psychological wellbeing of young people, experiences such as: holidays, activities and having fun; can create long lasting memories. Both care workers and young people became visibly happy when speaking about some of their shared experiences (even young people who had a negative response to residential care could still pick out such positive memories). *"We brought a kid to a concert last Sunday and he had an absolute ball and I had never seen*

him so happy and we got into the car and he just said, [42.53 unclear] thanks so much for bringing me I will never forget that for the rest of my life and that was his first concert he had ever been to" (CW - P4 P16 L13-17). *"I loved Christmas. Our house was all about traditions and Christmas started on the first of December, it was great...we sang songs and then after that everybody would be there so you would have past staff, past residents, the residents now and the staff now and even the residents families would be there and your friends could come as well and so it was like a giant house party and it was just filled with laughter"* (YP - P19 P12 L15-26).

Lastly, in terms of psychological wellbeing many of the young people reflected on how their peers or themselves had 'turned out' after leaving residential care. *"Don't go down the wrong route...there was three brothers. And two of them went down the wrong road and the third one died. I don't know what he had taken. And his brother found him the next morning...And then, the other two, one is locked up in England, the other, I don't know, still floating about somewhere. So, every time I see him, he just gets a slap on the ear. 'Like are you behaving yourself now?'"* (YP - P15 P12-13 L48-08). *"I'm glad that I grew up in care, Jesus, I'd probably be dead now. I know it's a horrible thing to say, but if I stayed with my parents, I'd probably be just like them. So, I'll always be grateful"* (YP - P16 P4 L37-40).

14 - Leaving Care (Joint Theme)

Both groups talked at length about the process of leaving residential care and what it was like for the young people. The care workers were very negative about the aftercare process; the young people reported largely mixed experiences. Firstly, the care workers, they were scathing of the aftercare system and said it essentially set many of the young people up to fail. *"The transition from being a teenager to being an adult is very stressful and they leave at eighteen with very little support and it's not like when you're part of a family and you leave the family home, you know that that place is there for you when you return, this is a major cut off so it's very different, it's very different support, very significant time for the young people so I don't think they feel particularly supported during that transition into adulthood"* (CW - P3 P3 L32-39). Most felt the quality of aftercare services was arbitrarily distributed and decided upon simply by: *"how good their social worker is"* (CW - P10 P15 L17).

The care workers approached the issue of young people leaving care from a largely systemic standpoint and spoke about changes they would like to see implemented. For example: *"I think what they should start doing is not waiting until the kids are 18. If legally they are going to be kids up to the age of 18, several of them go into aftercare when they are 16. Let them mess it up, let them have the 2 years to mess it up as much as they possibly can, and they're still in that realm where they are still not 18. So that they still have a chance. Whereas when they mess it up when they're 18 the attitude*

can be a bit like, wipe our hands, these are, like they are adults now, so I think it should start at 16" (CW - P1 P10-11 L46-02). One care worker had an interesting observation that could easily be adopted in other residential establishments (i.e. having past residents come in and speak with the current residents about what happens when a young person leaves residential care). *"Some of the young people I think have watched other young people turn 18 and have to leave, they have seen that struggle, they seem to understand a lot better than the kids who have never seen someone transition out"* (CW - P6 P12 L34-37).

The young people spoke about their personal experiences. When it came to preparation for leaving they mentioned doing things like shopping with the staff, but felt that the life skills emphasis could be improved. *"I can cook for everybody, I can wash some clothes, I can change fuses and light bulbs and sockets, I can change light bulbs but I didn't know how to pay a bill – that is essential. Go away with your light bulbs"* (YP - P19 P7-8 L49-02). Another young person felt that continuity between residential care staff and aftercare staff would greatly help young people to adjust. *"[Residential care workers] are not allowed to keep in contact after they move out. Like some staff will, and some staff won't...like you are building up these great attachments and your trust in this person so much and then it's like goodbye, farewell when you are eighteen and you are on your own devices"* (YP - P18 P17 L19-35).

When the time came to leave residential care, the reaction for most of the young people was fear. *"I think once that door closed, I was like 'oh, shit, this is real.' I've always loved my space, I need my space, but it's that thing when the space turns into isolation, cutting yourself off from anybody"* (YP - P16 P12 L10-12). Unfortunately, the reality that faces these young people can often lead to negative consequences. *"I just felt scared and didn't want to say anything...And gone into the flat, like basically isolated myself away from everyone...And then I overdosed as well, when I was living in the flat, as well. So, yeah, everything just went downhill completely when I moved out"* (YP - P20 P18-19 L46-03).

In contrast, other participants enjoyed being exposed to aftercare: *"I could go out drinking with my friends again and I could go out drinking in nightclubs and stuff like that but when you are in the care setting and you can't do anything"* (YP - P11 P12 L21-24). Indeed, they felt that aftercare was a very positive experience and beneficial for them. *"Just being in the aftercare helped me. But if I went straight from care straight out to live on my own I would have found it difficult. But some people can manage like that, you know. But just for me, that was the road I needed to go down and it worked"* (YP - P13 P13 L04-07).

Discussion

Assimilating the current study's findings

The current research sought to add to the findings from chapter two and to explore the views of young people who have been through residential care. The findings in chapter two yielded twelve themes across fifteen studies; this is similar to the current Irish study that produced fourteen themes (eleven of which were exclusively related to the young people). In both cases the same types of issues arose: familial relationships, peer relationships, young people's relationships with staff, systemic considerations and stigmatisation. The current study added to the findings from chapter two by highlighting other themes, such as the psychological imprint being 'in care' can have on a young person and looked at how some young people assessed residential care in relation to foster care.

When it came to exploring the views of care workers to see what they think is required (to help the young people they care for), the views of the care workers yielded three themes that were unique to them. These were: what makes a care worker, organisational support and the care team (briefly touched upon by a couple of the young people). Their views were similar to that of the young people on a range of themes and they were passionate in wanting to help the young people and calling for greater resources being invested in residential care.

In general, the viewpoints between the young people's views and the care workers' views were largely similar in both the questionnaire

analysis (only items Q3, Q32 and Q40 showed a large degree of fluctuation) and the qualitative interpretation of the themes (yielding nine combined group themes and just five individual group ones). However, the young people were a lot more extreme in their evaluation of residential care, in comparison the care workers demonstrated a much higher level of homogeneity. This could be down to the care workers addressing the topic in a generalised manner, while the young people focused on personal experiences. Another difference was the care workers wanted to discuss: policy issues, systemic issues and relational issues in equal measure. The young people in comparison primarily wanted to talk about the quality of personal relationships; it was an irritation to them that policy and systemic issues affect young people in residential care as much as they do.

The current study's findings in relation to prior research

As raised by Osborn and Delfabbro (2006), the current research also brought up the issue of placement breakdown and both the care workers and the young people were aware of young people who had gone through a number of placements and care settings (foster care / residential care / institutional care). They noted how different settings had been beneficial to different young people. In the main, the young people and the care workers were positive about the experiences young people have in residential care (in keeping with the research by: Lipsey, 2009; Loughran et al., 2009; De Swart et al. 2012). However, it should be noted that the care workers in particular did

not hold a good view of aftercare services (as per the *Leaving Care* theme, page 118). It is possible that the young people's views were both positive and negative on this topic because they only assessed aftercare on what they experienced (they knew no different). The care workers had actively seen how many of the young people they had cared for, fared upon leaving residential care.

Another topic that was very important to care workers and young people alike, was the need to work with young people's families. This can involve systemic work between the parents and the young people and this support is especially important when the young person is transitioning to aftercare services (lending credence to Frensch & Camerson's [2002] study and Grundle's [2002] study on wraparound care). Interestingly the young people in the study also argued about how siblings and wider family are often neglected when it comes to familial contact and systemic work (this was not considered by the care workers).

Van Gageldonk and Bartels (1990) study about successful residential care outcomes providing a very structured living environment and a care intervention aimed at increasing social skills were also supported by the current research. De Swart et al. (2012) maintains that increasing social skills does not improve treatment outcome for the young people, but a few care workers in the current study stated it was the most important attribute to foster in dysfunctional young people and they saw it as a cornerstone of their role. The young

people in the study may not have spoken about social skills to a great degree but did acknowledge that some young people may find it difficult to interact with their peers in places such as school because they felt they came from such a different background.

An interesting area in the international research that the current research touched upon was whether other residents' negative behaviour in the residential establishment increased problematic behaviour in others (Dishion, Poulin & Burraston, 2001); or if prosocial role modelling occurs (Lee, Chmelka & Thompson, 2010). The young people in the current study were of the opinion that negative behaviour by other residents did not cause them to externalise negative behaviours more. It did however cause them to internalise behaviours more and to become more withdrawn and to try to avoid conflict incidents as much as possible. The care workers were also vocal in describing how other residents can be a positive or negative influence for young people in care. Interestingly, the young people in the study who reported engaging well with their peers were usually more positive about the residential care system.

A number of residential care studies (for example, Weisz, Jensen-Doss and Hawley, 2006) cite the importance of evidence-based treatment and Cognitive Behavioural Therapy (CBT). The young people in the current research said that psychology services were available to them but they did not avail of it at the time, as they did not feel ready to discuss their emotions then. A number of the

participants said that they had sought psychological help in later years though and that they had found it very helpful. The care workers also spoke about the utility of therapeutic services and voiced how they felt clinical support and supervision helped them to work with the young people in a more therapeutic manner.

The current research endorsed the research literature on care workers and the role they play in successful treatment outcome for young people (see Duncan et al., 2009; Van der Helm, Boekee, Stams & Van der Laan, 2011). Both the care workers and the young people drew distinctions between the care worker who was there to 'help' and the care worker who was there for the 'paycheque.' A number of the young people even spoke about wishing to become care workers themselves when they were older and one participant was actually in the process of training to become a care worker.

The make up of the care team and the pro social role modelling aspect was touched on in an interesting way in the study. The care workers noted that based on what age they were, they would get asked different topics by the young people (for example young staff members would be asked about boyfriends/girlfriends). The care workers did not comment on the gender make up of their teams but this was a real issue for the males in the young people group. They spoke about not having positive male role models on the care staff teams, as the teams were almost exclusively female in the residential establishments they resided in. The young male participants said it

was important to have male care workers from a discipline standpoint and to have someone they would feel more comfortable talking to about certain personal matters, for example sexuality.

As noted by Kiraly's (2001) study appropriate staff training and supervision are imperative when it comes to allowing care workers to best address the young people's needs. A number of care workers in the current study spoke about harrowing experiences they had endured doing the role (with talk of assaults featuring prominently). What was most noteworthy was that it did not tend to be the instances themselves that bothered the care workers to a large degree, but rather what they felt was the non-response to incidents they received from the organisation's senior management. The support of the staff team was a really strong motivator in the care workers choosing to devote so much of their lives to this highly demanding job. The young people also acknowledged that the residential establishment was a calmer environment when the staff team communicated effectively.

Gallagher and Green (2012) and Bostock et al. (2009) discovered a focus on young people in care developing relationships with staff but these relationships not being maintained once the young people leave the care establishment. This same phenomenon was also noted in the current study. Furthermore, the young people who had some of the residential care staff transition with them to the aftercare service, all stated how much that had helped them at the time. The care workers

also seemed to be in favour of maintaining contact with residents who leave but said this was very much a personal endeavour and procedurally and organisationally there were no provisions in place to support this. The current research would suggest that this is a practice that should be encouraged.

Finally, Little and Kelly's (1995) study observed that young people in care are influenced by a variety of stakeholders and not just care workers. This was very much the case in the current research and it was a topic that the care workers spoke about at some length. Even on an anecdotal level from speaking to the young people and the care workers there appeared to be a clear correlation between how good a young person's relationship was with their social worker and the level of aftercare services they were afforded.

Methodological Limitations

There are a number of methodological areas that future research could improve upon, compared to the approach adopted in the current study. The convenience sample in the study could have lead to inherent bias and residential care phenomena could have been seen in an unrealistically positive light. The young people who agreed to take part in the research might have had a more positive view of residential care than the young people who refused to take part or were unable to do so due to other circumstances (for example due to incarceration).

Another issue that could be improved would be the ambiguous wording on certain questionnaire items and whether reverse scoring applied (for example questions 34 and 35). While no difficulties were noted with these items during the interview process, they could have been difficult to understand for the young people in particular.

In keeping with qualitative reporting guidelines an independent person should have been involved to use the researcher's codebook to code some sections of the transcripts. Best practice would incorporate a percentage agreement being determined at the outset within this process. This did not take place in the current study and it means the current research was more prone to researcher bias when the analysis of themes was being conducted.

Finally, due to logistical reasons the interviews took place in a number of different residential establishments across the country, which meant the environment was not standardised. One of the care worker interviews had to be terminated and completed at a later date due to an incident in the residential establishment at the time; this was not ideal but it is symptomatic of the kinds of challenges researchers face when conducting this type of research.

Suggestions for future research

The current research highlighted a number of important issues that could legitimately constitute valuable areas of research within residential care in the future. The researcher would suggest the

following three areas as being pertinent to advancing research knowledge in this area. 1) To investigate if an adverse familial background is a key characteristic of young people who fail to transition successfully from residential care to independent living 2) To look at the role of attachment and how more successfully attached young people may then be able to cope better when required to live independently 3) To pinpoint if any further revelations can be offered as to appropriate preparation work and aftercare transitions for young people in care.

Conclusion

The current research was attempting to focus on young people in care in an Irish context, as oppose to the international context highlighted in chapter two. It was concerned with the views of young people in care in comparison to the views of care workers. The findings showed there was a large convergence of opinion between the groups towards a mainly positive residential care experience for the young people involved. However, there appeared to be some disillusionment in both groups when it came to: aftercare, independent living and the long-term outlook for young people leaving residential care in Ireland. What emerged is a much larger systemic issue encompassing: the HSE, communities, teachers, social workers and a desperate need for cross sectional cooperation, if the lives of these young people are to be improved in the long-term.

The current research provides a framework from which to build on in a research sense but ultimately also one would hope in a policy sense. As one care worker noted, the landscape facing young people in residential care in Ireland is currently an uncertain one, even if intentions to help them are positive. *"Initially, it's about building a relationship with them to try and assess what they need. And, you're trying to create a home for them. You're trying to make them comfortable. You're trying to build up relationships. And then, obviously as things progress, you're trying to initially work on whatever issues they have. When they're leaving us, it's a total different ball game"* (CW – P9 P17 L24-29).

Rationale for chapter four

This chapter highlighted so many areas that may fundamentally impact on the psychological wellbeing of a young person in residential care. Some of these included: stigmatisation from society, difficult familial backgrounds, substance misuse issues and problematic dynamics between young people in residential establishments (for example bullying).

One of the psychometric tools psychologists often administer to young people in residential care is the TSCC-A. Wolpaw, Ford, Newman, Davis and Briere (2005) note that the TSCC has been used extensively with children/adolescents in residential and psychiatric settings to assess trauma symptomatology. When it comes to the evidence synthesis (chapter two) and the empirical research (chapter

three), many of the young people in residential care would display trauma symptomatology, and the TSCC was one of the psychometric instruments frequently used by clinicians within the Fresh Start organisation (the results of which were considered when planning the interview questionnaires based on previous clinical reports). This makes the TSCC-A extremely relevant to the current research and it was also used with an adolescent in secure psychiatric care in the case study (chapter five).

CHAPTER FOUR

A critique of the Trauma Symptom Checklist for Children - Alternate (TSCC-A)

Development of the TSCC

This psychometric critique is concerned with The Trauma Symptom Checklist for Children - Alternate (TSCC-A). The TSCC-A developed as a shortened version of The Trauma Symptom Checklist for Children (TSCC). Briere created the TSCC assessment in 1996 as a measure for evaluating trauma in children and adolescents. The measure examines posttraumatic symptomology with children/adolescents between the ages of 8 and 16 years (normative adjustments are available for 17-year-olds). Apart from posttraumatic stress, the measure also illustrates other symptom clusters that may be found in traumatised children/adolescents.

The literature at the time the TSCC was developed had identified a number of areas that may have been related to traumatising in children/adolescents. These included: parental sexual and physical abuse (Lanktree, Briere & Zaidi, 1991; Kiser, Heston, Millsap & Pruitt, 1991; Browne & Finkelhor, 1986), sibling and non-parental sexual and physical abuse (Singer, Anglin, Song & Lunghofer, 1995; Boney-McCoy & Finkelhor, 1995), exposure to intimate partner violence (Kashani, Daniel, Dandoy & Holcomb, 1992) and other traumatic family episodes such as parental divorce or a family member being hospitalised (Evans, Briere, Boggiano & Barrett, 1994). It should be

noted that non-familial factors have also been identified in perpetuating child traumatising, for example: war (Sack, Aangel, Kinzie & Rath, 1986; Baker, 1990) and natural disasters (Green et al., 1991).

A lot of research was being conducted on the prevalence of child abuse and this demonstrated significant levels of child victimisation. Approximately 25-30% of females and 10-15% of males in the United States had been sexually abused prior to adulthood (Finkelhor, Hotaling, Lewis & Smith, 1989; Wyatt, 1985). When it came to physical maltreatment the numbers were equally as problematic (10-20% of males and females were maimed to the point of bruising or bleeding) (Graziano & Namaste, 1990; Briere, 1992).

Researchers were interested in the way abuse impacted on trauma and the types of trauma that subsequently manifested. Research highlighted a number of characteristics in abused children: reduced self-esteem (Turner, Finkelhor & Ormrod, 2010), behavioural and school and related problems (Gomes-Schwartz, Horowitz & Cardarelli, 1990), dissociation and posttraumatic stress (Singer et al., 1995; Teicher et al., 2003), depression and anxiety (Martinez & Richters, 1993; Lanktree, Briere & Zaidi, 1991), substance misuse (Hussey, Chang & Kotch, 2006), increased aggression and anger (Shakoor & Chalmers, 1991) and earlier onset and/or engagement in inappropriate sexualised behaviours (Gale, Thompson, Moran & Sack, 1988).

When Briere was developing the TSCC the main motivation behind the design was to: “address the relative dearth of general trauma instruments for children” (Briere, 1996, p.3). As oppose to other more narrowly focused instruments, the TSCC assesses the child’s responses to unspecified traumatic events within a range of different symptom domains. Furthermore, the TSCC was standardised and is representative of a large sample of economically and racially diverse children/adolescents and it provides relative norms in relation to sex and age (Briere, 1996).

Characteristics of the TSCC

In order to administer the TSCC an item booklet is needed and the relevant profile form (there are four options: Male Age 8-12 years, Female Age 8-12 years, Male Age 13-16 years and Female Age 13-16 years). Briere and Lanktree (1995) found in the validation studies that the TSCC is suitable to use with adolescents aged 17 years, by comparing them to the age 13-16 years adolescent norms, with a 2-point adjustment for females on the Anger scale. The professional manual is then used to score the booklet; a computer-scoring programme is available but the measure can also be scored by hand. There are 54 self-report items written to be accessible for children aged 8 and older. The measure has two validity scales and six clinical scales (please see table 7 next page for a fuller explanation of these).

Table 7. Brief Description of Validity and Clinical Scales
Taken from the TSCC Professional Manual as per Briere (1996, p.2).

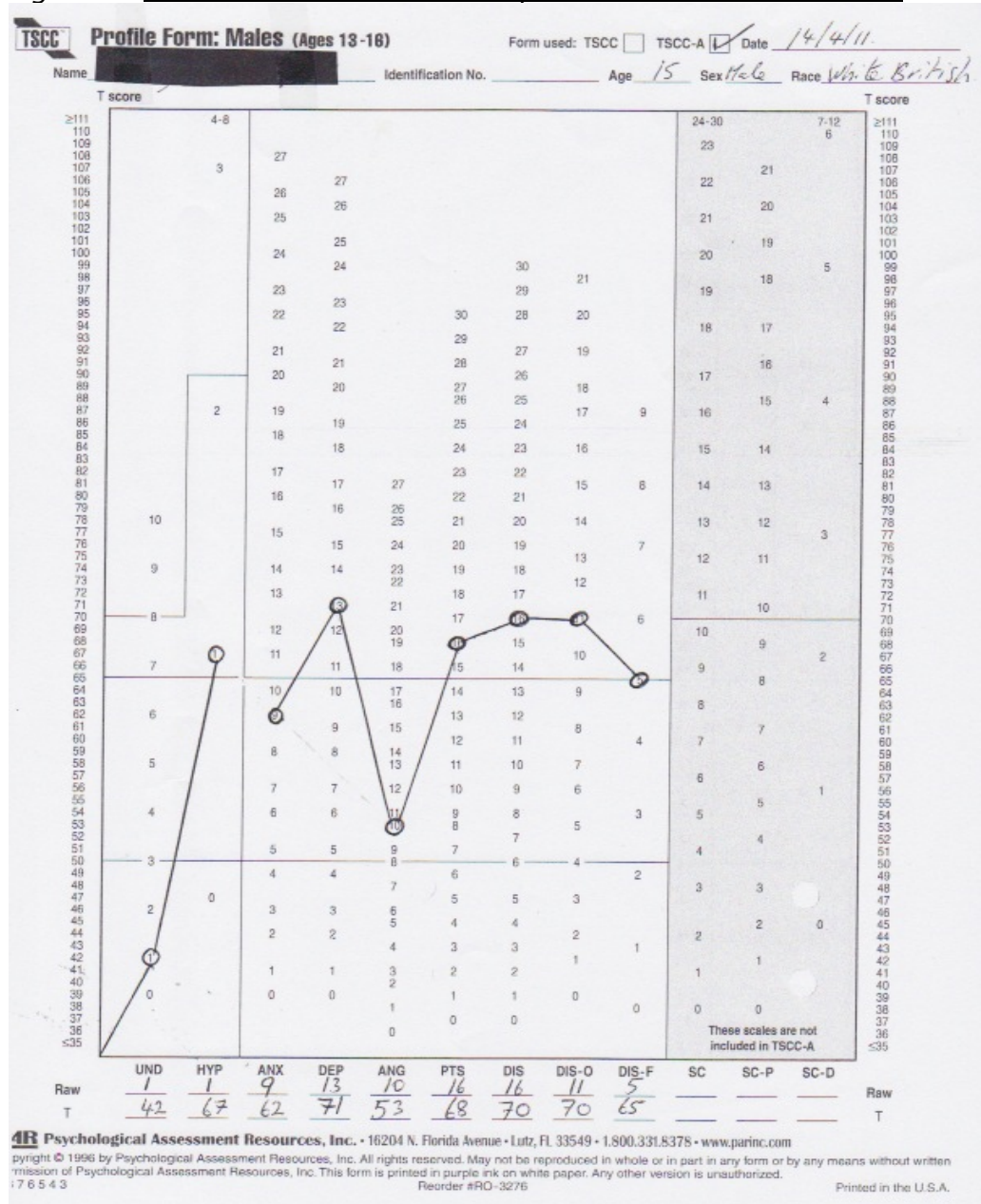
<u>Validity</u> Underresponse (UND)	Is correlated with: denial, underreporting of symptoms or a tendency to present as symptom free.
Hyperresponse (HYP)	Is correlated with the over reporting of symptoms, wanting to appear highly symptomatic or especially effected by traumatic stress.
<u>Clinical</u> Anxiety (ANX)	Encompasses: generalised anxiety; episodic anxiety; hyperarousal/worry; specific fears and expecting the worst to happen.
Depression (DEP)	Feeling: unhappy, sad, and/or lonely for a prolonged period of time; having depressing thoughts of guilt and self-denigration; contemplating self-harm and experiencing suicidal ideation.
Anger (ANG)	Aggressive: thoughts, feelings, and behaviours, characterised by the dehumanisation of others. This can include being quick to anger and engaging in an escalation of aggressive traits such as verbal to physical aggression.
Posttraumatic Stress (PTS)	Posttraumatic stress symptomatology includes: intrusive thoughts, fear, re-

	experiencing troubling memories from past events. This can be in the form of nightmares and is generally characterised by feelings of pain and hurt.
Dissociation (DIS)	Dissociation involves: derealisation; emotional numbing; pretending to be elsewhere; retreating to daydreaming and blanking memories. It has two subscales on the TSCC: DIS-O (Overt Dissociation) and DIS-F (Fantasy).
Sexual Concerns (SC)	Characterised by sexual thoughts or feelings that occur earlier than expected or with greater than frequency than normal; negative or scared responses to sexual stimuli; and fear of being sexually exploited. It has two subscales on the TSCC: SC-P (Sexual Preoccupation) and SC-D (Sexual Distress).

The child is given a list of items: feelings, thoughts and behaviours. Every symptom item is rated based on how frequently the child/adolescent believes it occurs. The four-point scale ranges from 0 ('never') to 3 ('almost all of the time'). Individual items on TSCC include: 'Bad dreams or nightmares,' 'Feeling lonely,' 'Crying,' and 'Feeling like I did something wrong.' There are also eight *critical* items (seven for the TSCC-A), for example: 'Wanting to hurt other people.'

Critical items examine areas like: self-harm, fear of others and aggression and they may be indicative of immediate clinical attention needing to be targeted in these areas. Briere (1996) recommends a completion time of between 10-20 minutes, with a scoring time of 5-10 minutes. Briere (1996) does acknowledge that it may take significantly longer than this for traumatised children and/or clinically impaired children to complete the psychometric test. The 40-page professional manual has information about: administration, scoring and interpretation and it also contains the relevant raw-scores to *T* scores conversion tables to use with each of the profile forms. The profile forms also allow a graph profile to be developed for each respondent, giving a visual representation of where the individual is compared to a normative population (please see figure 4 next page for an example of what a completed profile form might look like) (the profile form shown is the pre-intervention form for the young person in the case study, chapter 5).

Figure 4. D4's Pre-Intervention Completed T-Score Profile Form



To aid professionals working with traumatised children and/or clinically impaired children, Briere developed a shortened alternate version of the TSCC called the TSCC-A. The World Health Organisation (2017) define clinical impairment as: “any loss or abnormality of psychological, physiologic, or anatomic structure or function.” The TSCC-A 44-item version does not contain the sexual concerns items and is intended for use when sexual issues are not a concern and to

delve into these issues unnecessarily may cause the child extra undue stress and anxiety (as was the case with the current case study's young person whose profile form is shown in figure 4; his TSCC-A results are considered in detail in the next chapter). The psychometric statistical properties for the TSCC-A are the same as the TSCC, apart from the omission of the Sexual Concerns scales.

When it comes to administering the TSCC, no formal qualifications in clinical psychology or related fields are required. However, in keeping with the *Standards for Educational and Psychological Testing* (American Psychological Association, 1985), the interpretation of TSCC scores and profiles require formalised graduate training in psychology/psychiatry or a closely related discipline.

