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**The Transition to Adulthood and Independence:  
A Study of Young People Leaving Residential  
Care**

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**Submitted in Fulfilment of the Requirements for the Award  
of  
MPhil**

**School of Social Sciences and Law, Dublin Institute of  
Technology**

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Advisory Supervisor: Dr. Karen McElrath**

**November 2012**

## **ABSTRACT**

The transition to adulthood is difficult for most young people. It is a time when young people make important decisions about their lives including their future education, career and living arrangements. Most young people have strong family and social networks to support them in these decisions. However, young people leaving residential care are often expected to make this transition abruptly and at a young age with no family or social networks to support them. The leaving and aftercare supports provided by the State are often not sufficient to provide for the needs of these young people leaving them at risk of homelessness, substance abuse, low levels of educational attainment and unemployment. In order to gain a better understanding of the experiences of care leavers this study explores the journey of twenty young people who had travelled into, through and from the residential care system. In doing so, the differences and similarities of the participant's pre-care and in-care experiences were explored as well as the difficulties and challenges they faced throughout their journey, along with the experiences that shaped and informed their transition to adulthood and independence. The study identified three distinct transitions from residential care, those that had travelled a smooth transition, those that had experienced an unstable transition but whose circumstances improved over time and those whose transition was volatile or considerably more problematic and who are still mired in precarious social circumstances. The transitions highlight the diversity of the participants' experiences in such a way that emphasize more clearly the supports that enable some participants to transition successfully and the barriers that lead others towards social exclusion. The findings indicate that the participants' outcomes upon leaving residential care were ultimately dependent on the level of preparation given prior to leaving residential care, the level of the young person's involvement in the leaving care process, the type of post-care housing/accommodation offered and the availability or absence of resources and supports post residential care. What is important about this research is the detailed and reflective accounts provided by young people, which give human resonance to the care leavers' experiences.

## DECLARATION

I certify that this thesis which I now submit for examination for the award of Masters of Philosophy, is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

This thesis was prepared according to the regulations for postgraduate study by research of the Dublin Institute of Technology and has not been submitted in whole or in part for an award in any other Institute or University.

The work reported on in this thesis conforms to the principles and requirements of the Dublin Institute of Technology's guidelines for ethics in research.

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Signature \_\_\_\_\_  
Candidate

Date \_\_\_\_\_

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## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Introduction**

Every year a proportion of young people leave residential care in Ireland. These young people are referred to as care leavers. The term care leaver pertains to young people who have reached an age at which the State is withdrawing ‘parental support’ in order to allow them to move towards independence (Ward, 2008). Young people have little choice as to how and when they leave residential care. This is dictated to a large extent by their legal status under the Child Care Act, 1991. The age at which the Irish State withdraws ‘parental support’ is eighteen. There is currently no formal statistics on the numbers of young people that leave residential care each year and without such data, the destination, whereabouts and well-being of young people after they have left residential care cannot truly be determined.

There is a relatively poor understanding of the processes that lead to being a care leaver or of the events, circumstances and mechanisms associated with different care leaver’s journeys (Mc Dowall, 2008). In the absence of a uniformly accepted definition of leaving care and aftercare the process is frequently subject to misconceptions. The research highlights that for many young people who leave residential care, the concept of independence is often imbued with feelings of fear, isolation and uncertainty (Biehal, Clayden, Stein and Wade, 1995; Broad, 2005;

Kelleher, Kelleher and Corbett, 2000; Mayock, Corr and O'Sullivan, 2008). These young people, through no choice of their own are forced into an accelerated and compressed transition (Stein, 2006). They do not have the advantage of the gradual developmental transitions to adulthood that the majority of young people experience including opportunities to stay on longer at school, leave home later and return when they need a safe base when financial or relationship problems arise (Mendes, Johnson and Moslehuddin, 2011).

Few have committed relationships or connections with parents, extended family members or significant other adults in their lives who can provide the social support that people require to make the transition to adulthood (Mendes, Johnson and Moslehuddin, 2011). In the absence of a supportive network, the research has identified a range of difficulties that can exist for young people transitioning out of residential care. Biehal et al., (1995: 4) argue that *'upon leaving care, a lack of adequate preparation coupled with early age at which care leavers are expected to assume adult responsibilities have tended to mean that loneliness, isolation, unemployment, poverty and homelessness were likely to feature significantly in many of the young peoples lives'*. Other studies report that care leavers often experience social and educational deficits, poor social supports, early parenthood, substance misuse and a disproportionate involvement in crime (Cshmore and Paxman, 2007; Dixon, Wade, Bryford, Weatherly and Lee, 2004; Johnson, Natalier, Mendes, Liddiard, Thoresen, Hollows and Bailey, 2010; Kelleher et al., 2000; Mayock, Corr and O'Sullivan, 2008). The extent of the problems such young people experience has led them to be recognised as one of the most marginalised groups in society (Munro and Stein, 2008).



While the overall picture of care leavers' circumstances and outcomes after leaving care is fairly bleak, these young people are a mixed group and some fare better than others (Cahmore and Paxman, 2007; Stein, 2004). As Gilligan (2001) points out understanding why some young people *'make favourable progress in unfavourable circumstances may tell us more about how to help people exposed to potentially damaging experiences'* (p. 5).

## **1.2 Objectives of the Thesis**

Given the challenges, it is hardly surprising that young people leaving residential care have a more difficult time and fare less well than others of a similar age. I have experienced first hand as a social care practitioner the difficulties young care leavers face when reintegrating into the community after years spent living within the residential care system. It is from this viewpoint that I wish to undertake this study.

What is perhaps more important is to understand how and why some young people negotiate these changes more successfully than others. The aim of this thesis is to document the personal accounts of twenty young care leavers who journeyed into, through and from the residential care system. The thesis explores the reasons for their admission to care, their lived experiences of residential care, the timing of their transition from residential care and the context and circumstances in which it occurred. Their experiences and their views in relation to the level of support they received and how adequate this support was in meeting their needs post residential care is also explored.

### **1.2.1 *Research Questions***

The study focuses on three main questions.

What are the experiences of transition for young people who journey into, through and from residential care?

Why do some fare better than others after leaving residential care? What factors are linked to those who do well compared with those who do less well?

What can be done to improve their life chances and what supports are required in making the transition from residential care to adult independence?

First, we need to ask what is different for young people when they leave residential care and what is different for these young people at this point in their lives compared to other young people of a similar age. What changes for them at eighteen and what challenges do they face? How do these challenges differ from those faced by other young people their age? There are several main differences between young people leaving residential care and other young people their age. The first set of differences concerns the experiences they have had that brought them into residential care and their experiences while in residential care. The second concerns their legal status and the change in their status at the time their care order ends, and the uncertainty of support following that change of status. The third concerns the timing, the number of changes and the abruptness of the transitions they need to make in a short period of

time. The findings help to provide some answers to these questions and address the issues of equity, need and outcomes for young people leaving residential care.

### ***1.2.2 Structure of the Thesis***

This chapter goes on to explore the concept of residential child care by providing a historical background to the residential child care system in Ireland. It draws attention to the institutional nature of child care up to and including the 1960s, to the anti-institutional ideology that followed the publication of the Kennedy Report (1970). The chapter goes on to provide the reader with a general overview of the legislative provisions under the Child Care Act, 1991 in which children and young people enter the residential care system. Chapter Two reflects on how the Irish State fulfils its role as the ‘corporate parent’ in supporting young people leaving residential care. This chapter traces and explores the development of legislation and policy in Ireland to date with regard to leaving care and aftercare supports for care leavers. The chapter also considers legislative changes in other countries and explores the commonalities and differences these legislative developments have had in the type of State services offered to care leavers internationally. Chapter Three begins by providing a detailed review of the literature on the residential care experience. Framed within the attachment theory model, the chapter examines how specific pre-care experiences can shape and inform the lives of young people growing up in residential care. The chapter considers the factors associated with how young people fare in their journey through residential care and how these factors can affect post-care outcomes. By adopting a resilience framework, three broad outcome groups are identified, those ‘moving on’ from care, those ‘surviving’ and those who are ‘struggling’. Each group

will be explored as each has different risk and resilience factors that are relevant to how young people deal with their transitions from residential care to adulthood. The chapter goes on to examine the concept of 'emerging adulthood' and the importance of how a gradual transition to adulthood can impact on young people in general and will explore the transitions to adulthood and the challenges that care leavers experience.

The research strategy, study design, method of data collection and analysis used to conduct the study is the focus of Chapter Four. Chapter Five examines the participants' transitions into and through the residential care system. Although some participants experienced few transitions, others had transitions that were more disruptive, which were characterised by instability and multiple placements. The chapter documents the most salient findings from the interviews and these findings are presented in the young peoples own narrative. Chapter Six documents the participants exit from residential care into adulthood and towards independence. The adversities they faced are highlighted and particular attention is given to situations and circumstances that served to undermine their living situations post residential care. The narratives provide a detailed insight into the factors that helped and hindered their transition. Chapter Seven will provide the discussion and conclusions of this study and will be followed by recommendations that consider, in a broad sense, how outcomes for care leavers can best be framed and understood.

### **1.3 The Residential Child Care System**

This section will discuss the history of residential child care in Ireland, the legislation that regulated practice and the ideologies and policies that influenced it. It attempts to delineate a number of the key shifts in the organisation of residential child care in Ireland that have led to the current configuration of services.

#### **1.3.1 *Historical Overview***

Little consideration was given to the welfare of children in residential child care until the 1960s. At the time there were three broad categories of residential child care units, the Reformatory schools, the Industrial schools and Orphanages. This system originated with the Reformatory Schools Act, 1858 followed later by the Industrial Schools Act, 1868 and The Children Act, 1908 also known as the Children's Charter. All promoted the Victorian ideal of institutional care for children in State care. These Acts determined the shape of residential child care services into the second half of the twentieth century. Under the Reformatory School's Act, 1858, children convicted of criminal offences, usually minor acts of delinquency were sentenced by the courts to a period in a Reformatory school. The Industrial Schools Act, 1868 went on to broaden the provision of the Reformatory Schools Act by providing for the care of children other than those guilty of committing an offence. The Act provided that:

*'Certain classes of children under fourteen years of age could be committed to an Industrial school, children found begging in public, found wandering without a home or visible means of support, being orphans or whose surviving*

*parent was undergoing imprisonment or being a child that frequents the company of prostitutes'* (Robins, 1980: 302).

The Act also provided that:

*'Where a child under twelve years was convicted of an offence that was not a felony, the justice could order them to an Industrial school'* (Robins, 1980: 302).

The Industrial schools had two functions, the prevention of crime and the provision of State guardianship for children who had no other means of support. Reasons for admission were divided into three categories, 'lack of guardianship', 'non-attendance at school' and 'indictable offences'. Approximately eighty per cent of all children were admitted for reasons of 'lack of guardianship' (Raftery and O'Sullivan, 1999). This category seemed to be a catch-all group and included illegitimate children, orphans, poor children, homeless children and children of separated parents. The Irish Catholic Church was strongly supportive of the system of incarceration for destitute children and took on the responsibility of establishing these schools and orphanages and the maintenance of children within them (Barnes, 1989). The involvement of religious orders in the running of the schools was considered positively by a supportive public. The Aberdare Commission (Reformatories and Industrial Schools Commission-Great Britain, 1970) reported on the Industrial schools in 1884 and was approving of the Industrial schools as operated in Ireland. Religious education formed the bedrock of the schools. Moral regeneration was the goal. A school regime which ensured total obedience and conformity was the method (Barnes, 1989). No-

one challenged the Church's management of or its admission policies to Industrial schools. The one thing that they all had in common was the harshness of the care regime for the large numbers of children committed to their care (Barnes, 1989). The punitive nature of the Industrial schools was reflected in the fact that children were committed through the courts to the schools, they were brought to the schools by the police and any attempt to escape was considered an offence punishable by admission to a Reformatory school (Barnes, 1989). It was also considered necessary that '*the links between child and home be ruthlessly cut*' on the basis that the home was a bad influence (Barnes, 1989: 86). For this reason, committal was generally imposed for the maximum period, correspondence between children and families was vetted and the parental visits were allowed only at the discretion of the manager (Barnes, 1989). A total of one hundred and five thousand children were committed to Industrial schools by the courts between 1868 and 1969 (Raftery and O'Sullivan, 1999).

Legislation on Industrial schools and Reformatory schools was consolidated and amended with the passing of the Children Act, 1908. On its introduction, the Children Act, 1908 was the most significant piece of legislation pertaining to the care of children in Ireland as it superseded all previous legislation governing the treatment and care of children in the Irish Republic (Stewart, 1995). It included details pertaining to the categories of children that could potentially be committed to Reformatory and Industrial schools and the period of detention within them. The Act was to blur the distinction between the two types of school. Industrial schools were originally intended to deal with the neglected, with the Reformatory schools providing for offenders. However, under the 1908 Act, certain types of offender could be sent to Industrial schools and transfers between the two types of schools became possible.

The Children Act, 1908 based again on Victorian ideals continued to promote an institutional response to child care. It favoured the use of large institutions to segregate poor, begging, morally-at-risk children, from society. In these large institutions the aim was to provide basic care in a rigidly controlled structure (Barnes, 1989). This legislation concurred with the Catholic Church's thinking and enabled it to gain control of the child care sector, due to its superior understanding of institutions and ability to set them up in a way that enabled it to maintain total control (Barnes, 1989). The State had responsibility for these children, but chose to fund religious orders to incarcerate them in these institutions for their entire childhood years (Raftery and O'Sullivan, 1999).

Little attention was paid by society to the plight of its destitute children. Indeed the perception of children in terms of the role children held in society and attitudes and opinions regarding the matter of 'welfare' of children changed little in real terms in the years following the implementation of the Children Act, 1908. The Victorian model of care which perceived children as a social risk and a threat to society prevailed until the mid 1960s.

### ***1.3.2 The Beginning of Change***

Signs of change began to emerge in the 1960s where key debates in relation to the organisation, structure and delivery of residential child care services took place between the mid 1960s up to the 1980s. An important catalyst in these debates was the publication of three major reports, all of which strongly criticised the system of



residential child care that prevailed in Ireland. These were the Tuairim Report; Some of our Children (1966), the Report on the Committee of Enquiry into Reformatory and Industrial School's system (1970) otherwise known as the Kennedy Report and the Task Force on Child Care Services (1980).

#### 1.3.2.1 The Tuairim Report; Some of Our Children (1966)

Tuairim was a voluntary society which sought to encourage the participation of Irish citizens in public affairs. Their investigation of the Irish child care system resulted in the publication of a report that was strongly critical of the prevailing system that relied on large institutions to house thousands of children. The report recommended that children in need of alternative care be cared for in:

*'Small mixed units of all age groups...and the supervision exercised on the children.... Should be that of a reasonable parent, not a warder'* (The Tuairim Report, 1966: 147).

The Tuairim Report also recommended that training courses be established in Ireland for probation officers, residential child care workers, welfare workers and child care officers (p. 49). It demonstrated an understanding of the necessity to provide a broad conception of care encompassing physical, psychological and emotional needs of children. In response to this report, a committee was established by the Minister for Education in 1967, chaired by District Justice Eileen Kennedy, to make a detailed examination of the Industrial and Reformatory school's system in Ireland.

### 1.3.2.2 The Kennedy Report (1970)

The Kennedy committee was established in 1967 to examine the problems within the system of child care and to make suggestions for alterations that would improve it (Kennedy, 1970). The publication of the Kennedy Report in 1970 created, for the first time, an awareness of and concern regarding what residential child care actually constituted. It exposed the child care institutions at that time as being largely unfit to meet the complex needs of the children being admitted to their care and a picture of an apparent disregard for child welfare emerged (Raftery and O'Sullivan, 1999). The committee found that many of the children suffered from deprivation, the schools were inadequately staffed resulting in the majority of the children having '*no saleable skills to enable them to take their place in Society*' (p.12), along with what they described as the '*Dickensian and deplorable*' state of the buildings in which these children resided (p. 22). The Report was very much in tune with the changing times of child care provision in Ireland and it brought about a significant shift in emphasis- from a punitive and reformatory style which stressed the importance of correction and control, provided in large institutions to a more caring and understanding style provided in smaller family-style homes (Brennan, 1994). Among the many recommendations of the Kennedy Report was the adoption of the Tuairim Reports recommendation that '*residential homes should be broken up into self contained units with groups of seven-nine children in each unit*' (p.16). The Kennedy Report also identified the child in care as one often with complex emotional difficulties requiring the interventions of a competent and skilled work force, equipped with specific training to address the presenting needs of the children. This emphasis on the needs of children resulted in the recommendation that '*the provision of trained staff should*

*take precedence over any other recommendation*' (p.14). The report also pointed to the variety of residential care provision for children and strongly emphasised that *'all children in residential care should be educated to the ultimate of their capacities'* (p.7). The committee equally emphasised the importance of providing aftercare to young people when they leave residential care, they acknowledged that aftercare was practically non-existent and recommended that *'aftercare should form an integral part of the child care system'* (p.7). The Report was also a significant driver for change in legislation governing the area of child care in its recommendations that all laws pertaining to child care be examined and brought up to date. However, it was not until the publication of the 1991 Child Care Act that this review and amalgamation of legislation occurred bringing with it a new system of child care. Many of the Report's recommendations were acted upon. Some of the major changes included a shift from residential care to foster care. Placing children in foster care became viewed as the preferable mode of care. Children were placed with other families which could include relatives of the family of origin although the growth in relative care did not occur until the mid 1990s. Industrial schools were replaced with community based group homes that provide medium to long-term residential care for children. By 1974, primary responsibility for child care was allocated to the Department of Health which also set up a working party to report on the necessary updating and reform of child care legislation and child care services.

### 1.3.2.3 The Task Force on Child Care Services (1980)

An official committee was established in 1973 to review the implementation of the Kennedy Report recommendations. This committee felt that the question of

centralising the responsibility for policy, planning and administration of child care services should be considered, a question that resulted in the establishment of the Task Force on Child Care Services in 1974. The Task Force was asked to make recommendations on:

*‘The extension of services for deprived children and children at risk, to prepare a Bill updating the law in relation to children and to make recommendations on whatever administration reforms it considered necessary in the child care services’* (Task Force Report on Child Care Services 1980: 1).

The committee was expected to report on recommendations for change within six months, but it was not until late 1980 that they submitted the final report. It did not include a draft Bill but stated that this Bill would now be prepared by the Department of Health. The Report commented that:

*‘The most striking feature of the child care scene in Ireland was the alarming complacency and indifference of both the general public and various government departments and statutory bodies responsibility for the welfare of children. This state of affairs illustrated clearly the use by a society of residential establishments to divert itself of responsibility for deprived children and delinquent children’* (Task Force Report on Child Care Services 1980: 182).

The report acknowledged serious gaps in the residential child care services which had not been filled in the wake of the Kennedy Report. The report recommended that residential child care services should be provided, as far as possible, within the broader context of family support services and *'should be located within the child's own community unless there is good reason for doing otherwise'* (p. 268). The report made recommendations on the types of residential homes which should be provided and the functions that they should perform. The report also stated that the residential placement should *'ensure that the care being provided for the child meets his/her needs and that all necessary measures are being taken to promote his/her welfare'* (p. 203). However, it was not until 2008 that the policy recommendations articulated in the Kennedy Report and the Task Force on Child Care Services were by and large, fully implemented (Graham, 2011). By this time the vast majority of residential homes were managed directly by the Health Service Executive (HSE)<sup>1</sup> or its agents. This decision concluded a debate, initiated some forty years ago over who should have responsibility for the administration of residential child care in Ireland.