The TSCC has been used in a multitude of different studies as a measure of trauma symptoms (Bal, Van Oost, De Bourdeaudhuij & Crombez, 2003; Brady & Caraway, 2002; Shaw, Lewis, Loeb, Rosado & Rodrigues, 2000; Shaw, Lewis, Loeb, Rosado & Rodrigues, 2001; Cohen, Mannarino & Knudsen, 2005). It has also been used in many treatment outcome studies (Lanktree & Briere, 1995a; Nolan et al., 2002; Elhai, Gray, Kashdan & Franklin, 2005). The TSCC has been used by clinicians to examine trauma symptoms for a range of different problems, in a range of different settings and across different countries. Balaban (2006) notes a survey of the 'Members of the International Society for Traumatic Stress Studies' showed that the TSCC is the most widely used self-report measurement for trauma

symptomatology with children/adolescents (Balaban, 2006).

Comparable Psychometric Measures to the TSCC

When the TSCC was being developed most measures were focused on examining an area of trauma related distress or dysfunction as oppose to childhood posttraumatic symptomatology. Tests targeting one area included: The Child Post-Traumatic Stress Reaction Index (Pynoos et al., 1993) and the Children's Post Traumatic Stress Disorder Inventory both for posttraumatic stress disorder (Saigh, 1989), the Child Sexual Behaviour Inventory for child victim sexualised behaviour (Friedrich et al., 1992) and the Child Dissociative Checklist for dissociation (Putnam, Helmers & Trickett, 1993). Other available measures appeared to target just one type of abuse assess for assessment, in the main sexual abuse, for example the Children's Impact of Traumatic Events Scale-Revised (Wolfe et al., 1991) and the Sexual Abuse Fear Evaluation (Wolfe & Wolfe, 1986).

According to Sadowski and Friedrich (2000) the drawbacks for many of these instruments include:

- (1): They are not standardised.
- (2): They are lengthy to use for clinicians.
- (3): They assess only one area of trauma and its manifestation of its symptoms (for example sexual behaviour).
- (4): Some don't assess trauma related symptoms.
- (5): They are only self-report and do not gather collaborative evidence (multi-informant assessment).

The TSCC addresses all of these issues apart from the multi-informant issue (Wherry, Graves & Rhodes King, 2008). This is a significant issue though as victims may be avoidant or deny that abuse occurred in instances when it did (Shapiro & Dominiak, 1990). The child may feel ashamed in response to the abuse and censor the extent of the trauma they have experienced (Wyatt, Loeb, Solis & Carmona, 1999). Finally, a child might be intellectually impaired and not have the meta-cognitive skills to accurately report his/her symptoms. Other measures such as the Child Behavior Checklist (CBCL) (Achenbach, 1991) had included a parent rating form to address these concerns. In response to this main area of criticism Briere developed the Trauma Symptom Checklist for Young Children (TSCYC) in 1999. The TSCYC consists of 120 items and it allows a caretaker to rate trauma-related symptoms in the young person. Nader (2004) in his review of different instruments used to assess traumatic experiences in children and adolescents noted that the TSCC fails to address some significant aspects of trauma symptomatology in children/adolescents, such as pessimistic future and somatic complaints.

Reliability of the TSCC

Reliability analysis allows the researcher to study the properties of measurement items and scales. There are two types of reliability. Test-retest reliability ensures that a measure will deliver the same results from one application to the next. Correlational analysis is usually used (a Pearson's score of 0.7 being the acceptable level) (Kline, 1986). Briere (1996) did not report the test-retest reliability

score in the professional manual for the TSCC. However, the TSCC has been widely translated and trialled in other countries and these have shown high reliability scores: in Sweden ($r=.81$, Nilsson, Wadsby & Svedin, 2008) and in Korea ($r=.85$, Chung, 2014).

The second type of reliability is internal reliability (or internal consistency) which looks at how well individual items on a psychometric correlate with each other. A high level of correlation would be expected if the psychometric has a high level of internal consistency. Cronbach's alpha (α) is one model used to analyse internal consistency (Kline, 1986). Internal reliability on each of the TSCC scales showed positive reliability scores (minimum $\alpha=.58$, maximum $\alpha=.89$, average $\alpha=.84$). The full breakdown for each of the clinical scales was as follows: Anxiety $\alpha=.82$, Depression $\alpha=.86$, Anger $\alpha=.89$, Posttraumatic Stress $\alpha=.87$, Dissociation $\alpha=.83$, Sexual Concerns $\alpha=.77$. This demonstrates a high level of internal reliability for the first five clinical scales but the Sexual Concerns scale was only moderately reliable. When it came to the clinical subscales the results were mixed, Sexual Preoccupation and Overt Dissociation both showed high internal consistency ($\alpha=.81$ for each). Sexual Distress ($\alpha=.64$) and Dissociation-Fantasy ($\alpha=.58$) were found to be less reliable. Therefore, the TSCC-A can be considered to be more statistically robust than the TSCC and a more desirable choice for professionals (should the sexual scales are not be required for a given client). The Cronbach's alpha scores on the two validity scales also showed some fluctuation, Underresponse ($\alpha=.85$) and Hyperresponse

($\alpha=.66$). For the two validity scales and the four subscales the reliability coefficient rating for the three individual abuse samples was not reported (centres = Nelson-Gardell, 1995, $n=103$; Lanktree & Briere, 1995b, $n=105$; Elliott & Briere, 1994, $n=399$). The three-child abuse centre reliability scores were given for the clinical scales and these reflected the standardisation sample scores closely.

In 2000, Sadowski and Friedrich evaluated the psychometric properties of the TSCC on a sample of 119 consecutively hospitalised adolescents, which included 32 sexually abused adolescents. They determined the reliability and the validity for the six clinical scales and the four subscales. They found moderate to high levels of internal reliability for the subscales (Overt Dissociation: $\alpha=.88$, Dissociation Fantasy: $\alpha=.71$, Sexual Preoccupation $\alpha=.78$, Sexual Distress: $\alpha=.73$). Sadowski and Friedrich (2000) concluded that the individual scales are significantly correlated and the TSCC is a valid measure of distress with a psychiatric population. Sadowski and Friedrich's (2000) findings echo the findings of Ohan, Myers and Collett (2002) who conclude that: "the internal consistencies of the subscales are good, with the exception of the Sexual Concerns and Hyperresponse subscales, which are moderate" (Ohan, Myers & Collett, 2002, p.1408).

Validity of the TSCC

Scale Intercorrelations

The validity of an instrument is considered to be the degree to which the tool measures what it claims to measure (Kline, 1986). There are different types of validity, firstly the face validity of the TSCC will be considered. Face validity is a common-sense approach that the test appears to test what it is supposed to test (Kline, 1986). This is examined by looking at scale intercorrelations. Briere (1996) found that the clinical scale and subscale intercorrelations ranged from .19 (SC-D with ANG) to .96 (DIS-O with DIS). These would be expected and indicative of face validity. Similarly, the UND validity scale was negatively correlated with all of the clinical scales. It ranged from -.22 (with SC-D) to -.61 (with PTS). Furthermore, the HYP validity scale was most correlated with the DIS-O subscale ($r=.56$) and least correlated with the UND scale ($r=-.16$) (Briere, 1996). Sadowski and Friedrich (2002) in their study on the psychometric properties of the TSCC with hospitalised adolescents ($n=119$) concluded that independent measures of ANX, DEP, DIS and ANG normally correlate significantly with the reference TSCC scales. Friedrich, Jaworski, Huxsahl and Benston (1997) found that some of the TSCC subscales are more sensitive with adolescents than with younger children (for example DIS-O).

Convergent and Discriminant Validity

Briere (1996) notes that many different studies suggest that the TSCC scales have covariance with equivalent tests, correlating most

with similar content scales (known as concurrent or convergent validity) and least with less similar content scales (known as divergent or discriminant validity).

Crouch, Smith, Ezzell and Saunders (1999) conducted research with 80 children examining the convergent validity of the TSCC and the Children's Impact of Traumatic Events Scale-Revised (CITES-R). Crouch et al. (1999) found that the TSCC PTS scale was significantly correlated with the CITES-R PTSD subscales of hyperarousal and intrusive thoughts. The CITES-R Eroticism scale was significantly correlated with the TSCC SC scale (particularly the SC-P subscale). However, Crouch et al. (1999) also noted that there was an indication that the TSCC PTS scale inadequately assessed avoidant symptoms.

Lanktree et al. (2008) carried out large-scale research on 310 children to examine the convergent and discriminate validity of the TSCC and the Trauma Symptom Checklist for Young Children (TSCYC) scales in assessing symptomatology of maltreated children. They found that the equivalent scales measuring anger, dissociation, anxiety, depression and sexual concerns were largely correlated with each other. The Posttraumatic Stress-Intrusion scale of the TSCYC correlated most with the PTS and ANX and scales of the TSCC. The TSCYC Posttraumatic Stress-Avoidance scale did not correlate with any of the TSCC scales. The TSCC PTS scale was the best predictor of sexual abuse-related PTSD status in the TSCYC (shown through discriminant analysis). Finally, the TSCYC Posttraumatic Stress-

Arousal (PTS-AR) scale correlated with the TSCC ANX scale and the TSCC PTS scale was correlated highly with the TSCYC Posttraumatic Stress-Intrusion, Anxiety and Sexual Concerns scales. Overall, the TSCC and the TSCYC showed moderate convergent and discriminate towards each other.

Nilsson et al. (2008) had a normative group of 341 schoolchildren in Sweden and wanted to compare the convergent validity of the TSCC to the Dissociation-Questionnaire-Sweden (DIS-Q) (Svedin, Nilsson & Lindell, 2004). Total scores on the DIS-Q were correlated with DIS on the TSCC (Pearson's correlation was found to be $r=.75$) (Nilsson et al., 2008). Sadowski and Friedrich (2002) correlated the TSCC DIS scale with the Adolescent-Dissociative Experience Scale (Armstrong, Putnam & Carlson, 1990) and found a correlation of $r=.79$. Sadowski and Friedrich (2002) also examined the correlation between the TSCC DEP scale and the Beck Depression Inventory (Beck & Steer, 1987); the correlation was $r=.81$. The findings would indicate that the TSCC is valid as a measure of posttraumatic distress and its accompanying symptomatology.

Construct Validity

Construct validity is concerned with whether or not the instrument measures all aspects of the subject under investigation (Kline, 1986). Since the TSCC is concerned with trauma it must demonstrate certain aspects to evidence construct validity. The scale scores should: (1) be higher in samples of children who have histories of traumatic/stressful

occurrences, (2) the presence of severe trauma should increase the scores (especially PTS and DIS scale scores) and (3) decrease if the participant is confronted with meaningful therapeutic intervention aimed at targeting trauma-related distress (Briere, 1996).

In reference to point (1) Sadowski and Friedrich (2000) carried out their evaluation with a clinical sample (n=119) that included 32 sexually abused adolescents. Sadowski and Friedrich (2000) found that the PTS scale of the TSCC was able to successfully discriminate the sexually abused participants from the rest of the sample population. A study carried out by Elliot and Briere (1994) and also demonstrated point (1). In the study of 399 children (ages 8-15), some had disclosed abuse and others had not disclosed abuse. The TSCC showed no differences between the two subgroups of disclosing children (those with partial disclosure and those with full disclosure). There were significant differences found between the non-disclosing abused groups (children who had recanted abuse reported feeling more depressed and angry than the children sexually abused who never disclosed abuse). Furthermore, children who were sexually abused and disclosed their abuse reported trauma symptomatology at a high level; abused children who were not disclosing (denying or recanting) reportedly had lower levels of distress. The non-abused children reported trauma symptomatology at an intermediate level; this was consistent with the level of child distress and its symptomatology reported in the normative sample. Elliot and Briere (1994) maintain that the findings are suggestive of good known

groups validity.

When it comes to point (2) and showing sensitivity of the TSCC scale scores to severe trauma a study by Atlas and Ingram (1998) illustrated this very effectively. Atlas and Ingram (1998) found that: "adolescents who were sexually abused by family members have endorsed more sexual distress than those who were abused by non-family members or not abused at all, indicating that the TSCC's Sexual Concerns subscale is sensitive to the severity of sexual trauma" (In Ohan, Myers & Collett, 2002, p.1408). Smith, Swenson, Hanson and Saunders (1994) conducted a study (n=103) to show that the type of trauma a child experiences correlates with the different TSCC scales in a meaningful manner. Smith et al. (1994) found that ANX, DIS and PTS scales connected to life stresses/events that involve a perceived threat to life, also victims of sexual abuse who had been penetrated had higher SC scale scores in comparison to those who had not been.

Finally, in relation to point (3) Lanktree and Briere (1995a) wanted to look at the impact of meaningful therapeutic intervention on 105 sexually abused children (aged 8-15). Lanktree and Briere (1995a) found that all TSCC scales (apart from SC) decreased after three months of therapy. Furthermore, all of these scales (apart from DIS) continued to decline in the assessment periods thereafter. Even after six months, participants that remained in therapy continued to decrease on a number of the TSCC scales: PTS, ANX, DEP and SC

(Lanktree & Briere, 1995a). Najavits, Gallop and Weiss (2006) carried out another study that demonstrates point (3). Seeking safety therapy was performed with 33 outpatient girls who had PTSD and signs of substance misuse. Najavits et al. (2006) found a significant lowering in TSCC scale scores on the SC scale and the SC-D subscale when they compared pre and post treatment scores and further follow up scores.

Normative Data for the TSCC

The normative data for the TSCC came from a sample of 3,008 children (all from non-clinical / non-forensic populations). This was comprised of three subgroups: 1) 222 children in Minnesota who were at the Mayo Clinic, most of these were relatives of patients (Friedrich, 1995), 2) 387 school children in Colorado who were taking part in a larger study for the University of Colorado (Evans et al., 1994) and 3) 2,399 school children from suburban areas in Illinois and Colorado who were deemed suitable from a larger scale study or 3,735 participants (Singer et al., 1995).

The demographics for the standardisation sample was as follows:

- 1) Gender: 47% of the children were male and 53% were female.
- 2) Age: Males (43%) – 8-10 years (4%), 11-12 years (13%), 13-14 years (15%), 15-16 years (68%). Females (53%) - 8-12 years (17%), 13-16 years (83%).
- 3) Race: 44% Caucasian, 27% Black, 22% Hispanic, 2% Asian, 4% Other.

The different age categories were examined to see which separations produced major age differences in scale scores. Age and gender were found to be significant variables on which to standardise the TSCC scales (race was not). Only one subgroup (the third subgroup $n=222$) contained normative data on the Sexual Concerns scale and all of these respondents were Caucasian so race implications could not be examined. Since the Sexual Concerns scale and its two subscales (Sexual Preoccupation and Sexual Distress) had a smaller population base its normative scoring is different to the other clinical scales (a T score of 70 or above is deemed to be clinically significant). For all of the other clinical scales a T score of 65 or above is considered to be clinically significant; a T score of 60-65 subclinical or suggestive of requiring further attention).

Conclusion

"The clinical subscales are conceptually based on theories of development and child trauma" (Feindler, Rathus & Silver, 2003, p.209). "The TSCC is simply worded and easy to administer. It is particularly useful with children who have experienced multiple types of abuse and appears to be sensitive to the effects of therapy for abused children. It does not orient respondents to their abuse experiences and is appropriate for children who have not disclosed abuse, as well as those who have" (Feindler et al., 2003, pp.210-211).

"The TSCC has a large normative base of ethnically and economically diverse children who do not have a history of trauma" (Ohan, Myers & Collett, 2002, p.1408). Of all the trauma instruments available to measure child traumatology the TSCC is the only one that has over-reporting [HYP] and under-reporting [UND] validity scales with respect to trauma symptoms experienced. It has also been

standardised in both non-clinical populations and clinical populations (Nilsson et al., 2008; Chung, 2014). Furthermore, the TSCC as a clinical instrument has shown that it can be updated to reflect the most relevant: 1) theoretical underpinnings, 2) clinical applications and 3) statistical robustness. After the TSCC was developed, the TSCC-A followed, then the TSCYC and most recently the Trauma Symptom Checklist for Children - Short Form (TSCC-SF). The TSCC-SF contains 29 items and its normative data and early reliability and validity results are promising (Wherry, Huffhines & Walisky, 2015).

Regarding reliability and validity there are many studies endorsing the efficacy of the TSCC. The TSCC: ANX, DEP and PTS scales show moderate to good correlations between corresponding measures of internalising symptoms but lower correlations with externalising measures (Friedrich et al., 1997; Sadowski & Friedrich, 2000).

The TSCC assesses a range of childhood trauma symptomatology but it does not include childhood neglect. Neglect is considered to be a highly prevalent form of childhood trauma and the research literature has shown that the implications of neglect can be damaging psychologically (Hussey, Chang & Kotch, 2006). This is an area that may warrant inclusion in any future revisions of the TSCC/TSCC-A.

"The Posttraumatic Stress subscale contains mostly intrusion symptoms, and therefore does not comprehensively assess PTSD symptoms. In addition, caution is warranted regarding interpretation

if the user's intention is to assess the DSM-IV conceptualization of PTSD, as the TSCC's items do not fully overlap with DSM-IV symptom clusters for PTSD or dissociative disorders. Rather, the TSCC should be used to examine symptom profiles and symptom course following trauma" (Ohan, Myers & Collett, 2002, p.1408). Accordingly, as Briere himself acknowledges (1996; 2005), it is important to remember that the TSCC should be used in conjunction with other standardised instruments and not as a standalone assessment or diagnostic instrument.

Finally, Sadowski and Friedrich (2000) argue that the TSCC's utility could be improved by having the respondent name a traumatic event and then completing the TSCC items in relation to the event, especially when it comes to the PTS scale.

Rationale for chapter five

This chapter outlined the main psychometric measure used in the care system with young people suffering from trauma symptomatology. The TSCC-A provides many useful insights into the young person's psychological wellbeing. The next chapter outlines a case study in which the TSCC-A (along with other relevant psychometrics) was used to chart the psychological wellbeing of a young adolescent arsonist (aged 15), who was residing in secure institutional care. It was felt that examining secure care would be an interesting contrast to chapters two and three, which had explored residential care. It shall be interesting to see if the same issues the young people in residential care faced were apparent for the young person in secure

institutional care in the case study.

CHAPTER FIVE

An examination of the therapeutic progress of an adolescent arsonist who self-harms, when detained in institutional care.

Abstract

D4 is a 15-year-old male whose mother was a chronic alcoholic, and D4 found his mother dead in the bath when he was three years old. D4's father has a history of mental illness and has been detained in hospital as a result of schizophrenia. In D4's life, there is a long history of academic failure, truancy and substance misuse (mainly cannabis), which D4 claims exacerbated his psychosis and he frequently suffered from suicidal ideation leading to self-harm and attempted suicide. D4 was charged with two offences of arson and three of criminal damage (for his index offences in July 2010), for which he was admitted to a psychiatric hospital and detained under a section 37/41 of the Mental Health Act (MHA). D4 was subsequently diagnosed with "paranoid schizophrenia and mild mental retardation with other impairments of behaviour." To begin with a range of psychometric assessments were administered to D4 (including: The Trauma Symptoms Checklist for Children A, The Children's Assertive Behaviours Scale and The Negative Consequences of Fire and Victim Empathy). Clinical interviews and a Structured Assessment of Violence Risk in Youth (SAVRY), alongside an individualised functional analytic formulation were completed. In order to inform his specific individualised treatment pathway. Subsequently, ten months of individual 1:1 psychology work focussed on basic CBT. He could recognise thoughts, emotions and behaviours and the role his feelings of anxiety and depression had factored into his self-harming and antisocial behaviour. Indeed, he began depicting what he found difficult to verbalise into pictures (for example burning buildings). In order to improve his social skills and his firesetting behaviour he began a social skills group intervention and an arson group programme. Afterwards, post-psychometric measures were carried out and reliable change statistics used, these illustrated that D4's overall psychological wellbeing had improved, along with his ability to emotionally self-regulate. Recommendations for future therapeutic work were suggested.

Introduction

Establishment of adolescent secure care

The National Health Service (NHS) Health Advisory Service (1995) considered that approximately 20% of children and adolescents suffer from some form of mental health complaint; this can range from emotional disorders to psychiatric conditions. Rutter and Smith (1995) documented a strong relationship in adolescents between mental health problems and associated antisocial behaviour, substance misuse and self-harm. Vaughan (2004) maintains that extended in-patient care or residency in secure institutions must utilise a specialised response to address specific problems. The NHS Health Advisory Service (1995) outlined a system of four tiers of services for Child and Adolescent Mental Health Services (CAMHS) (Vaughan, 2004). The current case study relates to an individual who is at the highest tier level. Tier 4: highly specialised outpatient teams and in-patient units for older children and adolescents who have a severe mental illness or are deemed to be a suicide risk (NHS Health Advisory Service, 1995).

The NHS Health Advisory Service (1995) note a small but significant group of young people that require specialist secure psychiatric in-patient care because of their serious risk of harm to themselves or others. These young people often have a propensity to abscond from care settings. Due to a lack of provisions, CAMHS often have to utilise inadequate and inappropriate placements. The consequences of this

are that young people's problems can be addressed inappropriately, which can result in placements breaking down (Flood & Street, 2000).

Residential care / secure institutional care - what constitutes effective care provisions for young people?

The Stockholm Declaration on Children and Residential Care (2003) proclaim that residential care should be seen as negative towards a child's welfare, and state that residential care should be seen as a treatment option but only in the case of a last resort (in Anglin & Knorth, 2004). However, a range of review studies and meta-analyses into treatment effectiveness for young people subjected to residential care eschews this viewpoint, showing small but positive effects for residential care (Knorth et al., 2008; Lipsey, 2009; Loughran et al., 2009; De Swart et al. 2012). Souverein, Van der Helm and Stams (2013) maintain that residential care is usually a better alternative for young people in terms of treatment outcome than secure institutionalised care.

The effectiveness of residential treatment has been examined in many studies to find out what measures offer the highest intervention integrity and efficacy. Grietens (2002) conducted research into the basis of effect sizes from five previously conducted meta-analyses into residential treatment outcomes (including over 300 Studies). Grietens (2002) notes the seriousness of this issue. Residential treatment of delinquent young people appears to generate an average reduction of recidivism of about 9%. Grietens (2002) concludes that

delinquent behaviour is more difficult to treat in comparison to other problems and is a highly nuanced issue contingent on a multitude of care characteristics.

In 2008, Knorth et al. carried out a meta-analysis examining treatment outcome of residential child and youth care services between 1990 and 2005. The research encompassed twenty-seven studies and 2,345 children and adolescents. Knorth et al. (2008) concluded that quasi-experimental studies show that residential programmes that utilise behavioural therapeutic methods and focus on family involvement, demonstrate the most potential in achieving successful short-term outcomes. When it came to long-term treatment outcomes there was little evidence to determine what produces effective results. Knorth et al. (2008) suggest that when examining residential youth outcomes, more attention is needed when it comes to describing the residential intervention programme young people are receiving, in order to allow for effective treatment evaluation.

De Swart et al. (2012) conducted a meta-analysis examining the effectiveness of different types of care (residential/secure institutional care) over the past three decades; only using quasi-experimental studies with an appropriate comparable control group. De Swart et al. (2012) compared: institutional evidence-based treatment with non-institutional evidence-based treatment, institutional care as usual with non-institutional care as usual, institutional care as usual with non-

institutional evidence-based treatment and institutional evidence-based treatment with institutional care as usual. The only comparison that yielded a significant effect was institutional evidence-based treatment with institutional care as usual ($d = .34$), showing that residential care and institutional care can be equally as effective. Weisz, Jensen-Doss and Hawley (2006) highlight in their study though that it is promising to provide young people with evidence-based treatment during their stay in residential care.

Scherrer (1994) noted a number of interesting findings from a large-scale meta-analysis (based on 42 studies); when comparing young people in a residential treatment programme compared to young people in control/comparison groups (for example, a 14% improvement in emotional problems). Similar to other studies, Scherrer (1994) found that treatment programmes in which a cognitive behavioural methodology is used are more effective in bringing about meaningful lasting change in the young people (during follow up research after a year of leaving care). A significant finding was that 'therapeutic milieu' and family treatment produced the most effective outcomes for young people. Therapeutic milieu relates to the residential environment and the quality of relationships the young person experiences in that environment (with staff and the other young people).

Other review studies on residential care efficacy came to a similar conclusion in regards to the longer-term treatment effectiveness

showing less positive results (Lyman & Campbell, 1996; Frensch & Cameron, 2002). Both studies highlight the importance of aftercare work and of integrating the child's family in care work (Lyman & Campbell, 1996; Frensch & Cameron, 2002). James et al. (2013) carried out a meta-analysis on the effectiveness of aftercare, which yielded positive results. They concluded that well-implemented individualised aftercare can contribute to the effectiveness of residential care and it can help to reduce future recidivism.

So what treatment approaches constitute effective care for young people in care settings?

Curry (1991) also emphasises the importance of breaking down the intervention programme offered to the young person and tailoring it to his/her specific needs.

Most youngsters appear to improve within treatment. Some do not or else appear to get worse. Subject variables, including at least the severity or type of dysfunction and the reactive or process nature of its onset, appear to set limits on what can be achieved with such treatment. Adjustment within a program does not predict adjustment at a subsequent follow-up period, but degree of support and continuity in significant relationships does seem to predict better adjustment at follow-up (Curry, 1991, p.352).

The implications of this, according to Curry (1991), include: (1) the need for extensive aftercare treatment; (2) the need to work with the family including the young person for significant periods of time; only a proportion of this would be during residential treatment and (3) the need to include as many opportunities as possible within treatment

programmes for learning that can be generalised to the non-residential environment.

Van Gageldonk and Bartels (1990) looked into effective treatment approaches with young people and found two things to be effective in successful treatment outcome: 1) a very structured living environment, and 2) care intervention aimed at increasing social skills. De Swart et al. (2012) did not find that increasing social skills increase treatment outcome for young people. Quinn, Kavale, Mathur, Rutherford and Forness (1999) report small to medium effect sizes on the benefits of social skills training. However, this was with the caveat that effects do not persist for long once the intervention has ended, as social skills training does not occur in a naturalistic environment (Rutherford et al., 1999).

In 2005, Boendermaker and Van den Berg updated Van Gageldonk and Bartels' (1990) work and surmised that behavioural modification work and family focused intervention was effective for treating young people with behavioural disorders and internalising difficulties. Boendermaker and Van den Berg (2005) suggested a range of approaches that may be productive in helping these young people: medication, risk assessment, family therapy/training for parents, adapted education and cognitive behavioural therapeutic approaches.

Lipsey (2009) found that care interventions based on principles of punishment can actually produce counterproductive effects for the

young people, noting an increase in delinquent behaviour instead of the hoped-for decline in antisocial behaviour. Dishion, Poulin and Burraston (2001) believe treating deviant young people together will increase their problematic behaviour, because the influence they have over one another serves to increase deviancy through learned observed behaviour. One young person will view the other resident behaving in an aggressive and deviant manner and view this as acceptable behaviour (Dishion et al., 2001). Mager, Milich, Harris and Howard (2005) in their meta-analysis did not find this to be the case amongst young residential populations. Furthermore, Lee, Chmelka and Thompson (2010) actually found that young people in residential settings can have a positive influence on one another and noted that less aggression and delinquent behaviour was witnessed amongst young residents from the same care setting, as they develop positive relationships over time and the older residents acted as positive role models for the younger ones (Lee, Chmelka & Thompson, 2010).

Knorth et al. (2008) also found that: behaviour modification approaches, social skills training and family focused components to treatment appear to yield positive outcomes. Social skills training appears to strengthen treatment effect over time. Knorth et al. (2008) believe that residential care is a more effective intervention than keeping people at home when the young people appear to suffer from significant dysfunctional behaviour. Knorth et al. (2008) argue that young people with externalising difficulties and general problematic behaviour make more positive progress in residential care

than young people with internalising problems (medium effect $d=.50$).

Cognitive behavioural approaches have been shown to be successful in helping young people to make progress in a range of settings. Koehler et al. (2013) carried out a large-scale meta-analysis on young offenders and treatment approach. When CBT was delivered to offenders the successful recidivism odds they found were impressive (1.73). When the treatment was delivered according to '*Risks, Needs and Responsivity*' principles as purported by Andrews and Bonta (2010), the odds improved further (1.90), which could represent a 16% reduction in recidivism overall according to Koehler et al. (2013).

CBT with adolescents with social skills deficits

Crick and Dodge (1994) proposed social information-processing theory, which states that children encode social cues from their environment. A mental concept is formed and interpreted. The individual then searches for a potential response and decides on one. The response is then put into action. Dodge (1986) claims deficits during any of these stages (which are not completely sequential) can lead to antisocial or aggressive behaviour. Lemerise and Arsenio (2000) espoused that emotion related processes were important to aggression in the decision-making stages of the theory (intervention programmes utilised this progression, for example Muris et al., 2005; Van Manen, Prins & Emmelkamp, 2004).

"Social-cognitive interventions should be encouraged as a critical component of institutional and community-based programmes" (Tate, Reppucci & Mulvey, 1995, p.780). Lipsey and Wilson (1998) conducted a meta-analysis of 200 studies on effective intervention strategies with antisocial young people. Interpersonal skills followed by teaching in family homes and then behavioural programmes were found to be most successful. This suggests that programmes are effective but could potentially be improved (Hollin, 2004).

Cognitive behavioural methods include: behaviour modification and behaviour therapy (Martin & Pear, 1999), social learning theory (Bandura, 1977), skills training (Hollin & Trower, 1986) and cognitive behavioural modification (Meichenbaum, 1977). According to Sheldon (1996) successful techniques to utilise in successful behavioural programmes would include: self-instructional training, modelling, skills training, emotional control training, thought stopping, relaxation training and problem-solving training. Kendall and Bacon (1988) maintain that a cognitive behavioural approach to practice as a general perspective is preferable, rather than seeing it as a unified theory. One intervention programme that aims to address social skills deficits in young people is Aggression Replacement Training (ART) (Goldstein, Glick & Gibbs, 1998). ART is best utilised for interpersonal violence with or against peers (Hollin, 2004). Adapting it for use with mentally disordered offenders (Bonta, Law & Hanson, 1998) and offenders with learning disabilities has been suggested (Day, 2001). When it comes to selection and group dynamics Goldstein et al.

(1998, p.54) suggested that: "if they live together, hang around together, or even fight together, put them in the same group together." This would be in keeping with the findings in chapter two, showing how peer support can be a great aid to young people in care settings (Emond, 2014; Arthur et al, 2013). While a peer group may help group members to learn from one other with respect to social skills, a motivational individualised approach should also be adopted (Gilbert & Daffern, 2010). This case study was concerned with the individualised treatment need of an adolescent arsonist based in secure care. An awareness of firesetting in adolescents was very significant in the efficacy of his therapeutic progression and the associated benefits in boosting his psychological wellbeing.

Environmental factors significant when it comes to adolescent antisocial behaviour

When it comes to adolescent antisocial behaviour, many different risk factors have been identified in the literature. Despite the frequency and severity of individual risk factors, the importance of contextual risk factors is also paramount in predicting aggression in adolescence (Tompsett, Domoff & Boxer, 2011). Contextual risk factors can encompass histories of maltreatment, exposure to violence and peer victimisation, however it can also relate to the provision of care a young person has received, such as: residential care, foster care and in-patient care placements. Accordingly, this thesis sought to examine the experiences of an individual based in secure in-patient care, as a contrast to the wider dissertation detailing the experiences of young

people in residential care. Goodman, Zimet, Farley and Zimet (1994) compared the home behaviours of children across: an outpatient clinic, a day hospital and an inpatient hospital. Children beginning inpatient hospitalisation were viewed as being the most disordered, aggressive and anxious compared to their counterparts.

Treatment provision for antisocial adolescents in secure care

Once it was acknowledged that there was a population of young people best catered for with secure care, the national adolescent medium secure network was established (Withecumb & Jasti, 2004; Withecumb, 2007, 2008). Six medium secure in-patient units spread across England, operating under the auspices of the NHS were set up. These units cater for young people between the ages of 12–17, who have both displayed behaviour that creates serious risk for others and who are liable for detention under the MHA. Each unit has a multidisciplinary team, with clinicians from: psychiatry, psychology, social work, occupational therapy and nursing; contributing to the care and management of the client group (Withecumb, 2007, 2008).

All of the medium secure adolescent units provide assessment and treatment for those with serious and enduring mental illnesses (such as schizophrenia) and also cater for young people with emerging personality disorders and/or learning difficulties (Withecumb, 2008). The most commonly occurring psychiatric disorder in five to fifteen-year olds is conduct disorder, found in 5% of young people (Meltzer, Gatward & Ford, 1999), and defined by the presence of a persistent

pattern of behaviour in which the rights of others are violated. Conduct disorder is associated with: a focus on aggressive cues, hostile attributions, labelling one's own arousal as anger and poor verbal problem solving (Witthcomb & Jasti, 2004; Witthcomb, 2007; 2008).

Conduct problems in adolescence have repeatedly been shown to predict later offending behaviour, with earlier onset of problematic behaviours and a wider range of problematic behaviours increasing risk of offending in later life (Kratzer & Hodgins, 1997). When it comes to assessment this now works on structured professional judgment tools; within the medium secure hospitals the Structured Assessment of Violence Risk in Youth (SAVRY, Borum, Bartel & Forth, 2006) and the Adolescent Intervention Model (AIM) for sexually harmful behaviour, (Print, Griffin, Beech, 2007) are most commonly utilised (Witthcomb, 2007).

In terms of intervention in adolescent medium secure hospitals, the MHA 1983 is applicable (with a few minor exceptions) to those affected by mental disorder at any age. Among the forensic adolescent population, therapeutic interventions are usually utilised alongside psychotropic medications and often in combinations of individual/group therapeutic work and/or systemic familial therapy (Witthcomb, 2008).

Treatment needs of adolescents in secure care

Kroll et al. (2002) carried out longitudinal systematic research (n=97) in the UK on the mental health of male adolescents aged 12-17, all of whom were detained in secure care for persistent offending. Kroll et al. (2002) found that 27% of the males had an intelligence quotient of less than 70. On admission to the secure units, the most frequently reported disorders were anxiety and depression. There were also high rates of: aggression, self-harm, substance misuse, social problems, familial problems and educational difficulties. After the initial assessment period the young people's psychological needs persisted (Kroll et al., 2002). There were often new onsets of: depression, anxiety and post-traumatic stress symptomatology; while the young person struggled to adapt to his new environment. Within these establishments the most frequent and successful therapeutic work being carried out with the adolescents was cognitive behavioural work (Kroll et al., 2002).

Firesetting in children and adolescents

Firesetting is known to have significant consequences for individuals personally, the people associated with these individuals and society as a whole. By 2003, in England and Wales, approximately two people died every week due to deliberately set fires and the cost to the economy was believed to be over £50 million (Arson Prevention Bureau, 2010). In 2000, 40% of individuals cautioned or prosecuted for arson were aged between 10 and 17 years old (Arson Prevention Bureau, 2010). These statistics do not account for individuals who

have been involved in setting fires but have not come to the attention of law enforcement, thus the problem may be even greater.

Categorising firesetters

It appears to be the case that firesetting is one of the least understood criminal behaviours (Davis & Lauber, 1999). This could be because firesetters who are detected are not clearly distinguishable from other types of offenders engaged in an array of criminal behaviours (Soothill, Ackerley & Francis, 2004). Canter and Fritzon (1998) looked at adult firesetting and came up with four categories of firesetters, based upon their process of target selection and their emotional responses to the acts. They identified between those who offend against objects or people and those who do so for expressive or instrumental reasons. Santtila, Hakkanen, Alison and While (2003) used the same smallest space analysis method in relation to adolescents and came up with two clear themes. A delinquent group of firesetters who light fires for instrumental reasons and a depressed group that set fires because of their own psychopathology and a need for emotional expression.

Individual characteristics of firesetters

Even in 1985, Sakheim, Vigdor, Gordon and Helprin believed that juveniles at risk of firesetting demonstrate the following characteristics: 'more tenuous ego and superego control', 'poorer in judgment', 'more reactive than reflective,' 'less capacity for

internalisation,' 'less ability to express anger verbally' and they were more likely to have a psychiatric diagnosis for conduct disorder.

This would appear to represent firesetters who offend due to an interest in fire and this interest is deemed to be a risk factor towards offending (Dickens et al., 2009). Although the exact relationship between mental health and firesetting is not fully established, there does appear to be a connection. The DSM-IV-R refers to a pathological interest in fire as requiring a diagnosis of pyromania under the category of impulse control disorders (American Psychiatric Association, 2000). However, a diagnosis of pyromania is unusual due to the strict criteria requiring the absence of other arson motivators such as: psychotic symptomatology, substance misuse and antisocial personality disorder. Firesetting behaviour can be a comorbid behaviour but the diagnostic criteria does not allow for this. However, empirical evidence suggests firesetters have higher levels of hyperactivity and impulsivity than their non-firesetting peers (Kolko et al 1985; Martin et al., 2004).

Firesetting behaviour has also been associated with substance misuse. Martin et al. (2004) noted that juvenile firesetters utilised more severe narcotics and their usage of narcotics was more likely to be chronic, compared to their non-firesetting counterparts. Firesetters were also more likely to: have suicidal ideation, engage in deliberate self-harm behaviours, report low self-image and feelings of hopelessness or depression. The findings are indicative of a link

between firesetting behaviour and other psychological difficulties. Martin et al.'s (2004) study purports that firesetting individuals have complex difficulties that distinguish them from other antisocial adolescents.

Familial / social factors

Nadeau-Gaunce (2001) maintains that firesetting in juveniles is a complex problem for the individuals. It is said to be the result of feelings of inadequacy and a lack of control. According to Nadeau-Gaunce (2001) family disruption, learning disabilities, victimisation by peers and interpersonal difficulties at home must be considered. Kolko (1985) highlights the importance of: parental disciplining/supervision, parental pathology and early learning experiences with fire; as playing a key role in the likelihood of the individual becoming a firesetter. Kolko and Kazdin (1989) argue that young firesetters were significantly more likely to have peers or older role models who also experimented with fires. Role modelling may influence the behaviour of firesetters or help to endorse attitudes that this form of behaviour is acceptable.

One other environmental factor which can mitigate an individual's likelihood to set fires is their own resilience in coping with stressful events. This is something that firesetters do not normally have the capacity to do (Stewart & Culver, 1982). The potential for firesetting behaviour to desist is also influenced by an individual's familial and social backgrounds. Those who persist with firesetting were more

likely to: have low levels of academic achievement, to report generally abusive experiences in their childhoods and to come from single parent families/impoverished families or families with high levels of interpersonal hostility or depression (McCarty & McMahon, 2005). There are many individual and environmental characteristics associated with firesetting, so how do these factors combine to result in a young person engaging in firesetting behaviour?

Social learning model

In 1986, Kolko and Kazdin attempted to explain arson by identifying characteristics of young arsonists. The social-learning model of arson they derived focused on three distinct categories of social learning and how these constitute to the risk an individual may pose of committing arson. The categories are: 1) learning experience and cues, 2) personal repertoire and 3) parent and family influences and stressors.

1) Learning experience and cues is formed as a result of early modelling experiences and early interest and direct experiences.

2) Personal repertoire is due to: behavioural components (skills deficits/ interpersonal ineffectiveness/ covert antisocial behaviour excesses), cognitive components (limited awareness and safety skills) and motivational components.

3) Parent and family influences and stressors: parental distance and uninvolved/ limited supervision and monitoring/ stressful external events / parental pathology and limitations (Kolko & Kazdin, 1986).

This model highlights how multifaceted arson as a phenomenon is, and the different psychosocial factors that it can encompass. Kolko and Kazdin (1986) believe the model helps to identify which adolescents are most at risk of committing arson. Since a person with difficulties in one of the three categories present is deemed to be more at risk of committing arson, than an adolescent in whose case none of the three categories are a concern. It is important to note though that difficulties in these characteristics can vary in respect to the time in a person's life or their immediate environmental or personal stressors.

Developmental model

Jackson, Glass and Hope (1987) proposed the 'Only Viable Option' theory of fire setting, centring this theory in a developmental perspective. Arson is perceived as an effective means of changing or escaping circumstances perceived as being intolerable (arson is seen as a resolution for the firesetter). Jackson, Glass and Hope (1987) proclaim a developmental model that explains the transition from fire-play to pathological arson.

- 1) Arsonists are: personally, psychosocially or situationally disadvantaged and need to resolve internal or external problems. These disadvantages are the root cause of many types of offending, particularly of arson.
- 2) Arsonists are prevented from resolving problems due to a lack of opportunity, skill or confidence.

3) The factors leading to the use of fire may be apparently slight. Treatment needs to address underlying emotional and situational problems (Jackson, Glass and Hope, 1987; Jackson, 1994).

The event that triggers the firesetting behaviour for the arsonist is likely to be emotionally significant. The event may evoke feelings of: stress, anxiety, anger, disappointment and belittlement. The firesetting behaviour then serves to relieve tension from these feelings and may create feelings of excitement. This can reinforce an addiction to the firesetting behaviour (Jackson, Glass & Hope, 1987).

Motivation for firesetting behaviour

Wiklund (1978) reviewed many of the traditional motives used to explain firesetting behaviour. Early motivation theories focussed heavily on: 1) sexual disturbances, 2) reducing anxiety and 3) were frequently connected with mental health issues. He concluded that these theories could either be rational or irrational (Wiklund, 1978). Some other theories identified elsewhere regard motivations for firesetting as: 'a cry for help' (Awad & Harrison, 1976), retaliation against rejecting parents (Yarnell, 1940) and a desire to reunite the family (Macht & Mack, 1968). The most common motivations given for firesetting were: boredom, for fun or to see what would happen (Cotterall, McPhee & Plecas, 1999). This motivation was claimed to be especially true for younger children who enjoy exploring the world around them and have a need to satisfy his/her curiosity.

Stadolnik (2000) said that the motivations for firesetting vary at different times. He claimed there were four central motivations for setting fires. Stadolnik (2000) claimed that this group of individuals are characterised by high rates of: curiosity, attention deficit hyperactivity disorder (ADHD), impulsivity and aggression. These individuals may also display remorse for their behaviour. The parents of such firesetters are likely to be punitive in their approach and do not adequately supervise their children (Stadolnik, 2000).

The second motivation Stadolnik (2000) stated was crisis-motivated firesetters. This communication could be either conscious or unconscious and is about providing relief from distress. Stadolnik (2000) believed such individuals gain a sense of power from using fire, which compensates for their lack of control over other factors in their lives. These children come from family backgrounds that are characterised by: domestic violence, divorce, familial narcotic or alcohol misuse and a lack of emotional support from their parents. Such individuals often lack remorse and fail to understand the serious consequences their firesetting behaviour can have (Stadolnik, 2000).

The third motivation is delinquency. Delinquent firesetters typically set fires as part of a peer group, are influenced by negative peer group attitudes and the desire to be accepted. Such individuals are likely to have high levels of: anger, anxiety and behavioural difficulties; to the extent that they may meet the criteria for conduct disorder. This group may have witnessed domestic violence or have

parents who have been involved in criminal activity and substance misuse. This group are less likely to engage in firesetting behaviour when they are older.

The final motivation is a pathological need. These individuals present with emotional, cognitive and behavioural difficulties; they can present as paranoid, delusional and experiencing hallucinations. In addition to the parenting factors related to the previous motivation categories, these individuals are likely to have been neglected, abused and have a family history of mental illness. These individuals are also typically lacking social and problem-solving skills and are likely to have set a number of fires. This usually alone and the firesetting behaviour will usually persist into adulthood, if they are not caught and offered appropriate intervention (Stadolnik, 2000).

Therapeutic intervention with adolescent firesetters

The theories of firesetting have established that firesetters are likely to present with a broad range of psychological and developmental difficulties. Therefore, a thorough psychological assessment of cognitive and personality factors that could provide information regarding the individual's motives for his/her behaviour is essential (Tiffin & Cooper, 2006). While the specific forensic history is paramount, a clinical assessment should also encompass: familial, academic and interpersonal histories. Assessment should aim to produce a formulation that assists in the understanding of the factors that have contributed to and maintained the firesetting behaviour for

the individual. Contextualised formulations allow for informed interventions to be implemented and the firesetting behaviour to be risk managed effectively (Tiffin & Cooper, 2006). The research literature on effective interventions with adolescent firesetters suggests that helping to lower the firesetting psychopathology and behaviour, is likely to increase the young person's sense of self-efficacy and psychological wellbeing.

Client Information:

(For an overview of the organisational setting and the rehabilitative regime please see appendix Q)

Referral

For a patient to satisfy the eligibility criteria at the hospital they must show disordered or dangerous behaviours in the context of: a mental illness, personality disorder and/or learning disability. New admissions are referrals from: young offender institutes, the court system, other mental health services and the community. D4 was admitted from a residential home to the hospital ward in February 2011 under Section 38 of the MHA, for assessment of his mental state. This section allows a court to send a person to hospital for a temporary period to decide if a hospital order (Section 37) should be used. Following a court hearing in May 2011, the court sectioned D4 under a 37/41 of the MHA (hospital order with Home Office restrictions; the Home Office are involved in applications for leave and discharge).

Introduction

D4 is a 15-year-old boy, who was charged with two offences of arson and three counts of criminal damage. He may also have a possible developmental trauma disorder, as a result of exposure to neglect and domestic violence. He has a significant learning disability and is likely to have a psychotic illness exacerbated by significant cannabis use.

Presentation

D4 initially comes across as shy and somewhat reticent about speaking with individuals he does not know. He is diminutive in stature and appears to find the fact irksome. Most of his responses

are monosyllabic and he appears to have difficulty pronouncing some words properly from time to time. Inhibited body movements and an avoidant gaze reflect a lack of social confidence and forthright assertiveness.

Assessment:

(D4 has signed a consent form to be written about in this case study. All personal information related to D4 and anyone he knows has been anonymised throughout this thesis, please see appendix R)

Developmental history

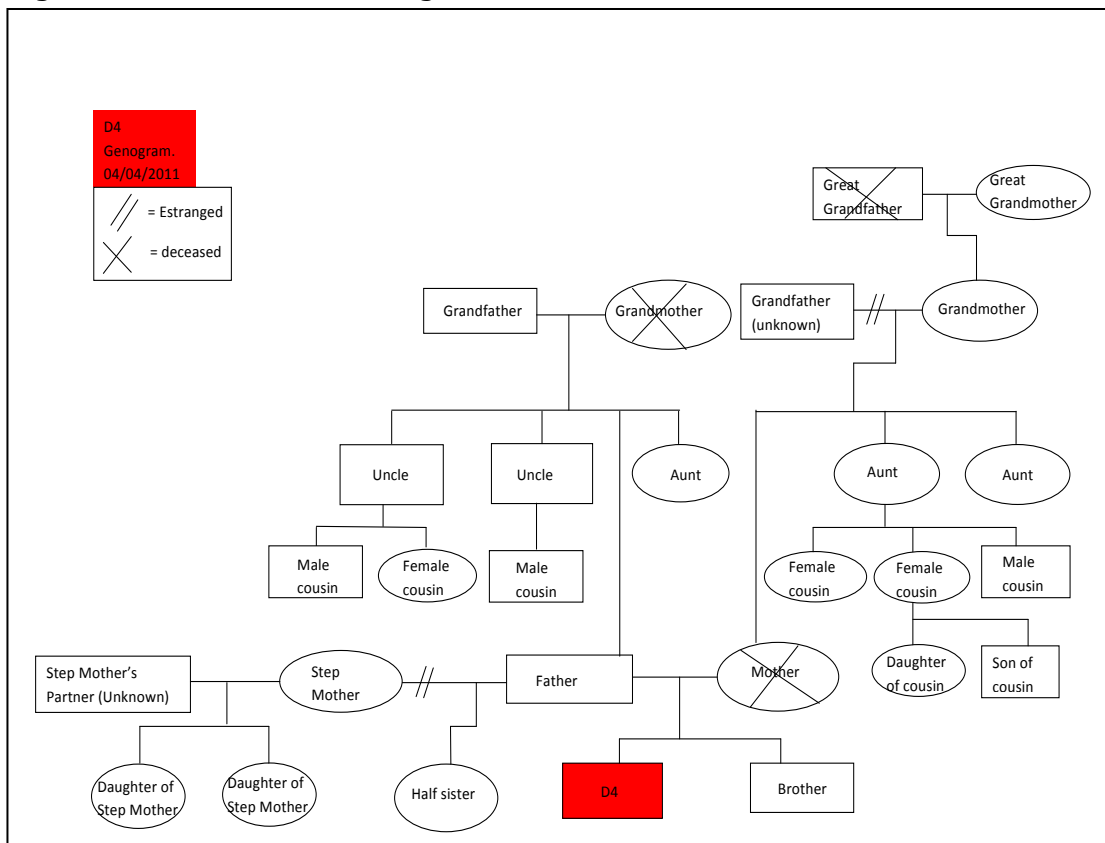
When D4 was born his mother had to have an emergency caesarean, as he had the umbilical cord around his neck. His early childhood was marred by domestic violence and neglect. D4 reported that he had a head injury when he was around 2/3 years of age, requiring an operation at the local infirmary to remove a splinter of wood. It appeared on interview that D4 had a mild facial dysmorphism (an abnormality that might indicate a genetic or congenital disorder like foetal alcohol syndrome).

Familial history - (please see the genogram on the next page, figure 5)

D4's mother had a history of alcohol misuse and was found dead in the bath by D4 when he was three years old (the death triggered by an epileptic fit). D4 said that his father had previously been a factory worker and lived alone; he is currently detained in a mental health hospital. D4's father has a long history of mental illness and of alcohol and cannabis misuse. He reports that his father has had at least two previous admissions to a psychiatric hospital for a paranoid psychotic illness. D4 has a full older brother who attends college. Following the

death of his mother, D4's father entered into a subsequent relationship and D4 has one half-sister as a result of this relationship, but he has no regular contact with her. His father and this woman separated approximately eight years ago due to domestic violence perpetrated by his father. In February 2010, D4 was residing with a foster carer. This was a private foster care arrangement, since the woman is a cousin of D4's father. This was considered appropriate at the time due to D4's father's on going mental health issues.

Figure 5. Constructed Genogram for D4



Educational history

D4 states that he had some one-to-one assistance at junior school, due to academic difficulties but also that he got into a number of fights with his peers. He says that he did not like school because

the teachers "got on [his] nerves." D4 stated he would verbally abuse pupils that he thought were "geeks." He said he also never went to lessons and was frequently truanting, going to McDonalds or sitting in his house when his father was at work. D4 reports having a number of fixed exclusions until he was permanently excluded in year 8, after he threw a chair at the head teacher. He reported that he was without education for two months until he joined a local youth project for excluded young people. According to D4, he remained there until the project closed when he was 14 due to "the manager running off with all the money." A subsequent move to a residential home for adolescents followed. D4 was attending another educational project five days a week. D4 says he liked it here because he was allowed to smoke cigarettes. He also claims to have been in less trouble there and to have attended more sessions because he had more friends. However, he claims the academic work was "difficult and boring."

Peer interpersonal history

D4 appears to be highly suggestible to the influence of his peers. According to D4 his truanting behaviour, consumption of alcohol, smoking of cannabis and assaulting of pedestrians all occurred while he was with a group of friends. He described himself as "popular" at school. D4 notes that his behaviour at school and the first youth project he attended was much worse than at the second youth project he attended, where his peers were behaving in a more pro-social manner.

Substance misuse and psychiatric history

D4 said his cannabis use significantly increased around March 2010 and reported that he first started using alcohol around the age of 11 years; drinking up to a bottle of vodka and three bottles of cider per day. According to D4 he would smoke at least six cannabis joints through the day, provided to him by his friends. D4 believes the amount of cannabis and alcohol he used was about the same as anyone else of his age and at the time he did not think it was a problem. He also reported that he first used cocaine at the age of 14 and that he used it on approximately four occasions.

Despite developing symptoms of psychosis, such as auditory hallucinations (which is thought to be cannabis induced), D4 continued to smoke cannabis and did not think it was a problem. He proclaimed that he likes to feel "stoned and forget everything."

D4 reportedly committed the index offences after drinking two bottles of vodka and smoking cannabis. He said he was hearing voices that told him to "set fires" and he could see "flames in front of his eyes." D4 was also under the influence of alcohol when he carried out the criminal damage offences.

Forensic history

In July 2006, D4's school reported that he had set fire to a group of bins located close to flats opposite the school. D4 informed the school that he had also been setting fires at home. In March 2010, D4 set fires to the girls' toilets in the park where he was attending

an education session. As a consequence, he was banned from the site. It is further documented that he had set a caravan near a youth centre alight and set fire to two buggies in a dwelling.

The index offence happened in July 2010 when D4 went to the male toilets of a Healthy Living Centre. He took some toilet paper and set it alight before leaving the building. The fire spread, damaging the entire interior of the toilets, which set off the fire alarm and alerted staff. The fire brigade attended the scene to put the fire out. Shortly afterwards, D4 went to a small set of flats above some shops (near to the Healthy Living Centre). He gained access to the communal hallway and then set a pushchair alight. This fire did not spread but caused smoke damage to the hallway. The fire brigade was also called to put this fire out. When D4 was interviewed he admitted to both incidents of arson, stating that he was alone and that no one had forced or dared him to set the fires. D4 maintained that he did not know why he had done it and that he had not intended to hurt anyone. He also stated that he was annoyed with himself for doing it and wanted help. D4 was aware his index offences included: damaging a car, smashing a kebab shop window, setting fire to pushchairs in the stairwell of a block of flats and setting fire to a toilet in a doctor's surgery. His memory for the chronology of the events was impaired and he was uncertain what order they had occurred in. After the index offence, D4 began making hoax calls to the police and fire service.