#### **1.4 The Changing Role of the State in the Residential Child Care System**

The enactment of the Children's Act in 1908 became the central legal framework governing the State's response to child welfare and remained so for over eighty years (Gilligan, 1991). With this legislation the institutional model of care provision continued and, as has been detailed, it was not until the 1970s when a definite shift in emphasis in relation to meeting the needs of children in care can be found (Gilligan, 1991; Buckley, 2002). The 1908 Act, which was brought into being at a time when

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<sup>1</sup> The organisation mandated to provide residential child care in Ireland is the Health Service Executive, HSE which was established in 2005. The HSE subsumed the former health boards.

the State was subject to British control, had been subject to criticism and continuous calls for reform by people who worked in Child Care Services were not responded to until the early 1990s when a new statute was introduced. The Child Care Act, 1991 was regarded as providing a response to the needs of vulnerable children that was both modern and progressive (Buckley, 2002). Even though the process of fully enacting the provisions of the Child Care Act, 1991 did not occur until December 1996, as the various sections were brought into being on a gradual basis.

#### **1.4.1 *The Child Care Act, 1991***

The Child Care Act, 1991 represents the first comprehensive legislation in relation to child welfare since the foundation of the State (Gilligan, 1992). The full implementation of this legislation signalled an end to the social, political and legislative impasse surrounding child welfare services. Under the Child Care Act 1991 Act, the health board (now the Health Services Executive) has a statutory duty to promote the welfare of children who are not receiving adequate care and protection. There are three philosophical principles underlying the Act. Firstly, that it is generally in the best interests of the child to be brought up in his/her own family. Secondly, having regard to the rights and duties of the parents, the welfare of the child is the first and paramount consideration and thirdly that, as far as is practicable, the wishes of the child should be considered (Section 3, Child Care Act, 1991). In essence, the Act mandates the HSE to identify children who are not receiving adequate care and protection and provide child care and family support services with the aim of helping parents to care for their children and to avoid the need for such children to be taken

into care. However, if a child is in need of care and protection and is unlikely to receive it at home, then the HSE must take them into care.

#### 1.4.1.1 The Main Provisions under the Act for Admission to Care

Part IV of the Child Care Act, 1991 deals with care proceedings and details the various mechanisms available where a child requires care and protection. Legal orders include *Voluntary Care Orders*, *Emergency Care Orders*, *Interim Care Orders* and *Care Orders*. Section 4 of the Child Care Act allows the HSE to take a child/young person into voluntary care with the consent of the parent(s) where the child/young person's care and protection requires it. Parent(s) of a child/young person can decide that they want or need to place their child/young person in the care of the HSE. In some cases where parents are unable to cope due to illness or other problems they may agree to their children being taken into voluntary care. In such cases, while the HSE has primary care of the children it must consider the parent(s) wishes as to how the care is provided. The HSE is obliged to maintain these children for as long as their welfare requires it. When the parent(s) is ready for their child/young person to come back and live with them, meaning when they are ready and able to meet the needs of the child/young person the child/young person returns home.

There are also a number of procedures which the HSE can use when dealing with children who are at risk or who are in need of care. The HSE can apply to the courts for a number of different orders which give the HSE as 'corporate parent' a range of powers including decisions about the kind of care and the access to the children for parent(s) and other relatives. Section 13 empowers the District Court to make an

*Emergency Care Order* which authorizes the placement of a child/young person in the care of the HSE for up to eight days where there is reasonable cause to believe that there is an immediate and serious risk to the child/young person's safety which necessitates placement in care. The *Interim Care Order* is a short-term provision which may be made where an application for a full care order is likely or pending. This is designed to 'bridge the gap' between the expiration of an emergency care order (after eight days) and the determination of an application for a full care order (Section 17). The *Care Order* commits a child/young person to the care of the HSE until the child/young person attains the age of eighteen or for a shorter period determined by the court. This order requires evidence of a child having been abused or of being at risk. Where a child/young person is the subject of a full care order, the HSE shall do what is reasonable to safeguard and promote his or her welfare. In effect the HSE has the rights and duties of a parent(s) for the duration of the care order (Section 18). Under the terms of Section 5 of the Child Care Act, 1991 the HSE are also statutorily responsible for the provision of suitable accommodation for young people up to the age of eighteen who are homeless or in need of care. Youth homelessness has being defined as:

*'Any young person found sleeping on the streets or sleeping anywhere not intended for night-time accommodation or not providing safe protection from the elements or those whose usual night-time residence is a public or private shelter, emergency lodgings, Bed and Breakfast accommodation or such, providing protection from the elements but lacking the other characteristics of a home and/or intended only for a short stay'* (Youth Homelessness Strategy, 2001: 11).



Also included within this meaning are:

*‘Young people who look for accommodation from the Out of Hours Service and those in insecure accommodation with relatives or friends regarded as inappropriate, that is to say where the young person is placed at risk or where he or she is not in a position to remain’ (Youth Homelessness Strategy, 2001: 11).*

Young people become homeless for a range of reasons and it is rare that one single event is the cause of leaving home. Instead, it is more likely that homelessness occurs following a series of events, or a build-up of situations. Triggers for youth homelessness in Ireland are varied. Examples include conflicts within the family and/or violence at home, parents being unable to cope due to issues such as addiction, mental health issues, housing or financial issues (Kelleher et al., 2000; Mayock, Corr and O’Sullivan, 2008; Mayock and Vekic, 2006). Services for homeless children are generally provided as part of the child protection and welfare services of the HSE. These services vary from region to region.

With regard to the Dublin region many young people who are out-of-home (have a home but cannot live or return there) come to the attention of the local Gardaí. Often, this is because the Gardaí come across these young people sleeping on the streets or in other places not designed for night-time use. In such situations, the common practice is for the Gardaí to contact the on-duty HSE social worker for the area so that emergency accommodation can be arranged. Following this, the short, medium and long-term needs of the young person are assessed by the HSE social worker and

where necessary, an appropriate plan is put in place. This may involve the young person being returned home or placed in the Youth Homeless Service otherwise known as the Out of Hours Service. The Out of Hours Service (OHS) was established (1992) in response to concerns raised regarding the situation of young homeless people in Dublin. The service offers emergency beds in a number of residential settings and short-term residential placements for young people up to three months.

When a child or young person is taken into the care of the State, the HSE take on parental responsibility in supporting that child/young person up to their eighteenth birthday and are referred to as the 'corporate parent'. Upon reaching the age of eighteen these young people leave the care of the State and are considered independent adults no longer in need of 'corporate parenting'.

## **1.5 Conclusion**

This historical overview of the residential child care system outlined and described a selective series of events that have contributed to the current organisation of the residential child care system in Ireland. The legislation introduced in the nineteenth and early twentieth century all promoted institutional care for destitute children. Very large numbers of Irish children were incarcerated in these institutions for long periods of time, a legacy which impacted significantly on child welfare provision in this country. The publication of the Kennedy Report (1970) is generally viewed as a pivotal moment in the history of residential child care in Ireland. The Report contributed significantly to the introduction of the long awaited Child Care Act, 1991 which mandates the provision of developmental care for all children. It placed responsibility for child welfare services firmly with the State in the name of the Health Service Executive (HSE).

**CHAPTER TWO**

**LEGISLATION AND POLICY RELATING TO LEAVING CARE AND  
AFTERCARE PROVISION**

**2.1 Introduction**

Research undertaken by Kelleher et al., (2000) put the plight of young people leaving State care under the spotlight in Ireland and highlighted for the first time the inadequacies of legislative provision and its consequences. The study found that young people did not receive the required levels of support that they needed to prepare them for leaving care and aftercare. The following chapter reflects on how the Irish State fulfils its role as the ‘corporate parent’ in supporting young people leaving residential care. The chapter traces and explores the development of legislation and policy in Ireland with regard to leaving and aftercare supports for young people leaving care. The chapter also considers the legislative position in other countries and explores the commonalities and differences these legislative developments have had in the type of State services offered to care leavers internationally.

**2.2 Irelands Legislative Framework on Aftercare**

The Child Care Act, 1991 was the first piece of legislation in Ireland to identify the need for leaving and aftercare provision for young people leaving State care. The framework for this is provided under Section 45.

### **2.2.1 *The Child Care Act, 1991, Part IV Section 45***

This section of the Child Care Act, 1991 outlines how young people leaving care ‘may’ be supported when they reach their eighteenth birthday. It empowers the HSE should it see fit to make continuing provision for persons formally in its care. It allows the HSE to assist ‘*such persons until they have reached the age of twenty one should it be satisfied that such assistance is needed*’ (Section 45) (1) (a). Subsection (2) of this section details what form such assistance may take including continuous monitoring by the HSE by firstly, arranging for the completion of the young person’s education. Paying such fees or sums as may be required for that purpose and/or contributing towards maintenance or by placing him or her in a suitable trade, calling or business. Assistance may also be given by co-operating with Housing Authorities in planning accommodation for young people leaving care on reaching their eighteenth birthday or until their education is completed (Section 45b, The Child Care Act, 1991). One could argue that Section 45 of the Child Care Act, 1991 has brought those young people who leave State care onto a more formal footing as it does set down foundations for service provisions. Prior to this time, services for care leavers were very inconsistent throughout the country and the needs of care leavers would have competed with the needs of child protection cases and the needs of the in-care population. Despite the changes in legislation the needs of care leavers were not viewed with the same priority and consequently did not attract the same attention (Kelleher et al., 2000, Gilligan, 1991).

The current legislation, however, does not place a statutory obligation on the HSE to provide for the young person who has left its care, the Child Care Act, 1991 uses the term ‘may’ rather than ‘shall’ in reference to the HSE providing assistance to this group of young people. What this means is that while the legislation empowers the HSE to make continuing provision for young people formally in its care, it is a purely discretionary power and may only be used in very limited circumstances. It is an aspirational rather than a binding article of legislation given that, a care leaver ‘may’ be supported upon reaching their eighteenth birthday and/or until they are twenty one, if they are in full-time education. It would appear therefore that only those care leavers who remain in full-time education have the opportunity to receive support, and even then, it is not guaranteed. But critically, research has consistently shown that care leavers tend to have much lower levels of educational attainment than their peers and are less likely to remain in full-time education (Cashmore and Paxman, 2007; Munro and Stein, 2008). Arguably, we are faced with the irony that those who do not qualify for leaving and aftercare support are those who need it the most.

During the recent passing of the Child Care Amendment Act, 2011, there were extensive lobbying efforts by Barnardos<sup>1</sup>, TD’s, Senators and the Ombudsman for Children to extend the section on aftercare and to place the provision of these services on a statutory basis by changing the wording from ‘may’ to ‘shall’. However, these efforts were unsuccessful as the Government upheld the previous Government’s legal advice that there was no need to change the wording stating the current legislative wording should not be understood as ‘discretionary’ but rather that where a young person’s need for aftercare has been identified there is an obligation on the HSE to

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<sup>1</sup> Barnardos works to protect the rights of children in Ireland by campaigning and lobbying to influence Government and decision makers.

meet it. The continued absence of an unambiguous legislative framework means that efforts to progress provision of aftercare services at a policy level are weakened. The need to support children leaving care has long been identified as an area requiring improvement.

## **2.3 Regulations/Standards/Guidelines/Policies/Recommendations/Reports**

### **Relating to Leaving Care and Aftercare Provision**

Since the Kennedy Report, 1970 and in particular since the enactment of the Child Care Act of 1991, there has been a greater emphasis by the State on the need to provide policy and guidance concerning all aspects related to care provision for young people. For example, The Child Care (Placement of Children in Residential Care) Regulations, (1995), The Guide to Good Practice in Children's Residential Centres, (1996), The National Children's Strategy (2000) and The National Standards for Children's Residential Centres, (2001). These documents give recognition of the preparation needed to develop the skills, knowledge and competence necessary for adult living. At the core of the regulatory documents is recognition that the development and co-ordination of leaving and aftercare services is a key component towards strengthening the position of young people leaving State care. On a broader policy scale, the ratification by Ireland of the United Nations Convention on the Rights of the Child (1989) and the publication of the Youth Homelessness Strategy (2001) have provided detail in relation to rights and policy issues concerning all children in the State, but also have reference to young people who have experience of leaving care.

### **2.3.1 *The Youth Homelessness Strategy (YHS), 2001***

Drawing on the research from Kelleher et al., (2000) which highlighted the significant number of young people who leave care and experience homelessness, The Youth Homelessness Strategy sets out in Objective 4, that *'aftercare services for children leaving residential care will be strengthened so that children are supported in making the transition to living independently or returning to their families'* (Department. of Health and Children, 2001: 26). The main focus of the Youth Homelessness Strategy was on setting up protocols and setting out procedures to ensure young people with care experiences do not experience homelessness as adults. The strategy identified aftercare as an important part of the care process and not an optional extra and in doing so set out an aftercare protocol requiring that each HSE Local Health Office in collaboration with the Local Housing Authority along with other statutory and voluntary groups devise a comprehensive strategy for effective leaving and aftercare service provision. The strategy was to identify what supports young people may need upon leaving care. The Youth Homelessness Strategy made reference to the point that *'whatever the reason a child is taken into care, when their time in care ends, every effort should be made in helping the young person reintegrate into their community'* (2001: 17). As it currently exists, leaving and aftercare services have been available on an ad-hoc basis with some HSE regions having a well developed service while in other regions aftercare is almost non existent (Empowering People In Care, 2011)<sup>2</sup>. Some HSE regions provide leaving and aftercare services only to young people who have been in their care for a specific length of time, for others, support is offered only

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<sup>2</sup> EPIC (formerly IAYPIC) is an independent association that works throughout the Republic of Ireland, with and for children and young people who are currently living in care or who have had an experience of living in care.



in the immediate period of them leaving their respective care placements. In light of the serious lack of consistency and the haphazard approach to the delivery of leaving and after care services nationally, it was considered that a closer look at the policy for leaving and aftercare services in the Dublin region (where the participants in this study resided) was warranted.

### ***2.3.2 The Model for the Delivery of Leaving Care and Aftercare Service in HSE, North West Dublin, North Central Dublin and North Dublin (2006)***

The Model for the Delivery of Leaving and Aftercare Services was a response to the requirements outlined by the Youth Homelessness Strategy (2001) which highlighted the vulnerability to homelessness of those young people who have left the care of the State. The model was adopted as policy in November, 2006 in North West Dublin, North Central Dublin and North Dublin. The aim of the model was:

*'To improve assessment, preparation and planning for leaving care by providing better personal support for young people leaving care through improving financial support and increasing the capacity for accommodation for care leavers'* (HSE, 2006: 9).

The model was to be a source of information for the young person and a guidance tool for those involved in the delivery of leaving care services. The model featured three components, preparation for leaving care, leaving care and aftercare. An internal review of the model, based on the responses by the HSE areas (North West Dublin, North Central Dublin and North Dublin) was undertaken by the Health Service

Executive (Kilkenny, 2010). The review highlighted a number of difficulties namely the absence of a designated budget for the delivery of different components to the model, inconsistent levels of aftercare support between the three HSE areas and a lack of aftercare workers<sup>3</sup> for the numbers of young people the model was to cater for. On examining the findings of the review it appears that in light of insufficient resources and assistance, coupled with the differences in how the model was interpreted and delivered, there appears to be a lack of any co-ordinated approach emerging. In addition, the absence of any studies on the outcomes of how the young people in receipt of leaving and aftercare support in this HSE region are doing creates difficulty in evaluating how effective this model is.

In terms of the importance of providing leaving and aftercare provision to care leavers, reference is also made in European reports of the need for Ireland as a member State to meet its obligations with regard to this vulnerable group.

### ***2.3.3 Recommendation 2005(5) of the European Council Committee***

In 2005, the Committee of Ministers of the Council of Europe issued a recommendation to Member States on the rights of children living in residential care and one of the basic principles contained in that recommendation was that a child leaving care should be entitled to appropriate aftercare support (Recommendation 5).

A report on the implementation of the recommendation across the Member States of the Council of Europe found, however, that in many States including Ireland adequate

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<sup>3</sup> Aftercare workers work with the social work teams to support and facilitate the preparation of young people in care and also provide for post leaving care support and outreach services that will be required for aftercare. Aftercare workers are assigned to the young person six months prior to the expected date of transition from care.

support measures based on individual plans for aftercare were not in place and that evidence of the child's right to participate in developing such aftercare plans were generally not found (Report on the Implementation of the Council of Europe Recommendation 5 on the Rights of children living in residential institutions, 2005).

#### **2.3.4 *United Nations Guidelines for the Alternative Care of Children, 2009***

In its concluding observations on Ireland's most recent report on the implementation of the United Nations Convention on the Rights of the Child, the United Nations recommended that the State strengthen its efforts to ensure and provide for follow-up and aftercare to young people leaving care (United Nations Committee on the Rights of the Child, 2006: 7-8). The United Nations Guidelines on the Alternative Care of Children provide greater detail on this point and elaborate on States obligation in this regard. The Guidelines state that *'the process of transition from care to aftercare should take into consideration the child's gender, age, maturity and particular circumstances and include counselling and support. Children leaving care should be encouraged to take part in the planning of their aftercare life'* (p. 132). The guidelines specifically state that the State should, throughout the period of a child's care, aim at preparing the child to assume self-reliance and to integrate fully in the community through the acquisition of social and life skills. Special efforts should be made to ensure that a young person leaving care has a person who can help facilitate his/her independent living. Aftercare arrangements should be prepared as early as possible. Ongoing educational and vocational training opportunities should be part of the young person's life skill education so as to help them to become financially independent (United Nations Guidelines for the Alternative Care of Children, 2009).

### ***2.3.5 The Report of the Commission to Inquire into Child Abuse (2009)***

The issue of leaving care was again brought to the forefront with the publication of the Report of the Commission to Inquire into Child Abuse (2009). The Report, commonly known as the Ryan Report, includes accounts of the abuse experienced in Industrial and Reformatory schools run by the religious orders. The link was made between some of the same ongoing difficulties experienced by young people who are currently leaving care and those that left the institutions from the 1930s to the 1970s. The key problems identified were homelessness, mental health problems, addiction problems, educational deficits and loneliness (The Ryan Report, 2009: 47). The Report (2009) recommended the introduction of aftercare for all young people leaving the State care system arguing that *'comprehensive aftercare services that assist young people in the transition to independent living are vital'* (p. 396). The Report pointed out that leaving and aftercare services should be provided to give young adults a support structure they can rely on. In a similar way to families, child care services should continue contact with young people after they left the care of the State. The Report went on to recommend that the provision of aftercare by the HSE should form an integral part of the care delivery for children who have been in the care of the State. It should not be seen as a discretionary service or as a once off event that occurs on a young person's eighteenth birthday, but rather a service that he/she may avail of up to the age of twenty one (The Ryan Report, 2009).

### **2.3.6 The Report of the Commission to Inquire into Child Abuse (2009)**

#### ***Implementation Plan***

The Implementation Plan which was published by the Minister for Children and Youth Affairs two months after the Ryan Report (2009) outlines the Government's response to the recommendations of the Ryan Report. In responding to Recommendation 16 of the Report (children who have been in State care should have access to aftercare support services), the Implementation Plan outlines a number of actions to be taken in addressing the needs of young people which include that the *'HSE will ensure the provision of aftercare services for children leaving care in all instances where the professional judgement of the allocated social worker determines it is required'* (p.48). The Implementation Plan (2009) also made recommendations with regard to data collection and to improve planning for leaving care and enhance the availability and quality of aftercare supports, resulting in the introduction of the HSE Leaving and Aftercare Services National Policy and Procedures Document. This policy was finalised in April, 2012 to provide the basis for implementing an effective equitable service across the country. It plans to engage with the young person from the age of sixteen in preparing for leaving care and devising a care plan jointly with them. According to the policy, aftercare services are to be available to all those eligible irrespective of which care sector they have been in, foster care, residential care and/or high support<sup>4</sup> up to twenty one years (unless they are in education in which case the HSE can support them until twenty three years).

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<sup>4</sup> High Support Units provide residential care to young people with particular emotional and behavioural problems who cannot be adequately cared for in mainstream residential care. The primary purpose of a high support is to respond to complex needs in a flexible way. High Support Units are open, the young person is not detained and there is a high ratio of staff to children (Social Information Systems, 2003).

While, this policy development is greatly welcomed, its implementation has been hampered by inadequate resources (Barnardos, 2012). A clear implementation plan on how to roll the policy out has yet to be finalised. Presently, there continues to be an insufficient number of aftercare workers across the country resulting in an inability to prepare, engage and oversee each leaving care plan. As a result, many care leavers do not have an aftercare worker (Barnardos, 2012). Also the eligibility criteria, outlined in the HSE policy, governing access to aftercare support excludes a variety of vulnerable children who have had experience of the residential care system and are often ill-equipped to make a successful transition to independent adulthood. These include children deemed to be homeless as per section 5 of the 1991 Child Care Act, young people who have experienced frequent but short-term placements throughout their entire engagement with the care system and young people who have been taken into care at seventeen years but have not spent twelve consecutive months in care.

The Department of Children and Youth Affairs (2011) study which asked young people about their experiences of aftercare support found that they were critical of the lack of comprehensive services available to ease their transition from care to independent living. The lack of availability of aftercare workers (working office hours only) and promises being made and not met were identified as ongoing issues. The research also showed that aftercare services vary enormously in each area, resulting in considerable confusion and increased fear among young people about what to expect. They also highlighted that every care leaver should receive the same treatment regardless of where they live or which type of care they have experienced (Department of Children and Youth Affairs, 2011).

Given the vulnerability of young people leaving care, Stein (2009) argues that the State has a responsibility morally and legally to provide for young people and equip them for their journey to adulthood. Placing aftercare on a statutory basis would strengthen the political commitment to these children and ensure better outcomes for them, their families and wider society. A number of organisations have called for the legislation to be changed to make aftercare support for young people leaving State care mandatory (Focus Ireland, Empowering People in Care)<sup>5</sup>. Both organisations assert that a change in legislation would ensure that young people have the right to receive aftercare should they need it. Both organisations put forward the argument that by introducing effective and detailed legislation, those entering aftercare would be aware of their entitlements, and that social workers and aftercare workers would have specific and measurable targets and universal standards could be applied on a national basis. Indeed the Irish Social Service Inspectorate<sup>6</sup> (now the Health Information and Quality Authority, HIQA) in their Practice Guidelines on Leaving Care and Aftercare Support (2004) made reference to the point that service providers must, in effect, '*act in the manner of a good parent*' (ISSI, Practice Guidelines, 2004: 1), therefore there is an implicit obligation to continue to support the young person after they leave the care system.

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<sup>5</sup>Focus Ireland operates preventative strategies for reducing the risks to a young person who has been in State care of experiencing homelessness, disadvantage and social exclusion soon after leaving care.

<sup>6</sup> The SSI was set up in 1999 to inspect social services in Ireland. It was administered by the Department of Health and Children until May 2007, when it was established on a statutory basis as the Office of the Chief Inspector of Social Services within the Health Information and Quality Authority (HIQA).

The Inspectorate, in detailing ways of promoting good outcomes for care leavers have recommended that the Government consider amending the Child Care Act, 1991 Section 45 (1) to provide mandatory leaving and aftercare support services to all young people leaving State care (Social Services Inspectorate, 2006).

It is unclear why a statutory obligation to providing aftercare services is not forthcoming if the Government is committing to providing such services to all children who need it. The obligation to provide support to children who are leaving care is no less important in principle than the obligation on the HSE under Section 3 of the Child Care Act, 1991 to provide care and family support services to those under the age of eighteen. This is especially important when one considers the particular vulnerability of children who have been in care and the fact that they are at greater risk than their peers of experiencing difficulties such as homelessness. The obligation placed on parents to support their children under the Family Law (Maintenance of Spouses and Children) Act, 1976 provides an instructive comparison with the State's position vis-à-vis children leaving care. Parents are obliged under Section 5 of the Act to support their children up to the age of eighteen or, if the child is in full time education, up to the age of twenty three. Yet there is no corresponding legislative obligation on the State to provide for children and young people who have been in its care.



If the State's aim is to act as a 'corporate parent' to children who find themselves without effective parental care, this disparity is entirely illogical. In spite of the fact that most children do not need to demand support of their parents after they reach the age of eighteen, the Family Law (Maintenance of Spouses and Children) Act, 1976 nonetheless ensures that such an obligation is placed on parents. The situation for children in care is the opposite although they are invariably in greater need of support past the age of eighteen.

The following section will examine the different ways that other countries balance the responsibilities of the individual, the State and the family and may prove a fruitful way of exploring and identifying whether different legislative frameworks produce better experiences and better outcomes for care leavers.

## **2.4 International Legislative Frameworks**

In the United Kingdom, specialist leaving care schemes have developed particularly since the introduction of the Children (Leaving Care) Act, 2000, in responding to the core needs of care leavers for assistance with accommodation, finance, careers and personal support networks. At the core of the Act are new mandatory duties rather than obligations, to assess needs and develop planning for care leavers up to the age of twenty one (or beyond if continuing in education). Ward (2008) argues that *'such legislation has been introduced in response to the evidence showing the adverse consequences both for young people and for society as a whole of failing to prepare care leavers for independent adulthood and of withdrawing 'parental support' at too*

*early a stage*' (p. 271). The enactment of this legislation has led to the development of a 'corporate parenting case model' in some areas, leading to better resourcing and overall to the increased profile of leaving care services. It has strengthened the responsibilities and clarification of roles towards care leavers by Local Authorities<sup>7</sup>, with an emphasis on preparation for leaving care and addressing both practical and personal skills (Stein, 2004).

The legislative framework for developing leaving and aftercare services in Northern Ireland and Scotland is primarily the Leaving Care (Northern Ireland) Act, 2002 and the subsequent Children (Leaving Care) Regulations (Northern Ireland) 2005 and the Aftercare and the Regulation of Care (Scotland) Act, 2001 and the Support and Assistance of Young People Leaving Care (Scotland) Regulations 2003. These Acts form the basis for improved leaving and aftercare services by further strengthening the mandatory duties placed on Local Authorities. The intention is to improve the young person's life chances by ensuring that they do not leave care until they are ready to do so. The services provided under the legislation include formal education and life skills training as well as the continuing provision of accommodation and financial and emotional support for an extended period, usually into the early twenties. The overall aim of the process in each country is comparable, in that it enables a care leaver to make a successful normative transition to independent living experienced in most cases by their peers in society.

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<sup>7</sup> Local Authorities are the equivalent of the Local Health Office in the United Kingdom, Scotland and Northern Ireland.

Comparable legislation and improvements to existing legislation have also been implemented in the United States and Canada<sup>8</sup>. They include regulations for the provision of aftercare supports including accommodation and financial support, health care, education and/or vocational training for young care leavers. The allowances and financial benefits continue until the young person reaches twenty one however, services may be extended to twenty three in some jurisdictions (Osgood, Foster, Flanagan and Ruth 2005; Serge, Eberle, Goldberg, Sullivan and Dudding, 2002). The legislative frameworks for the provision of aftercare in each of the countries appears to reflect different combinations of four elements, financial support, emotional support, provision of supported housing/accommodation and preparation for independence through skills training and education. All four elements have been found to be crucial factors in the successful transition to adulthood (Biehal et al., 1995; Broad, 2005; Pecora, Kessler, Hiripi, Williams, O'Brien, Emerson, Herrick and Torres, 2006). However, Ward (2008) purports that legislation and policy intended to support care leavers can only be adequately assessed within a wider framework of interlocking policy areas which influence the transitions to adulthood of vulnerable young people. Ward (2008) argues that *'education, social security, health and housing will all reflect the extent to which the State substitutes, for, or compliments the family in supporting young people as they move towards independence, and therefore will impact on the transition to adulthood of care leavers'* (p. 274).

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<sup>8</sup>All Provinces and Territories in Canada follow different legislative guidelines. Each jurisdiction's legislation has its own definitions, policies and structures of services for care leavers (Serge, et al., 2002).

### ***2.4.1 The Impact of International Legislative Frameworks***

Research evaluating the impact of the international legislative changes suggests that the legislation has contributed to a number of positive changes. These include the increase in take up of further education and reductions in those not in education, employment or training. This has been directly linked to improvements in financial support for young people provided by the Local Authorities and an increase in the provision of supported accommodation (Dixon, Wade, Byford, Weatherly and Lee, 2004). Good data information systems were also found to be working well. These systems automatically flag service eligibility, thereby ensuring that leaving care services are aware of all young people in care who are eligible for support (Hai and Williams, 2004). This stands in contrast to Ireland where no such data systems exist. Nevertheless, despite some improvements in outcomes, research suggests that variations between services provided by leaving care projects and Local Authorities still exist within the United Kingdom. Research by Collins and Pinkerton (2008) suggests that progress has taken place in more areas of assessment and planning and less so in the service delivery, resources and outcomes. They argue that this will have obvious implications for improving the life chances of young people leaving care, not least because better assessments are simply not enough on their own.

The difficulty of variations in the services has also been shown to be a problem in the United States. As legislation and policy is decentralised in the United States it results in significant discrepancies in policies and practices across the different States (Courtney and Dworsky, 2006). Although the increase in funding from the implementation of the Foster Care Independence Act, 1999 has meant an increase in

expansion of existing services, considerable gaps in the provision of services between the States have been found (US General Accountability Office, 2004). Much of the evidence base regarding service delivery effectiveness is limited as there has been no long-term analysis of outcomes (Nollan, 2006). However, a national data system on care leavers (The National Youth in Transition Database) is being implemented which will collect data on services that young care leavers receive and outcomes (Courtney and Dworsky, 2006). Again this appears to be non-existent in Ireland as there is no formal data on either the numbers of care leavers in receipt of aftercare services or the destination and status of care leavers once they leave the care of the State.

As can be seen, there have been positive developments arising from the implementation of a comprehensive legal framework in each country. The different Acts recognise that preparation for leaving care and aftercare support are vitally important stages to ensure that young people are adequately equipped with the necessary life skills to live independently after care. It places a clear onus on the Local Authorities to continue their role as a 'corporate parent' and meet the needs of these young people. Needless to say, some failings have been identified in each jurisdiction. The evidence from each country suggests that challenges in delivering consistent services to care leavers through their legislation and policies exist. However, there are lessons for Ireland in the way that each country has approached their responsibilities around care leavers, the most significant of which is placing aftercare on a legislative footing. While it is acknowledged that Ireland has seen a gradual increase in the recognition of the vulnerability of young people leaving State care as evidenced in the number of policy documents published in recent years, these remain ineffective in the absence of any legislative backing.

Overall it is argued that three critical impediments remain in regard to the current service delivery of aftercare provision. Firstly, the Child Care Act, 1991 does not require the HSE to provide either a leaving care service or an aftercare service to young people. In the absence of this requirement, it can be argued that the concept of ‘corporate parenting’ in relation to ongoing responsibility of young people leaving residential care is not strongly upheld in Ireland. Secondly, there is an absence of a national framework which guarantees consistent provision for young people who leave residential care, either planned or unplanned each year. Thirdly, there is a complete absence of official data on care leavers therefore, critical information such as what happens to young people once they leave residential care or how many young people are in receipt of the current aftercare services in Ireland remains unknown. Indeed, the absence of a specific budget means even the total cost of service provision in this area is unknown.

## **2.5 Conclusion:**

This chapter explored the legislative and policy frameworks surrounding aftercare provision for care leavers in Ireland. The chapter highlighted the need for a national framework to guide and direct the delivery of an equitable leaving and aftercare support service for young people leaving residential care. The chapter also highlighted the growing international awareness of the needs of young people leaving care reflected in the introduction of leaving care and aftercare legislation and policy in the respective countries mentioned.

The chapter discussed how these countries have responded to the leaving and aftercare needs of the young people who leave their care. It was found that much of the service provision in each country is focussed around the areas of education and training, housing, healthcare and finance. The challenge therefore is to learn from the international experience and build on the strengths of an inclusive legislative approach to tackling the aftercare needs of Irish care leavers.

## **CHAPTER THREE**

### **LITERATURE REVIEW**

#### **3.1 Introduction**

The experiences of entering care, moving placement and leaving care are three crucial transitions in the lives of young people in residential care. The factors associated with how young people fare in their transitions through and from residential care will be the main focus of this chapter. The chapter begins by introducing the concept of residential care in terms of purpose as well as the functions and models associated with residential care. The chapter also examines the factors precipitating entry to residential care. The chapter goes on to explore Bowlby's theoretical work on attachment and examines how specific pre-care experiences can shape and inform the lives of young people growing up in residential care. The experiences of residential care itself and the challenges and difficulties encountered are also discussed. In spite of the many factors young people encounter on their journey through the residential care system some young people grow up to be competent young adults. In examining why some young people succeed and others do not the theory of resilience is explored. By adopting a resilience framework three broad outcome groups are identified those 'moving on' from care, those 'surviving' and those who are 'struggling'. Each group will be explored as each has different risk and resilience



factors that are relevant to how young people deal with their transition from residential care to independence. The chapter goes on to consider the concept of 'emerging adulthood' and describes the period's distinctive features and explores the characteristics of emerging adults. The chapter looks at the experience of emerging adulthood for young people leaving residential care and explores the challenges and difficulties encountered during this period.

### **3.2 The Concept of Residential Care**

When the State takes on the role of 'corporate parent' the primary goal is to provide children and young people with a safe, secure and stable environment to enable them to reach their full potential (Rushton and Minnis, 2002). The psycho-social context and the quality of the environment and relationships from which a child/young person is removed as well as the quality of the alternative placement should be carefully considered (Lieberman, Weston and Pawl, 1991). Foster care and residential care have been and continue to be the two main alternative placements for children and young people in State care. There is traditionally a clear difference between foster care and residential care. Foster care involves the placement of a child or young person in a home in the community. It is a form of substitute care by which a child is cared for in a foster family by people other than their own parents although statutory responsibility for them remains with the State. Carers are reimbursed for the financial costs they incur in looking after the young people. This is a home-like environment where life is structured around normal family life. In contrast, residential care involves the placement of young people in buildings owned/rented by the State which typically have a limited number of children who are cared for around-the-clock by

care staff (Johansson, 2007). The purpose of residential care is to provide a safe, nurturing environment for individual children and young people who cannot live at home or in an alternative family environment such as foster care (Health Service Executive, 2011). According to Gilligan (1999) residential care should maintain the physical and emotional needs of the individual, it should provide protection to those deemed as being vulnerable, it should compensate those children who have experienced 'deficits' in their lives, and it should prepare them in an emotional and practical sense for the time when they leave residential care and have to make their own 'way in the world' (Gilligan, 1999:188). The last function is relevant to the present study as one of the deficits experienced by the subject group, and which will be explored in later chapters, is that of preparation for life after residential care. Gilligan (1991) suggests two models of residential care, the traditional missionary/rescue model and the traditional medical treatment/sterile protection model. The former can be shown to have links with the origins of child care services both in this country and elsewhere, where the emphasis was on 'saving' children from what was regarded as an 'unsavoury existence'. Historically, this is evidenced in the activities of the Reformatory and Industrial schools where children were committed for their entire childhood years as opposed to being allowed to be raised by their birth family. Thus, social order was maintained and social control was exercised, but this was the social order of the ruling class, which included the church, and this class wanted to perpetuate it's own values and ideas (Gilligan, 1991). It has been argued that this form of social order and control exists today in the residential care system but that it is the cultural values of the dominant class that are perpetuated (Gilligan, 1991; 195). The majority of the young people in this country who are taken into residential care are from lower socio-economic groups (Gilligan, 1991; 19-68). They are then

placed in residential units where the values they are being taught are middle-class. Are these young people, as Gilligan (1991) suggests, surrendering ‘the values of working-class culture in order to adapt to the cultural norms of their caretakers?’ This is an area for further research and discussion in terms of the social origin of our young people in the residential care system and how their cultural values are influenced by a move into residential care with the values that may exist in these environments. The second model is the ‘traditional medical model/sterile protection model’, where the emphasis is placed on ‘curing’ the young person of the ‘malign influences’ (Gilligan, 1991:197) of their family and social environment. This is achieved through placing them in the residential care system where efforts are made to assist the young person in recovering ‘through a course of treatment – care in a sterile environment residential children’s home’ (Gilligan, 1991:197). This particular model would also have direct resonance with the historical approach to ‘caring’ for children in an institutional environment in this country. However, the situation of a young person being placed a significant distance away from their birth family, friends and local community is not unusual even today. This issue will be explored later in the study.

Today, there is a growing shift to move beyond the traditional residential model of daily care and accommodation to a therapeutic needs-based model of care that addresses the challenges posed by young people’s often compromised and complex developmental needs (Bath, 2009). The therapeutic residential model for young people in statutory care within a residential setting aims to address the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences, informed by a sound understanding of trauma, attachment, and developmental needs (McLean, Price-

Robertson and Robinson, 2011). This option is a time-limited and intensive support model in which the ultimate goal is to strengthen young peoples' positive relationships and to support the young person to transition to a preferred care environment, such as a family-based foster care placement, or to independent living. The model is underpinned by a recognition of the importance of specialist supports, healthy relationships and good communication between all stakeholders. The importance of quality and safety in relationships is also acknowledged in addressing disrupted attachments and relationships (Anglin, 2002).

The profile of the young people who were admitted to residential care over the years has changed. From the time of the Workhouse when in response to a social and human calamity, the service was directed at those young people who were destitute, orphaned or in extreme poverty (Fahy, 1995). With the advent of the Reformatory and Industrial school system, there was a greater emphasis on those young people who were alleged to be involved in criminal activity or who were viewed as being at risk of becoming involved in such activity (Gilligan, 1991). The development of a more enlightened approach to children in residential care in Ireland did not surface until the 1970s when the debate moved to looking at children who were at risk and in need of care and protection. Today a young person is normally referred to residential care because of complex needs and attachment issues. Often these young people display behaviours which are difficult to manage and which have been factors in the reasons that other forms of care such as foster care have not been successful (Ainsworth and Hansen, 2005). Whilst residential care may often be seen as a last resort, MacLean (2003) argues that residential care can be viewed as a positive choice for some young

people that need the level of routine and treatment that can be provided for within a residential setting and is a valued part of the placement spectrum.

Anglin (2002) contends that for some young people at a certain stage of their lives usually adolescence, it can be regarded as the preferred option. Some young people cannot be successfully fostered because of their damaging life experiences and many foster carers do not possess the skills, experience and family structures needed to care for them. Residential care can provide the necessary specialist services that meets all of the developmental, physical, psychological and emotional needs for children and young people with complex difficulties (Anglin, 2002). Studies undertaken in the United Kingdom and the United States (Fratter, Rowe, Sapsford and Thoburn, 1991; Hudson, Nutter and Galaway, 1994; Whittaker, 2000) have revealed that residential settings may be the best alternative to foster care as they provide support, structure and therapeutic interventions that are often required to meet the varying needs of children especially children and young people who exhibit major behavioural and emotional problems.

There has been a significant reduction in the number of young people placed in residential care over the last number of decades. The number of children in residential care at the time of the Kennedy Report (1970) was three thousand four hundred and seventy two (Kennedy Report, Table 4:12) compared to four hundred and forty three in 2011 (Health Service Executive, 2011). The decline in the number of children in residential care in Ireland is largely accounted for by a major shift since the Kennedy Report (1970) away from residential care in favour of foster care. Foster care is now the largest care category with ninety per cent (five thousand seven hundred and

seventeen) of all children in State care<sup>1</sup> in foster care (2011)<sup>2</sup>. Residential care accounts for ten per cent (four hundred and forty three). As a result of this shift in policy, young people in residential care today, tend to be those, for whom it has been difficult to find foster homes, or whose foster care placement has broken down.