D4's other offences included possession of cannabis for which he was committed on bail. The offences of criminal damage in July 2010 were to the value of £5000. D4's school have also reported criminal damage over time. D4's foster carer reported that monies had often gone missing in the house and it was likely that D4 had been involved with this. During the practitioner's psychology sessions, D4 admitted to carrying out a number of interpersonal assaults while he was under the influence of alcohol and cannabis, in order to pay for illicit substances.

Psychometrics

(For an overview of further psychometrics conducted [but which are not as significant to this case study], please see appendix S. A Structured Assessment of Violence Risk in Youth [SAVRY] Risk Assessment was also carried out).

Pre-intervention psychometric testing

i) Children's Assertive Behaviours Scale (CABS)

The CABS is a behaviourally designed self-report measure designed to assess general and specific social skills across a range of situations relevant to children. D4 aged fifteen completed this in March 2011. D4 scored: 24 on the over-assertive scale (*average*), 20 on the under-assertive scale (*average*), but these combined for a total CABS score of 44 which is *above average*. The scores suggested that D4 has problems with both over-assertiveness and under-assertiveness at different times.

ii) Negative consequences of fire and victim empathy

This is a self-report measure that assesses an individual's understanding of the consequences of fire and his/her level of victim empathy for both imaginary situations and their own fire-setting history. D4 completed the assessment in March 2011. Overall, D4 had an adequate understanding of the different consequences of fire in the scenarios; however, he tended to reiterate similar responses, which may have been due to practice effects. For example, for an office building fire the consequences D4 identified were the business closing down and people losing their jobs. In his own crimes he again identified that office workers could be affected by losing their jobs. Similarly, in both imaginary and real scenarios, D4 listed that people hurt in a fire would be feeling angry and upset (because they would have to live somewhere else). For his own fire-setting history, D4 was able to identify some of the people affected, such as police respondents and people who worked in the building; but he did not offer too much insight into what they might be experiencing (they could have died). When asked what other effects the fire could have had, D4 replied that he could not think of anything; he appeared to find it more difficult talking about the real scenario than the imaginary one.

iii) The Trauma Symptom Checklist for Children - Alternate (TSCC-A)

D4 completed the TSCC-A on the 14th of April 2011. The profile form was shown in chapter 4 figure 4. The TSCC-A is a 44-item self-report checklist with the 10 sexual symptoms and preoccupation items

removed. These address concerns that some children might be upset by reference to sexual issues in a psychological test. The TSCC-A measures posttraumatic symptoms in relation to a number of traumatic events including: child maltreatment, exposure to domestic violence and natural disasters. As demonstrated in chapter 4, the TSCC-A has been used for both clinical and research purposes and has been demonstrated to be a reliable and valid measure (Briere, 1996; Crouch, Smith Ezzel & Saunders, 1999; Sadowski & Freiderich, 2000).

D4's under-response (UND) T-score was 42 which is below the 70 T-score threshold, his hyper-response (HYP) T-score was 67 which is below the 90 T-score threshold; this implies that his responses to the test and accordingly the test itself were valid.

The ANX scale reflects the extent to which the child is feeling hyper arousal and worry, as well as specific fears (for example of men or women). D4 did not seem to have any specific fears but does tend to worry a lot, his T-score of 62 while not quite at the T-score 65 threshold, is suggestive of difficulty in this area. The ANG scale examines angry feelings, cognitions and behaviours reported by the child, in this category D4 was in the normal population range. D4's highest T-score was on the DEP scale, this suggests D4 may have: feelings of sadness, unhappiness, loneliness, episodes of tearfulness and depressive cognitions, such as guilt and self-denigration. D4's high PTS T-score of 68 is likely to manifest itself in: intrusive

thoughts, sensations and memories of painful past events, nightmares and cognitive avoidance. D4 engages in a large amount of dissociation (T-score 70) characterised by: emotional numbing, one's mind going blank, pretending to be somewhere else, daydreaming, derealisation and memory problems. His overt dissociation could lead to reduced responsivity to the external environment or emotional detachment. His fantasy dissociation could be seen by others as an over willingness to immerse himself in things which are not real. Dissociative symptoms often serve to reduce painful internal experiences. Please see table 8 (below).

Table 8. D4 Pre-Intervention TSCC-A Scores

Clinical Scales	T-score	Range
Anxiety (ANX)	62	Sub Clinical
Depression (DEP)	71	Clinically Significant
Anger (ANG)	53	Non Clinical
Posttraumatic Stress (PTS)	68	Clinically Significant
Dissociation (DIS)	70	Clinically Significant
Dissociation- Overt (DIS-O)	70	Clinically Significant
Dissociation- Fantasy (Dis-F)	65	Clinically Significant

Narrative Formulation

Functional Analysis

A functional analysis is a behavioural assessment that explores the relationship between the individual and his or her environment (Falshaw & Browne, 1999). The framework utilises an ABC approach. A) Antecedents: what occurs before a certain behaviour (for example cognitions or emotions). B) Behaviour: the specific behaviour and the ritual involved. C) Consequences: what impact does the behaviour have for the individual (Falshaw & Browne, 1999). The early initial psychometric assessments, the background reports compiled by other

professionals and findings from clinical interviews with D4 were composited together. This was performed in order to formulate an early working functional analysis to explain his offending behaviour and what factors may have influenced his decision to offend (please see table 9 below).

Table 9. Functional analysis of D4's interpersonal relating style, educational difficulties, self-harming behaviour and offending behaviour

Antecedents	Behaviour	Consequences
Exposure to domestic violence.	Becomes more avoidant and fearful of others.	Lacks self-confidence and self-efficacy.
Difficulty forming relationships.	Becomes more Withdrawn.	Leads to a sense of not 'belonging'
Peer Rejection and Bullying.	He Becomes Frequently Truant and develops an active dislike of school were the bullying takes place.	Leads to a reduced ability for academic achievement.
Dislike of school and what it represents. It is made up of 'geeks'	Bullies other pupils of lower status to himself.	Reinforces his own feelings of self-worth and increases his own personal status.
Frustration and Difficulty in Recognising and Coping with his feelings. He experiences a lot of conflicting emotions and is unable to process the meaning of them for himself.	Substance Misuse (Alcohol and Cannabis)	Provides him with Escapism and he can temporarily avoid thinking about his build of emotions, by masking them.
Need for attention and self-gratification.	Associating with antisocial peers.	Provides a sense of approval and belonging. He does

		not feel the rejection he felt from other peers.
He still experiences residual Trauma Symptoms from his difficult childhood and associated feelings of: Anxiety and Depression.	Physical & Verbal Aggression.	Allows him to process his feelings (stemming from a place of hurt) as anger, which is a more acceptable and easily understood emotion for him.
Grievant thinking and feelings of anxiety and anger. Psychotic hallucinations tell him to 'break things'	Destructive Behaviours such as Criminal Damage.	Maladaptive coping mechanism allowing him to express the anger he feels. Externalises his feelings for him.
Anxious and depressive symptomatology leads to suicidal ideation. Psychotic hallucinations also link here telling him things like "hurt yourself...nobody likes you"	Self-Harm.	Maladaptive coping mechanism allowing him to express the depressive episode he is experiencing. Also gives him a way to manifest the anger he feels at not being able to sort out his problems onto himself. Finally, can be seen as a physical 'cry for help' as he is unable to ask for help.
Impulsivity, Lack of Consequential Thinking, Low mood and psychotic hallucinations.	Fire setting.	Offers sense of personal empowerment. It is also exciting for D4 and provokes a significant reaction in others.

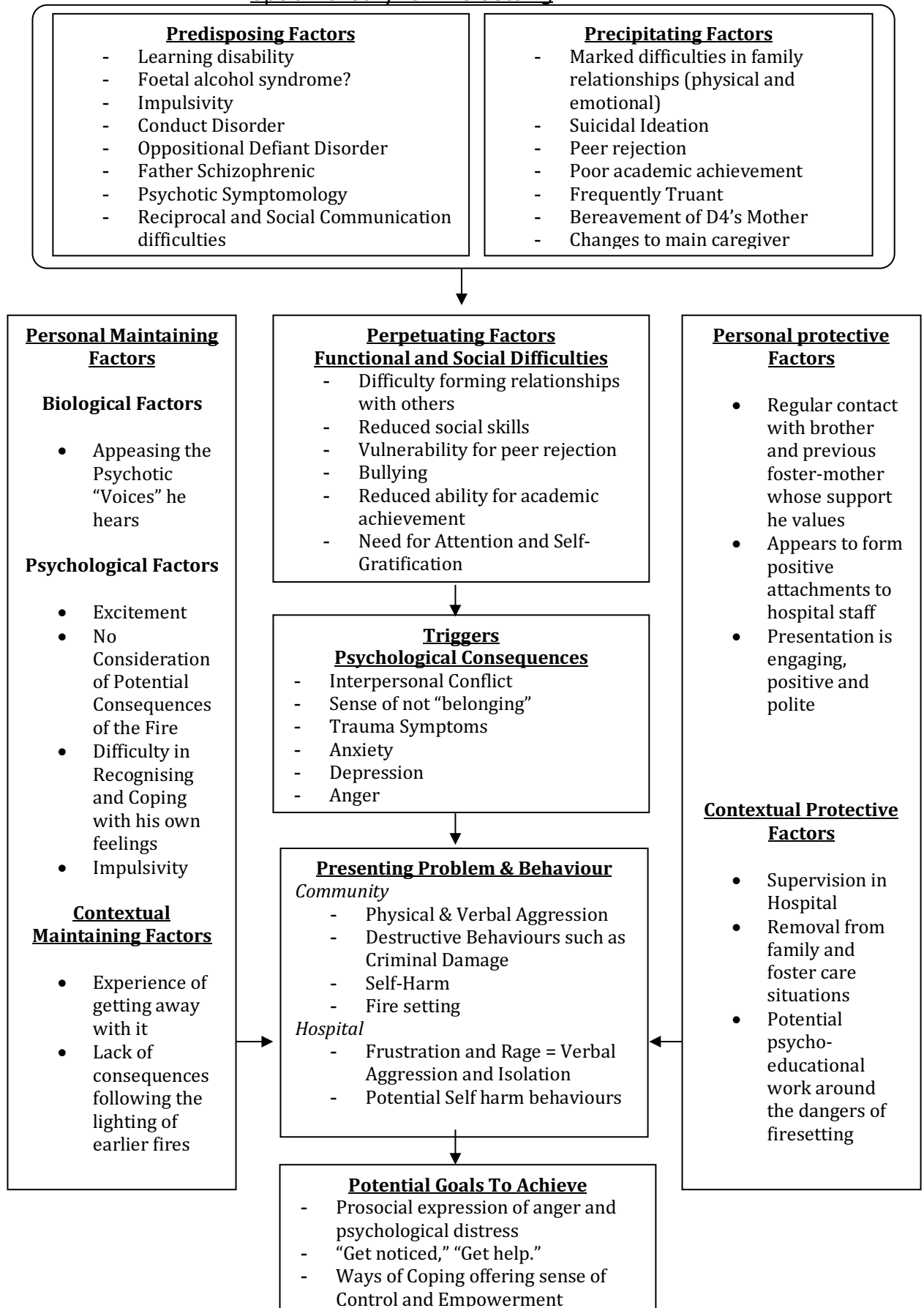
(For associated risk scenarios developed from the SAVRY and informed by this functional analysis, please see Appendix T).

Diagrammatical Formulation

'Four P's'

A theoretically informed approach to formulation utilising Weerasekera's 'Four P's' framework (1996) was carried out, this approach attempts to generate hypotheses about the reasons for D4's offending behaviour. Case formulation has been defined by a number of researchers, for example Eells (2007) described psychotherapy case formulation as a hypothesis about: the causes, precipitants and maintaining influences of a person's interpersonal, behavioural and psychological problems. When using the 'Four P's' approach to formulation the practitioner is encouraged to consider: predisposing, precipitating, perpetuating and protective factors; and the individual's coping skills in order to identify what may need to be targeted in therapeutic work (Weerasekera, 1996). Weerasekera (1996) described the 'Four P's' as follows: predisposing factors: the distal factors that increase vulnerability. Precipitating factors: the more proximate factors that trigger the onset or exacerbation of the problem(s). Perpetuating factors: the factors that maintain the problem(s) and prevent its resolution. And protective factors: the factors that prevent any deterioration of the problem(s). Please see figure 6 on the next page.

Figure 6. Diagrammatical 'Four P's' syndromical formulation for D4's behaviour. Informed by Jackson et al.'s (1987) 'only viable option theory' of fire setting



Intervention

A triangulated approach was decided upon, encompassing: 1) group therapy to address his social skills deficits, 2) an arson group intervention to address his firesetting behaviour, and 3) individual therapy to address his feelings of anxiety and depression.

Group based approaches in forensic inpatient settings

Focusing specifically upon the forensic psychiatric population, in recent decades there has been a greater focus upon how individual criminal behaviour is influenced by the social environment (Haynie, 2001; 2002), as well as this impacting upon one's physical and mental health (Van der Horst, Snijders, Volker & Spreen, 2010). Researchers have argued that types of relationships between forensic patients are fundamental in their therapy, in particular for group interventions. Furthermore, these relationships are considered to have an impact upon their future risk of recidivism (Van der Horst et al., 2010).

1. Social skills group for adolescents with learning disabilities

Forness and Kavale (1996) conducted a meta-analysis and found that on average 75% of students with learning disabilities have social skills deficits when compared to non learning-disabled peers. These deficits might be due to skills not being acquired, or a competing impairment (such as anxiety) prevents the acquisition or performance of the skill (Kavale & Mostert, 2004).

A group-based approach has a good evidence base within social skills training and allows the young people involved to practice skills within the group setting. It is a way of encouraging appropriate peer interaction and improved peer relationships. The majority of the ward members in the hospital attend which assists with building a group identity and allows patients to know what level of social skills knowledge other patients have.

Aims

1. To improve understanding and application of social skills.
2. To improve peer relationships and interactions.
3. To develop awareness of bullying and strategies to reduce bullying behaviours.
4. To develop skills which can be applicable both in an inpatient setting and in a community setting.

Format

The group developed by psychologists in the secure establishment, was run for half an hour each week for twenty weeks in order to best meet the needs of the young people with attention difficulties. The group incorporated didactic teaching, with activities to practice the social skills learnt. Patients work as a whole group, in smaller groups and in pairs with staff support, in order to develop positive group interactions, as well as ensuring each group member understands the session and works at a level best suited to their needs. Teaching methods employed include: group discussions, use of pictures and

role plays, watching DVD clips and discussing these in order to best meet the specific learning styles of different group members. This helps to maintain the group members' attention and keep the group interesting and interactive.

Much of the research base illustrates that social skills training is not easily extrapolated by clients to other settings (Kavale & Mostert, 2004). To counteract this there is emphasis within the group work to discuss how the skills learnt can be applied both within the ward setting but also in the community.

Topics covered within the group included:

- Initiating and maintaining appropriate conversations
- Body language and personal space
- Criticising and teasing - the consequences of this and how to deal with it
- Rumours and gossip
- Dealing with embarrassment
- Emotion identification
- Bullying - the consequences and how to deal with it
- Conflict resolution
- Electronic communication

2. Arson prevention group

No systematic approach to address the needs of young fire setters in England and Wales existed. The prison service and youth justice

board had no accredited programmes, though there was an intention to introduce one (Palmer, Caulfield & Hollin, 2007). The arson prevention group programme was developed by psychologists in the secure establishment and was based on an existing evidence base of research into effective measures and firesetting.

According to Tiffin and Cooper (2006) recurring motivations for fire setting include: unexpressed anger, impulsivity, poor problem-solving skills and escapism from problematic situations. There is evidence that for some firesetters an educational intervention (often incorporating visits by the fire service) is effective (Canter & Almond, 2002). However, for more persistent and pathological firesetters a more intensive approach is recommended (Tiffin & Cooper, 2006). Kolko (2001) has demonstrated that using CBT principles is beneficial in reducing the frequency of the firesetting behaviour. Prins (2002) showed that motivation to change can be increased by the firesetters gaining insight into their difficulties and recognising that this situation can be addressed.

Aims

1. To educate individuals in terms of fire safety and the risks and consequences of fire setting.
2. To help individuals to gain insight into the functions and maintenance of their own firesetting behaviour using CBT techniques.

3. To assist individuals in identifying: triggers, settings and vulnerabilities that could contribute to their future risk of firesetting behaviour.

4. To assist individuals with developing appropriate problem-solving and coping skills, to reduce future risk.

Format

In order to increase the young person's responsibility, an eclectic array of teaching methods was utilised, for example: role plays, group discussions and practical activities.

Each session lasted for sixty minutes duration. The number of sessions in each module was dependent on the group members' ability to focus on session content; therefore, the programme schedule is subject to tasks being completed rather than operating on a specific time frame.

Module One: was psycho-educational in orientation. It aimed (by the end of the module) for the young people to have a better understanding of how a fire develops and spreads and situations where fires are a risk. Additionally, what to do in the event of a fire was discussed. This initial module also aimed at motivating the young person to engage in the remainder of the programme.

Module Two: aimed to develop a greater understanding of the consequences of setting fires. The sessions encouraged an

understanding of the wider costs of firesetting and greater victim empathy within the young people. Consequences for the young person who set fires were also discussed.

Module Three: followed a cognitive-behavioural model and therefore focused upon understanding the links between: feelings, thoughts and behaviours. A life map was used to enable the young person to understand the development of their firesetting behaviour and when they could be most at risk of setting fires in the future. The young person was encouraged to challenge existing beliefs and to generate alternative thoughts; to understand what justifications (cognitive distortions) are and how they can lead to offending. Problem-solving, coping techniques and relapse prevention strategies were also discussed.

3. Individual psychology sessions

In 2004, the NHS recommended that education and general coping skills training (including problem-solving therapy) be used, in order to decrease deliberate self-harm and prevent suicidal potential and depression. Problem-solving interventions have been found to significantly reduce levels of: anxiety, depression and hopelessness. All of these conditions are by-products of deficits in problem-solving skills (Salkovskis, Atha & Storer, 1990). Problem-solving interventions with positive coping strategies, have been found to reduce maladaptive coping strategies such as parasuicidal behaviour, in terms of frequency and severity (Linehan et al., 1991).

CBT focuses on the relationship between: cognitions, emotions and behaviour. For example, children with anxiety disorders might be more likely to perceive situations as threatening (Kendall, 1993). Aggressive children perceive more aggressive intent (Dodge, 1986) and depressed children may assign more negative aspects to events (Kendall, 1993). These perceptions may subsequently lead to maladaptive/antisocial behaviour.

Aims

1. To encourage the individual to monitor his/her emotions and to consider what may have triggered him/her to feel that way.
2. To increase his/her knowledge of how his/her: thoughts, feelings and behaviours are interlinked.
3. To assist the individual in developing CBT techniques, in order to manage and reduce negative emotions and the behaviour that this may lead to, for example self-harm.
4. To promote and develop his/her use of behavioural coping skills and assertion, in order to help him/her to deal with negative emotions in a prosocial manner.

Format

1:1 psychology sessions occur for between 30-45 minutes duration once per week and are dependent on the needs and capability of the individual.

Paul Stallard's (2002) 'Think Good, Feel Good' programme workbook provided the raw materials for the sessions. Stallard's adapted CBT work (for use with children/adolescents) is the most widely used CBT intervention with young people in the United States and Europe by psychiatrists/psychologists/therapists. Belsher and Wilkes (1994) identified a number of developmental considerations that needed to be considered during the sessions. These encompassed: acknowledging the adolescent's self-centredness, promoting collaboration, promoting objectivity, using Socratic questions, challenging dichotomous thinking and involving a systemic approach with other significant people (for example the individual's care coordinator). The sessions operated in accordance with Whitaker's (2001) argument that presenting information more visually, using simpler language and presenting abstract concepts in more concrete ways, can make it easier for people with learning disabilities to engage in CBT.

Topics Covered within the sessions included:

- Thoughts, feelings and what you do
- Automatic thoughts
- Thinking errors
- Balanced thinking
- Core beliefs
- Controlling your thoughts
- How you feel
- Controlling your feelings

- Changing your behaviour
- Learning to solve problems

Evaluation

Behavioural Monitoring

The OAS-MNR (Overt Aggression Scale Modified for Neuro-Rehabilitation) was used. (For a more in depth look at the information collected by the OAS-MNR, including D4's antecedents to aggressive behaviour, please see appendix U).

Since his admission to the hospital staff, recorded observed incidents of aggression exhibited by D4 using the OAS-MNR. Information gathered from these recordings is used to look at the frequency and severity of aggression (physical aggression against others; objects and self; and verbal aggression), and to highlight common antecedents and styles of intervention used to manage D4's behaviour. Recordings focussed on incidents over a 12-month period. Encouragingly, all of the incidents (apart from one) occurred in his first six-month period after arriving, suggesting that D4 was benefitting from the stability the secure institutional environment afforded him.

Risk assessment scores

Approximately nine months after a *Structured Assessment of Violence Risk in Youth (SAVRY)* was completed, it was rescored and D4 had improved on a number of risk item scores. Please see the next page.

Peer rejection	<i>HIGH to MODERATE</i>
Stress and poor coping	<i>HIGH to MODERATE</i>
Community disorganisation	<i>HIGH to MODERATE</i>
Negative attitudes	<i>HIGH to MODERATE</i>
Low empathy/remorse	<i>HIGH to MODERATE</i>

And protective item scores:

Strong attachment and bonds	<i>ABSENT to PARTIALLY PRESENT</i>
Resilient personality traits	<i>ABSENT to PARTIALLY PRESENT</i>

Post-intervention psychometric testing

i) Children's Assertive Behaviours Scale (CABS)

The CABS was re-administered with D4 after he completed the social skills programme (in September 2011). D4 scored: -3 on the over-assertive scale (*below average*), -9 on the under-assertive scale (*average*) and these combined for a total CABS score of -12, which is *average*. The scores suggested that D4's problems with both over-assertiveness and under-assertiveness have improved, as his overall score has reduced from being *above average* to *average*.

ii) Negative Consequences of Fire and Victim Empathy

When the arson prevention group was completed, D4 again completed this qualitative psychometric (December 2011). In the first section on the different consequences of fire in the scenarios (imaginary scenarios), D4 replied in a similar manner to how he had done when he was first given the self-report questionnaire, but the answers tended to have greater detail. For example, in the pre-intervention

questionnaire, D4 gave the response of "upset...angry" to the question of: 'in what ways would these people be affected by the person's death? Can you think of one way each person would be affected?' In the post-intervention questionnaire, D4 replied: "police would have to carry the body out which would make them upset; family would be upset because they lost their family member." D4's responses in the second section (on the participant's own real fires) followed a similar level of improvement. In the pre-intervention psychometric, D4 said he "can't think of anything," when asked 'what other effects did the fire(s) you set have? Can you think of two other effects?' In the post-intervention psychometric, D4 responded: "police and fire brigade, they would be at risk because they are trying to get people out of the building...friends of me and friends of people in the building: would be worried what will happen to us." Overall, D4 demonstrated a greater level of insight and also empathy (commenting more on emotional content) than he had done previously. While by no means definitive, this is indicative that the arson intervention group has been beneficial in attempting to target D4's level of risk.

iii) The Trauma Symptom Checklist for Children A

D4 completed a second TSCC-A on the 14th of December 2011. D4's under-response (UND) T-score was 46, which is below the 70 T-score threshold, his hyper-response (HYP) T-score was 47, which is below the 90 T-score threshold. This implies that his responses to the test and accordingly the test itself are valid.

Clinical observations suggested that D4 was very settled in mood and mental state at the time the test was administered and this may have led to him under reporting the extent of certain symptomology. Historically, D4 engaged well in psychology sessions and he was very talkative when he was having external problems. When his mental state was more settled, he did not want to engage in psychology sessions as much, as they brought up "painful memories" for him. Accordingly, caution should be exercised when interpreting his results.

On the previous occasion when D4 completed the TSCC-A (the 14th of April 2011), his highest T-score was on the DEP scale, it was still high (T-score 59) and just below the sub-clinical threshold of 60. This suggested D4 may still have: feelings of sadness, unhappiness, loneliness, episodes of tearfulness and depressive cognitions, such as guilt and self-denigration. D4 engages in a large amount of dissociation (T-score 58) (just below the sub-clinical threshold), characterised by: emotional numbing, one's mind going blank, pretending to be somewhere else, daydreaming, derealisation and memory problems. His fantasy dissociation (T-score 60) could be seen by others as an over willingness to immerse himself in things which are not real. Dissociative symptoms often serve to reduce painful internal experiences. Based on D4's responses there was still a link between his feelings of depression and his likelihood to engage in fantasy disassociation to try and avoid it. However, the TSCC-A scores were indicative of an improvement in his overall psychological

wellbeing (please see table 10 below).

Table 10. D4 Post-Intervention TSCC-A Scores

Clinical Scales	Raw score	T-score	Range
Anxiety (ANX)	5	51	Non Clinical
Depression (DEP)	8	59	Non Clinical
Anger (ANG)	7	48	Non Clinical
Posttraumatic Stress (PTS)	9	54	Non Clinical
Dissociation (DIS)	10	58	Non Clinical
Dissociation-Overt (DIS-O)	6	56	Non Clinical
Dissociation-Fantasy (Dis-F)	4	60	Sub Clinical

Reliable Change Statistics

In order to measure change at an individual level, reliable change statistics are used (Wise, 2004). The assumption is that clinically significant change has something to do with returning to a normal population after previously being in a dysfunctional population. In order to demonstrate clinical significance, the client's level of functioning subsequent to therapy should fall two-standard deviations beyond the range of the dysfunctional population (Wise, 2004). Accordingly, the following reliability change index formulae were developed:

SE = Standard Error

SD = Standard Deviation

r = Reliability measure

Sdiff = Standard Difference

RC = Reliable Change (*RC needs to be above 1.96 for a clinically significant improvement*)

x^2 = Pre Test Score

x^1 = Post Test Score

$$1. SE = SD\sqrt{1 - r}$$

$$2. S_{diff} = \sqrt{2(SE)^2}$$

$$3. RC = \frac{x^2 - x^1}{S_{diff}}$$

The TSCC Professional Manual page 29 Table 7 gives the Standardisation Sample and Three Child Abuse Centre Samples Reliability scores for each of the TSCC Scales: ANX, DEP, ANG, PTS, DIS, DIS-O and DIS-F. This was supplemented with the appropriate dataset from Table 4: Means and Standard Deviations of TSCC Raw Scores for Younger (Ages 8-12 years) and Older (Ages 13-16 years) Males and Females in the standardisation Sample (TSCC Professional Manual page 25).