### **3.3 Reasons for Admission to Residential Care**

In gaining a better understanding of the pre-care experiences of children in residential care, it is useful to know the primary reasons for children being placed in residential care. From a general point of view, the literature tells us that children and young people who come into residential care tend to show a number of characteristics. They have a high frequency of social, emotional, behavioural and educational problems (Rutter, 2000). Many have not experienced a nurturing, stable environment during their early years of life even though such experiences have been shown to be critical in the short and long-term developmental needs of a child (Garbarino, Guttman and seely, 1986; Campbell and Ramey, 1994). Most come from families with multiple disadvantages (Osborn and Delfabbro, 2006). Families of children in residential care often lack natural supporting networks and sources of help in the community and relationships to close relatives are also more likely to be strained (Frensch and Cameron, 2002). Many are likely to have experienced significant disruption at home due to their family circumstances leading to familial instability (European Association for Research into Residential Childcare, 1998). Family problems constituted the single biggest reason for children being placed in care, accounting for fifty three per cent of the total figure of those in care in Ireland in 2011 (Health Service Executive,

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<sup>1</sup> There were six thousand one hundred and sixty children in care at the end of December 2011.

<sup>2</sup> Foster care includes relative foster care and also pre-adoptive placements.

2011). Family problems included the parent's or parents' inability to cope and family difficulties around housing and finance (twenty two per cent), family members abusing alcohol/drugs (sixteen per cent) and mental health difficulties (four per cent). Other family problems included parental separation, the death of a parent and domestic violence (eleven per cent). All are known to have a significant impact on the quality of family life in the home. Other reasons for admission into care included child abuse which accounted for forty one per cent which included neglect (twenty nine per cent), physical abuse (seven per cent), emotional abuse (three per cent) and sexual abuse (two per cent) (Health Service Executive, 2011).

Child problems accounted for the remaining six per cent. These included children with emotional and behavioural problems (three per cent) and other problems, (three per cent) including teen pregnancy, children abusing alcohol and drugs and unaccompanied minors<sup>3</sup> (Health Service Executive, 2011). It can be suggested that these figures for admission into care may be linked to a greater awareness in recent years over abuse and neglect following high-profile cases such as the Roscommon abuse case (Irish Examiner, 26 November, 2011). It may also be linked to the economic downturn in recent years which saw cutbacks to support services such as early intervention services resulting in increasing numbers of families experiencing difficulties in coping in the absence of such services.

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<sup>3</sup> An Unaccompanied Minor is a person who is under the age of eighteen or the legal age of majority, is separated from both parents and is not with and being cared for by a guardian or other adult who, by law or custom, is responsible for him or her (Irish Refugee Council , 2006).

### **3.3.1 Family Problems**

Most families experience some periods of time when functioning is impaired by stressful circumstances such as a death in the family, but these families tend to return to normal functioning after the crisis passes. In dysfunctional families, however problems tend to be chronic. A dysfunctional family is one in which the relationship between the parents and the children is strained. This is usually because one or both parents have a serious problem that impacts on the family as a whole (Forward, 1989). These families tend to be chaotic and unpredictable (Forward, 1989). Rules that apply one day may not apply the next. Promises are neither kept nor remembered. Expectations vary from one day to the next. Children tend to take on adult responsibilities from a young age in these families. Parental needs tend to take precedence and children are often robbed of their own childhood and learn to ignore their own needs and feelings, because they are simply unable to play an adult role and take care of their parents (Forward, 1989). There are many causes of family dysfunction which affects a parent's ability to cope and ultimately affects the parent-child relationship.

#### **3.3.1.1 Mental Health Difficulties**

The impact of mental health difficulties on family life and children's well-being can be significant. Mental health difficulties can result in a parent's inability to cope with life's ordinary demands and routines and can have significant impact on family life (Maybery, Ling, Szakacs and Reupert, 2005). When parents are depressed, for example, they may become less emotionally involved and invested in their children's



daily lives. Consequently, parent-child communication may be impaired. The environment in which children grow affects their development and emotional well-being. It can affect attachment formation and the cognitive, social, emotional and behavioural developments of children (Campbell, Brownell, Hungerford, Spieker, Mohan and Blessing, 2004). A number of challenges faced by children of parents who suffer from mental health difficulties have been identified in the literature. For example, children may take on the responsibility in caring for themselves and managing the household. They may give up on childhood needs and take on a surrogate spousal role that is a kind of reverse parenting known as 'Parentification' (Aldridge and Becker, 2003). Parentification is the process of role reversal whereby a child is obliged to act as parent to their own parent. Parentification may be viewed on two distinct axes, instrumental parentification and emotional parentification. Instrumental parentification means completing physical tasks for the family, such as paying bills or helping a younger sibling do well in school. Emotional parentification occurs when a child or adolescent must take on the role of confidant or mediator for or between parents and or family members (Hooper and Doehler, 2011). Foreman (1998) in examining the impact that depressed mothers have on their children found that these children tend to display more behavioural disturbances, poorer cognitive functioning and a more difficult temperament. Children sometimes blame themselves for their parent's difficulties and experience anger, or guilt. They may feel embarrassed as a result of the stigma associated with their parent's mental health difficulties and maybe at greater risk of being isolated from their peers and other community members. They may also be at increased risk for problems at school, drug use and poor social relations (Manning and Gregoire, 2006).

### 3.3.1.2 Family Members Abusing Alcohol/Drugs

Research on alcohol/drug-dependent parents has consistently shown that parental alcohol/drug dependency has an effect on children directly and/or indirectly (Cleaver, Nicholson, Tarr, and Cleaver 2007). Symptoms of a typically negative parent-child relationship where the parent is alcohol/drug dependent include prolonged absences from the family home and mood swings on the part of the alcohol/drug-dependent parent (Hogan, 2003). According to the literature (Butler, 2002; Christoffersen and Soothill, 2003; Mongan, Reynolds, Fanagan and Long, 2009; Vellernan and Templeton, 2003) the family and social environment of children with alcohol/drug-dependent parents is often chaotic, confusing and unpredictable and consequently not disposed to fostering balanced development. A parent who has an addiction can have sporadic behaviour and mood changes which can cause the child to be scared, nervous, or not want to be around the parent (Mongan et al., 2007).

Neglect of children is also said to be particularly common among families with alcohol/drug dependent-parents. Children in families where one or both parent's abuse alcohol/drugs can suffer from material deprivation such as lack of proper diet, lack of school books, clothes and toys due to the high family spend on these substances (Butler, 2002). Affected children often have particular difficulties which can emerge while they are still young including emotional problems and problems in the school environment. They also tend to have a more difficult transition from childhood to adolescence (Vellernan and Templeton, 2003). During adolescence they may be at an increased risk of being socially isolated from peer groups because they may feel that it is too problematic or shameful to bring friends home or visit friends.

They may display anger and violence and often attempt to escape from their family home by running away (Christoffersen and Soothill, 2003). Research also suggests that young people who have parents with alcohol/drug problems are also more likely to develop an alcohol or drug use problem later in life (Anderson and Henry, 1994).

### 3.3.1.3 Parental Separation

Parental separation often triggers a series of changes in a child's life, such as changes in relationships with parents and changes in residence and school. It can also represent their first experience of transitions in close relationships (Kelly and Emery, 2003). Transitions related to parental separation typically involve possible loss of contact or diminished contact with the parent who has left, along with the potential for reduced parental availability and responsiveness from the remaining parent. Adolescents who have experienced parental separation may view their parents as responsible for the problems associated with the separation and this perspective may serve to drive a wedge between parents and adolescents (Videon, 2002). There may exist ongoing inter-parental conflict. Evidence suggests that it may be the antecedent family climate and the degree of inter-parental conflict that accompanies a separation, rather than the separation itself that accounts for the difficulties experienced by the children (Bream and Buchanan, 2003). Studies on the short-term and long-term effects of parental separation have for the most part focussed on the behavioural outcomes for children. These include behavioural problems, such as aggression, delinquency, and other anti-social behaviours. Parental separation has also been found to lead to modest increases in risks of academic underachievement, psychological maladjustment, low self-esteem and interpersonal difficulties from childhood to adulthood (Bartle-

Haring, Brucker and Hock, 2002). It has also been suggested that as a result of parental separation some adolescents disengage at an earlier age from the family and leave home (Chase-Lansdale, Cherlin and Kiernan, 1995). They also tend to report higher levels of drinking and more drug use during adolescence and adulthood (Woodward, Fergusson and Belsky, 2000).

#### 3.3.1.4 Parental Bereavement

The loss of a parent by death is one of the most significant developmental challenges a dependent child can face (Rutter and Taylor, 2002). For many children the loss of a parent means the loss of stability, security, nurturing and affection (Despelder and Strickland, 2005). Bowlby characterised it as the loss of the child's 'safe haven' or 'secure base' (cited in Davis, 2004). There is some evidence in the literature about groups of children who might be more vulnerable than others following bereavement. These include boys who lose fathers and girls who lose mothers (Abdelnoor and Hollins, 2004). They often present with a wide range of emotional and behavioural symptoms with more aggression and acting-out behaviours being experienced by boys while girls were found to display more internalising problems. Bereaved children have also been found to express their grief by engaging in negative behaviours which can lead to conflict involving the surviving parent (Dowdney, 2000). As both parent and child grieve, symptoms in each may well affect their relationship, roles and naturally occurring separation process. The death of a partner has been associated with lower levels of functioning in surviving parents, with bereaved mothers reporting higher levels of depression and mental health difficulties and bereaved fathers reporting higher levels of substance misuse (Currier, Holland and Neimeyer, 2007).

### 3.3.1.5 Domestic Violence

Children exposed to violence are at risk from a range of psycho-social problems even when they themselves are not the target of the physical aggression. Infants and small children who are exposed to violence in the home experience a level of additional emotional stress that can harm their overall development (Osofsky, 1999). Children in a violent family have been found to experience emotional abuse and behavioural problems which can have potentially long lasting psychological effects (Katz, Hessler and Arnett, 2007). Primary school-age children may have more trouble with school work, and show poor concentration and focus. They tend not to do as well in school. They may project their problems in the classroom and behave violently to peers or siblings. In one study, forty per cent had lower reading abilities than children from non-violent homes (McGee, 2000). Personality and behavioural problems among children exposed to violence in the home can take the forms of psychosomatic illnesses, depression, suicidal tendencies, and bed-wetting (James, 1994). Later in life, these children are at greater risk of substance abuse, teen pregnancy and criminal behaviour than those raised in homes without violence (James, 1994). Some studies suggest social development is also damaged. Some children lose the ability to feel empathy for others. Others feel socially isolated, unable to make friends as easily due to social discomfort or confusion over what is acceptable (Buckley, Whelan and Holt, 2006). Many studies have noted that children from violent homes exhibit signs of more aggressive behaviour, such as bullying, and are up to three times more likely to be involved in fighting (Baldry, 2003). As they approach adolescence many of these young people run away from home. These behaviours may suggest an attempt to escape from an emotionally and physically deprived situation (Katz et al., 2007).

### 3.3.1.6 Neglect

An increasing number of young children are also placed into care because of parental neglect. Neglect is a form of abuse that is defined as *'an omission, where the child suffers significant harm or impairment of development by being deprived of food, medical care, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, as well as attachment to and affection from adults'* (Children First, 2011: 8). Many cases of neglect occur because the parent experiences strong negative feelings towards the child. At other times, the parent may truly care about the child but lacks the ability or strength to adequately provide for the child's needs because they may suffer from depression, drug abuse or some other problem (Frank, Klass, Earls and Eisenberg, 1996). Neglected children often do not receive adequate nourishment or emotional and mental stimulation. As a result their physical, social, emotional and mental development may be hindered. The effects of neglect vary depending on the circumstances of the neglect, personal characteristics of the child and the child's environment (Chalk, Gibbons and Scarupa, 2002). Consequences may be mild or severe, disappear after a short period or last a lifetime and can affect the child physically, psychologically and behaviourally or in some circumstances a combination of all three (Herrenkohl, 2005). Neglect can have a number of profound and long lasting consequences on all aspects of a child's development including poor attachment formation, development delays, poor physical development and anti-social behaviours (Frank et al., 1996). Neglected children are also more likely to experience problems such as delinquency, teen pregnancy, drug use and mental health problems (Kelley, Thornberry and Smith, 1997).

### 3.3.1.7 Physical and Emotional Abuse

By its very nature, physical abuse is threatening and disruptive to normal child development and damages the most fundamental relationship that of a parent and child (Teisi and Cicchetti 2008). Physical abuse of a child is *‘that which results in actual or potential physical harm from an interaction or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust’* (Children First, 2011: 9). Children who are physically abused exhibit a wide array of characteristics and behaviours. Beyond the physical trauma there are other consequences of physical abuse. Social, cognitive and emotional development may be adversely affected (Saltzman, Holden and Holahen, 2005). They often have a predisposition to a host of emotional disturbances and experience feelings of low-self esteem, hyperactivity and anxiety (Wolfe, Crooks, Lee, McIntyre and Jaffee, 2003). Other emotional problems include anger, hostility, fear, humiliation and an inability to express feelings (Teisl and Cicchetti, 2008). Many of these children may exhibit behavioural problems such as aggression towards other children and siblings (Tyler, 2006).

Emotional abuse is normally to be found in the relationship between parent and a child rather than in a specific event or pattern of events (Children First, 2011). It occurs when a child’s developmental needs for affection, approval, consistency and security are not met. Emotional abuse rarely manifests in terms of physical signs and symptoms (Iwaniec, 2006). Examples may include the imposition of negative attributes on a child, expressed by persistent criticism, sarcasm, hostility or blaming. Emotional abuse also includes conditional parenting in which the level of care shown

to a child is made contingent on his or her behaviours or actions. It may also include parents being emotional unavailable to the child's needs and a failure on the part of a parent to show interest in, or provide age appropriate opportunities for the child's cognitive and emotional development (Evans, 2002). Exposure to domestic violence and use of unreasonable or over-harsh disciplinary measures can also constitute emotional abuse. Emotional abuse can be manifested in terms of the child's behavioural, cognitive, affective or physical functioning. Examples of these include insecure attachment, unhappiness, low self-esteem, educational and developmental underachievement and oppositional behaviour (Fahlberg, 1994).

#### 3.3.1.8 Emotional and Behavioural Problems of Children

Emotional problems are also normally to be found in the relationship between a parent and a child. They can occur when a child's need for affection, approval, consistency and security are not met. The mother or primary care giver may neglect the child's emotional needs because of a pre-occupation with the demands of caring for others within the family, her own emotional problems, substance abuse or a lack of understanding of her child's needs (Skuse and Bentovim, 1994). Psychological, social or emotional problems within the family almost always play a role. Children often struggle to deal with the emotional and behavioural difficulties arising out of their home life. Emotional problems can be manifested in terms of the child's behavioural, cognitive and affective functioning. Examples include anxious attachment, unhappiness, low self-esteem and oppositional behaviour, mood disorders and anxiety issues as well as aggression and self-harm (Fahlberg, 1994). Parents find



it difficult to manage and control such behaviours resulting in the young people either being placed voluntarily in care or running away from home (Fahlberg, 1994).

In order to develop into a psychologically healthy young person, a child must have a relationship with an adult who is nurturing, protective and fosters trust and security (Werner and Smith, 1982). Such relationships for children are only possible in the context of satisfactory attachments. Therefore, attachment to a primary care giver is essential to the development of emotional security (Lieberman et al., 1991). The importance of such relationships is mainly based on psychoanalytically inspired theories. Bowlby's theoretical work on attachment attempts to explain both attachment and attachment behaviour and provides a greater understanding of the difficulties faced by children who enter residential care.

### **3.4 Attachment Theory**

Bowlby (1951) pioneered the concept of attachment in the 1940s and used the term 'attachment bond' to describe a warm, intimate and continuous relationship with a mother or permanent mother substitute in which both find satisfaction and enjoyment (Bowlby, 1951). The term attachment is most often used to refer to the relationship between an infant or young child and infant or child's parent (usually the mother) or preferred caregiver (Klaus and Kennell, 1976). The purpose of attachment is twofold, the provision of safety and the provision of comfort. The theoretical basis of most of the attachment research is that secure attachment in infancy will predict good social and emotional outcomes (Tyler, 2006). Ainsworth, Blehar, Waters and Wall (1978) expanded upon Bowlby's original work and went on to describe two further styles of

attachment, ambivalent-insecure attachment and avoidant-insecure attachment. Later, Main and Solomon (1990) added a fourth attachment style called disorganised-insecure attachment.

### ***3.4.1 Secure Attachment***

A child who experiences parenting that predictably offers safety and comfort, where attachment behaviour is recognised for its communicative properties and is responded to in a way that facilitates the achievement of emotional quiescence, develops trust in the attachment figure and a feeling of security in his/her environment (Fahlberg, 1994). When children have strong and secure attachments it allows them to develop both trust for others and self-reliance and influences both physical and intellectual development as well as forming the foundations for psychological development (Bowlby, 1973). The secure attachment relationship is the medium through which the child learns to organise and model experiences, forms a core concept of self, copes with anxiety, develops social understanding, make sense of other people and copes with social relationships. Healthy and secure attachments have been found to promote resilience, increase feelings of self-worth, build confidence and promote independence (Gilligan, 2000).

### ***3.4.2 Ambivalent-insecure Attachment***

The signs and symptoms of attachment problems in a particular child have been found to be as a result of the way his or her parents behaved towards the child and the environment in which the child has been reared (Iwaniec and McSherry, 2002).

Children who display ambivalent-insecure attachment have experiences of an unpredictable environment. They cannot depend on their mother (or caregiver) to be there when they are in need. Essentially, the child cannot rely on being predictably responded to by their caregiver in a manner that achieves safety and/or comfort. On some occasions the caregiver may be fully available to the child which facilitates the achievement of emotional quiescence while on other occasions, the attachment figure's response may not result in feelings of comfort and in more severe situations the child may fail to experience safety or comfort (Graham, 2006). The child experiences his/her caregivers as indecisively loving which exacerbates his/her feelings of frustration, dependence, anger and/or fearfulness (Graham, 2006). Children with ambivalent-insecure attachment may not be able predict the outcome of their attachment behaviours. The result is that they may become anxious about their safety and comfort which can result in feelings of confusion, anger and despair, often expressed as difficult behaviour. They may be uncertain of their worth and unsure of the availability of others which can result in an inability to trust others. They suffer separation anxiety that affects their willingness to explore their world. This can result in the development of a sense of low self-esteem, low self-confidence and relationships racked by self-doubt, uncertainty and ambivalence (Graham, 2006).

### ***3.4.3 Avoidant-insecure Attachment***

Children with an avoidant-insecure attachment tend to avoid parents or caregivers. They have learned that signals for protection and/or comfort predictably result in a rejecting response from the caregiver. The child will not achieve the feeling of safety or comfort desired. This results in feelings of confusion and anxiety. These children

try to cope with turning inwards. They expect rejection and tend to generate a sense of others as being emotionally unavailable, untrustworthy and rejecting and of themselves as unlovable and of low value (Graham, 2006). Children with this style of attachment are particularly vulnerable in times of crisis as they are less likely to be continuously demanding and can be easily over looked. A child whose need for safety is reliably unmet is vulnerable to the development of behaviours characterised by levels of compulsion and compulsive care-giving where neglect is a threat (Graham, 2006).

#### ***3.4.4 Disorganised-insecure Attachment***

Children with disorganised-insecure attachment style show a lack of clear attachment behaviour. Their actions and responses to caregivers are often a mix of behaviours, including avoidance or resistance. For example, the child may sit comfortably on the caregivers lap while simultaneously ignoring the caregivers repeated overtures (Graham, 2006). These children are described as displaying dazed behaviour, sometimes seeming either confused or apprehensive in the presence of a caregiver. Main and Soloman (1990) proposed that inconsistent behaviour on the part of parents might be a contributing factor in this style of attachment. In other research, Main and Hesse (1990) argued that parents who act as figures of both fear and reassurance to a child contribute to a disorganised-insecure attachment style. This is because the child feels both comforted and frightened by the parent. The child's display of disorganised-insecure attachment behaviours is thought to occur because he/she is faced with an irresolvable paradox. When fear is aroused, the infant experiences irresolvable conflict with respect to seeking comfort from a frightened or frightening

care giver, who is the only haven of safety (Main and Hesse, 1990). There is also evidence to suggest that this style of attachment is associated with parents' own unresolved experience of loss, separation and trauma (Schuengel, Bakermans-Kranenburg, Van Ijzendoorn and Blom, 1999).

### ***3.4.5 The Impact of Insecure Attachments on the Child***

The failure to form secure attachments early in life can have a negative impact on behaviour in later childhood (Goldberg, 2000). Where a child has not experienced a positive attachment relationship this can result in feelings of confusion, anger, despair, often expressed as difficult behaviour (Goldberg, 2000). They may be uncertain of their worth and unsure of the availability of others which results in an inability to trust others (Green, 2003). They may suffer separation anxiety which affects their willingness to explore their world. This may result in the development of a sense of low self-esteem, low self-confidence and relationships racked by self doubt, uncertainty and ambivalence (Crittenden, 1999). Lack of attachment in infancy has been shown to result in controlling behaviours on behalf of the child with his/her caregivers, aggressive and fearful peer relations, internalising and externalising problems in pre-school and elevated psychopathology in adolescence (Lyons-Ruth and Jacobvitz, 1999). It is often difficult for children with attachment problems to grow socially. They experience difficulty learning to build and maintain relationships of any sort (Fahlberg, 1994). If attachments have not been established in the family unit, they will be very difficult to form elsewhere.

The removal of a child from the primary caregiver can have a traumatic and long-lasting effect, even though the reason for the removal may be justified. The more serious effects of the disruption to the primary attachment relationship tend to manifest themselves in the pre-school and school years and can last into adolescence and adulthood. Examples include mistrust and difficulties in establishing supportive and sensitive relationships as few opportunities existed in the past to trust one person because these relationships were often interrupted, disrupted or consistently unreliable. This pattern can continue into adult life and can adversely affect adult relationships (Lubit, 2009). The traumatic upheaval of being estranged from their families and entering an unknown and unfamiliar environment, that of a residential care setting, can exacerbate young people's emotional trauma (Broad, 2005). As a result, many encounter problems in relation to their psychological development and adjustment compared to young people from a supportive family background (Muldaly and Goddard, 2006). That is not to say that all children and young people entering residential care have experienced attachment difficulties. However, if a secure attachment is not formed, it makes it much harder for a person to cope effectively with stress and they will feel little confidence either in coping as an individual or in relying on others for help. Many children in residential care have never learned psychologically healthy ways to connect with others. Their past relationships may not have supported growth and development. As a consequence, they are likely to experience patterns of detachment (Sinclair, Baker, Wilson and Gibbs, 2005).

Many of the behaviours they exhibit are aimed at keeping people at an emotional distance. Closeness in the past has led to either physical or emotional pain (Fahlberg, 1994). Separation from family, if there was any attachment is likely to have led to the

pain of loss and can interfere with the young person's formation of new attachments (Fahlberg, 1994). Children and young people can feel powerless and anxious, even frightened about what is happening to them and confused about why it is happening. They may feel a sense of being lost from all that is familiar or important to them and feel unable to remedy this, because of their lack of control. It is not surprising therefore that the young people who enter residential care are likely to perceive adults as a source of pain rather than comfort (Fahlberg, 1994).

### **3.5 Young People in Residential Care**

Children and young people being cared for in residential care demonstrate a wide variety of problems. Some have developmental delays and most show evidence of underlying problems by their behaviours (Iwaniec, 2006). Studies have indicated that children and young people raised without a specific carer can suffer from cognitive delays (Rutter, 2000) increased impulsivity (Fraiberg, 1977) and a lowered frustration tolerance (Goldfarb, 1954). The literature attributed these problems to the young people in residential care being deprived of primary and consistent carers. Specific behavioural or emotional symptoms such as poor eye contact, withdrawal, aggression, indiscriminate affection, over competency, lack of self-awareness, constant control issues are frequently seen in young people with attachment problems in residential care (Fahlberg, 1994). Many behavioural problems represent an expression, inappropriate as it may be, of underlying emotional problems. Green (2003) suggests that some behavioural problems occur because of unresolved separation or loss issues.

However, the imported issues are not the only source of difficulty and uncertainty for young people in residential care. In a study of forty eight Children's Homes<sup>4</sup> in England and Wales, two hundred and twenty three children and adolescents were interviewed about their experiences of living in residential care (Sinclair and Gibbs, 1998). Seventy one per cent had been expelled from school or were frequent truants, sixty three per cent had been involved in delinquent acts and one third had been violent with others. A similar study also in the United Kingdom on peer violence in residential care showed that nearly all young people in the Children's Homes under study had experienced verbal attacks and that this was a common feature of life in residential care (Barter, Renold, Berridge and Cawson, 2004). Altogether seventy four young people aged between six and seventeen in fourteen different children's homes were interviewed about their past and present experiences of peer violence and aggression. Almost half of the young people had reported being victims of physical attacks or had experienced attacks on personal property. This finding is not altogether surprising as young people living in residential care are more vulnerable to abuse than others because they have also often been victims of abuse earlier in their lives. These young people's histories are often littered with experiences of abuse and neglect which resulted in them being placed in care (McLean, Price-Robertson and Robinson, 2011).

This is comparable with studies carried out in the United States among children and youths also living in residential care settings. A study by Curtis, Alexander and Longhofer (2001) compared the outcomes of residential care to that of Therapeutic

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<sup>4</sup> In the United Kingdom residential units taking care of children and youths are called Children's Homes.



Foster Care (TFC)<sup>5</sup> and found that there were high incidences of aggression, truancy, interpersonal and academic problems along with delayed social development among children and youths in residential care compared with those living in Therapeutic Foster Care. Another study also in the United States by Connor, Doerfler, Toscano, Volungis and Steingard (2002) studied a total of three hundred and seventy one youths admitted to a residential care centre and found high levels of psychiatric symptomatology. The most common psychiatric diagnoses were disruptive behaviour disorders such as conduct disorders and attention deficit hyperactive disorder (forty nine per cent) and anxiety disorders (thirty one per cent).

Despite these problems, research has shown that many young people in residential care want their lives to be as normal as possible (Anglin, 2002). Young people including those with severe experiences want to be treated as competent young persons who are not different from others and want their experiences to be as close to that of young people who grow up in a family home (Ward, 2004). The need for continuity has been identified as a core element in achieving this (Gilligan, 2001; McIntosh, 2001). Continuing relationships with family, friends and other people significant to the child and continuing connections to familiar environments, can help children and young people in residential care experience an upbringing as normative as possible to that of their peers (McIntosh, 2001). However, the reality is that a significant number of young people in residential care have moved from one placement to another never having experienced the continuity in relationships (Rutter, 2000).

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<sup>5</sup> Therapeutic Foster Care (TFC) is a foster family-based intervention that aims to provide young people with an individually tailored programme designed to help bring about positive changes in their lives (Curtis et al., 2001).

### **3.5.1 *The Impact of Multiple Placements***

Young people in residential care have revealed their experience of losing '*pieces of self*' in placement moves, losing '*a sense of themselves as being wanted, connected*' and '*all sense of familiarity, self agency and a sense of being in control*' (Mc Intosh, 1999: 30). Changing placement often means changing carers, schools and neighbourhoods and provides little security or continuity of care in the young person's life (Stein, 2005). High levels of placement instability have been found to hold back young people in residential care from achieving their full potential. Instability can disrupt schooling, prevent the acquisition of basic academic skills such as numeracy and literacy and are reflected in poor exam results. Research undertaken in the United Kingdom found that eighty per cent of children in care in the United Kingdom, whose placements break down, change schools and these moves, lead to problems in coping with a number of curriculum changes during these formative years (Morgan, 1999). With every placement move, young people become less likely to attempt to establish close relationships with future carers and are more likely to display behaviours that keep carers emotionally distant (Broad, 2005). Such maladaptive coping techniques and challenging behaviour may lead to further placement breakdowns and rejection (Sinclair, Baker, Wilson and Gibbs, 2007).

Multiple placements or placement instability, together with changes of school are also associated with an increased risk of difficult behaviour and later offending. Widom (1992) for example, found that it was not being placed in residential care itself that made children in care more likely to be involved in crime, but the stability and number of their placements. She found that children who moved three or more times

had significant higher arrest rates than children who moved less than three times. The nature of this relationship, however, is likely to be complex since one of the main reasons for changes in placement and school exclusion occurring is that care staff and schools have difficulty tolerating and managing the difficult or anti-social behaviour of children who do not feel secure and engaged in those environments (Taylor, 2006). In some cases, the child's behaviour may also lead to direct police involvement. While children and young people in their family home may cause damage or threaten harm in anger and upset, their difficult behaviour is generally dealt with by the family. In contrast, when a child is in residential care, staff may call in the police to manage their behaviour, leading in many cases to charges being laid (McFarland, 2010-11; Taylor, 2006). Once involved with the criminal justice system, it is difficult to disentangle children in residential care from it (Taylor, 2006). This makes the lives of many young people living in residential care qualitatively different from those living in families where there is some consistency within the family group. Nonetheless, some young people living in residential care grow up to be competent young adults in spite of the many risk factors they encounter in their journey into and through residential care. In examining why some young people succeed and others do not, the concept of resilience is explored.

### **3.6 The Concept of Resilience**

There are many definitions of resilience but most have similar components. Resilience has been described as '*a set of qualities that help a person to withstand many of the negative effects of adversity, or the ability to recover rapidly from difficult situations*' (Gilligan 2000: 38). Resilience explains why some young people

overcome overwhelming obstacles while others become victims of their early experiences and environments (Gilligan, 2000). A resilient person therefore is one who bounces back or copes successfully despite substantial adversity (Rutter, 1999). It is not simply an inborn trait found in a select few individuals, in fact, many consider that resilience is a mixture of nature and nurture as suggested by Tomison and Wise (1999) who believe it consists of a set of skills and strengths that are utilized to cope with and recover from problems and challenges. In terms of the debate on resilience, it has been detailed that the discussion has shifted from an emphasis on identifying resilience to promoting resilience in young people (Schofield and Beek, 2005, Gilligan, 2000).

### ***3.6.1 Key Factors in Promoting Resilience***

A number of qualities associated with resilience have been identified which develop through a person's life experiences. These include positive self-esteem which derives from being accepted by people, a belief in one's own self efficacy (Emond, 2002), having the qualities of optimism and believing that one's own efforts can make a difference (Grotberg, 1997). Resilience among young people has also been found to be associated with a number of factors namely a redeeming and warm relationship with at least one unconditionally supportive parent or a secure attachment to at least one person in the family, along with positive peer influences and positive school experiences (Rutter, 1999). In order for children to receive support, develop trust, develop attachments and build a positive identity they need to remain connected to key figures in their lives such as parents, siblings, aunts, uncles and so on (Mullender, 1994). Sibling relationships are usually the longest relationships in life and research

shows that most are viewed positively (Mullender, 1994). Friends have also being found to be important as potential resources for resolving difficulties (Hill, 1999). Close relationships with peers can increase self-esteem and reduce some of the negative effects of abuse on children's development (Bolger, Patterson and Kupersmidt, 1998).

The importance of educational attainment for building resilience has also being identified. School itself can provide a turning point, opening doors for participation in a range of leisure or extra-curricular activities that can lead to new friendships and promotes resilience (Rutter, Giller and Hagell, 1998). One of the protective factors strongly associated with later educational success was having a friend outside care who did well at school (Jackson and Martin, 1998). Education can also provide a number of resilience opportunities including the learning of competencies and the development of emotional maturity which in turn can promote resilience (Newman and Blackburn, 2002). Gender has also an effect on resilience, girls have been found to benefit from reliable emotional supports (Grothberg, 1997) while boys have been found to benefit from greater structure and rules, adult supervision and the availability of a positive role model (Sinclair and Gibbs, 2002).

Due to the experience of multiple placements many young people in residential care have unstable care experiences, which has been found to be a barrier to promoting resilience and is associated with poor outcomes (Biehal et al., 1995). The consequence of movement and disruption denies many young people in care the experience of a stable family background, stable educational opportunities and consistent peer influences. A study by Baldry and Kemmis (1998) into the quality of

child care in one Local Authority in the United Kingdom found that over twenty per cent of the children in residential care in their sample of one hundred and sixty young people did not have contact numbers or addresses for family and friends with whom they wanted to keep in touch and one in three did not have photos or items to remind them of their family. Sinclair and Gibbs (2002) suggest that for children in residential care who have little contact with family members, the concept of family may need to be broadened to include youth leaders, teachers and close friends. Where siblings are unable to live together which is often the case in residential care, contact is very important in promoting resilience. Borland, Pearson, Hill, Tisdall and Bloomfield (1998) in a research summary concerning the educational experiences of looked after children in the United Kingdom reported that schooling may be vital in enabling children to make the best of adverse circumstances like being in care. They suggested that this can be achieved through offering opportunities for academic success to compensate for the 'failure' in family life and in affording access to alternative supporting relationships with teachers and peers.

### ***3.6.2 Resilience and Young People Leaving Residential Care***

Although young people in residential care are consistently depicted in research as being acutely disadvantaged, care leavers are a heterogeneous group. As unique as individuals are, also unique is individual's capacity to engage in the process of change and adapt with or without support. Not every young person is going to struggle leaving residential care and experience poor outcomes. Personal circumstances, levels of supports, peer networks, education, placement history and a diverse array of factors

all play a part in determining a young person's future. Research highlights that how well young people are faring is:

*'A function of the complex interactions of factors relating to their in-care experiences and their experiences before coming into care, the timing and circumstances of their transition from care and the extent of the supportive networks they had around them in the period after leaving care'* (Cashmore and Paxman, 2007: 3).

Despite the differences in the experiences and outcomes, the research that has been undertaken has clearly identified common themes that emerge amongst care leavers that form subgroups shaped by common experiences. Examining these sub-groups provides valuable insight into early predictors of young people who are likely to struggle as they leave residential care and transition to adulthood and independence. Stein (2004) classified three distinct subgroups the 'moving on' group, the 'survivors' and the 'victims' group which has been renamed the 'strugglers' group. Each of these groups has a clear set of similarities that are likely indicators of capacity to transition from residential care to independence successfully. The characteristics of the 'move on' group were largely young people who typically tended to have more stability and continuity in their lives and were likely to have benefited from the assistance offered on leaving care as well as maintaining contact with former carers. They were likely to have made sense of their family relationships so that they could psychologically move on from them (Stein, 2004). They were likely to achieve some educational success before leaving care. Their preparation was likely to have been gradual and their moving on was likely to be planned. This group were likely to welcome the challenge

of independent living and gaining more control over their lives often contrasting this with the restrictions imposed whilst living in residential care, including the lack of opportunities to make or participate in decisions that were likely to affect their lives. They were likely to have seen this as improving their confidence and self-esteem. In general, their resilience was likely to have been enhanced by their experiences whilst in care, leaving care and aftercare and they were likely to be able to make good use of the help they had been offered, often maintaining contact with and support from former carers (Sinclair et al., 2005). The second group, who Stein terms 'survivors', had more disruption, instability and movement while living in care. They were more likely than the moving on group to have had several placements and were likely to have experienced elements of a disrupted educational experience and have few or no qualifications. They were also likely to leave care younger following a breakdown or sudden exit from their residential homes. They were likely to experience further movement and problems after leaving care including periods of homelessness, low-paid casual or short-term work and unemployment. They were also likely to experience problems in their personal relationships through patterns of detachment. According to Stein (2004) many in this group saw themselves as 'more tough' they believed that the many problems they had faced and often were still coping with had made them more grown up and self reliant (Stein, 2004: 21). However, they were generally likely to respond positively to any support or assistance they received once leaving care. Stein (2004) asserts that such supports have the potential to provide a number of resilience-enhancing opportunities such as problem-solving, planning and the learning of new competencies. Supports may include the development of self-care skills such as personal hygiene, diet and health, practical skills which include budgeting, shopping, cooking, cleaning and interpersonal skills (Stein, 2004).



The third group, the 'strugglers' also referred to as the 'victims' group contrasted strongly with the 'moving on' group. They were likely to be the most disadvantaged group. They were more likely to have had the most damaging pre-care family experiences and, in the main, residential care was unable to help them overcome their past difficulties. They were likely to have had a number of care placements, a disrupted education and were likely to have had a negative self-image. This group were less likely to have a redeeming relationship with a family member or carer, and were more likely to have experienced several placement breakdowns. On leaving care, this group were likely to be unemployed, become homeless, have difficulty maintaining their accommodation, experience isolation and have mental health problems. Aftercare supports were unlikely to be able to help them overcome their very poor starting points and they were likely to lack or alienate personal support. But according to Stein (2004) it was very important to these young people that somebody was there that they were not abandoned.

Research undertaken by Keller, Cusick and Ruth (2007) defined four distinct subgroups the 'distressed and disconnected' group, the 'competent and connected' group, the 'struggling but staying' group and the 'hindered and homebound' group. Each group had similar characteristics to those identified by Stein. The characteristics of the 'distressed and disconnected' were largely young people who experienced a history of placement instability, absconding and high levels of problem behaviour, including mental health issues and substance abuse and lower employment levels. Keller et al., (2007) identified that this group were perceptibly disconnected from society in general and that while these young people were in greater need of leaving care supports, they were the group less likely to be receptive to the support available.

This population of care leavers shared many characteristics with Stein's 'strugglers group'. The 'competent and connected' group were more likely to have had an education and employment experience and less likely to have had problem behaviours. These young people were more likely to have experienced placement stability that enabled them to develop the skills and requirements for a more successful transition. Keller et al., (2007) suggested that this group were more connected to the community have had a broader range of social supports upon which to call upon in times of need, but still remained vulnerable due to their circumstances post care. Members of this group were more likely to value leaving care support services. The 'strugglers but staying' group were more likely to exhibit problem behaviours such as criminal activity and expulsion from school. However, this group of young people were also likely to respond well to leaving care support services such as skill development and independent living opportunities that were made available. The 'hindered and homebound' group were characterised by early parenthood, little or no qualifications, poor employment experience and lacked preparedness for independent living. While the 'strugglers' and 'distressed and disconnected' group may pose the greatest challenge due to their poor starting points, the research suggests that each group needs support, but of differing degrees. This involves giving care leavers adequate practical and emotional support and allowing them the psychological space to cope with changes over time. The absence of such supports is especially relevant for those who struggle with their emerging adulthood.