D4	TSCC	Depression	
SE =	4.0 $\sqrt{1 - 0.86}$	= 1.50	
Sdiff =	$\sqrt{2 \times (1.50)^2}$	= 2.12	
RC =	13 - 8		
	$\frac{2.12}{2.12}$	= 2.36*	= *Above 1.96, therefore clinically significant change.
D4	TSCC	Posttraumatic Stress	
SE =	5.1 $\sqrt{1 - 0.87}$	= 1.84	
Sdiff =	$\sqrt{2 \times (1.84)^2}$	= 2.60	
RC =	16 - 9		
	$\frac{2.60}{2.60}$	= 2.69*	= Clinically significant change.

D4	TSCC	Dissociation	
SE =	4.9 $\sqrt{1 - 0.83}$	= 2.02	
Sdiff =	$\sqrt{2 \times (2.02)^2}$	= 2.86	
RC =	16 - 10		
	$\frac{2.86}{2.86}$	= 2.10*	= Clinically significant change.

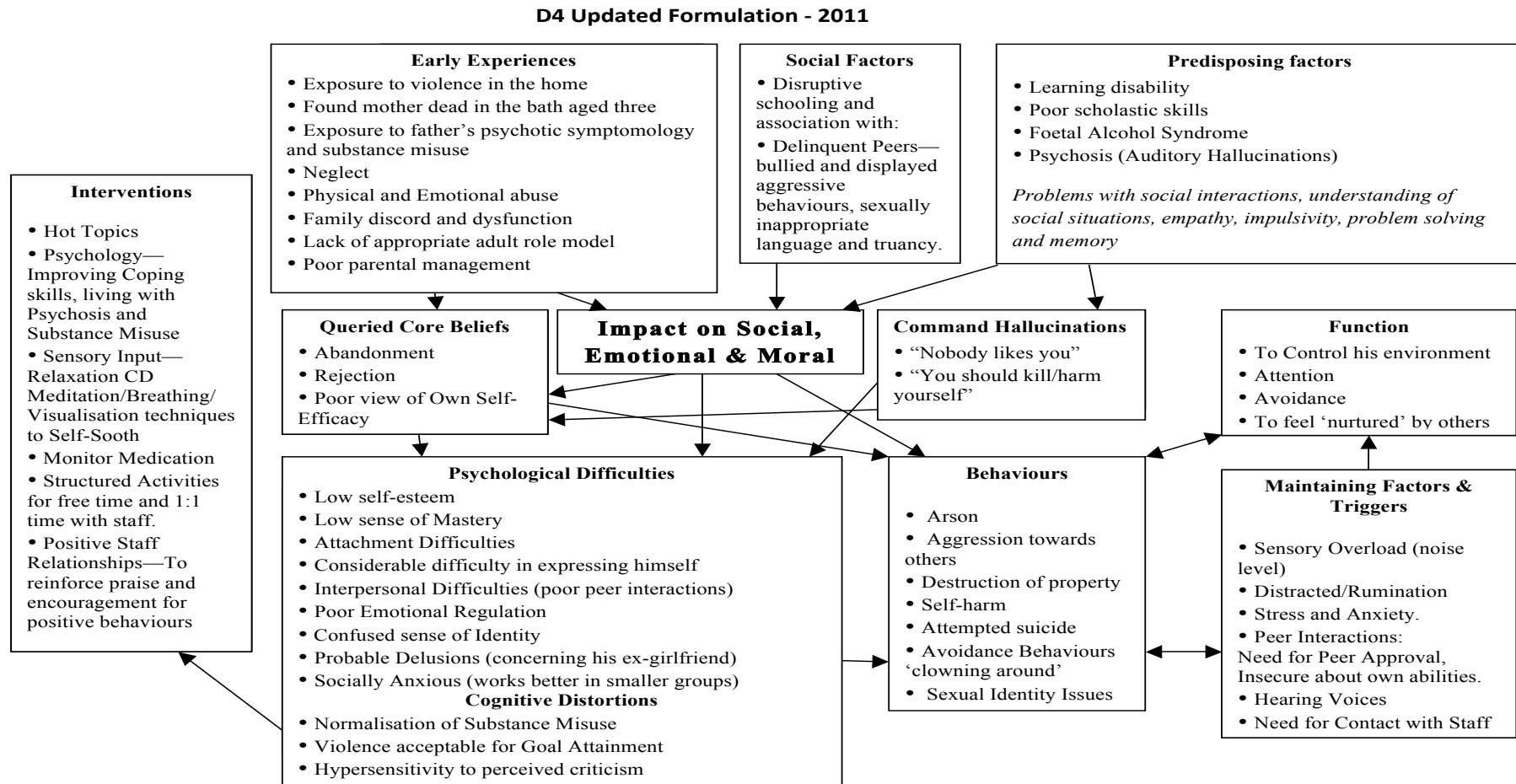
D4	TSCC	Dissociation Overt	
SE =	3.5 $\sqrt{1 - 0.81}$	= 1.53	
Sdiff =	$\sqrt{2 \times (1.53)^2}$	= 2.16	
RC =	11 - 6		
	$\frac{2.16}{2.16}$	= 2.31*	= Clinically significant change.

***The reliable change statistics for the insignificant TSCC-A scales are also available (please see appendix V).*

Clinically significant change was found in relation to D4's:
posttraumatic stress, depression, dissociation and overt dissociation.

Outcome:

Figure 7. Updated Diagrammatical Formulation for D4's Current Functioning



Summary and continued treatment plan

D4 was very honest when discussing his past offences. He said he found it difficult initially to adapt to life in a secure setting, since he missed his family. He also expressed his intent to abscond from the secure care establishment on more than one occasion.

The OAS-MNR showed that during the initial six-month period D4 displayed four incidents of aggression on three separate occasions. However, he had only displayed one instance of aggression in the following six-month period, suggesting a period of greater stability for D4. D4's initial SAVRY risk assessment put D4 at a high risk of violent reoffending, including firesetting; without close supervision and intervention. The factors contributing to his high risk included his: lack of remorse and empathy, a tendency to associate with delinquent peers, poor emotional regulation, a high level of impulsivity and a lack of insight into his problems. However, he had improved in relation to his dynamic risk on a number of the risk items and protective items, when the SAVRY was re-scored nine months later.

The aims for D4 to focus on during his next review period would be:

- To continue to monitor aggressive and inappropriate sexualised behaviours using the OAS-MNR.
- To clarify D4's current pattern of cognitive strengths and weaknesses through administration of the Adaptive Behaviour Assessment System (ABAS). Other cognitive assessments should also be completed if deemed to be necessary.

- For D4 to continue contributing to community meetings on his ward in the secure care establishment, to enhance his social skills further and to improve his confidence in expressing himself in a group setting.
- To continue to assess D4's needs with regards to intervention work. D4 may benefit from anger management work incorporating identifying triggers, emotional awareness and aggression reduction techniques and more therapeutic work around his propensity to self-harm.

Therapeutic Reflections

Recapping D4's experience in the secure care establishment and how his progression relates to the research literature.

D4 was a 15-year-old male, who had gone through: a social skills group, an arson prevention group and individual psychology sessions based on a CBT approach. In many ways, D4 adheres to the DSM-IV-R when it refers to a pathological interest in fire related to impulse control disorders (American Psychiatric Association, 2000). However, he would not meet a diagnosis of pyromania, as other arson motivators existed for D4, such as: psychotic symptomatology, substance misuse and antisocial personality disorder (resembling a pathological arsonist, see Forensic Psychology Practice [FPP], 1999). His pre-intervention TSCC-A scores on: depression, posttraumatic stress, dissociation and dissociation overt were clinically significantly higher than his post-intervention scores. This was in keeping with clinical observations in sessions, whereby D4 appeared to be more relaxed in later sessions compared to how he had been in the earlier sessions. It should be highlighted that Kroll et al. (2002) maintain that adolescents when initially taken into secure care may show onsets of: depression, anxiety and post-traumatic stress symptomatology. While these characteristics do seem to apply to D4 outside of secure care too; they could have been exacerbated when first resident in secure institutional care. However, within this establishment CBT work did seem to provide therapeutic utility (Kroll et al., 2002).

Ross, Polaschek and Ward (2008) argue that for offenders who come from an insecure attachment base it can take a long time to establish treatment readiness in the offender. This was certainly the case with D4; he came from a very chaotic background with negative childhood experiences. He had suffered emotional abuse, physical abuse and neglect as a child. He had learned that setting fires or self-harm was his maladaptive form of self-expression (see Santilla et al., 2003). Accordingly, D4 spent many years believing he could only rely on himself and he is very slow to trust others. The practitioner utilised a motivational interviewing approach (rolling with a lot of resistance) to foster the therapeutic alliance (Ross et al., 2008). Trust developed slowly overtime, but people who come from an insecure attachment base often take longer to feel comfortable enough being vulnerable before they can open up in a therapeutic context (see the works of Polashek & Collie, 2004; Ross et al., 2008).

When psychology sessions started with D4 he completed a range of psychometric assessments. These identified that D4 had difficulties with emotional regulation and empathic perspective taking. In the early sessions D4 presented as very anxious and he was monosyllabic and inhibited in his responses. He found doing the quantitative psychometrics to be "alright," but found completing the qualitative ones to be more challenging. The practitioner started to use pages with emoticons on them; D4 would point at the relevant pictures to express his feelings. This approach appeared to help him and he became more comfortable in psychology sessions. Bordin's (1979)

model would propose that the reason for D4 becoming more relaxed was because we had collaboratively gone through the three stages of forming a therapeutic alliance, after the initial sessions (goals/ tasks / bond). We had developed an ability to communicate at a suitable level for D4.

The therapeutic work with D4 was founded upon basic CBT in the beginning. He gradually began to recognise: thoughts, emotions and behaviours; and the interrelationship between them. The Beck's Youth Inventories and the TSCC-A had both identified that D4 had feelings of anxiety and depression, which factor into his self-harming behaviour. Accordingly, Paul Stallard's (2002) 'Think Good, Feel Good' work on using CBT to treat anxiety was thought to be the most appropriate therapeutic method with D4. This work encompassed looking at 'thinking errors' and how these can lead to us perceiving the world in a negative way. Overtime D4 became more adept at challenging negative cognitive distortions and choosing more pro-social responses to the presented scenarios. One of the coping mechanisms recommended for use with anxiety is to use progressive relaxation techniques and D4 found utility in these. He enjoyed practicing them in sessions and would claim to use them in his spare time too. D4 gradually became more talkative in sessions and able to express himself to a greater degree. He would fill in forms describing incidents occurring in the secure care establishment or in his personal life. The practitioner would then spend sessions speaking with D4 about the forms he completed and how he had addressed the

situation well and/or looking at aspects he might improve upon in the future.

Approximately five months into the sessions, D4's mental state began to deteriorate due to: anxiety over courtroom appearances, his relationship with a peer on the ward and confusion over his own sexual orientation. Furthermore, he began re-experiencing difficult memories triggered by being in the arson prevention group. D4 began to draw pictures depicting houses on fire and a graveyard with family members names etched on gravestones nearby. D4 claimed that dying in the fire would be his way of getting back to the people he loved and the people that loved him. For approximately one month, the drawings continued and D4 claimed to be experiencing a lot of auditory and visual hallucinations (seeing buildings on fire). D4 claimed to hear two angry male voices that argued a lot and said derogatory things about D4; encouraging D4 to "kick off" or to harm himself. At this time psychology sessions functioned as support sessions for D4 to try to process his feelings. Structured CBT work with D4 was postponed. As per Withecomb (2007, 2008) most interaction with D4 was addressed from a multidisciplinary team perspective and this proved to be useful.

The practitioner met with D4 after he had an aggressive incident on the ward. He said he was "hearing the voices" and "seeing the flames" and that had made him "kick off." The practitioner asked D4 to draw the fire pictures for him and to talk through how he was

feeling while he drew the picture. Interestingly, the picture he drew was the same as the others with one key difference; it did not contain him caught in the fire like the previous pictures had done. D4 did not notice this at first, but then said he had not felt angry when drawing the picture; whereas normally he would feel angry when he drew them. As noted by Linehan et al. (1991) coping strategies have been found to reduce maladaptive coping strategies, such as parasuicidal behaviour. After this incident, D4 stopped drawing the pictures and his mental state appeared to be more settled. Interestingly, D4's level of engagement in psychology sessions improved, when he was having personal difficulties and felt like he needed the chance to express himself. When his mental state was more settled his level of engagement was more superficial.

Once D4's mental state had become more settled, the practitioner started examining the Kolko graph technique with D4 (see Kolko, 2001; Kolko & Kazdin, 1986). He would need to use this when discussing his offences in the arson group and the practitioner (in consultation with his supervisor) felt it would be helpful for D4 to gain experience of doing this work in a 'safer' environment first. Past incidents of arson and how D4 felt: prior, during and after the incidents, were discussed (see FPP's [1999] work on antecedents, behaviours and consequences). D4 performed well in this task in individual sessions and it was noticeable that he had much more difficulty doing the same task in front of his peers (in the arson group).

D4 also progressed well in both his social skills group and his arson prevention group, while doing individual sessions (evaluated through psychometric testing and behavioural observation). This was very significant, especially since D4 has a learning disability and social skills are usually more impaired in this population (see Forness & Kavale, 1996). The types of relationships fostered between forensic patients are fundamental to their therapy, for their own psychological wellbeing (in particular for group interventions). Plus, they are also likely to impact on their future risk of recidivism (Van der Horst et al., 2010).

After completing work around emotional management and offence-focused work (for arson), substance misuse work was deemed to be appropriate. This was due to the historical link between D4's psychosis being exacerbated by cannabis misuse and his engagement in physical assaults and criminal damage, being fuelled by alcohol consumption. D4 recognised the positives and negatives of narcotics and alcohol misuse. The next stage was to conduct cost/benefit analysis therapeutic work into challenging D4's propensity for drug/alcohol use into the future. D4 engaged well in psychology sessions, he was able to meaningfully engage and was motivated. In the early sessions he would often opt out but he did not do this as the sessions progressed.

D4 appeared to display mental rigidity in which he believed people thought of him as a bad individual, therefore he sometimes responded

to this and believed he might as well be the worst individual he can be. This appeared to serve as D4's 'only viable option' for him when he felt under distress (Jackson, Hope & Glass, 1987). This maladaptive cycle of trying to manage dysphoric states of depression and chronic anger permeated in a number of ways for D4. Dutton (1999) proposed that offenders who have been abused as children develop: attributional styles (such as blaming of victims), defensive strategies such as externalising and projection, a tendency to ruminate on negative emotions and accumulations of internal tension. D4 displayed a large amount of mental rigidity and if asked to do something directly he would refuse without even considering the request. All of the factors Dutton (1999) mentions are present for D4, but he was beginning to develop greater insight into how his life choices in the past did not help him and left him in a situation he does not want to be in. Hopefully, one he can successfully rectify.

Discussion

The young person in the case study largely adhered to Kroll et al.'s (2002) research on adolescents in secure institutional care. Post-traumatic stress symptomatology encompassing depression and anxiety was unfortunately apparent; and D4 initially struggled to adapt to his new environment (even attempting to abscond). However, as noted by Withecomb (2007, 2008) one strength of tier 4 secure care in the United Kingdom is the availability of multi-disciplinary teams (these teams are not normally available in residential care). In the care establishment, D4 had: psychiatry, psychology, social work, occupational therapy and nursing attempting to meet his diverse needs. These professionals attempted to operate in a manner consistent with Vaughan's (2004) assertion that extended in-patient care in secure institutions must utilise a specialised response to address specific problems.

As Boendermaker and Van den Berg (2005) argued: risk assessment, psychotropic medication, adapted education, CBT and familial systemic work constitute useful strategies for use with securely institutionalised adolescents. D4 benefitted from all of these (apart from family involvement) and his TSCC-A scores documented his therapeutic progress. Koehler et al. (2013) and Scherrer (1994) proposed that treatment programmes in which a CBT methodology is prioritised show the greatest efficacy. Again, this was clearly evident with D4 and he appeared to benefit more from this treatment approach the longer he was exposed to it.

As mentioned earlier, family involvement is deemed to be important in the research literature (Boendermaker & Van den Berg, 2005). Bringing a 'family environment' into the secure care institution also helps. Chapters two and three both demonstrated how important the characteristics of care staff can be in helping to ameliorate vulnerable young people. Scherrer (1994) maintains that a 'therapeutic milieu' helps to facilitate the most successful treatment outcomes for young people in care. This care establishment operated on 'therapeutic milieu' principles and indeed even held workshops to educate its care staff on therapeutic community principles. D4's progress was indicative of the utility of care settings adopting this approach.

The research literature stipulates that increasing the interpersonal skills of delinquent young people helps to aid their psychological wellbeing and to reduce the likelihood of recidivism (Lipsey & Wilson, 1998; Knorth et al., 2008). D4 showed improvement in his pre and post Children's Assertive Behaviours Scale scores; this corresponded to his behavioural monitoring results (OAS-MNR) also improving over time.

D4's behavioural monitoring is also significant when his reduction in aggressive behaviour over time is considered with the research literature. Dishion et al. (2001) maintained that a young person seeing another resident behaving in a deviant manner would lead to the young person viewing deviant behaviour as being acceptable. Lee et al. (2010) believed the opposite and claimed that young people

would view their prosocial peers as being positive role models. Indeed, Goldstein et al. (1998) advocated for having young people mix with each other in a group dynamic as much as possible, in order to aid the young person's improved socialisation. D4 was involved in two formal treatment groups (social skills group and arson prevention group) and he consistently interacted with the other young people in the secure institutional care establishment. The practitioner felt that this had a positive impact for D4 and helped to reduce his shyness and to boost his confidence. Anecdotally, it appeared that D4 was less inclined to behave in a deviant manner as he became more comfortable around his peers and care staff.

Rationale for chapter six

The case study demonstrated that through an individualised approach to intervention, a propensity for antisocial behaviour (especially arson) can be reduced and a sense of psychological wellbeing can be improved (based on D4's pre and post TSCC-A scores). Secure care does present some differences to residential care for young people; please consider the: stigmatisation and systemic issues raised in chapters two and three (for example peers in the community viewing young people in care differently). However, responsive care (regardless of setting) appears to be based on the support provisions provided (including the therapeutic milieu) and the relational opportunities available to the young people. These factors are crucial in helping to shape young people's experience of the care system. The next chapter now attempts to pull the learning points from the

different chapters together, to yield some suggestions about what could help to improve the experience of young people entering the care system in the future.

CHAPTER SIX

Discussion

The previous four chapters have highlighted many aspects of the care system that could be developed in order to improve the psychological wellbeing of the young people who reside there currently and/or will do so in the future. Many salient issues re-occurred through more than one chapter in this thesis and thus should be considered, as they could be indicative of a given phenomenon.

The first of the findings to arise across the qualitative review (chapter two), the empirical research (chapter three) and the case study (chapter five) was the importance of the relationships young people in the care system have with their peers. The young people in the United Kingdom care system are usually coming from a vulnerable psychological state (due to problematic backgrounds) and the relationships formed by the young people in the care establishment are of paramount importance in shaping their 'lived experience' within the care system (Emond 2014; Tatlow-Golden & McElvaney, 2015).

The interpersonal dynamics young people have with peers has been shown to play a key role in how they behave in care; and it seems to be significant in treatment outcome for the young people also. In chapter two, the themes: *Peer support more important to young people than adult support* and *the Social hierarchy & impression management amongst young people* both showed how young people are heavily influenced by peers and that they shape their own

behaviour accordingly. Both care workers and young people in the *Peers* theme in chapter three discussed how social role modelling could have a positive or detrimental impact on other young residents. Some of the young people were happy to describe their peers as being like siblings; other participants in contrast viewed their peers as people they lived with who were rather unpleasant towards them. The young person in the case study was a nice illustration of the power of peer influence and impression management. D4 had a need for peer approval and was hypersensitive to perceived criticism. When he was in therapy groups he was afraid to be honest in front of his peers for fear of being judged and would agree with whatever response they gave, regardless of how he personally felt about it (see Haynie 2001, 2002). In D4's behavioural monitoring records there was a clear pattern (please see appendix U). Under his antecedents to aggression, it is noted that the most frequent antecedent was a 'response to a patient's verbal behaviour', accounting for 75% of all recordings. The examples of aggression detailed highlight that D4 responds aggressively when other patients make inflammatory remarks or comments to him.

The behavioural monitoring data from chapter five also raised another key finding across the thesis and that is the nature of the residential environment and how structured it stays at adhering to boundaries. Appendix U notes that under the frequency and type of aggression in which D4 engaged; 100% of recordings occurred during unstructured times, when there were no planned staff led sessions. Additionally,

75% of incidences occurred when the ward environment was noisy. Chapter two provided the theme of *Structured environment versus personal autonomy*; it highlighted how some young people enjoyed the structure and stability the care establishment provided for them. Other young people felt that the residential establishments they were in were too restrictive. These findings were mirrored in chapter three under the themes: *Care environment* and *Level of agency*. Most of the young people and the care workers felt that structure and boundaries help the young people; but there needs to be more consistency in how rules and boundaries are maintained: between organisational settings, permanent staff and temporary staff. These themes also suggested that there are practical measures residential care establishments can take to help make the environment to feel more like a 'home.' In terms of making an environment feel like 'home,' chapter two provided two studies that operated off a therapeutic community ethos and this relational model appears to be helpful for the young people (Carter, 2011; Gallagher & Green, 2012). The secure care setting in chapter five also utilised 'therapeutic milieu' and again this appeared to facilitate an environment that D4 felt comfortable and became increasingly settled in.

Another finding occurring across the entire thesis was how divisive an issue family contact is for young people within the care system. The international research in chapter two yielded the theme *Parental contact*, which showed that family contact can be positive in many cases but it can also be negative for some young people. These

findings were echoed in the opinions of care workers and young people in chapter three's theme *Familial ties*, but they also pinpointed how care establishments can focus heavily on parental contact while often not being inclusive towards wider family members (for example grandparents). In chapter five, D4 came from a highly problematic background and was often subjected to physical abuse by his father, but he still spent psychology sessions speaking about how much he wanted a reunion with his father and brother when he is released from secure care.

As purported by Flood and Street (2000) young people's problems are frequently addressed inappropriately, leading to breakdowns and multiple placements. Chapter two provided the *Termination of care* theme and chapter three the *Leaving care* theme. In both cases the damaging impact of multiple placements was highlighted. This also relates to the other themes of *Sense of belonging* (chapter two) and *Fitting in* (chapter three). When a young person is being moved around a lot, how are they meant to adapt quickly and in a meaningful manner; it must impact on his/her motivation. In chapter five, D4 was moved around between multiple placements. There now appears to be a positive treatment pathway for D4 in secure institutional care. This is meeting his needs through an individualised approach and he appears to be channelling his own motivation towards this in the right way instead of negatively, as he has done in the past. This suggests that many of the young people in the care system may be instrumental in bringing about psychological change

for themselves (as seen in Nourian et. al's [2016] resilience study); or that the care establishment could be instrumental in bringing about positive change for the young people (as seen in Carter's 2011 therapeutic community study).

In reality, helping to boost young people's psychological wellbeing and improving treatment integrity in the care system are probably going to require both external and internal change (as the *Psychological wellbeing* theme in chapter three showed and the TSCC-A research literature in chapter four discussed). However, from a sociological standpoint it is the care system we need to focus on while being mindful of Johansson and Andersson's (2006) research (young people in the same situation view the situation differently).

Linehan (1988) argues that reframing of self-destructive behaviour into positive behaviour requires automaticity so that prosocial behaviour becomes the habitual behaviour. This is achieved through: (1) increasing interpersonal skills in conflict situations, (2) improving internal regulation of difficult emotions (like anger), (3) developing coping skills to tolerate emotional distress thereby facilitating change, and (4) learning other self-management skills (Linehan, 1988).

The *Pros and cons of therapy* theme in chapter two suggests that therapy can help to achieve this personal change; some of the young people in chapter three spoke about the utility of counselling for young people. In chapter five, D4 had begun this process but he

illustrated that going through the stages of change model with troubled young people is characterised by frequent shifts between the stages and it is rarely a linear process (Prochaska, DiClemente & Norcross, 1992).

What the care system gives to those who have gone through it

Throughout the thesis the views of young people towards care has been in the main very positive. Although aspects of care have been maligned in parts of the research literature, in most cases the young people themselves reflect upon positive experiences they had while in care and how these experiences helped to build their characters for the future. One young person in chapter three outlined the growth process: *"I got to grow up a lot. Like I was quite immature and I didn't have the best views on life when I went in, but then I have come out of residential care with a better view on life nearly. I have grown up and I'm a lot more mature than I, than I would expect"* (YP - P17 P12 L19-22).

Young people throughout this thesis spoke about growing up in difficult circumstances and the impact this had on their own sense of identity and wellbeing. They described the care establishment as being their 'home,' and they often viewed their peers as being like 'siblings' and the staff as being 'friends' or 'mother' or 'father.' The young people spoke about the 'stability' being in care gave them; the opportunity to meet their educational/occupational needs. Many of the young people spoke about the 'safety' they felt in care and said that

the boundaries helped them with respect to: friendships, substance misuse and avoiding criminality. Being in care gave the young people a place to fit into, where they felt a sense of belonging. Many young people were also able to repair relationships with family members and felt like the staff supported them in transitioning out of care. Indeed, a lot of the young people felt being in the care system was something they would always remember and it had helped to shape their future lives for the better.

One of the young people in chapter three spoke poignantly about what being in care meant to him. *"I think if my mam hadn't put me into care my life would have turned out a lot differently, you know. We would have lost the relationship I think, me and my mam. But I actually would thank her now for bringing me into care. That's what I'd say to a person, it might look bad to begin with but down the future you'll look back and say that it was probably one of the best things that could happen to you. The majority of people that I know, that's what they have said. That if they hadn't have gone into care their lives would have turned out differently, like"* (YP - P13 P14 L32-39).

Researcher reflections on conducting qualitative research on the care system

As part of preparing to conduct this ethnographic research the researcher provided a timeline on how long it would take to collect the empirical data. When the researcher began the data gathering

process it quickly became apparent that the timeline was incredibly aspirational. With researchers there can be a tendency to always aim towards best practice and to expect things to run smoothly, however, the real world of the care system is a lot more 'messy.' Going through the care system was a growing experience for the participants in this research; this was mirrored for the researcher in bringing the thesis to fruition.

Firstly, there were a number of interviews that had to be postponed or rearranged due to the changing nature of staff rotas and the unpredictability of the planned schedules in the residential establishments.

Not all of the interviews scheduled to occur could be facilitated. Two interviews were agreed with the participants but unfortunately could not take place and the researcher had to follow up with other potential participants. This was because the two identified participants were incarcerated in prison at the time and the prison refused to grant permission for the audio recording of the interviews to take place. One 'incident' occurred during an interview with a care worker; when a current resident needed urgent assistance. The interview was terminated and it was completed at a later date over Skype. There were also small miscellaneous considerations, such as shouting and screaming from current residents when the past residents were being interviewed. Even logistical issues occurred, for example, the care staff not being able to drive the researcher to the train station

because of turbulence in the care establishment impacting on staffing levels.