### 3.7 The Concept of Emerging Adulthood

The concept of emerging adulthood was proposed by Arnett (2006) to describe the phase of the life span between adolescence and fully-fledged adulthood. He suggested that this period is not simply an extended adolescence as it is much more different from adolescence, in the sense that young people are much freer from parental control, it is much more a period of independent exploration. Nor is it really young adulthood since this term implies that an early stage of adulthood has been reached, whereas most young people in their twenties have not made the transitions historically associated with adult status namely marriage and parenthood. It is a new and historically unprecedented period of the life course:

*‘Having left the dependency of childhood and adolescence and having not yet entered the enduring responsibilities that are normative in adulthood, emerging adults often explore a variety of possible life directions in love, work and worldviews’ (Arnett, 2006: 469).*

In recent decades, the median age for completing school, marrying and becoming a parent has steadily risen and young adults well into their twenties continue to juggle work and school, live at home longer and delay marriage and their own nuclear family formation. For example, a study by Shirk and Strangler (2004) in the United States found that most Americans do not expect their children to complete the transition to adulthood until the age of twenty six. Arnett (2006) suggests that young people of the past were constricted in a variety of ways, from gender roles to economics, which prevented them from using their late teens and twenties for exploration. In contrast,

today's emerging adults have unprecedented freedom. People are freer now than they were in the past to use the intervening years, between end of secondary school and entry to marriage and parenthood, to explore a wide range of different possible future paths (Avery and Freundlich, 2009).

### ***3.7.1 The Distinguishing Features of Emerging Adulthood***

This period from eighteen to twenty five is a transitional period with certain distinguishing features, different in important ways from adolescence that precedes it and adulthood that follows it (Arnett, 2006). It is an age of feeling in-between, in transition, neither adolescent nor adult. It is an age of possibilities, when hopes flourish, when people have an unparalleled opportunity to transform their lives. It tends to be an age of high hopes and great expectations. One of the most distinguishing characteristics of this period is that it offers the best opportunity for self-exploration. By having the freedom to explore their possibilities, '*emerging adults clarify their identities and learn more about who they are and what they want out of life*' (Arnett, 2006: 8). Many of the identity explorations of the emerging adult years are simply part of gaining a broad range of life experiences before settling down and taking on the responsibilities of adult life. Arnett (2006) asserts that there is no time in life that is more self-focussed than emerging adulthood.

By focussing on themselves emerging adults develop skills for daily living, gain a better understanding of who they are and what they want from life and begin to build a foundation for their adult lives. The goal of self-focussing is self-sufficiency, learning to stand alone as a self-sufficient person. The exploration of emerging

adulthood give it the quality of an in-between period between adolescence, when most people live in their parents home and go to school, and adulthood, when most people have entered marriage and parenthood and have settled into a stable occupational path (Arnett, 2006). In between the restrictions of adolescence and the responsibilities of adulthood lies the exploration of emerging adulthood. During emerging adulthood young people have an exceptionally wide scope for making their own decisions. One feature of emerging adulthood that makes it an age of possibilities is that, typically, emerging adults leave the family of origin. However, the family may continue to function as a support both financially and practically, as well as continuing to be a source of wisdom and guidance. Coleman (1998) uses the concept of 'social capital' to explain the resources that exist within a family, which he suggests can be used to advance the chance of success for a young person emerging into adulthood. Enhancing the young person's life using social capital during this period relies on a strong relationship between the parents and young person and this can be strengthened further when the family is embedded in social relationships with other families and community institutions. Regardless of their family background, all emerging adults carry their family influences with them when they leave home, and the extent to which they can change what they have become by the end of adolescence is not unlimited. More than any other period of life, emerging adulthood presents the possibility of change. For this limited window in time the fulfilment of all their hopes seems possible, because for most people the range of choices for how to live is greater than it has ever been before and greater than it will ever be again (Arnett, 2006).

### ***3.7.2 The Meaning of Emerging Adulthood for Those Leaving Residential Care***

The possibilities of emerging adulthood make it a fascinating and eventful time of life for most young people. However, for many young people leaving residential care this period is a time of anxiety and uncertainty, because their lives are so unsettled. They struggle with uncertainty even as they revel in being freer than they ever were in childhood or ever will be once they take on the full weight of adult responsibilities. It represents a closing of doors, the end of a sense of wide-open possibilities. The nature of emerging adulthood for these young people is often deeply intertwined with their own personal histories, the family relationships and also the degree to which they can rely on them for support (Biehal et al., 1995). It is a time in which many young people attempt to make sense of their past and to create a sense of belonging. Biehal et al.'s (1995) study of care leavers found that these young people needed a 'story' of their lives that made sense and provided greater clarity as to why and how events in their lives had happened. Having a story provided a '*more secure platform for their futures in the adult community*' (Biehal et al., 1995: 115). Those who lacked a clear sense of their past were found in general to be less able to cope with independent living after leaving residential care and lacked self-esteem, were less confident and less assertive (Biehal et al., 1995).

Contact with families has been identified an important symbolic function for young people emerging into adulthood. It can have positive implications for a young person's sense of self-identity which has been found to be important in how individuals cope with changes in their lives during this period despite the poor quality of some of those relationships. Even if relationships with parents have irretrievably

broken down, other family members of the young person's extended family may be able to offer some support during this period (Beer and Faulkner, 2009). This support does not necessarily have to be an offer of somewhere to stay, but by simply keeping in touch, it can make a young person feel less isolated, something which is experienced by many young people after leaving residential care (Sinclair et al., 2005). The failure to maintain or renew family relationships has been shown to influence young people's ability to manage their transitions to adulthood. With limited family support, the transition from residential care to adulthood and independence carries a risk of loneliness and isolation (Mendes, Johnson and Moslehuddin 2011; Wade, 2008).

Unfortunately the reality for many young people leaving residential care is that they do not have the strong familial scaffolding that most young people require in modern societies to establish themselves as independent young adults. Raman, Inder and Forbes (2005) found that just under half of their sample of sixty care leavers had received no help from any family members. When there is no safety net of support to fall back on in times of need many care leavers experience high levels of social disadvantage after leaving residential care making many of them vulnerable to a number of poor outcomes. Despite a broad recognition that young people leaving care require considerable preparation and planning in their transition to adulthood and independence such preparation and planning is not always available to them. The following section examines what the existing literature tells us about experiences of preparation and planning for leaving care.

### ***3.7.3 Preparation for Emerging Adulthood***

Preparation for adulthood is generally defined as the development of practical, emotional and interpersonal living skills that enable us to cope physically and emotionally and form effective social relationships (Dixon and Stein, 2005). Most young people acquire these skills gradually over time, with the support of their parents and extended family. In contrast, many young people leaving residential care experience rapid, uneven and compressed transitions to adulthood with very little preparation or planning involved. Research suggests that leaving care is a three stage process that consists of preparation, transition and aftercare. This model is largely reliant upon the view that developing the necessary skills to successfully transition from residential care is a process that takes place on a continuum and the development of key skills involves preparation, practice, refinement and consolidation (Maunder, Liddell, Liddell and Green 1999). Preparation for leaving residential care requires the learning of both ‘soft’ and ‘hard’ skills. Hard skills are based on the learning of practical skills such as cooking, cleaning and financial management. Soft skills encompass character strengths and include personality characteristics that support and promote the development of social capital, and the life skills necessary to connect with community, including the ability to make good decisions, problem solve, resolve conflict and form and navigate healthy relationships both social and intimate (Green and Jones, 1999). A number of researchers suggest that rather than striving to make young people independent, we need to reframe the goals to make them interdependent. That is, the focus on working with young people transitioning from residential care is to promote their capacity to engage meaningfully in relationships that will support them through this challenging time and thus replicate some of the



support that their peers can assume from their parents. In essence, the research articulates a need to provide opportunities and develop the capacity of young people to build their social capital in a meaningful way that will assist them both within residential care but also once they leave residential care. This does not diminish the need for comprehensive independent skill development but rather acknowledges the importance of relationship skills and relational supports as key elements for transition success (Reid and Dudding, 2006; Frey, Greenblatt and Brown, 2005).

Dixon and Stein (2005) conducted a national policy survey of Scottish Local Authorities, and case studies of three Local Authorities, including consultations with one hundred and seven young people. They identified a range of positive and negative experiences of preparation for leaving care. Most young people felt well-trained in practical and self-care skills such as cooking and shopping and health promotion, but there was less evidence of good preparation in budgeting, self-esteem and social relationships. The authors found a strong association between good preparation and a successful transition from care in terms of how well these young people were coping six months after leaving care. Moslehuddin (2010) undertook a study with twenty care leavers in Victoria aged eighteen to twenty six years. He found that four of the young people felt adequately prepared for leaving care. They received ongoing support from their placement, secured stable housing, and generally coped well with the transition. These young people felt accepted and valued by their carers, which facilitated a smooth transition to independence. Furthermore these young people were found to have achieved better outcomes in education, training and housing following discharge from care. In contrast, the other sixteen young people reported a range of problems and unhelpful experiences concerning preparation, including limited independent living skills, little opportunity to be involved in the discharge process, lack of

emotional preparedness and maturity, and the absence of basic necessities including housing. The importance of a leaving care plan was highlighted by Raman, Inder and Forbes (2005) who found that of the sixty young people in their sample those who reported having a leaving care plan were twice as likely to be in stable housing, three times more likely to be employed, and those in receipt of a range of advice and support services had significantly improved outcomes. Conversely, McDowall (2009) found that sixty four per cent of the young people in their sample of four hundred and seventy one who had left care reported they did not have a leaving care plan. The majority of the respondents also reported they felt unhappy about the planning process. Johnson et al., (2010) undertook in-depth interviews with seventy seven young people who had been in State care in Victoria. The authors found that while the State of Victoria has a legislative requirement that care leavers have a leaving care plan, only twenty of the seventy seven young people seemed to have had a leaving care plan. The authors concluded that a meaningful leaving-care plan needs to offer a concrete plan of action that specifies how a care leaver can avail themselves of housing, training, employment, state support, health and other services. In addition, the plan must be supported by caseworkers who provide periodic follow-up and ensure accountability for implementation throughout the leaving-care process. But perhaps, most importantly, transition planning must involve the young people themselves in order to produce effective outcomes in housing and other areas (Johnson et al., 2010). These studies suggest an association between good preparation for leaving care and positive post-care experiences. It appears that the key components required for a successful transition to adulthood for those leaving care should include early planning for the leaving-care process, active participation of the young person in the preparation process, a detailed leaving-care plan that includes

well-defined accommodation arrangements, access to independent living skills training, with levels of support tailored to reflect individual needs, including additional support for those with behaviour or substance abuse problems and an ongoing process of assessment and monitoring (Raman et al., 2005; Johnson et al., 2010). Canadian research identifies ‘seven pillars’ that support successful transitions from residential care to adulthood and independence. The pillars create a relationship synergy that necessitates development across all pillars as each is required for success and no one pillar is more important than the other. The pillars represent the following areas, education, housing, relationships, life skills, identity, young person’s engagement and emotional healing (Reid, 2006). In order to make a successful transition, young people must be prepared across all these areas. Every young person should be able to maintain employment that provides a viable career path, engage in sufficient education and training to achieve this, have a stable and supportive placement that is close to supports and amenities in order to maintain education and employment, have sufficient independent living skills to be able to maintain accommodation, have a range of supportive relationships from formal and informal supports that are integrated into the community that they live in. Have a strong sense of their identity, have the relevant documentation and information about themselves and be able to access affordable health services (Reid, 2006). The rationale behind the ‘pillars’ model is not only to create the interconnectedness and interdependent relationships between care leavers and the broader community, but also to create an environment that supports the development of personal resilience factors such as the promotion of self-esteem, trusting relationships, personal achievements, community acceptance, an external support network and a capacity to exercise self-determination (Stein, 2005; Reid, 2006).

Maunder et al (1999) found that there were key factors that promoted and inhibited a successful transition to independence. Their research identified that success is largely driven by a stable and positive experience in care, personal resilience and self belief, extended support after care and family contact. The factors that inhibited independence included unresolved anger, unsuitable placements and a lack of long term goals, teenage pregnancies and mental illness (Maunder et al., 1999). In the absence of planning, preparation and supports many care leavers can experience difficulties on leaving care.

### **3. 8 Difficulties Experienced by Young People Leaving Care**

Research studies completed over the last number of decades have provided evidence of the high risk of social exclusion for young people leaving care especially through homelessness, educational deficits, unemployment, drugs abuse and crime along with loneliness and isolation (Biehal et al., 1995; Broad, 1998; 1999, Dixon and Stein, 2005; Dixon et al., 2004). Although much of this research was carried out in England, similar findings emerged from Scotland where a number of small scale descriptive studies documented the difficulties experienced by many young people leaving the care of Scottish local Authorities (Emond, 2002; Morgan-Klein, 1985; Triseliotis, Borland, Hill and Lambert, 1995). Irish research on leaving care outcomes is comparatively limited. It tends to be based on small-scale studies of care leavers in general. Nevertheless, the findings (Kelleher et al., 2000; Mayock, Corr and O'Sullivan, 2008) are consistent with those of international studies.

### **3.8.1 Homelessness**

In the United Kingdom, Dixon and Stein (2005) reported difficulties in obtaining accurate estimations of the extent of homelessness among care leavers as they found that care leavers drift in and out of homelessness and often move through a series of housing experiences as part of an overall homeless career. Biehal et al., (1995) and Broad (1998) estimated that twenty per cent of all care leavers in the United Kingdom will experience some kind of homelessness within the first two years of leaving care. Kelleher et al.,'s (2000) study found that six months after leaving State care thirty three per cent of the forty nine of the original population of fifty six who were tracked six months after leaving Health Board care experienced homelessness. Two years after leaving care, this figure had increased dramatically to sixty eight per cent. It is well established that the younger individuals are when they first become homeless the risk of remaining homeless for long periods is much higher (Kelleher et al., 2000; Mayock, Corr and O'Sullivan, 2008). When this goes on for a number of years people are said to be chronically homeless as they often accept homelessness as a way of life (Chamberlain and McKenzie, 2007).

Homelessness among care leavers can take many forms the most obvious being 'street homelessness'. This constitutes the narrowest definition of homelessness as this represents only a minority that are known as the 'visible homeless' (O'Sullivan, 2008). The other end of the continuum includes care leavers who are in inadequate/insecure accommodation such as those living in emergency and temporary accommodation, such as night shelters, hostels, staying with friends (also known as 'couch surfing') or relatives, squatting, as well as those who experience overcrowding

or live in substandard accommodation. These are referred to as the 'hidden homeless'. Care leavers are commonly recognised as being vulnerable to accommodating themselves in hidden situations such as squatting (O'Connor and Molloy, 2001; Fitzpatrick, 2005). The group in the middle are those who are 'at risk' of homelessness. Those who currently have housing but are likely to become homeless due to economic difficulties, have too high a rent burden and have insecure tenure or health difficulties (O'Sullivan, 2008).

Hostel accommodation remains a basic element in the provision of services for those who find themselves homeless in Ireland (O'Sullivan, 2008). Hostels are distinguished from other temporary accommodation not least through the limited private space on offer. Several people often sleep in the same room. Space for eating is usually communal and shared space also includes sanitary facilities (bath/toilet). Most hostels have some staff supervision but the standard varies considerably. The level of independence in some of the hostels is also limited with communal chores and meals. Many young people have a preference to squatting over other temporary accommodation (hostels, staying with friends) due in part because alternative provisions do not meet their needs and/or they have exhausted other temporary accommodation and want to avoid rough sleeping (Fitparick, 2005). Squatting is a relatively common means through which homeless people obtain shelter when conditions are too harsh for rough sleeping or as one of the many homeless accommodation situations they move quickly and frequently between (Reeve and Batty, 2011). The living environments within squats are varied and can range from residential disused commercial properties, to vacant flats, factories and shops.

Street life has been described as transitory and predatory and most young people on the streets want to address their homelessness (Hagan and McCarthy, 1997). Addressing the physical impact of homelessness is obviously important however, addressing the social and psychological impact of prolonged homelessness is more complex (O’Sullivan, 2008). The complexity of their social problems is made more evident when it is appreciated that a secure and safe dwelling provides more than just shelter. A home is not just bricks and mortar, it is a place where people relax, rejuvenate, entertain and have a sense of belonging. Havel describes the home as ‘*an inseparable element of our human identity, deprived of all aspects of his home, man would be deprived of himself and of his humanity*’ (cited in Tucker, 1994: 184). Home provides us with physical and psychological security, defines our social position, represents a source of pride and respect and offers a tangible measure of our self-worth (Daly, 1996). Housing is a particularly important dimension for care leavers. The provision of safe, secure and affordable accommodation is a crucial component of any successful transition from care to independent living and is closely linked to positive outcomes in health, emotional well-being, social connections, education attainment, employment and future aspirations (Biehal et al., 1995; Cashmore and Paxman, 2007). However, care leavers ability to access stable housing can be reduced by educational deficits, alcohol and substance abuse and the combined impact which these issues have upon the capacity to access and maintain meaningful employment.

### ***3.8.2 Educational Deficits***

Research from the United Kingdom attests to the poor educational outcomes for young people in residential care, compared with other young people. One such study

which explored the patterns of outcomes for a sample of one hundred and six young people leaving the care of seven Local Authorities found that educational attainment was quite poor. Fifty four per cent had left school with no qualifications and forty four per cent were unemployed (Dixon et al., 2004). Findings from Biehal et al.'s study found that more than half of their sample of one hundred and eighty three young people had left school with no formal qualifications and half were unemployed several months after leaving care (Biehal et al., 1995). Kelleher et al., (2000) found that sixteen per cent of young people who had left Health Board care had difficulties reading and writing. Two years after leaving care twenty five per cent needed assistance to develop an education and training plan. In a society in which qualifications are of major importance for success in the labour market, the educational disadvantage suffered by young people in residential care is great. Bearing this in mind, it is unsurprising that care leavers are over-represented among the long-term unemployed (Allen, 2003). The failure of care leavers to obtain qualifications at school, together with a difficulty of establishing themselves in a community at an early age with little or no social or familial support has made gaining and sustaining employment extremely difficult.

### ***3.8.3 Unemployment***

Employment outcomes for care leavers tend to be particularly poor, which leaves many of them reliant on unemployment benefit (Biehal et al., 1995; Hai and Williams, 2004; Wade and Dixon, 2006). A 1998 U.K. survey of two thousand nine hundred and five care leavers found that fifty one per cent were unemployed. The fifty one per cent figure was two and a half times the average unemployment figure (nineteen per cent)



for young people as a whole in that age range (Broad, 1999). A later study of one hundred and six young people in seven English Local Authorities found that a total of fifty six per cent of the group were not in education, employment or training (Dixon et al., 2004). These findings are comparable with studies carried out in Australia. In their longitudinal study of forty seven care leavers, Cashmore and Paxman (2007) found that forty four per cent of the respondents were unemployed. Similarly, a survey of sixty care leavers in Victoria found a massive seventy one per cent of the respondents were unemployed (Raman, Inder and Forbes, 2005). In Kelleher's et al., (2000) Irish study, thirty nine per cent of their respondents were found to be unemployed.

#### ***3.8.4 Substance Abuse Problems***

To date little research has focussed on care leavers and their drug use. However evidence suggests that young people who have grown up in residential care are particularly vulnerable to developing drug misuse problems. Their vulnerability to drug use can be seen to exist for a range of reasons including adverse childhood experiences and the feelings of loss and fragmentation that characterise living in care (Carr, 2003). Young people in residential care differ from other young people because they have not learned techniques for controlling the use of substances in the same way as those from stable family homes (McCrystal, Percy and Higgins, 2008). Care homes themselves can provide ready made peer groups that can increase the chances of peer pressure in relation to experimenting with illegal drugs (Doolan, 2002). In their study, Mayock, Corr and O'Sullivan (2008) found that drug use escalated for the majority of the young people as their 'careers' in homelessness progressed and this pattern of

drug consumption was especially apparent among those who moved constantly between Out of Hours hostels. When drug use has become established while living in residential care, risky drug using behaviours may develop when a young person exits the care system.

A U.K. survey conducted with two hundred young people in the process of leaving care or having recently left care, on their experiences with drugs found high levels of self-reporting drug use compared with the general population surveys (Ward, Henderson and Pearson, 2003). Almost three quarters (seventy three per cent) reported smoking cannabis, of which thirty four per cent reported that they smoke it daily. Ten per cent reported the use of heroin and crack cocaine. Little difference was found in drug use between men and women. Increased levels were reported among those whose movement to independent living was premature (Ward et al., 2003). When people have a substance abuse problem, their day to day lives are sharply focussed on the here and now what Snow and Anderson (1993) describe as a 'present orientation'. When people have a present orientation it is difficult to think about the future and things like housing, work and education, which requires time and patience to organise, are often neglected. For drug users living with the constraints of a homeless lifestyle, the continued demands of their drug consumption often becomes their daily priority, having enough money to secure a daily supply of drugs can be an essential element in their day to day activities which can propel many into daily criminal activity (Mayock, Corr and O'Sullivan, 2008).

### **3.8.5 *Involvement in Crime***

The transition from care has been found to make care leavers vulnerable to involvement in the criminal justice system and as the transition from State care occurs after the age of eighteen they are subject to the adult rather than the juvenile justice system (Taylor, 2006). US and Canadian as well as English and Irish studies have indicated that care leavers are over-represented in the criminal justice system (Courtney and Dworsky, 2006; Cusick and Courtney, 2007; Jonson-Reid and Barth, 2000a; Kelleher et al., 2000; Taylor, 2006). A study in the United Kingdom reported that twenty three per cent of the adult prison population had previously been in State care, even though care leavers account for less than one per cent of the total population in the United Kingdom (Department of Children, Schools and Families, 2007). Other research revealed that children who have been in care account for forty nine per cent of the eleven thousand, six hundred and seventy two under twenty one years in contact with the criminal Justice System in the United Kingdom (Goldson, 2008).

### **3.9 Conclusion**

The factors for admission into residential care suggest that young people are already disadvantaged at the point of entry. However, there is no doubt that separation from one's family of origin, for whatever reason is a high risk factor for poor developmental outcomes. On their journey through residential care which can include multiple placements and disruption many young people amass a history of adverse life

experiences. They leave residential care with different support needs and differing levels of practical and emotional capability for independent living. The opportunity for a gradual self explorative transition to adulthood appears to be non-existent for most care leavers. Their journey to adulthood appears to be shorter, steeper and often hazardous. The poor outcomes for this group of young people emphasises the sheer difficulty surrounding their transition out of residential care in many cases with little support. Lack of access to housing has been shown to create negative consequences not just homelessness, but also lower rates of educational attainment, employment and increased exposure to and subsequent involvement in drug misuse and crime which, in turn, can lead to social exclusion.

## **CHAPTER FOUR**

### **METHODOLOGY**

#### **4.1 Introduction**

This chapter outlines the research methodology including the research strategy, study design and method of data collection and data analysis used to conduct the study. The chapter addresses a number of ethical issues such as confidentiality and informed consent. A number of methodological issues including access issues as well as environmental and individual factors that impacted on the study are also addressed.

#### **4.2 Research Strategy and Study Design**

Qualitative research comes from an interpretative perspective and is concerned with interpreting and understanding phenomena through the meanings that people attach to them (Greenhalgh, 2001). There has been a substantial growth in recent years in the use of qualitative methods when conducting research with young people and an interest in obtaining information directly from young people which explores their own perspective on their thoughts, feelings, experiences and opinions (Smith and Ravenhill, 2004). Given these considerations, along with the fact that qualitative research can give a richness and depth that is unlikely to be obtained through other methods, as it involves personal

contact and insight and places the findings in a social, historical and temporal context, a qualitative research strategy was selected for this study. As the study was exploratory in nature it therefore fits with an approach emphasising the generation of theories, rather than testing current theories as is inherent in quantitative research (Bryman, 2004). The nature of the study, with its focus upon understanding the views and experiences of young people's journey through the residential care system and the social processes that impact on their current living situations, is consistent with an interpretive epistemological position. Therefore an exploratory and descriptive design was employed in this study.

### **4.3 Research Methods**

An interpretative approach, qualitative in nature, was adopted for the study. The research methods employed included a combination of purposive (Patton, 1990) and targeted (Watters and Biernacki, 1989) sampling strategies both are deliberately non-random methods of selecting participants for research. Both allow individuals to be selected because they have knowledge relevant to the research (Bowling, 2002). Criteria for inclusion in the current study were being a care leaver with a history of residential care and being between eighteen and twenty five years. One of the factors which influenced the decision to include young people up to and including twenty five was the researcher's belief that the evidence of the older care leavers was significant in demonstrating that the transition from residential care is an extended process that can take longer than two years. Although some of the young people in the present study may have experienced foster care at some stage in their care careers, the criteria for selection focussed specifically on

those young people who had been in residential care at the time of their formal discharge from statutory care. Therefore, the experiences of young people in foster care in terms of their journey into, through and from State care was not addressed although, their experience is no less relevant. The definition of care leaver which was used for the purposes of defining the parameters of the study population was as follows: any adult who spent time as a child under the age of eighteen years in residential care. This care would have been approved by the State through a court order or on a voluntary basis. It can range from as little as a few months to as long as ones whole childhood (eighteen years). The care could have been provided directly by the State or by the voluntary sector.

#### ***4.3.1 Community Assessment Process***

The study began with a community assessment process (Clatts, Welle, Goldsamt and Lankenaw, 2002) which was conducted between May and July 2007. Contact was established with twenty five key service providers that worked directly or indirectly with care leavers in the provision of support services (APPENDIX I). These included service providers involved in adult homeless services, senior managers in statutory and voluntary sector agencies that provide aftercare support services to care leavers and specialist services within the care sector such as EPIC (Empowering People In Care, formerly known as the Irish Association of Young People in Care). This was designed to achieve a number of goals. Firstly, to inform service providers about the study and to enlist their co-operation in the recruitment process, secondly, to gather existing local knowledge

about care leavers at community level and thirdly, to guide the sampling and selection procedures with the aim of achieving diversity across the sample in relation to age, gender and experience. These goals were achieved by firstly writing to these service providers outlining the purpose of the study and what participation would involve (APPENDIX II). Following this, telephone contact was then made which allowed for some informal meetings to be arranged with these stakeholders. These meetings provided important information regarding where, when and how young people might be targeted for participation in the study.

#### ***4.3.2 The Recruitment and Selection Process***

An important component of the community assessment process was that the service providers were able to identify possible participants and provide introductions. The process of negotiating the conduct of the interviews was often initiated by workers within the individual services and agencies who informed the young people about the study. The researcher was then introduced to them and at this stage, all prospective participants received detailed information on the aims of the research and the demands, in terms of time and so on associated with participation. In other instances direct contact was made with young people during the course of conducting fieldwork and this typically occurred in the drop-in centres. In total, twenty participants were recruited for the study. The majority (twelve) were recruited through two homeless drop-in centres located in the inner city of Dublin, four were recruited from an aftercare support centre and four were recruited from the offices of EPIC. Eighteen of the participants were born in Ireland, one



participant was born in Albania and one participant was born in Romania. Seventeen were male and three were female. Fifteen said they were single while the remainder (five) reported being in a relationship. Five of the young people reported being a parent (four fathers and one mother) and in four of the five cases they had their first child under the age of eighteen. At the time of the interviews, there were two expectant fathers and one expectant mother. All three were under the age of twenty and had left the residential care system within the last two years. While all of the participants were currently living in the Dublin Metropolitan area at the time of interview, they reported considerable variation in their living situations. Overall, it could be said that eight of the participants had acquired some stability in their housing circumstances however the remaining twelve participants resided in unstable living situations. Of those who reported 'stable living circumstances' (eight cases) five were living in transitional housing and aftercare residential settings, one was residing in a corporation flat and two were living in private rental accommodation. In contrast, six of the twelve who reported unstable living circumstances were sleeping rough while a further four were accommodated in emergency homeless hostels, of the remaining two participants, one stated he was staying with friends and one reported residing in bed and breakfast accommodation. The highest number of participants was in the eighteen to twenty year category. Table 4.1 provides detailed information on the participants by sampling centre.

Table 4.1: Detailed Information on Participants by Sampling Centre

Sampling Centre	Pseud.	Age	Care Data	Duration of Interview	Current Circumstances
Homeless drop-in centre 1	Jack	21 yrs	Foster/Res/OHS	60 minutes.	Homeless Hostel
	Matt	19 yrs	Res/OHS	63 minutes.	Staying with friends
	Paddy	18 yrs	Res/OHS	72 minutes.	Sleeping Rough
	Gavin	24 yrs	Res/OHS	86 minutes.	Sleeping Rough
	Joe	25 yrs	Res/OHS	78 minutes.	Staying in a B&B
	Ann	20 yrs	Res/OHS	90 minutes.	Homeless Hostel
	Harry	20 yrs	Res/OHS	67 minutes.	Homeless Hostel
Homeless drop-in centre 2	Peter	22 yrs	Foster/Res/OHS	87 minutes.	Sleeping Rough
	Connor	25 yrs	Res/OHS	69 minutes.	Homeless Hostel
	Liam	22 yrs	Foster/Res/OHS	79 minutes.	Sleeping Rough
	Fergal	24 yrs	Res/OHS/	85 minutes.	Sleeping Rough
	Andrew	20 yrs	Foster/Res/OHS	90 minutes.	Sleeping Rough
Aftercare Centre	Tom	19 yrs	Res/OHSE	61 minutes.	Transitional Housing.
	Adam	21 yrs	Res/OHS	68 minutes.	Private Rental
	Tina	19 yrs	Res/OHS	79 minutes.	Transitional Housing
	Patrick	19 yrs	Res/OHS	86 minutes.	Transitional Housing
Epic Offices	Claire	19 yrs	Res/OHS	78 minutes.	Private Rental
	Michael	25 yrs	Res/OHS	62 minutes.	Corporation Flat
	John	22 yrs	Foster/Res/OHS	87 minutes.	Transitional Housing
	Jim	23 yrs	Res/OHS	70 minutes.	Transitional Housing.

\*Foster Care, Residential Care (Res), Out of Hours Service (OHS).

#### 4.3.3 Semi-structured Interviews

Interviews have been used extensively for data collection across all the disciplines of the social sciences and it is now generally agreed that interviewing is a key method of data collection (Briggs, 1986). Semi-structured interviewing is a type of interview which researchers use to elicit information in order to achieve a holistic understanding of the

interviewee's point of view or situation (Bryman, 2004). Given that the aim of the research was to explore the views, experiences and challenges experienced by care leavers, semi-structured interviews were considered the most effective method for addressing this aim. All semi-structured interviews commenced with an invitation to young people to tell their experiences of their journey into, through and from residential care. Several key topic areas were then prompted during the interview. Participants were asked to describe their family history, including early family environment and childhood experiences along with key events or milestones during their time in residential care. Specific areas which were addressed during the semi-structured interviews included events and circumstances leading to their admission into residential care, their experiences of journeying through the residential care system, events and experiences subsequent to them leaving residential care and finally their current circumstances. Interview schedules were designed to allow for flexibility in structure and content in order to facilitate the exploration of circumstances and experiences in response to the accounts of individual participants. The interview itself was informal in tone and participants were allowed to take the lead in introducing topics for discussion. This format was adopted to maximise clarity and to help the participants focus on particular events and experiences during different phases of their journey into, through and from the residential care system. The semi-structured format was advantageous in the present study because it did provide a high degree of consistency but also allowed the interviewer to probe further at times. As such it was adaptable and allowed the interviewer to *'follow up ideas, probe responses and investigate motives and feelings'* (Bell, 1999: 135). This

adaptability has been highlighted in other studies concerning the same subject group (McGree, Mc Evoy, Brown and Mc Cormack, 2006).

#### **4.4 Ethical Issues**

Ethical considerations play a very important role in all research studies (Oliver, 2003). With the emphasis on examining ideas and testing hypotheses, an ethical approach in research is now a fundamental element in any study and all professions who engage in research and value the process must address this issue (Bell, 1999). Conducting research with what is perceived to be a vulnerable group can present specific dilemmas, and researching such a group is challenging for the researcher and demands careful thought and consideration of the methods and process adopted (Duerr Berrick, Frasch and Fox, 2000). For the group of young people who have had experience of statutory care, there is an anxiety amongst researchers that involving them in research is a path which is fraught with ethical dilemmas, virtually impossible to gain access to and ultimately lengthy and time consuming. This may account, in some way, for the lack of research in this country that focuses on care leavers as the subject. Not including the views of the young person is missing a valuable source of data and ultimately not providing the complete picture. Inevitably there are obstacles and challenges with this type of research, but by adhering to basic principles and standards these obstacles are not insurmountable.

With the ultimate aim of enabling and ascertaining the views of young people, there is the corresponding need to ensure that they are not subjected to exploitation and that clear standards are adhered to. In reviewing a selection of the literature concerning ethical approaches to research, the following principles are generally agreed upon, clarity in the aims and objectives of the study, honesty with and a responsibility to the subjects, and a commitment 'not to harm' (Kane, 1995, Bell, 1999). In approaching the subject group of young people who are in statutory care, the researcher must ask themselves whether the study will have any positive and/or negative effects on the young people in question, also, what benefit, if any, may come out of the work (Alderson, 1995). This cost / benefit analysis has been highlighted elsewhere (Shaw, 2003) and it's purpose and importance is to encourage critical thinking as to the potential outcomes for the subject group in proceeding with a research study. The ethical issues inherent in this study included ethical approval, informed consent, confidentiality of information and the anonymity of participants.

#### ***4.4.1 Ethical Approval***

Ethical approval for this study was sought during the planning stage of the study and was granted by the Dublin Institute of Technology Research Ethics Committee in April 2007. The Ethics Committee recommended that all participants be offered a list of support services that they could contact and a support person from the various centres that would be facilitating the interviews be made available to the participants after the interview. The researcher acknowledges that above all else the welfare of the participants, including

their mental and physical health and safety is paramount, thus a list of support services was furnished to each participant in the four centres where the interviews were carried out along with an identifiable support person should they need to talk about any issues after the interview.

#### ***4.4.2 Informed Consent***

Letters were provided to the identified centres to explain the purpose of the study and what involvement would entail for potential participants (APPENDIX II). Potential participants were given time to decide whether they would like to participate. As all the participants were of the required legal age to give their own informed consent, voluntary informed consent was obtained prior to commencement of the interview. As it is increasingly required that researcher's obtain written consent from participants rather than relying solely on verbal consent (Miller and Bell, 2002) written consent was obtained from participants using a consent form which had previously been scrutinised by the Ethics Committee (APPENDIX III).

#### ***4.4.3 Confidentiality***

In terms of discussing privacy and confidentiality in research studies with young people who have been in statutory care, there are the practical considerations that the researcher must adhere to, but there are also other reasons why adopting such an approach is necessary. Confidentiality encompasses both gaining access to a sample group and

addressing consent issues (Cree, Kay and Tisdall, 2002). Its importance is linked with general principles characteristic of an ethically responsible study, including being clear as to the aim and objectives of the study, a commitment not to do any harm and a respect for the participants in the study. Being clear at the beginning as to what is meant by anonymity and confidentiality makes the process more manageable (Bell, 1999). Essentially disseminating research findings can involve recounting quite personal details of the participant's life. Ensuring that individuals cannot be recognised from the findings is important. This task becomes more difficult in smaller studies involving a limited population from an identified geographical area. In addition it has been highlighted how challenges related to confidentiality are greater in qualitative research as opposed to quantitative research where techniques can be employed to ensure anonymity (Shaw, 2003). A further question to be considered is whether it is possible to guarantee complete confidentiality. Again, this has been addressed in the literature concerning research with vulnerable young people (McAuley, 1998; Cree, Kay and Tisdall, 2002). The difficulties arise, when, during the research interview, the young person discloses information that may put either them or others at risk. In such circumstances a previous assurance of complete confidentiality becomes an onerous responsibility for the researcher. There are ways of addressing this issue and clarification with the young person as to the limits of confidentiality at the beginning of the process allows the researcher the ability to pass on potentially harmful information. A protocol detailing the situations where the confidentiality clause can be circumvented in addition to what happens after a disclosure, who is informed and what support is provided to the young person is essential (Munroe, Holmes and Ward, 2005). Practical strategies to ensure confidentiality include a safe and

secure method of storing data, the use of codes as opposed to names for the participants and agreeing a procedure to destroy data on the completion of the study that could potentially identify the participant. The confidentiality aspect and safeguards to ensure anonymity were outlined to all the participants during the initial stages of the study. Participants were assured that the data collection for the study would be treated in the strictest of confidence. The computer on which the data would be stored would be password protected and paper records and interview tapes would be secured in a locked cabinet where the researcher would have the only access. The participants were also advised that all data with identifiable information, as well as taped interviews, would be destroyed within one year following full completion of the research study (Reamer, 2001). The anonymity of participants would be protected to ensure individuals would not be identified at any point in the study. All names and contact details were stored separate to interview transcripts, and each transcript was identified by an individual code and not the young person's name. In relation to transcribing, the young person's name was not used and a reference code appeared at the top of the page. A fictional name was used when presenting transcript quotations in the study. Participants were also instructed not to use people's real names at any stage which may make them identifiable in some way as the sample was small and some participants were aware of others also taking part in the study. Participants were also informed at the outset of the interview that if they disclosed any information which indicated they were 'at risk' or 'in danger' it was the obligation of the researcher to inform a relevant individual as recommended by Mahon, Glendinning, Clarke and Craig (1996). None of the participants expressed concern about such an arrangement. Indeed, many of the participants seemed to be highly familiar and



comfortable with this exception to confidentiality, which may have been a result of their previous experiences within the residential care system. Despite such awareness, all of the participants were reminded during the interview process whenever it was appropriate to ensure that they had no doubts or misunderstandings regarding the decision to disclose information. On the whole, this did not emerge as an obstacle to the collection of data or development of rapport in the study. Over the course of the interview process, participants did enquire if their friends had participated in the research. In these circumstances, the researcher explained that such information could not be disclosed for confidentiality reasons and again the issue of confidentiality was expressed and accepted.

#### ***4.4.4. Protection from Distress***

It is acknowledged that some of the issues raised during the interview process could cause distress or sadness for the young person involved. Prior to the interview the young person was informed that if they found any issue upsetting them the process could be halted. The researcher approached the interview process itself in a sympathetic manner and listened to and observed the responses of the participants. The venue for the interview was important in this regard and the young person was informed that they could choose a setting that they were comfortable with. Upon completion of the entire interview process, the researcher made contact with all of the participants that were interviewed to ask them if they were happy with the process and if they had any concerns or anxieties following the interview. Also, it was agreed that a summary of the research findings

would be sent to all of the participants who were willing to receive one following completion of the study.

Finally, it was made clear that as a researcher, and also as a social care practitioner, the researcher was in no position, able to change their individual situations, although they were informed that a potentially positive outcome could be that the information they provided could help promote positive changes for young people in similar situations in the future. In approaching the present study, the researcher was aware of the ethical dilemmas that present themselves when interviewing such a sample group as young people who have experience of the care system. The process of seeking informed consent from the participants, adhering to safeguards concerning privacy and confidentiality, protecting the participants from any distress, and acknowledging potential issues of power in the research process, contributed to an ethical approach in the present study. It is important to report the experience of this subject group for a number of reasons, including, the fact that there is little research on their experiences in this country, their reflections on their experience can assist service planners in better meeting the needs of these young people, and, most importantly, the young people themselves tell us that they have things that they want to say. The purpose of this research has been clearly presented and has been undertaken with the hope that the understanding it seeks will benefit the lived experiences of young people leaving residential care.