Conclusion

In concluding this thesis, the researcher thought that listing some of the implementations for improving treatment integrity (based on the findings of the earlier chapters) would be the most meaningful. This helps to demonstrate the value of conducting research into young people's experiences of care, for the point of improving care services (which is under researched). It also serves to capture the young people's lived phenomenological experiences within the care system; since the impact of these experiences will inevitably shape them into the future. The participants in chapter three described how speaking about this topic had been cathartic for them. The author brought together information garnered throughout the process of completing all four previous chapters; but chose to write this section from the worldview of residential care within Fresh Start (as outlined in chapter three) (since this is the care system the author has the most experience of).

Suggestions

Towards improving treatment integrity for young people in care

There are a number of changes that could be implemented to improve treatment integrity for young people in residential care. Improved communication is needed at all levels of the care system. At the residential establishment level, communication between: 1) care

workers and the young people, 2) care workers and senior management and 3) senior management and the young people; needs to be examined. Communication should be more: honest, transparent and holistic in including everybody in the care process. This would facilitate increasing responsibility and ownership in his/her own care pathway within the young people.

At a wider systemic level, so many stakeholders: HSE, social workers, care workers and educational staff; are often operating on their own agendas and they are not collaborating with one another to run things in the most efficient manner.

The care workers outlined how they often feel supported by their residential establishment manager but do not feel supported by the wider organisation. They cited: a lack of training, an inability on the part of the organisation to acknowledge and to manage dysfunctional staff team dynamics, emotional loneliness and not feeling like the role they play was being valued enough, as being inhibitory factors in allowing them to perform their job role to the best of their abilities.

Stigmatisation encompassing feelings of shame and a lack of acceptance were one of the biggest issues facing the young people in residential care. Greater provisions need to be invested into helping residential care establishments to integrate into communities in a more positive manner. This means improved facilities but more importantly fostering links with local communities, so that young

people in care are not viewed differently to their peers in 'mainstream society.'

Many of the young people felt like they were treated differently to other residents and were not devoted as much time, because they behaved more prosocially. Care Workers should set aside time for each young person, so they feel as valued as his/her peers, and do not feel like they need to engage in maladaptive behaviours to garner attention.

Having a male and female presence among the care worker teams was something that the young people believed to be very important in recreating a positive 'family dynamic' for them. Currently, many staff teams are all female and this is something for senior management to consider, in terms of what dynamics might best serve the young people's needs.

Arranging to bring in ex-residents who have been through the care establishment (and the care system as a whole), might help current residents. Being able to relate and understand the opinion of another individual (who has been through the experience you are currently going through), is likely to resonate with the current young people in a way that care workers would find difficult to achieve.

Organisational due care and attention should be devoted to allocating young people to the most appropriate residential care establishment

and key worker for him/her. This occurs to an extent but is largely determined on a 'case load' basis; when a relational model is likely to be much more successful (this should include consideration of existing peer relationships). This greater emphasis on positive placement of young people into the correct residential establishment for him/her, is likely to limit the frequency of placement breakdowns (which are known to have detrimental effects on the young person's psychological wellbeing).

The young people and care workers were largely positive in their views on residential care. However, their views on: preparation for aftercare, aftercare itself and independent living were more conflicted. The central message here is that the journey for young people from being supported in care as children (below 18), to having to independently support themselves, is not a linear one. People need to be allowed to make mistakes and to learn. At the moment the system is completely arbitrary and new policies need to be put in place to ensure that preparation for independent living and aftercare is happening for every young person who is entitled to it.

Within the research it was also apparent that many young people felt disillusioned with how their time in residential care ended. Endings are very important psychological markers (especially for young people). Giving the young person due time to prepare to leave and perhaps visiting the place he/she will go to next prior to moving out of the care establishment, would be beneficial. Furthermore, giving the

young person the opportunity to say goodbye to the other residents and the care workers before they leave is fundamental. For his/her own psychological wellbeing before moving on, but also for the other young people who remain in the care establishment and how they will be impacted.

When the young person transitions to a new care placement or independent living, there should still be provision for the young person to maintain meaningful relational ties (contact) to care workers they are close to. This attachment is important to the young person in feeling supported and it matters to the care workers too.

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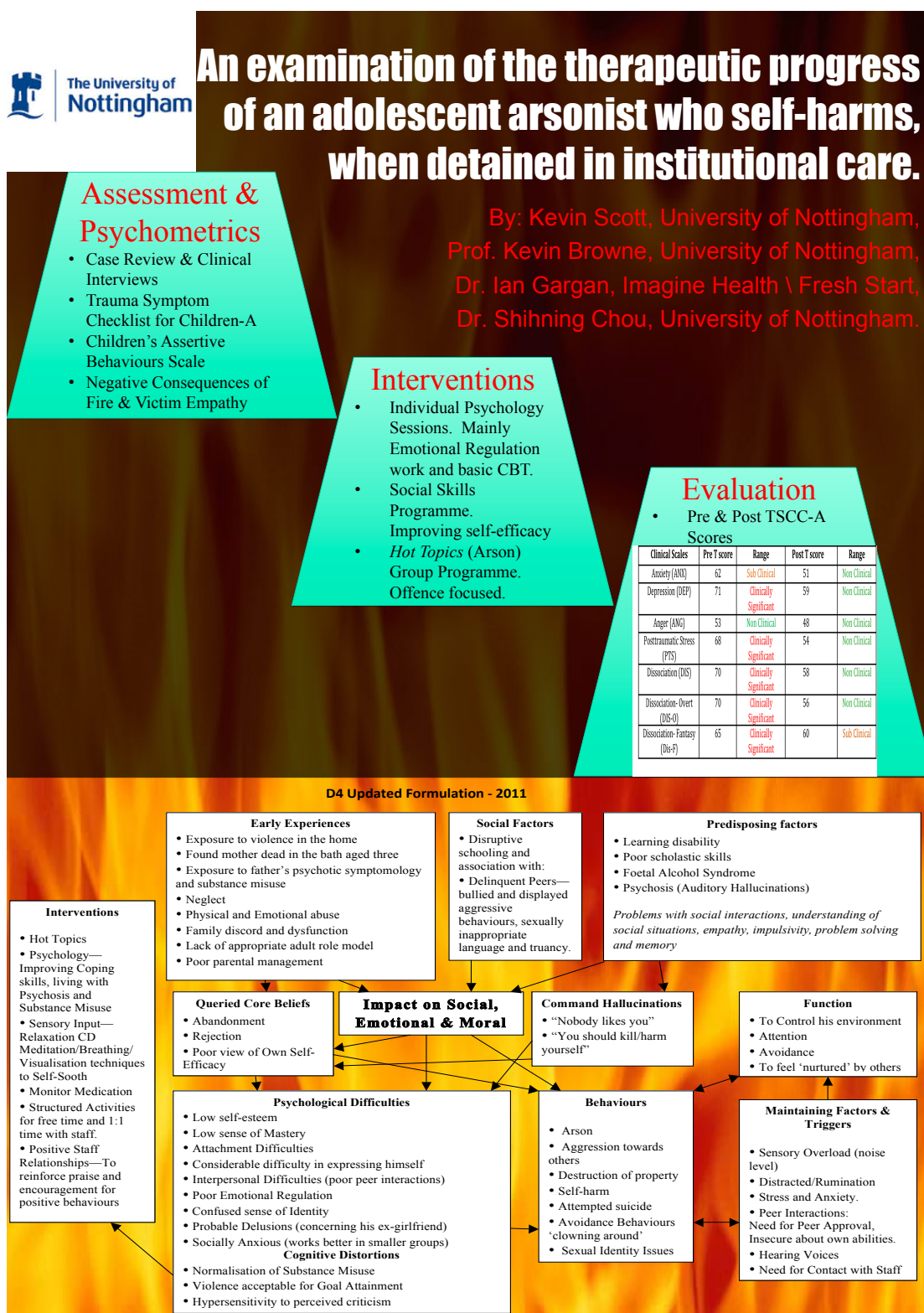
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APPENDICES

Appendix A

Poster Presented at the 2014 NIBPS Annual Conference



Appendix B

Search syntax - first database search

All OVID (Embase, PsychINFO and Medline)

(Young people) OR (Children) OR (Adolescents) OR (People)
AND
(Care) OR (Residential care) OR (Institutional care**)
AND
(Experien*)

No limits applied other than title and abstract search only.

Search syntax - second database search

Social Care Institute for Excellence (SCIE) - Social Care Online*

Campbell Collaboration

Cochrane Central

(Young people) OR (Children) OR (Adolescents) OR (People)
AND
(Care) OR (Residential care) OR (Institutional care)
AND
(Experienc*)

Title and abstract search performed.

*The SCIE standard search has an option to perform an advanced search – this streamlines the search results accurately by relevance. This option was utilised and it brought the 2,526 search results down to 400 search results.

Appendix C

QRQC Form for Quality Assessment

Qualitative Research Quality Checklist

Reference Review:

Reference Number:

Reviewer:

Date(s) of the Review:

Reference ID:

Author(s):

Year of Publication:

Title:

Location of Reference:

Source:

☐ Book

☐ Dissertation

☐ Conference Paper

☐ Report

☐ Peer Reviewed Journal Article

☐ Government Publication

☐ Non-Peer Reviewed Journal
Article

☐ Other: _____

Search Method:

☐ Electronic Search:

☐ Hand Search:

☐ Grey Literature:

☐ Reference Check:

☐ Consultation:

☐ Other: _____

Qualitative Framework	Applicable	Addressed	Review Comments
1. Is the purpose and research question(s) stated clearly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
2. Is a qualitative approach appropriate to answer the research question (e.g., exploratory vs. explanatory)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
Study Setting	Applicable	Addressed	Review Comments
3. Is the setting of the study appropriate and specific for exploring the research question?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
4. Is there prolonged engagement to render the inquirer open to multiple influences?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
5. Is there persistent observation in the setting to focus on the issues relevant to the research question?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
Study Design	Applicable	Addressed	Review Comments
6. Is the research design appropriate for the research question?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
Sampling Procedures	Applicable	Addressed	Review Comments
7. Is the process of sample selection adequately described and consistent with the research design/ research question?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
8. Is the sample size and composition justified	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

and appropriate for the research design/
research question?

☐ Unclear ☐ Unclear

Data Collection	Applicable	Addressed	Review Comments
9. Are the methods for data collection adequately described?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
10. Are the methods for data collection consistent with the research question?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
11. Is a range of methods used for triangulation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
12. Is there an articulation of who collected the data, when the data was collected and who analyzed the data?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
13. Is there an audit trail regarding data collection including tapes, memos, and note taking of decisions made in the study?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	

Ethical Issues	Applicable	Addressed	Review Comments
14. Is there adequate consideration for ethical issues, such as informed consent, privacy, and confidentiality and protection from harm?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	

Reflexivity of the Researcher	Applicable	Addressed	Review Comments
15. Has the researcher identified potential and actual biases (both as researcher and in the research design)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
16. Did the researcher integrate the use of a reflexive journal in the data analysis and interpretation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
Data Analysis	Applicable	Addressed	Review Comments
17. Is the process of data analysis presented with sufficient detail and depth to provide insight into the meanings and perceptions of the sample?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
18. Are quotes used to match concepts and themes derived from the raw data?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
Findings	Applicable	Addressed	Review Comments
19. Do the findings emerge from the experiences/ subjective interpretations of the sample?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
20. Was member checking employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
21. Does the researcher provide "thick	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

description” of the sample and results to appraise transferability? Unclear ☐ Unclear

Authenticity	Applicable	Addressed	Review Comments
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22. Were stakeholders involved in the project?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
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Fairness	Applicable	Addressed	Review Comments
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23. Did all stakeholders have equal access to the research process and benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
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Promotion of Justice	Applicable	Addressed	Review Comments
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24. Did all stakeholders enhance their understanding of their own reality due to the research process and results?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	
25. Are the stakeholders empowered to act as a result of the research process?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear	

Overall Impressions:

Appendix D

NICE Guidelines Pro Forma for Data Extraction in Qualitative Research

Heading	Subheading		For completion by reviewer(s)
	Bibliographic details		Journal article Report Website Book Book chapter
	Name of reviewer	Circle	Reviewer 1 Reviewer 2 Reviewer 3
	Eligible?	<i>Does the evidence fit within the scope of the review? i.e. non-UK, professional data only, quantitative data only</i>	Yes No Unclear
	Reviewers' rating	<i>As matrix</i>	
	Typology	<i>Review (systematic or narrative)? Primary research? Case studies or descriptive accounts?</i>	Systematic review Narrative review Primary Research Case studies Descriptive account
	Participants	<i>Evidence from service users, carers, policy or practitioner</i>	Evidence from... ... people with dementia ... carers ... PWD and carers ... professionals ... professionals and PWD ... professionals and carers ... professionals, PWD and carers
	Study aims	<i>What were the study's aims and purpose?</i>	
	Key findings	<i>What are the key study findings?</i>	

	Evaluative summary	<i>Draw together brief comments on the study as a whole and its strengths and weaknesses. Is further work required? What are its implications for policy, practice and theory, if any?</i>	
	Service users' and carers' perspective	<i>Does the study report on the experience of service users? Does the study report on the experience of carers? How were they involved in the study (e.g. as advisors for the research, in the design and execution of the study, in dissemination)?</i>	<div>Users</div> <div>Carers</div> <div>Professionals</div> <div>Advisors</div> <div>Design</div> <div>Dissemination</div> <div>Participants</div>
Ethical standards		<i>Was ethical committee approval obtained? Was informed consent obtained? Does the study address ethical issues adequately? Has confidentiality been maintained?</i>	<div>Ethical approval: Yes No Unclear</div> <div>Informed consent: Yes No Unclear</div> <div>Ethical issues addressed: Yes No Unclear</div> <div>Confidentiality maintained: Yes No Unclear</div>
Context	Aims	<i>Are the aims and purpose of the study clearly stated?</i>	<div>Yes</div> <div>No</div> <div>Unclear</div>
Setting	Area and care setting	<i>What is the geographical and care setting for the study?</i>	<div>Urban</div> <div>Rural</div> <div>Semi-urban</div> <div>Semi-rural</div> <div>Mixed</div>
	Rationale	<i>What is the rationale and appropriateness for this choice?</i>	
	Detail	<i>Is there sufficient detail about the setting?</i>	<div>Yes</div> <div>No</div> <div>Unclear</div>
	Timing	<i>Over what period did the data collection take place?</i>	
Sample	Inclusion criteria	<i>Who was included in the study?</i>	

	Exclusion criteria	<i>Who was excluded from the study?</i>	
	Selection	<i>How was the sample selected? Were there any factors that influenced how the sample was selected (e.g. access, timescale issues)?</i>	
	Size	<i>What is the size of the sample and groups comprising the study?</i>	
	Appropriateness	<i>Is the sample appropriate in terms of its ability to meet the aims of the study, the depth of data that it is enables to be collected, and its breadth?</i>	Yes No Unclear
Data collection	Methods	<i>What data collection methods were used? Was the data collection adequately described and rigorously conducted?</i>	<div> Interview Focus group Observation Mixed methods Yes No Unclear </div>
	Role of researcher	<i>What is the role of the researcher within the setting? Are there any potential conflicts of interest?</i>	
	Fieldwork	<i>Is the process of fieldwork adequately described?</i>	Yes No Unclear
	Data analysis	<i>How are the data analysed? How adequate is the description of the data analysis? Is adequate evidence provided to support the analysis (e.g. use of original data, iterative analysis, efforts to establish validity and reliability)? Is the study set in context in terms of findings and relevant theory?</i>	

	Researcher's potential bias	<i>Are the researcher's /researchers' own position, assumptions and possible biases outlined? Indicate how they could affect the study in terms of analysis and interpretation of the data</i>	
	Reflexivity	<i>Are the findings substantiated by the data and has consideration been given to any limitations of the methods or data that may have affected the results?</i>	Yes No Unclear
Outcomes	Outcomes	<i>What outcome measures were adopted? What was the impact of the study for (a) service users (b) carers (c) practitioners (d) organisation responsible for service</i>	
Findings	Themes		
	Conclusions		
	Opinions	<i>What this person argues</i>	
Policy and practice	Generalisability	<i>To what extent are the study findings generalisable? What is the country of study? How applicable are the study findings to the system in the UK? Are the conclusions justified?</i>	

	Implications for policy	<i>What are the implications for policy?</i>	
	Implications for practice	<i>What are the implications for practice?</i>	
Other comments	Format	<i>Comments on study format (book, journal article, report etc.) and how this may have implications for style and presentation of the text</i>	
	Links to other references to be followed up	<i>List any links to other references that should be followed up</i>	
Decisions	Name of second reviewer		
	Agreement with reviewer		
	Inclusion	<i>Should this study be included in the final review?</i>	Yes No Unclear
	Topic Question	<i>As defined on the Matrix from the DGDG Topic Q's</i>	
	Date		

Appendix E

Ethical Approval



Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk

6th March 2014

Kevin Scott
Trainee Forensic Psychologist Student
c/o Professor Kevin Browne
Professor of Forensic Psychology & Child Health
Division of Psychiatry & Applied Psychology
School of Medicine
IB25, YANG Fujia Building
University of Nottingham
Jubilee Campus
NG8 1BB

Faculty of Medicine and Health Sciences

Research Ethics Committee
Division of Respiratory Medicine
D Floor, South Block
Queen's Medical Centre
Nottingham University Hospitals
Nottingham
NG7 2UH

Dear Professor Brown and Kevin

Ethics Reference No: C15082013 SoM Psychiatry – **please always quote on correspondence**

Study Title: An exploratory examination of the comparative views of residential care held by careworkers and young people in care.

Chief Investigators/Supervisors: Professor Kevin Browne, Professor of Forensic Psychology & Child Health, School of Medicine, Division of Psychiatry and Applied Psychology.

Duration of Study Aug-Dec 2013 – 6 mths **No of Participants:** 20

Thank you for your letter dated 25th February 2014 responding to the issues raised by the Committee and the following revised documents were received:

- Letter of response dated 6th February 2014.
- FHMS Medical School Research Ethics Application Form dated 25/02/2014
- Proposal for Care Research, Version 3 dated 31st March 2014
- Care Research Letter to Social Workers, Version 2, 31st March 2014
- Care Worker Information Sheet, Version 2, 31st March 2014
- Care Worker Consent Form, Version 2, 31st March 2014
- Care Worker Questionnaire, Version 2, 31st March 2014
- Parent Information Sheet, version 3, 31st March 2014
- Parent Consent Form, Version 2, 31st March 2014
- Young Person Information Sheet, Version 2, 31st March 2014
- Young Person Consent Form, Version 2, 31st March 2014
- Young Person Questionnaire, Version 2, 31st March 2014
- Care Worker Interview Schedule, Version 2, 31st March 2014
- Young Person Interview Schedule, Version 2, 31st March 2014
- Letter of Endorsement from Dr Ian Gargan, Clinical Director Fresh Start/Imagine Health, Carlow, Ireland, dated 30th January 2014.
- Letter of Approval from the Health Services Executive Research Ethics Committee in Ireland ref 051011IG dated 8th December 2011.

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the Conditions of Approval set out below are followed.

1. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

2. You must notify the Chair of any serious or unexpected event.
3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.
4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely



Dr Clodagh Dugdale
Chair, Nottingham University Medical School Research Ethics Committee

Appendix F

Access Letter to Social Workers

Dear Sir or Madam,

My name Kevin Scott and I am a Trainee Forensic Psychologist working in Fresh Start. I would like to invite young people who have gone through our care to take part in a research study about young people's experiences in residential care and how they cope upon leaving it. This study is being carried out as part of a Doctoral Degree I am completing at The University of Nottingham. **I would be very grateful if you could provide me with their contact details and I will then contact them directly to see if they would be interested in taking part in the research. If they are not interested I will fully accept that and not pursue the matter any further.** I have given an overview of the research below.

Research Title:

An exploratory examination of the comparative views of residential care services held by care workers and young people who have been through the residential care system.

Specific Research Aim:

To examine the quality of care services for adolescents and how successfully they transition into aftercare services; the research aims to examine this topic from the viewpoint of the young people in care, but also from the professionals who are responsible for the quality of their care. This will help to differentiate if what constitutes quality of care is the same for the professionals and the young people involved.

Background Information ~ Theoretical Underpinnings:

In the past, the outcome figures from residential institutions were not very positive, with studies showing that between 30% and 50% of the youngsters leave the residential homes prematurely, usually because of unmanageable problematic behaviours (Scholte, 1997). Residential treatment of adolescents with severe behavioural problems succeeds in keeping up to 80% of the adolescents in care. Outcome figures show the effectiveness of residential care for helping young people with behavioural and emotional problems (Bullock, Little & Millham, 1998).

Procedure:

The young people who express an interest in participating will be given a consent form to complete. This form will be read aloud to the participant and they will be given the opportunity to ask questions to ensure they are giving informed consent, including being made aware of the electronic recording of the interview with a Dictaphone (all anonymity and confidentiality protocols will be followed). The participant will then be required to complete a short questionnaire and an interview of one-hour duration, they will be given ample time for breaks if required.

Thank you very much for your assistance,
Best Regards,
Kevin Scott (Trainee Forensic Psychologist)
Fresh Start/Imagine Health
16 Pembroke Street Upper,
Dublin 2
kevinscott@freshstart.ie

Appendix G

Information Sheet for the Young People

Information Sheet and Letter of Invitation

Hello,

I am Kevin Scott, a trainee forensic psychologist working in Fresh Start. I would like to invite you to take part in a research study about your experiences in residential care and your experiences upon leaving Fresh Start. This study is being carried out as part of a degree I am completing at The University of Nottingham. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Information about the study

What is the purpose of this study?

This study aims to understand how young people in Fresh Start found the quality of care whilst they were resident there. The study will then look at how young people handle the transition from leaving Fresh Start and what their experiences of that time were. Could more be done when young people leave to make the transition less problematic?

Why have I been chosen?

You have been asked to participate because you have left Fresh Start in the last three years. This study would like to include as many people as possible who have left the service in this time as all of your contributions are important to this study.

Do I have to take part?

No. It is entirely up to you to decide whether or not to take part. If you choose not to participate, there will be no ramifications at all. If you do decide to take part, you will be given this information sheet to

keep and you will be asked to sign a consent form. You may decide to withdraw from the study at any point; again, there will be no negative consequences to this. If you decide to withdraw, all your data collected will be destroyed.

What will happen to me if I take part?

If you decide to take part, you will be asked to complete a short questionnaire about your experiences in care. There will then be an interview of one-hour duration. The researcher will read your existing clinical notes from your stay in Fresh Start to get information about you (for example verify how long you were in care, your name, date of birth, section status). You will not be required to do anything else.

What are the possible benefits of taking part?

It is hoped the results of this study will help us improve our service for current service users and service users in the future. This will be achieved by developing a better understanding of what benefits young people in care and what more can be done to help them when they leave.

Contact Details

Please feel free to discuss this research or any other concerns you may have with: your friends, social worker and your family. Yourself or anybody you have spoken to can contact myself (Kevin Scott) to ask any questions you may have about the research before deciding whether or not to take part.

This completes part one of the information sheet. If this information has interested you and you are considering taking part, please read on before you make your decision

Sensitive information for individuals wishing to take part

What if there is a problem?

If you have any concern about any aspects of this study; you should ask to speak to the researcher who will do his best to answer any questions you may have. If you remain unhappy and wish to complain formally you can do this by speaking to your social worker or a manager within Fresh Start.

If any information came to light during this study that suggested your care has not been of a high standard, the researcher would have to tell their supervisor.

Will my taking part in the study be confidential?

If you choose to join the study, the researcher will look at some information from your stay in Fresh Start. Everybody involved the research has a duty of confidentiality to you as a research participant.

No information that could personally identify you will be used outside of this research. Information collected during this study will be kept in a locked drawer and the research team will be the only people to have access to this anonymous information.

Information that is kept on the computer will not include your name; instead there will be a number to ensure confidentiality.

When the results of the study are written up, nobody will be able to identify you and no information that may lead to you being identified will be included.

What will happen to the results of the study?

The results of this study will be written up when the study is complete. Should you wish to be notified about the outcome of this study please tick the box on the consent form. Should you wish to participate, you will not be identifiable from the research report.

Will I find out the results of the study?

The researcher will provide Fresh Start with a formal copy of the completed research which will be made available to you should you wish to read it. The researcher will also provide informal easily

understood information to Fresh Start staff to feedback to the participants who took part in the research.

Who has reviewed the study?

The University of Nottingham will review the proposal for this study.

You do not have to decide straight away if you wish to participate, you will be contacted again in due course. Thank you for your time.

Yours Sincerely

Kevin Scott (Trainee Forensic Psychologist)

If you wish to speak with me, please ask any member of staff to contact me in the Pembroke Street office.

Appendix H

Information Sheet for the Care Workers

Information Sheet and Letter of Invitation

Hello,

I am Kevin Scott, a trainee forensic psychologist working in Fresh Start. I would like to invite you to take part in a research study about young people's experiences in residential care and how they cope upon leaving Fresh Start. This study is being carried out as part of a degree I am completing at The University of Nottingham. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Information about the study

What is the purpose of this study?

This study aims to understand how young people in Fresh Start found the quality of care whilst they were resident there. The study will then look at how young people handle the transition from leaving Fresh Start and what their experiences of that time are. Could more be done when young people leave to make the transition less problematic?

Why have I been chosen?

You have been asked to participate because you are directly involved in Fresh Start care services. This study would like to include as many professionals as possible as all of your contributions are important to this study.

Do I have to take part?

No. It is entirely up to you to decide whether or not to take part. If you choose not to participate, there will be no ramifications at all. If you do decide to take part, you will be given this information sheet to keep and you will be asked to sign a consent form. You may decide to withdraw from the study at any point; again, there will be no negative

consequences to this. If you decide to withdraw, all your data collected will be destroyed.

What will happen to me if I take part?

If you decide to take part, you will be asked to complete a short questionnaire about your views on quality of care services. There will then be an interview of one-hour duration. You will not be required to do anything else.

What are the possible benefits of taking part?

It is hoped the results of this study will help us improve our service for current service users and service users in the future. This will be achieved by developing a better understanding of what benefits young people in care and what more can be done to help them when they leave.

Contact Details

Please feel free to discuss this research or any other concerns you may have with your friends and fellow colleagues. Yourself or anybody you have spoken to can contact myself (Kevin Scott) to ask any questions you may have about the research before deciding whether or not to take part.

This completes part one of the information sheet. If this information has interested you and you are considering taking part, please read on before you make your decision

Sensitive information for individuals wishing to take part

What if there is a problem?

If you have any concern about any aspects of this study; you should ask to speak to the researcher who will do his best to answer any questions you may have. If you remain unhappy and wish to complain formally you can do this by speaking to a manager within Fresh Start.

Will my taking part in the study be confidential?

If you choose to join the study everybody involved the research has a duty of confidentiality to you as a research participant.

No information that could personally identify you will be used outside of this research. Information collected during this study will be kept in a locked drawer and the research team will be the only people to have access to this anonymous information.

Information that is kept on the computer will not include your name; instead there will be a number to ensure confidentiality.

When the results of the study are written up, nobody will be able to identify you and no information that may lead to you being identified will be included.

What will happen to the results of the study?

The results of this study will be written up when the study is complete. Should you wish to be notified about the outcome of this study please tick the box on the consent form. Should you wish to participate, you will not be identifiable from the research report.

Will I find out the results of the study?

The researcher will provide Fresh Start with a formal copy of the completed research which will be made available to you should you wish to read it.

Who has reviewed the study?

The University of Nottingham will review the proposal for this study.

You do not have to decide straight away if you wish to participate, you will be contacted again in due course. Thank you for your time.

Yours Sincerely

Kevin Scott (Trainee Forensic Psychologist)

If you wish to speak with me, please ask any member of staff to contact me in the Pembroke Street office.

Appendix I

Young Person Interview Schedule

Young Person Interview Schedule

- 1. Why did you go into care?**
 - How long were you in residential care for?
 - Can you tell me a bit about your family circumstances?
 - How were you getting on in school?
 - Were there any personal problems or crime problems at the time?
- 2. What did you understand was going to happen for you in care?**
 - What were your expectations of the house and living setup?
 - What were your expectations of staff and the rules?
 - What did you expect from your family / friends / the Health Service Executive (HSE).
- 3. Can you please tell me about your experiences of residential care? Did you receive everything you felt you needed with respect to:**
 - Your general health and psychological wellbeing?
 - Your socialisation and interpersonal needs (staff, family, friends)?
 - Your educational and leisure activity needs?
 - Your personal development, sense of boundaries and personal safety?
- 4. What did you think aftercare and leaving residential care meant?**
 - What is the role of aftercare?
 - How is it meant to differ from residential care?
 - Who would be involved in it?
- 5. What did you end up receiving?**
 - How much staff time and attention?
 - Was there education \ working \ training opportunities?
 - Did you get your own income and were you responsible for it?
- 6. What were your experiences of aftercare?**
 - Was it a smooth transition from residential care?
 - How did you find having to do more things for yourself?
 - Did aftercare prepare you for independent living without care?
- 7. Tell me 3 of the best things about residential care or your most positive experiences?**
- 8. Tell me 3 of the worst things about residential care or your most negative experiences?**
- 9. Can you tell me 1 thing about aftercare that you think was good?**
- 10. Can you tell me 1 thing about aftercare that you think could have been done better?**
- 11. If you were arranging care for a young person going into residential care what do you think would be the 3 most important things to do \ look after?**

Appendix J Care Questionnaire for Young People

Please circle the number that most closely represents how you feel about each statement. 1 = Strongly Disagree (SA) 7 = Strongly Agree (SD) 4 = No Opinion

Q1.	The house was a clean and safe environment.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q2.	The facilities in the house were adequate for my needs.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q3.	The house was made to feel like my home.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q4.	I always knew what was expected of me.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q5.	Staff always kept me informed of what was happening.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q6.	There were helpful review meetings with staff to let me know how I was getting on.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q7.	I had somebody to talk to if I needed to, such as a key-worker.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q8.	I was aware of what way to behave around others.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q9.	I understood appropriate and inappropriate behaviours with different people.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q10.	I had a structured daily routine with plenty of things to do.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q11.	I was given every opportunity to do well in school.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q12.	I was given every opportunity to do well in leisure activities.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q13.	I was given every opportunity to learn new skills if I wanted to.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q14.	I was taught life skills to help prepare me for independent living.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q15.	I was taught life-skills such as how to manage my personal hygiene.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q16.	I was taught life-skills such as how to manage money.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q17.	I was taught life-skills such as how to use public transport.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q18.	I was taught life-skills such as how to manage my own shopping.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q19.	I was taught life-skills such as how to manage my own cooking.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q20.	I was taught about things such as substance misuse.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q21.	I was taught about things such as sex and sexuality.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q22.	The food I was given was varied and good for me.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q23.	The exercise activities I did were varied	1 - 2 - 3 - 4 - 5 - 6 - 7

	and good for me.	SD	SA
Q24.	I was able to spend enough time with my family.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q25.	I was able to spend enough time with my friends.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q26.	I was able to spend enough time with my boyfriend / girlfriend.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q27.	I was able to spend enough time with other residents.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q28.	I was able to spend time by myself when I needed to.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q29.	I could see a psychologist if I wanted to.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q30.	I could see an occupational therapist if I wanted to.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q31.	My input was listened to and taken into account by staff.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q32.	I was encouraged and rewarded by staff when I did well.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q33.	When I got into trouble I was treated fairly by staff.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q34.	At times I felt like there were too many members of staff around.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q35.	At times I felt like there were too few members of staff around.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q36.	I felt comfortable and accepted by the other residents.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q37.	I felt comfortable and accepted in the community when I was in care.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q38.	I felt like my physical needs were met.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q39.	I felt like my medical and health needs were met.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q40.	I felt like my educational / occupational needs were met.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q41.	I felt like my social needs were met.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q42.	I felt like my emotional needs were met.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q43.	I was able to attend a place of worship if I wanted to. My spiritual learning was supported.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q44.	My behaviour improved and became less extreme while I was in care.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q45.	I felt prepared when the time came to leave residential care.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA

Appendix K

Care Worker Interview Schedule

Care Worker Interview Schedule

- 1. Why did you go into care work?**
 - How long have you worked in residential care?
 - What were your expectations of care work?
 - What was the level of training?
 - Did you feel prepared for the work when you started?
- 2. What is your understanding of what residential care provides?**
 - Are you aware of what the care system provides and the reasons for the different structures and innovations?
 - Is there a connection between what the young person perceives they are trying to achieve and what the care system feels it needs for the young person to achieve?
- 3. Can you please tell me about your experiences of working in residential care? Do you think residential care provides what young people need?**
 - Does it meet their: health \ educational \ interpersonal \ personal development needs?
 - Do the mechanisms recognise the young person's needs? Are they fulfilled? If not, then why do you feel this might be the case?
 - Are the resources available to allow care workers to do their jobs to the best of their ability? Is there a way the situation could be improved?
- 4. Do you think aftercare provisions are established into the residential care work remit? How do you feel the transition to aftercare services is handled?**
 - What is working in aftercare?
 - What is lacking in aftercare?
 - Does it prepare the young people for independent living?
 - What do you think are the main challenges facing residential care and aftercare services?
- 5. What is your opinion of what constitutes success and failure when looking after young people in care?**
- 6. Tell me 3 of the best things about residential care or your most positive experiences?**
- 7. Tell me 3 of the worst things about residential care or your most negative experiences?**
- 8. Can you tell me 1 thing about aftercare that you think is good?**
- 9. Can you tell me 1 thing about aftercare that you think could be done better?**
- 10. If you were arranging care for a young person going into residential care what do you think would be the 3 most important things to do \ look after?**

Appendix L Care Questionnaire Care Workers

Please circle the number that most closely represents how you feel about each statement. 1 = Strongly Disagree (SA) 7 = Strongly Agree (SD) 4 = No Opinion

Q1.	The houses are clean and a safe environment for the young people.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q2.	The facilities in the house are adequate for the young peoples' needs.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q3.	The house is made to feel like home for the young people.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q4.	The young people always know what is expected of them.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q5.	Staff always keep the young people informed about what is happening.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q6.	There are helpful review meetings with staff to let the young people know how they are getting on.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q7.	The young people have somebody to talk to if they need to, such as a key-worker.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q8.	The young people are aware of what way to behave around others.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q9.	The young people understand appropriate and inappropriate behaviours with different people.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q10.	The young people have a structured daily routine with plenty of things to do.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q11.	The young people are given every opportunity to do well in school.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q12.	The young people are given every opportunity to do well in leisure activities.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q13.	The young people are given every opportunity to learn new skills if they want to.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q14.	The young people are taught life skills to help prepare them for independent living.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q15.	The young people are taught life-skills such as how to manage their personal hygiene.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q16.	The young people are taught life-skills such as how to manage money.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q17.	The young people are taught life-skills such as how to use public transport.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q18.	The young people are taught life-skills such as how to manage their own shopping.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q19.	The young people are taught life-skills such as how to manage their own cooking.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q20.	The young people are taught about things such as substance misuse.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q21.	The young people are taught about things	1 - 2 - 3 - 4 - 5 - 6 - 7

	such as sex and sexuality.	SD	SA
Q22.	The food the young people are given is varied and good for them.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q23.	The exercise activities the young people do are varied and good for them.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q24.	The young people are able to spend enough time with their families.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q25.	The young people are able to spend enough time with their friends.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q26.	The young people are able to spend enough time with their boyfriends / girlfriends.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q27.	The young people are able to spend enough time with other residents.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q28.	The young people are able to spend time by themselves when they need to.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q29.	The young people can see a psychologist if they want to.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q30.	The young people can see an occupational therapist if they want to.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q31.	The young peoples' input is listened to and taken into account by staff.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q32.	The young people are encouraged and rewarded by staff when they do well.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q33.	When the young people get into trouble they are treated fairly by staff.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q34.	At times it feels like there are too many members of staff around.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q35.	At times it feels like there are too few members of staff around.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q36.	The young people feel comfortable and accepted by the other residents.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q37.	The young people feel comfortable and accepted in the community when they are in care.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q38.	The young peoples' physical needs are met.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q39.	The young peoples' medical and health needs are met.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q40.	The young peoples' educational / occupational needs are met.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q41.	The young peoples' social needs are met.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q42.	The young peoples' emotional needs are met.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA
Q43.	The young people can attend a place of worship if they want to. Their spiritual learning is supported.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD	SA

Q44.	The young peoples' behaviour improves and they become less extreme whilst they are in care.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q45.	The young people feel prepared when the time comes to leave residential care.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA
Q46.	The young people are able to manage well when they leave residential care.	1 - 2 - 3 - 4 - 5 - 6 - 7 SD SA

Appendix M

Young Person Participant Consent Form

Young Person Participant Consent Form

Hello,

If you wish to take part in the study, you will need to provide your consent to do so. Please read the following statements and tick the boxes to show that you understand information that has been given to you and which information will be used in the study.

- I have read the information sheet ☐
- I understand what the research is about ☐
- I have been able to ask questions about the research ☐
- I am satisfied with the answers to the questions I have asked ☐
- I agree that the researchers will read my clinical notes in order to get any background information necessary for the research. I give my permission for the researchers to have access to my clinical notes. ☐
- I am happy for the interview to be electronically recorded and know that my quotations may be used. ☐
- I understand that I can change my mind about taking part and can withdraw from the study at any time without giving a reason. ☐
- I agree to take part in the study ☐
- * I would like to know the results of this study. ☐

Signed.....

Name (in capital letters)

Signature of researcher.....

Date.....

* CONFIDENTIALITY AND DATA PROTECTION

-Information from the study will be kept in a locked filing cabinet

-Information kept on computer will be coded so that individual names cannot be identified.

This study complies with the requirements of the Data Protection Act (1998)

Appendix N

Care Worker Participant Consent Form

Care Worker Participant Consent Form

Hello,

If you wish to take part in the study, you will need to provide your consent to do so. Please read the following statements and tick the boxes to show that you understand information that has been given to you and which information will be used in the study.

- I have read the information sheet ☐
 - I understand what the research is about ☐
 - I have been able to ask questions about the research ☐
 - I am satisfied with the answers to the questions I have asked ☐
 - I understand that I can change my mind about taking part and can withdraw from the study at any time without giving a reason. ☐
 - I am happy for the interview to be electronically recorded and know that my quotations may be used. ☐
 - I agree to take part in the study ☐
- * I would like to know the results of this study. ☐

Signed.....

Name (in capital letters)

Signature of researcher.....

Date.....

* CONFIDENTIALITY AND DATA PROTECTION

- Information from the study will be kept in a locked filing cabinet
- Information kept on computer will be coded so that individual names cannot be identified.

This study complies with the requirements of the Data Protection Act (1998)

Appendix O Tables for Young Person & Care Worker Questionnaire scores

Table 5. Shows the score each young person gave to each questionnaire item on the care questionnaire

Question Number.	Questionnaire Item.	Young Person Number & Scores									
		YP11.	YP12.	YP13.	YP14.	YP15.	YP16.	YP17.	YP18.	YP19.	YP20.
Q1.	The house was a clean and safe environment.	7	6	7	5	7	5	5	7	6	6
Q2.	The facilities in the house were adequate for my needs.	7	7	7	3	7	6	5	7	6	5
Q3.	The house was made to feel like my home.	2	5	7	5	7	3	3	1	7	7
Q4.	I always knew what was expected of me.	5	7	5	3	5	5	4	6	6	4
Q5.	Staff always kept me informed of what was happening.	7	7	4	4	3	5	3	3	3	6
Q6.	There were helpful review meetings with staff to let me know how I was getting on.	3	4	6	5	1	4	5	7	1	4
Q7.	I had somebody to talk to if I needed to, such as a key-worker.	4	7	7	6	7	6	3	7	6	7
Q8.	I was aware of what way to behave around others.	7	7	5	7	6	5	3	7	6	6
Q9.	I understood appropriate and inappropriate behaviours with different people.	6	7	6	5	7	7	5	7	6	7
Q10.	I had a structured daily routine with plenty of things to do.	2	7	5	3	7	3	5	7	6	6
Q11.	I was given every opportunity to do well in school.	7	7	6	7	7	5	5	7	5	7

Q12.	I was given every opportunity to do well in leisure activities.	7	7	6	6	7	5	5	7	6	7
Q13.	I was given every opportunity to learn new skills if I wanted to.	7	6	4	3	7	5	5	7	4	7
Q14.	I was taught life skills to help prepare me for independent living.	6	6	6	3	6	1	7	5	5	3
Q15.	I was taught life-skills such as how to manage my personal hygiene.	6	6	6	4	7	7	7	7	6	7
Q16.	I was taught life-skills such as how to manage money.	6	6	6	5	4	3	7	4	6	3
Q17.	I was taught life-skills such as how to use public transport.	7	7	6	4	4	4	7	7	7	3
Q18.	I was taught life-skills such as how to manage my own shopping.	7	7	6	6	1	2	7	5	6	3
Q19.	I was taught life-skills such as how to manage my own cooking.	6	7	6	3	5	5	7	7	7	7
Q20.	I was taught about things such as substance misuse.	7	7	4	2	1	4	7	7	3	1
Q21.	I was taught about things such as sex and sexuality.	7	7	6	4	7	7	7	7	3	1
Q22.	The food I was given was varied and good for me.	7	7	6	6	7	7	6	7	5	5
Q23.	The exercise activities I did were varied and good for me.	7	7	4	3	7	7	4	5	6	7
Q24.	I was able to spend enough time with my family.	4	7	6	5	1	5	7	2	5	5
Q25.	I was able to spend enough time with my friends.	7	7	6	5	7	6	5	4	6	7
Q26.	I was able to spend enough time with my boyfriend / girlfriend.	7	7	4	4	4	6	5	7	4	5

Q27.	I was able to spend enough time with other residents.	4	7	6	6	7	7	5	4	6	5
Q28.	I was able to spend time by myself when I needed to.	7	5	6	6	7	7	5	4	6	7
Q29.	I could see a psychologist if I wanted to.	1	7	6	4	7	3	3	4	4	7
Q30.	I could see an occupational therapist if I wanted to.	4	5	6	5	7	4	3	4	4	6
Q31.	My input was listened to and taken into account by staff.	7	5	6	5	7	5	3	3	5	4
Q32.	I was encouraged and rewarded by staff when I did well.	4	7	4	5	6	6	6	7	5	3
Q33.	When I got into trouble I was treated fairly by staff.	7	7	5	3	7	6	5	3	3	6
Q34.	At times I felt like there were too many members of staff around.	1	1	4	7	7	5	3	7	5	1
Q35.	At times I felt like there were too few members of staff around.	4	7	4	7	5	4	6	1	3	6
Q36.	I felt comfortable and accepted by the other residents.	1	5	6	5	5	5	4	7	6	6
Q37.	I felt comfortable and accepted in the community when I was in care.	1	1	6	5	7	3	4	1	3	6
Q38.	I felt like my physical needs were met.	7	6	6	4	7	5	3	7	6	4
Q39.	I felt like my medical and health needs were met.	7	7	6	6	6	6	5	7	6	7
Q40.	I felt like my educational / occupational needs were met.	7	7	6	6	7	5	5	7	6	6
Q41.	I felt like my social needs were met.	7	4	6	2	4	5	5	3	6	4
Q42.	I felt like my emotional needs were met.	4	7	5	7	4	5	3	7	5	2

Q43.	I was able to attend a place of worship if I wanted to. My spiritual learning was supported.	4	7	4	4	4	5	4	7	4	4
Q44.	My behaviour improved and became less extreme while I was in care.	1	7	6	1	5	4	6	2	7	2
Q45.	I felt prepared when the time came to leave residential care.	7	7	6	5	1	1	7	5	2	2

Table 6. Shows the score each care worker gave to each questionnaire item on the care questionnaire

Question Number.	Questionnaire Item.	Care Worker Number & Scores									
		CW1.	CW2.	CW3.	CW4.	CW5.	CW6.	CW7.	CW8.	CW9.	CW10.
Q1.	The houses are clean and a safe environment for the young people.	6	7	7	6	5	7	7	7	6	3
Q2.	The facilities in the house are adequate for the young peoples' needs.	5	5	6	5	6	7	6	6	5	5
Q3.	The house is made to feel like home for the young people.	7	7	7	6	6	6	7	6	6.0	5
Q4.	The young people always know what is expected of them.	6	3	6	4	3	5	7	5	7.0	3
Q5.	Staff always keep the young people informed about what is happening	6	5	5	7	5	5	7	5	5.0	5
Q6.	There are helpful review meetings with staff to let the young people know how they are getting on.	6	6	6	6	6	6	7	4	3	6
Q7.	The young people have somebody to talk to if they need to, such as a key-worker.	7	7	6	7	7	5	7	5	7	7
Q8.	The young people are aware of what way to behave around others.	6	6	3	5	5	3	7	4	5	5

Q9.	The young people understand appropriate and inappropriate behaviours with different people.	6	3	3	5	5	3	5	4	3	6
Q10.	The young people have a structured daily routine with plenty of things to do.	7	6	5	5	5	3	6	5	6	6
Q11.	The young people are given every opportunity to do well in school.	7	7	7	6	3	3	7	6	6	7
Q12.	The young people are given every opportunity to do well in leisure activities.	7	7	7	6	3	5	7	6	4	6
Q13.	The young people are given every opportunity to learn new skills if they want to.	7	7	7	6	5	6	7	6	7	5
Q14.	The young people are taught life skills to help prepare them for independent living.	6	6	7	6	5	6	6	6	3	6
Q15.	The young people are taught life-skills such as how to manage their personal hygiene.	6	7	7	6	6	6	7	6	7	7
Q16.	The young people are taught life-skills such as how to manage money.	6	7	5	6	5	3	7	6	3	6
Q17.	The young people are taught life-skills such as how to use public transport.	3	7	6	5	5	5	7	6	6	7
Q18.	The young people are taught life-skills such as how to manage their own shopping.	5	7	6	6	5	5	7	6	3	6
Q19.	The young people are taught life-skills such as how to manage their own cooking.	5	7	6	6	6	3	6	6	5	6
Q20.	The young people are taught about things such as substance misuse.	5	7	6	7	3	6	7	6	7	7
Q21.	The young people are taught about things such as sex and sexuality.	3	7	7	7	5	7	7	6	7	7
Q22.	The food the young people are given is varied and good for them.	6	7	7	7	5	6	7	7	6	5
Q23.	The exercise activities the young people do are varied and good for them.	7	7	4	7	4	6	6	5	6	3

Q24.	The young people are able to spend enough time with their families.	3	5	4	5	3	3	7	4	3	5
Q25.	The young people are able to spend enough time with their friends.	3	5	4	3	3	3	7	5	7	5
Q26.	The young people are able to spend enough time with their boyfriends / girlfriends.	3	5	4	4	3	3	6	5	7	5
Q27.	The young people are able to spend enough time with other residents.	6	7	5	5	5	5	7	6	7	4
Q28.	The young people are able to spend time by themselves when they need to.	6	7	7	3	6	6	7	6	7	6
Q29.	The young people can see a psychologist if they want to.	5	7	5	3	3	7	7	4	7	5
Q30.	The young people can see an occupational therapist if I they want to.	3	7	5	1	3	2	7	4	5	3
Q31.	The young peoples' input is listened to and taken into account by staff.	6	7	7	5	6	6	7	5	7	6
Q32.	The young people are encouraged and rewarded by staff when they do well.	6	7	6	6	6	7	7	6	7	6
Q33.	When the young people get into trouble they are treated fairly by staff.	6	6	7	7	6	6	7	5	6	5

Q34.	At times it feels like there are too many members of staff around.	3	5	2	1	5	2	6	6	3	3
Q35.	At times it feels like there are too few members of staff around.	3	2	5	5	5	5	3	3	6	6
Q36.	The young people feel comfortable and accepted by the other residents.	6.0	6	4	1	4	3	6	4	7	5
Q37.	The young people feel comfortable and accepted in the community when they are in care.	3	5	2	3	3	3	5	4	6	3
Q38.	The young peoples' physical needs are met.	6	7	6	6	5	7	7	6	7	6
Q39.	The young peoples' medical and health needs are met.	6	7	7	6	5	7	7	6	7	6
Q40.	The young peoples' educational / occupational needs are met.	6	6	5	3	3	2	7	5	5	3
Q41.	The young peoples' social needs are met.	3	5	5	3	6	1	6	5	7	6
Q42.	The young peoples' emotional needs are met.	6	6	7	6	6	3	7	5	5	5
Q43.	The young people can attend a place of worship if they want to. Their spiritual learning is supported.	6	7	7	7	5	7	7	4	7	7
Q44.	The young peoples' behaviour improves and they become less extreme whilst they are in care.	5	5	6	4	6	5	6	4	1	1
Q45.	The young people feel prepared when the time comes to leave residential care.	3	3	5	3	3	2	3	2	1	1
Q46.	The young people are able to manage well when they leave residential care.	1	3	2	4	3	1	2	2	1	2

Appendix P Mind Maps for Young Person & Care Worker Thematic Analysis and final coded headings for themes identified

Figure 2. Depicts a Mind Map of the NVivo Thematic Analysis performed on the twenty participant interviews. Red = Care Worker Interview Transcripts – Orange = Young Person Interview Transcripts

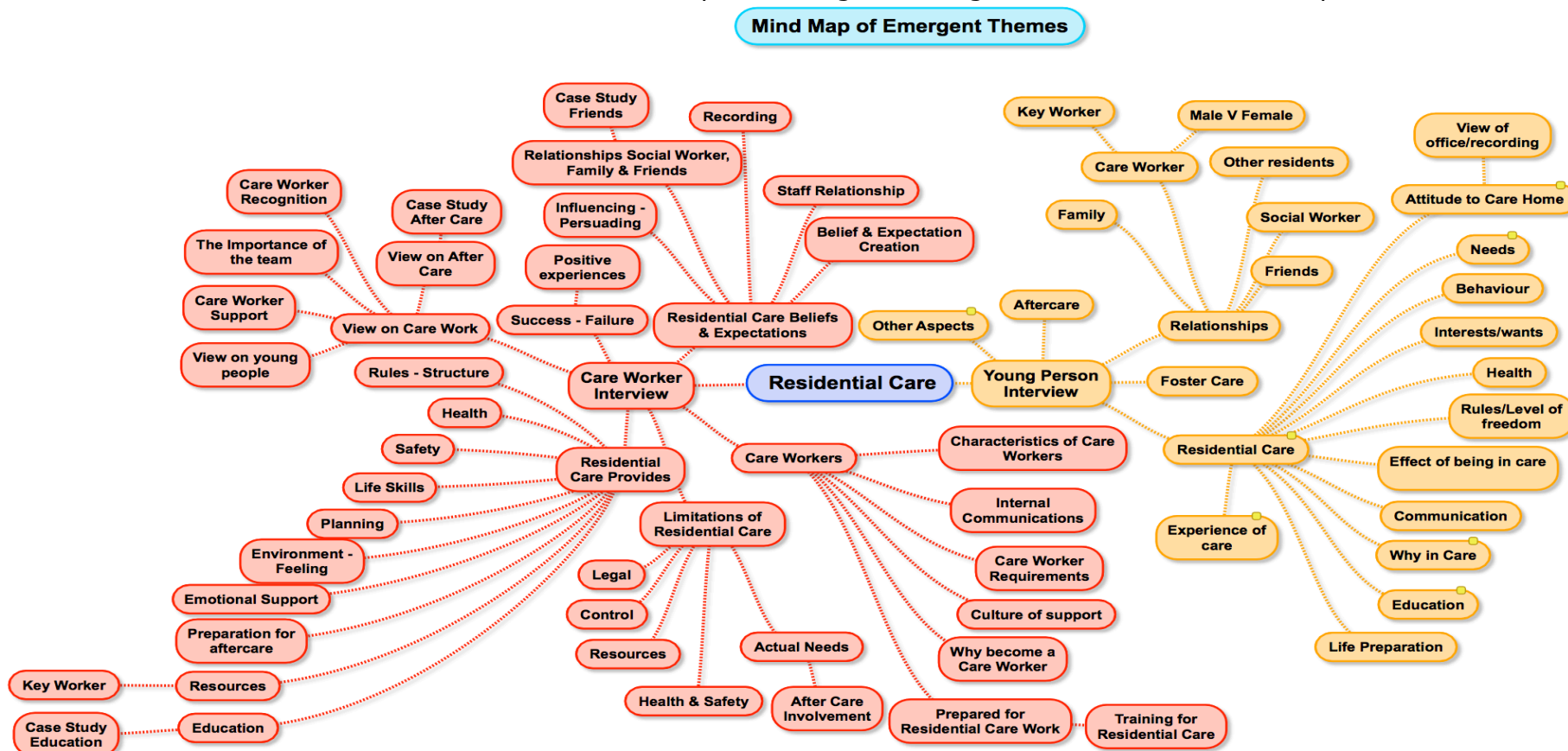
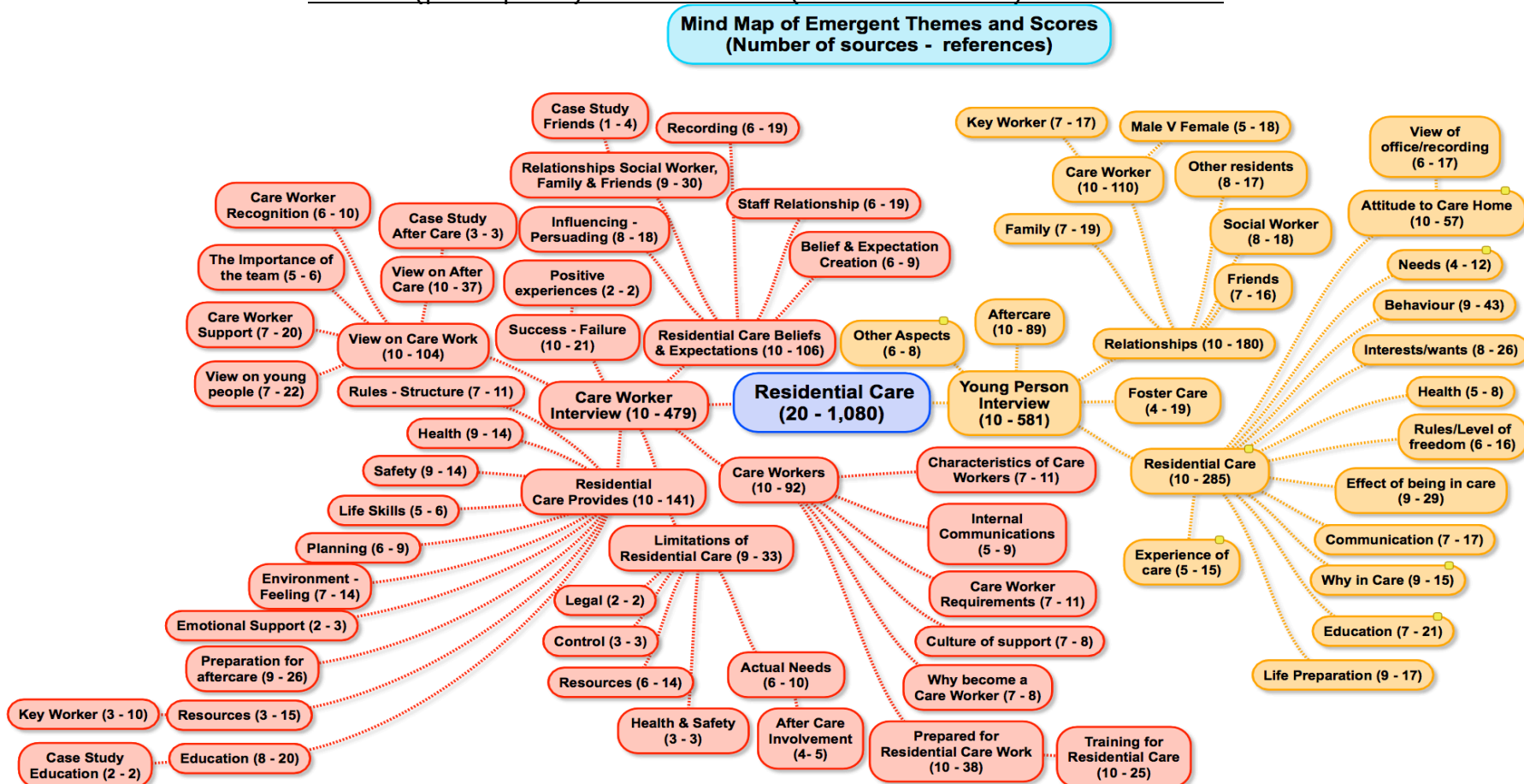


Figure 3. Depicts the Mind Map of Nivo Emergent Themes after tracking the number of sources (participants) and references (times mentioned) for each theme



The Mind Map provided a number of domains. In the case of the care workers there were six, namely:

1. Care Workers: which covered the characteristics, training and preparation for being a care worker (92 references).
2. Views on Care Work: which covered care workers perspective of the job (104 references).
3. Residential Care Provides: which covered all the aspects of service provision (141 references).
4. Residential Care Beliefs & Expectations: that covered "People interaction" (106 references).
5. Limitations of Residential Care: that encompassed system failure (33 references).
6. Success – Failure: covered references that indicated how care workers regarded how successful their work with young people was (21 references).

In the case of young people there were two primary domains and three others namely:

1. Relationships: which covered their relationships with care workers, family, other residents, friends and social worker (180 references).
2. Residential Care: how young people found residential care (285 references).
3. Aftercare (89 references).
4. Foster Care (19 references).
5. Other Aspects (8 references).

Final coded headings for themes identified

Once the mind map derived from the NVivo analysis was completed, the young person themes (orange) and the care worker themes (red) were merged together. This led to the creation of: 2 young people themes*, 3 care workers themes**, and 9 joint themes***. These fourteen themes (green) provided the basis for chapter three's thematic analysis. Please see the colour coding below.

- 1 These Experience of Care – Foster Care = Previous Care Experience*
- 2 Effects of being in care – Why in Care = Psychological Imprint*
- 3 Why become a Care Worker - Characteristics of Care Workers – Care Worker Requirements - Training for Residential Care - Prepared for Residential Care Work = What makes a Care worker**
- 4 Culture of support - The importance of the team - Internal Communications = The Care Work Team**
- 5 Care worker Support - Care Worker Recognition = Organisational Support**
- 6 Attitude to Care Home - Environment – Feeling = Care Environment***
- 7 Rules / Level of Freedom - Rules- Structure – Control - Health & Safety = Level of Agency***
- 8 Education – Social Worker – Education - Relationships Social Worker - Legal - Case Study Education – Resources = Wider Connected Processes***
- 9 Other Residents - View on young people - Influencing – Persuading = Peers***
- 10 Key Worker – Care Worker – Male V Female - Key Worker - Staff Relationship = Staff***
- 11 Family - Family & friends = Familial Ties***
- 12 Friends – Communication - Case Study Friends – Safety = Fitting in***
- 13 Health - Needs – Behaviour – Interests / Wants - Positive Experiences - Emotional Support – Health - Belief & Expectation Creation - Actual Needs = Psychological Wellbeing***
- 14 Life Preparation – Aftercare - Life Skills - Planning - Preparation for aftercare - View on After Care - After Care Involvement - Case Study After Care = Leaving Care***

Appendix Q

Organisation

The organisation was a medium secure psychiatric hospital providing specialist services for young people in complex mental health, acquired brain injury and learning disabilities. The inpatient service provided service for young people in the United Kingdom. The service caters for males and females between the ages of 13 and 18 (at time of admission). In the adolescent service there are wards split across two directorates (1- mental illness and personality disorder and 2- learning disability and autistic spectrum disorder). Multi-disciplinary assessment, treatment and rehabilitation care pathways are provided. The organisation believes that every interaction with a young person has the potential to be therapeutic.

Many of the patients have a history of substance misuse, violent/sexual risk-taking, and/or antisocial or aggressive behaviour. As well as externalising their feelings through aggression, some also engage in self-harm. Some of the patients present with complex social and behavioural difficulties, which confer a high risk of their developing an enduring adult personality disorder; a group often described as having emerging personality disorder.

Risk management

From admission each patient is assigned a risk management number between one and six that constitutes his or her level of hospital/community access. Increased privileges are associated with higher risk management numbers, this can be used to intrinsically increase patient motivation to engage in meaningful change and be deemed to be less of a risk of harm to self or others. Risk levels are reviewed during ward round meetings by the multi-disciplinary team (MDT) on a fortnightly basis; apart from level one which is reviewed by the nurse in charge on the ward every eight hours.

Level One: Confined to room

Level Two: Confined to ward

Level Three: Can access hospital grounds once supervised

Level Four: Can access hospital grounds unsupervised

Level Five: Can access community once supervised

Level Six: Can access community unsupervised

Rehabilitation and Therapeutic Milieu

The MDT works with each patient to optimise their level of functioning, promote recovery and manage the risks they present. In addition to milieu, nursing, occupational, social, educational and pharmacological therapies, patients also receive specific individual and group cognitive-behaviourally based treatment interventions. Depending upon individual need these may include: psychoeducation, communication skills enhancement, relapse prevention, substance abuse prevention and offence specific interventions focused on reducing risk and criminogenic factors.

A therapeutic milieu is a structured group setting in which the existence of the group is a key force in the outcome of treatment. Using the combined elements of positive peer pressure, trust, safety and repetition, the therapeutic milieu provides an idealised setting for patients to work through their psychological issues. Patients learn healthy patterns of living through constant exposure to role models and strict expectations.

The keys to a successful therapeutic milieu are: support, structure, repetition and consistent expectations. Patients feel free to experiment with behavioural changes and discuss deep secrets without fear of judgment or reprisal. Members are also exposed to the struggles of others. This can build empathy and understanding, reduce the feeling of being alone and help spark new ideas on how people can handle their own difficulties.


Appendix R

Redacted Consent Form signed by D4


Case Study Title: The effectiveness of an arson prevention programme with an adolescent arsonist. [REDACTED]

Consent Form ✓/ X

Based on the Portsmouth City NHS Teaching Primary Care Trust Consent form, which has been appraised by the Portsmouth City Accessible Information Group.

I agree that [REDACTED] can do research on the work we are doing. ☒ 

I understand that my name will not be written on the report and will not be identified. ☒

I know that I can change my mind and say "no" at any point and my information will not be used. ☒ 

I know I can ask questions whenever I want to. ☒

I have been given the opportunity to ask questions about the work. ☒

I agree that the researchers can read and use my clinical notes to gain information necessary for the research. ☒

I give permission for the psychometrics I complete during the research to be used to assist my treatment on the unit and kept in my psychology file. ☒

If you agree with these things, please sign your name here:

Signed: [REDACTED]
Name: [REDACTED]
Date: [REDACTED]
Witnessed By: [REDACTED]

Appendix S

Description of the Risk Assessment and Further Psychometrics Used with D4

iv) The Structured Assessment of Violence Risk in Youth (SAVRY)

The Structured Assessment of Violence Risk in Youth (SAVRY Version 1.1: Borum, Bartel & Forth, 2003) was used as a framework for considering issues relating to D4's risk. It is designed to assist professional evaluators in assessing and making judgements about a juvenile's risk for violence. The SAVRY is composed of 24 risk items (Historical, Social/Contextual and Individual). An additional 6 Protective factors are also provided. Thus, this scale contains static and dynamic items relating to the risk of violence. The static factors are historical and are therefore fixed. Dynamic factors are considered amenable to change in either direction. As adolescence is a time of significant change it is important to recognise that the nature and degree of violence risk may frequently change or vary. It is important to consider that the SAVRY is not specifically designed for the learning disability population. For this reason, a number of key risk factors or deficits are not included and additional items have been added to the 'Individual Factors' section. A breakdown of D4's coding on each item can be found in the appendices.

SCALE	ITEM	RATING January 2011
Historical Risk Factors	History of violence	HIGH
	History of non-violent offending	HIGH
	Early initiation of violence	HIGH
	Past supervision/intervention failures	MODERATE
	History of self-harm or suicide attempts	HIGH
	Exposure to violence in the home	HIGH
	Childhood history of maltreatment	HIGH
	Parental/caregiver criminality	HIGH
	Early caregiver disruption	LOW
	Poor school achievement	HIGH
Social/Contextual Risk Factors	Peer delinquency	HIGH
	Peer rejection	HIGH
	Stress and poor coping	HIGH
	Poor parental management	HIGH
	Lack of personal/social support	MODERATE

	Community disorganisation	<i>HIGH</i>
Individual/Clinical Risk Factors	Negative attitudes	<i>HIGH</i>
	Risk taking/impulsivity	<i>HIGH</i>
	Substance use difficulties	<i>HIGH</i>
	Anger management problems	<i>MODERATE</i>
	Low empathy/remorse	<i>HIGH</i>
	Attention deficit/hyperactivity difficulties	<i>MODERATE</i>
	Poor compliance	<i>MODERATE</i>
	Low interest/commitment to school	<i>MODERATE</i>
Other Factors	Psychosis Cognitive Functioning	
Protective Factors	Prosocial involvement	<i>PARTIALLY PRESENT</i>
	Strong social support	<i>PARTIALLY PRESENT</i>
	Strong attachment and bonds	<i>ABSENT</i>
	Positive attitude towards intervention and authority	<i>PARTIALLY PRESENT</i>
	Strong commitment to school	<i>PARTIALLY PRESENT</i>
	Resilient personality traits	<i>ABSENT</i>

v) The Beck Youth Inventories- second edition (BYI-II)

The BYI-II comprises five self-report scales to assess the young person's experience of depression, anxiety, anger, disruptive behaviour and self-concept. Each inventory contains twenty statements about thoughts, feelings, or behaviours associated with emotional and social impairment in young people. Each item is rated on a four-point Likert scale. D4 completed this in February 2011. D4 scored in the '*much lower than average*' range on self-concept; in the '*moderately elevated*' range on anxiety, depression, and anger; and in the '*mildly elevated*' range on disruptive behaviours (which are behaviours associated with conduct disorder and oppositional defiant disorder).

vi) Adolescent Anger Rating Scales (AARS)

The AARS is designed to assist in the assessment of several aspects of anger and anger control in adolescents. D4 completed the AARS in February 2011. He scored in the '*very high*' range on Total Anger, Instrumental Anger, and Reactive Anger. This suggests that D4 tends to respond angrily due to a planned goal of revenge and/or retaliation

and also to a perceived negative, threatening or fear-provoking event. He will display negative attributions that lead to impulsive and hyperactive response styles and will demonstrate few positive solutions to problems when he is angry. He scored in the 'average' range on the Anger Control items suggesting he has strategies to manage his anger, although the level of insight in appropriate strategies or whether he is implementing them is uncertain.

vii) Barrett Impulsiveness Scale (BIS)

This is a self-report measure consisting of 30 statements relating to trait impulsivity. The measure consists of three sub-scales measuring specific aspects of impulsivity: motor impulsiveness, non-planning impulsiveness and attentional impulsiveness. D4 completed this in February 2011. He scored in the '*well above average*' range on motor impulsiveness and on cognitive impulsiveness, and in the '*above average*' range on non-planning impulsiveness. These scores suggest that D4 has a tendency to act without thinking, making quick decisions and not thinking things through. He may also have a tendency to not have concern for nor plan for the future.

viii) Conners 3

This is an assessment of Attention Deficit and Hyperactivity, its most common comorbid problems (e.g. executive functioning, peer/family relations, learning problems and aggression) and disorders (e.g. conduct disorder, oppositional defiant disorder) in children and adolescents. The psychometric has good reliability and validity and can be administered to 6 to 18 years olds.

The Conners 3 was completed in March 2011. On the Teacher Form D4 scored in the '*elevated range*' on Inattention (T score 62), and Learning Problems (T score 63), and on the '*very elevated range*' on Aggression (T score 86), Peer Relations (T score 81). He did not meet the criteria for ADHD although he had an elevated score on the Inattentive type (T score 64). He met the criteria for Conduct Disorder (T score 85) and Oppositional Defiant Disorder (T score 75). This was deemed a valid assessment.

On the Parent form, completed in March 2011 by his Named Nurse, D4 also did not meet the criteria for ADHD Inattentive or Hyperactive-Impulsive, although he had a '*very elevated*' score on Hyperactive-Impulsive (T score 78) and Inattention (T score 62). However, he did not meet the criteria for Conduct Disorder and Oppositional Defiant Disorder. He had an '*elevated*' score on Learning Problems (T score 80).

On the Self-Report Form, D4 scored in the '*very elevated range*' on Inattention (T score 81), Hyperactivity/Impulsivity (T score 81), Learning Problems (T score 81), Aggression (T score >90), Inattentive type (T score 81), Hyperactive Impulsive type (T score 80), Conduct Disorder (T score >90) and Oppositional Defiant Disorder (T score 77). He also had an '*elevated*' score for Family Relations (T score 67). D4 met the criteria for ADHD Combined,

Conduct Disorder and Oppositional Defiant Disorder. He had a Conners 3 ADHD Index score of 12 (probability 96%). This is a very high score; the responses are very similar to those for youth with ADHD and a classification of ADHD is very likely. This was deemed a valid assessment.

ix) Fire Interest Rating Scale

This is a seven-point Likert scale assessing an individuals' interest in fire related situations. Individuals are asked to rate how excited they would be by events such as 'holding matches' and 'watching a person with their clothes on fire'. D4 completed this in March 2011 and endorsed a number of items highlighting an abnormal interest in fire. For example, he said that watching a house burn down, watching the fireman get their equipment ready, watching a person with his clothes on fire, striking a match to set fire to a building, and seeing a hotel fire on the news as the '*most exciting*'. He also said that it would be upsetting to give matches back to someone and that it did not bother him to go to the police station to be questioned about a fire.

x) Fire Attitude Scale

This is a self-report measure that assesses an individual's attitude towards fire related events and activities and highlights cognitive distortions. D4 completed this in March 2011 and indicated a distorted attitude on the Fire Attitude Scale. He agreed that people often set fires when they are angry and that they can make you feel better; that the best thing about fire is watching it spread; and they can sort out your problems.

xi) Functional Assessment of Fire-setting

This is a self-report measure, which consists of 16 statements relating to the frequency (usually, sometimes, never) of eight events, feelings and cognitions that can occur both before and after incidents of fire setting and are possible motives for such behaviour. D4 completed this in March 2011 and said that he started fires because of boredom, feeling anxious, responding to inner voices, feeling sad, feeling angry and wanting to avoid situations. After the fires had started D4 said he felt excited, he gained attention and peer approval, his anger reduced, and was able to avoid undesirable situations.

xii) Dangerousness of Fire

This questionnaire assesses an individual's understanding of the potential dangers of fire. This is a non-standardised questionnaire and is therefore the answers are interpreted qualitatively. This was completed in March 2011. Overall D4 had a decent understanding of the dangers of fire, including how fire can burn and kill people, damage property and the high financial costs of fire. However, while he understood the seriousness of fire he underestimated how quickly fire can spread listing a chip-pan fire taking 10 minutes to get out of control and 15 minutes of available time to get out of a burning house. He knew that the first thing you should do in a fire was to wake everyone else up but thought that most clean air in a fire is near the ceiling. D4 seems to have some awareness of how

dangerous a fire he lit could potentially be but this does not appear to inhibit his behaviour.

xiii) The Relapse Prevention Interview

This psychometric is a semi-structured interview that assesses an individual's awareness of their risk situations and associated thoughts and feelings and their strategies to deal with these. This was completed in March 2011. D4 appears to have a limited understanding of what puts him more at risk of reoffending. His risky feelings include the need for excitement; he stated he would cope with this by smoking a cigarette. He also said he would do something he enjoys such as playing football. On the topic of risky thoughts D4 labelled when he "*hears the angry voices*". Coping strategies are centred on avoidance, such as walking off or playing football. D4 said that he would be most at risk of having these thoughts when he is "*pissed off*" after an argument.

D4 denies any planning element and reports that he is likely to set fire to whatever is around at the time. This appears to concur with the circumstances around the two counts of arson on his index offence, which were different in terms of target selection. D4 identified that other people would know if he was at risk if he was acting "*strange*" or had a "*weird expression*" on his face. He said that this is because he gets angry and his heart beats very fast. The interview highlighted that D4 does not give much thought to the consequences of his fire setting but does not try to deny responsibility for it either. D4 claims he is very unlikely to re-offend (listing himself as 1) in the future because he does not want to be sent back to a place like a secure hospital again. D4 scored a 9 on both recognition of risk factors and identification of coping strategies, placing him in the mid range of the scoring, so he can certainly learn much more about: cognitions, emotions and physiological responses in relation to his offending. The arson programme intervention should help to expand D4's risk awareness and coping strategies.

Appendix T

The Structured Assessment of Violence Risk in Youth (SAVRY) Risk Scenarios Identified for D4

An initial risk assessment and appropriate psychometrics have been carried out with D4. This information puts D4 at a high risk of violent reoffending, including fire setting, without close supervision and intervention. The factors contributing to his high risk include a lack of remorse and empathy, a tendency to associate with delinquent peers, poor emotional regulation, a high level of impulsivity and a lack of insight into his problems. As regards to D4's possible future risk the following scenarios were identified from the SAVRY, and these should be considered provisional:

Scenario 1: Arson

The first risk scenario focuses on the future risk of arson. D4 has engaged in arson on many occasions including twice in one day, which he was charged for. The fires for D4 appear to be motivated by a desire to seek stimulation through setting the fire which provides him with excitement, control and empowerment. He struggles to express his anxiety and depression in other ways and this can be seen as his "only viable option" (Jackson et al, 1987). The victims could be anyone who is in close proximity to the fire at the time; this could include emergency response personnel such as the fire brigade. D4 does not think through the potential consequences or harm (physical or psychological) the fire can cause and has used accelerants in the past. D4 is likely to indiscriminately light any object on fire (for example a bin or chair) and depending on where the object is the fire could easily spread to life-threatening levels. D4 does not select a specific type of target or victim instead he appears to seek excitement, release of negative emotions and possibly to communicate distress through the fire setting.

Based on D4's prior history he is likely to set fires in the future and has shown that his fire setting behaviour escalates when he is stressed and having personal difficulties. D4 identifies two warning signs in himself when he is about to light a fire: his face goes red (in a state of physiological arousal) and he looks 'strange' (probably due to his cognitions at the time). Without therapeutic intervention around the consequences of fire and alternative strategies for managing difficulties this risk is unlikely to decrease. His risk of setting fires is currently controlled by being in a medium secure environment that does not provide him access to contraband items such as cigarette lighters or boxes of matches.

Scenario 2: Violence

The most common form of violence D4 engages in is criminal damage or aggression aimed at objects; this appears to be his way of venting his frustration. This is not always the case though and he has physically assaulted peers and adults in school and the community previously. In both the current and community setting potential targets would be people that D4 perceives as insulting him or

behaving in a hostile manner towards him. Ordinarily this does not go beyond verbal aggression. During his current admission there have been a few incidents of non-compliance and verbal aggression towards staff and peers when he has felt anxious and had difficulty adapting to being in a secure environment away from his family. He can also on occasion get more agitated when staff members attempt to enforce the rules with him. D4 has threatened to physically assault a peer but the level of physical aggression overall has reduced significantly.

Warning signs for D4's violence appear to be keeping really quiet and hiding his emotions to the point where he then finally ends up lashing out at an object/person. D4 has been encouraged to seek staff support when there has been something bothering him and this has seemed to work well for him. It appears that although D4 continues to have difficulties in regulating negative emotions he responds well to the level of supervision and boundaries provided by a secure environment. D4 can also become agitated when feeling bored, highlighting the importance of structured activities to reduce his level of risk, and he has been amenable to engaging in pro-social activities.

Scenario 3: Self-harm

D4 has previously attempted suicide twice with tablets, cut himself, burnt himself, ingested crushed glass and hit his fists against walls. D4 has expressed that self-harm used to be one of his main coping strategies for managing feelings of anger and distress. Triggers to the negative affect include poor understanding of social situations, peer victimisation and feeling isolated. D4 has been observed to be visibly distressed and in tears at times since he arrived at the hospital, so far, no self-harming behaviours have been engaged in which is reassuring. At one point he handed broken pens into staff however D4 must be observed for signs of intention to engage in self-harming behaviours. This highlights the importance of professional support in helping D4 appropriately manage his emotions but also how supervision is crucial in helping D4 to remain safe.

Since being detained in the hospital D4 has said that he has been upset because he wants to leave and the "voices" were telling him to get away and go back to his father's house. Should D4 abscond it is unlikely that he would represent an immediate risk of fire setting or violent behaviour, he would however be very vulnerable in the community, especially with his learning disability. D4 is currently being managed safely by the restrictions of a medium secure service, decreasing the likelihood of absconson.

Appendix U

OAS-MNR (Overt Aggression Scale Modified for Neuro-Rehabilitation) behaviour recordings – Frequency and type of Aggression, Antecedents to Aggression, Interventions to Aggression and a Sexualised Incident

Frequency and Type of Aggression

D4 displayed 5 incidents of aggressive behaviour on four occasions during the 12-month review period. Analysis of the data collected illustrated that D4 was most likely to be aggressive during the afternoon (75%). In terms of level of structure, 100% of recordings occurred during unstructured times, when there were no planned staff lead sessions. Additionally, 75% of incidences occurred when the ward environment was noisy.

Aggression is categorised into different types: verbal aggression, physical aggression towards objects, physical aggression towards other people and physical aggression towards self. The most frequent type of aggression displayed by D4 was against objects, accounting for 50% of all recordings. D4 has displayed mild aggression against objects; this category includes slamming doors, scattering clothing and making a mess. 25% of aggression was directed towards people and was classified as mild in nature. This category includes threatening gestures clearly person directed, swinging at people, grabbing clothes and spitting at people. A further 25% of incidents were incidents of verbal aggression and was classified as severe in nature. This category includes swearing, moderate threats clearly person directed.

Antecedents to Aggression

In terms of general antecedents, the most frequent antecedent was a 'response to a patient's verbal behaviour', accounting for 75% of all recordings. The examples of aggression detailed highlight that D4 responds aggressively when other patients make inflammatory remarks or comments to him. A further 25% of incidents have been due to D4 being 'obviously agitated/distressed.'

Interventions to Aggression

Two interventions have routinely been used to manage and bring D4's aggressive behaviour to an end. The most prevalent is verbal interaction, which includes talking to him, utilising de-escalation techniques and prompts. This is a non-intrusive style of intervention and was utilised to manage 75% of D4's aggressive behaviour. The other intervention included 'physical distraction' (25%) which included leading D4 away from the situation or person to calm him down.

Sexualised Incident

Since his admission, D4 displayed one incident of sexualised behaviour. The incident was non-contact and deemed to be of moderate severity. This category includes a person making an obscene gesture including touching themselves sexually over clothes. The antecedent recorded for this incident was a 'response to a patient's verbal behaviour' and staff talking to D4 using de-escalation techniques and prompts managed the incident.

Appendix V

Reliable Change Statistics for the Insignificant TSCC-A Scales on the Pre to Post Intervention Scores

	D4	TSCC	Anxiety
1.	SE =	$3.9 \sqrt{1 - 0.82}$	= 1.65
2.	Sdiff =	$\sqrt{2} \times (1.65)^2$	= 2.33
3.	RC =	$\frac{9 - 5}{2.33}$	= 1.72*

**Below 1.96, therefore not clinically significant change.*

	D4	TSCC	Anger
1.	SE =	$6.1 \sqrt{1 - 0.89}$	= 2.02
2.	Sdiff =	$\sqrt{2} \times (2.02)^2$	= 2.86
3.	RC =	$\frac{10 - 7}{2.86}$	= 1.05*

**Below 1.96, therefore not clinically significant change.*

	D4	TSCC	Dissociation Fantasy
1.	SE =	$1.8 \sqrt{1 - 0.58}$	= 1.17
2.	Sdiff =	$\sqrt{2} \times (1.17)^2$	= 1.65
3.	RC =	$\frac{5 - 4}{1.65}$	= 0.61*

**Below 1.96, therefore not clinically significant change.*