## **4.5 Research Implementation**

This section will consider the interview process itself. It will include the process used prior to the actual interviews in terms of contacting the young person, agreeing an appropriate venue, and ensuring supports available to the young person if required. The procedure prior to the main interviews will be discussed and as well as the techniques used during the actual interviews and other relevant issues.

### **4.5.1 Pilot Study**

A pilot study was undertaken which had a dual purpose, to explore topics for investigation and to ensure that any anomalies in the interview schedule would be addressed prior to conducting the main interviews. A sample group representative of the main target group was recruited from both the drop-in centres and the aftercare support centre. Four care leavers, three male and one female, participated in the pilot study. Two of the young people were accessing the drop-in centres while two were involved in the aftercare support centre. All four were between eighteen and twenty years. Written informed consent was obtained prior to the pilot interview commencing. One to one interviews were carried out, using a mixed interview method, a combination of the informal conversational interview techniques and the general interview guide approach. Several useful discoveries were also made from this pilot study experience. Firstly, it was found helpful to start the interview with a topic the participants felt comfortable with. Something related to every day life was found to be a good starting point for

conversations. Secondly, finding the optimal time for interviewing was important. When arranging an interview time with participants matters such as everyday routines, access visits, appointments, needed to be taken into consideration. Thirdly, on some occasions, the interviews were interrupted. To avoid disturbances during the interview, it was found useful to put a note on the door, stating 'interview in progress'. Also as there was a no smoking policy in all the centres, some young people did request a break during the interview and this was agreed and facilitated for. Lastly, one observation made by the researcher was the initial focus the audio-taping device was having on the participants. In order to divert such focus, time was spent at the start of the interview establishing rapport, and providing some background information on the researcher. Assurances around anonymity and confidentiality were again relayed to the participants. A list of support services was also furnished to the participants on completion of the interview.

#### ***4.5.2 Data Collection***

The main interviews were conducted between June and December, 2007. Each centre had identified a number of service users who had stated that they would be interested in participating in the study. A number of participants had given their permission to pass on their telephone number (where one was available) to the researcher. The researcher contacted those participants to make an appointment for an interview. Where participants did not have a telephone contact number (those accessing the drop-in centres), the centre managers suggested I spend some time in the centres and meet potential participants face to face to discuss the research and establish their interest in participating. Morning times

were identified as the most favourable time as the majority of young people congregate for breakfast and avail of the laundry facilities provided in these centres. On arrival, the staff in the centres would identify possible participants and introductions were made. Following informal discussions, a number of service users volunteered to participate. The face to face approach proved very fruitful in the recruitment process.

Once interview dates had been agreed a nominated centre that was convenient to the participant was chosen to conduct the interview. Each centre provided a room where the interviews could take place confidentially, but where staff would be nearby and available, if required. In general, these were rooms with which the young people were familiar with and had associated with relaxation and chatting to staff. When each participant entered the room the researcher shook their hand introduced herself clarifying her role in the HSE and that the present study was separate to this role. The literature has highlighted the significance of this stage of the interview process (Kane, 1999). The researcher then thanked the individual for agreeing to partake in the interview. Informal conversation was engaged in before the researcher explained the purpose of the interview and highlighted the voluntary nature of the research. Refreshments were provided for the participants in all four centres. Although each participant had agreed to the interview being tape recorded in the initial contact, permission was requested again just before the interview commenced to allow the participants the opportunity to withdraw from signing the consent form. None of the participants objected to the interview being taped. The content of each consent form was read aloud to the participants prior to their signing. This was to ensure that all individuals, particularly those with literacy difficulties, were aware of their rights. Where the participants were unable to sign their name due to literacy difficulties,

the researcher asked the participants to place their initials or a tick on the form. All such participants agreed to this procedure and did not express any concerns with this arrangement allowing written consent to be obtained from all twenty participants.

It is important at the outset to note that these young people are not often given an opportunity to express themselves. They are generally so marginalised that they are not expected to have anything important to say. The aim of the interview was to provide a comfortable environment (as much as was possible) which would enable the participants to tell their own stories and share their experiences, thereby providing a better understanding of the social world they inhabit. To facilitate this, the researcher read aloud the interview schedule prior to the interview so as to avoid making the participants feel anxious about what would be asked. The interview schedule designed for the study is presented in APPENDIX IV. The interviews in general lasted sixty to ninety minutes. During the interview the researcher was careful to observe for any signs of distress. It had been agreed that if this occurred then the support staff in the centre would be informed following the interview. However, none of the young people displayed any feeling of distress or unhappiness with the questions posed. Similar approaches have been adopted in other studies with the same subject group (Mc Gree et al., 2006). Consideration was made of the use of appropriate tone, gestures and general manner, recognising their contribution to the overall quality of the interview (Kane, 1999). Each interview ended with the researcher thanking the participant for sharing their story and allowed time for them to ask any questions regarding the outcome of the research. The participant was also asked if the interview was difficult for them in any way. They were further asked if they

needed to speak to a member of the centre in which the interview took place. None of the participants expressed a need to do this. This was included to resolve any sense of confusion or unease participants may have regarding their participation in the research and to allow the interview to conclude in a positive and empowering manner. The list of support services with contact details was given to each participant and where necessary was read aloud.

#### **4.6 Data Analysis**

In order to analyse and interpret the data in a structured manner all tapes were transcribed verbatim. This is considered to increase the validity of qualitative research findings, as it enables the researcher a valid description of what they heard during the interview (Robson, 2002). The analytical objective was not merely to describe the situated production of talk but to show what is being said relates to the experiences and lives of those being studied. The interview transcripts were then analysed thematically as soon as possible after completion of each interview. In regard to coding, the study was influenced by the principals of analysis used in Charmaz (2006) work which consists of initial coding, applying provisional codes that remain close to the data, followed by focused coding, in which the most significant codes are used to synthesise and categorise the data (APPENDIX V). A case profile was prepared for each study participant. This involved documenting key events, changes and transitions according to a set of categories of life experiences and events such as their admission to residential care, placement types, family relationships and so on (APPENDIX VI). The analytic task aimed to generate a

perspective on leaving the residential care system that reflects care leavers experiences, views and interpretations. The findings documented in the next two chapters are constructed around the young peoples' narratives allowing a range of themes to emerge from similarities and differences in their stories. Particular pieces of narrative have been selected for presentation because they illustrate broad thematic patterns observed across many of the interview transcripts. All quoted excerpts from full interview transcripts are presented as close as possible to the participant's spoken words. Where necessary, however, these quotes have been slightly amended to enable the spoken word to be more easily read. Each participant was assigned a pseudonym which is used consistently throughout the presentation of the study's findings. All identifiers such as names of places and residential centres, hostels, names of family members have been removed from quoted excerpts as a further measure to preserve the anonymity of the participants.

#### **4.7 Methodological Issues**

There are a number of methodological concerns which emerged during the research study which are worthy of attention.

##### **4.7.1 Access issues**

Although the researcher has been successful in obtaining extremely rich qualitative accounts from twenty willing young people, it needs to be recognised that attempting to elicit the views of a vulnerable and highly mobile population can be extremely



challenging. While young males eighteen to twenty five were present on a regular basis at the drop-in centres, the same could not always be said for females of the same age category. Thus, significant delays occurred while the researcher sometimes had to wait for female individuals to present themselves at the drop-in centres and be approached to participate in the interview process. The drop-in centres acknowledged that female clients were for the most part less consistent in their attendance. Thus, the female participants were expected to be small in number and access required flexibility around organising dates and times for interviews due in part to them having to organise their childcare needs. While the data collection process required more flexibility and time than initially envisaged, it is important to highlight that such restraints were not viewed in a negative light. The delays that were encountered enabled the data on the males to be transcribed and analysed on a continuing basis, which helped to aid data analysis by increasing the researcher's familiarity with the data.

#### ***4.7.2 Environmental and Individual Factors***

Considering the nature of the study and the study's population it is important to reflect on the environmental and individual factors which may have impacted on the research data. No environmental difficulties arose during the research process indeed, the environmental surroundings in this study were considered acceptable, especially given the constraints within which research on marginalised people can take place. The inclusion of different settings for the interview process enabled the researcher to reflect on the different experiences of care leavers in the different settings thus providing a wider

and more complete picture of the experiences encountered by care leavers on their journey to adulthood and independence. Gaining access to the required number of research participants and building the rapport necessary to undertake these interviews was a particularly successful aspect of this study. The adoption of a person centred approach enabled an informed insight to be gained into this under-researched area from those experiencing difficulties on leaving residential care. Many of the participants reported that they enjoyed taking part in the study and felt that their account of their lives and experiences could benefit other young care leavers.

The researchers' background in the field of Social Care was not found to create difficulties or have a negative reaction among the participants and in general and was viewed as benefiting the study. Nevertheless, there were occasions where this did arise. A small number of participants requested particular tasks that the researcher may undertake in her role as a social care practitioner. Examples included filling in housing applications and providing a reference for their housing application. However, the researcher respectfully informed each of the participants that as a researcher, she had no authority to fill out such forms and explained it may be more beneficial for them to discuss their requests with the appropriate staff on duty after the interview. All of the young people appeared to be satisfied with this explanation. Participants were constantly encouraged to speak freely during the interview. The voluntary nature of the study helped to minimise any pressure the young people may have felt to answer in a particular way, especially as no rewards were offered for participation. The assurances of anonymity and confidentiality enabled the participants to talk freely in the knowledge that the

information given would only be used for research purposes. Many agreed to take part as they felt it would be of benefit to them and to others in the future. This provided a common goal for the participants and the researcher and helped to reduce any power imbalance which may have prevailed. The semi-structured interview style and the lack of emphasis on literacy skills also helped to minimise any power imbalance between the participants and the researcher. Overall the researcher's background in Social Care appeared to aid rapport and create a sense of openness in the interviews and provided a solid base for the data collection. The experience of working within the field of Social Care appeared to facilitate a good level of understanding and empathy. It became apparent during the interview process that the greater exposure and contact the researcher had with the participants particularly those from the drop-in centres led to a deeper appreciation and understanding of concepts and issues that emerged during the interviews. However, it was always necessary for the researcher to be consciously aware of the importance of not becoming too biased or to be seen to be taking sides at any time throughout the research process with the participant's views of the residential care system and that of their experience of leaving care and aftercare.

#### ***4.7.3 Reliability and Validity:***

The present study is a research project exploring the experiences of a group of young people who have journeyed into, through and from the residential care system. As has been outlined in detail above, a qualitative research approach was used in the present study. By striving to ensure reliability and validity in the research process it was

important to emulate the scientific method in striving for empirical groundedness, generalizability, and minimization of bias (Hammersly, 1992). In defining reliability in qualitative research, Franklin and Ballan (2001: 273) refer to the work of LeCompte and Goetz (1982) by describing the concept 'as the extent to which the set of meanings derived from several interpreters are sufficiently congruent'. In effect it relates to the extent to which other researchers using the same research approach would come to the same conclusions (Kirk and Miller, 1986). Miles and Huberman (1994) suggest a number of methods of assessing reliability specifically in qualitative research. They emphasise a number of issues, including the following, clarity in the research question, the importance of detailing the role and status of the researcher and was the data collated according to the procedure set down in the research question? In the present study various methods were employed to increase reliability. These included examining participants' responses across alternate form questions (Franklin and Ballan, 2001). Due to the nature of the semi-structured interview this allows the interviewer flexibility in terms of sub-questions to ensure that the participant has a clear understanding of the topic. In the present study standard probes were used to explore issues further with the participants and also to ensure that they understood the question. Emphasis was also placed on ensuring a proper and efficient procedure for data collection. Detailed records were kept of each interview, including transcripts of the interview itself. Interviews were recorded and the information transcribed verbatim which assists in increasing reliability. In addition, the formulation and preparation of the interview schedule as well as the pilot interview process were beneficial in striving for greater reliability in the research findings. Validity refers to the ability of the 'researcher to see what they think they see' (Franklin and Ballan, 2001:

279). With reference to validity in the present study, the following methods were employed, the use of verbatim transcripts to accurately reflect the narrative of the participants, the use of quotes from the participants as well as the appropriate use of related literature to support the findings all assisted in increasing validity.

#### **4.7.4 Limitations**

One of the limitations of this study involved the area of generalisation. This study was conducted among a small group of care leavers (twenty) in a particular city during a particular time frame. There is no evidence to support that this study's findings reflect populations of care leavers in other cities, and therefore, should not be generalised to them. In addition, the study targeted the most marginalised of care leavers i.e those that were using homeless and related services. A second important limitation into the data produced in this study may be the retrospective nature which may prompt concerns about the reliability of the participant's recall of past events particularly for those with chaotic and/or transient lifestyles. A third limitation may include the low number of female participants. A balanced gender group may have produced different results. While disadvantageous, this limitation could be said to be somewhat minimised by the fact that the female participants experience of residential care and leaving care differed little with that of the male participants perspective.

## **4.8 Conclusion**

This chapter provided a detailed insight into the research methodology. It highlighted the appropriateness of an exploratory and descriptive strategy and design for the purpose of the study and the suitability of semi-structured interviews for meeting the research aim. The chapter conveyed the detailed and effective nature of the data collection and data analysis process. The chapter identified a number of methodological issues that occurred during the research. The findings that emerged from the methodological process are presented in the following chapters.

## **CHAPTER FIVE**

### **THE JOURNEY INTO AND THROUGH RESIDENTIAL CARE**

#### **5.1 Introduction**

This chapter examines the participants residential care experience in detail, covering their admission into care, placement histories and the difficulties and challenges the participants experienced in their journey through residential care. The chapter provides an overview of a number of key issues and themes to arise from a detailed analysis of the narratives of the participants.

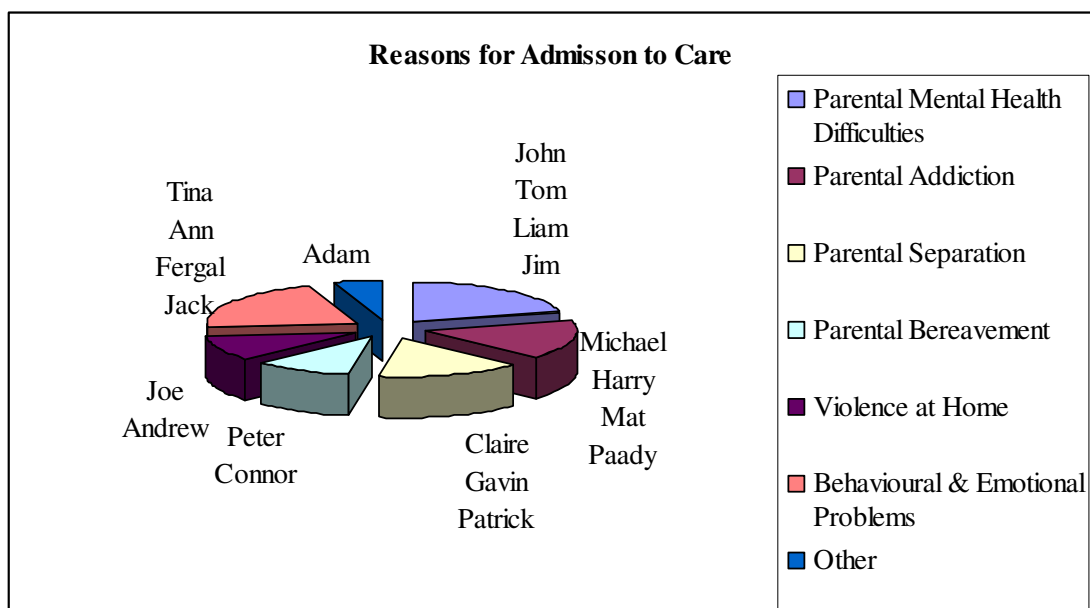
#### **5.2 Admission to Care**

It is still widely held that the traditional or conventional nuclear family is the only suitable environment in which children can grow up and that any deviation from this norm puts children at a considerable disadvantage (Kahan, 1989). However, every year a significant number of young people in Ireland are taken out of the 'care' of their families and placed in the 'care' of the State. In general, children are taken into care for a range of reasons, including concerns regarding their welfare related to physical and emotional abuse and/or neglect. For the young people in this study the findings reveal a complex mix of factors and circumstances that resulted in their placement in residential care. What was apparent from the outset was that all of the study's participants came from difficult family circumstances.

### 5.2.1 Reasons for Admission to Care

This section provides an overview of the dominant reasons to emerge from the participant's understanding of their admission into care. According to what the participants said, family problems resulting in parents being unable to cope accounted as the main reason underpinning nineteen of the twenty cases. It was rare for young people to identify one factor in isolation and, in general, a number of contributory factors were identified by the participant's which is presented in Figure 5.1.

Figure 5.1 Reasons for Admission to Care.





### 5.2.1.1 Parental Mental Health Difficulties

Four of the young people explained that their mother experienced depression and/or anxiety or as they described ‘suffered from her nerves’ and linked these difficulties to their admission to care:

“I’ve been in care since I was two. The reason for that was my ma had depression so I couldn’t come home because she couldn’t look after me she was always in and out of hospital [psychiatric]. When I was younger I didn’t understand why she was the way she was or did the things she did, now I do” (John, 22 years).

“My ma she was always in and out of [psychiatric hospital] she suffered from depression she couldn’t cope. See she thought that people and things were out to get her, confused like do you know what I mean. When she was like that it was mad we’d have to look after ourselves really. Some days when she was good it was grand then there were days she’d be off the wall [manic] and crazy. You never knew from day to day what to expect. What was good for us one day was bad for us the next, it was crazy shit. When I think back now I just get angry at her for putting us through that shit” (Tom, 19 years).

Liam recalls a similar experience:

“I was put into care because my ma, she wasn’t able to look after me because she suffered from her nerves. I went back to live with my ma but then her nerves got the better of her again and she was taken back into hospital [psychiatric]. It happened a lot I didn’t understand it when I was younger. Sometimes I didn’t know what she was doing or why she was acting mad, she was always stressed about something or other and when that happened nothing made sense I thought it was my fault” (Liam, 22 years).

As pointed out by Campbell et al., (2004) one of the greatest risks to children of parents with a mental health difficulty is to their attachment and development as it can compromise parenting and can affect parent-child attachment patterns. John, Tom and Liam’s accounts illustrate how their mother’s mental health difficulties interfered in efforts to parent consistently. They appeared to lack a stable and predictable

environment. Boundary and limit settings appeared to be influenced by stress and confusion. Sticking to a regular routine appeared impossible. Their narratives point to having to care for themselves more than they would in other situations. The narratives depict a sense of social isolation. All three appeared confused and frightened and lacked understanding around their mother's behaviour. This created frustration even anger at their mother's behaviour. In Liam's case he blamed himself and thought that it was his fault. Their recollections of their mother's illness resulted in many absences due to hospitalisation. When unwell, their mothers appeared vulnerable in their capacity to maintain a consistent ongoing parental relationship with their children. All three participants appeared to experience disrupted attachments as a result of being separated again and again from their mothers when they needed treatment. Proponents of the attachment theory may argue that the resulting disruption to the parent-child bond from parental mental illness puts the child at 'risk' not only in the short-term but also for poor long-term psychological adjustment (Bowlby, 1982). For John, Tom and Liam their mother's struggle with the day to day tasks of caring for them placed them 'at risk' and was a contributory factor that resulted in their admission into the State care system.

#### **5.2.1.2 Parental Addiction**

Just under a quarter (four cases) of the participants interviewed reported familial disruption which centred on parental addiction. It usually involved both alcohol and drugs and affected the participants in different ways creating both economic and psychological hardship invariably leading to family breakdown. Paddy explained:

“I never got on with my da, never knew him really. I can’t remember any good times just him being a junkie [drug addict] and a waster. He spent the family’s money on them drugs. He was never at home always out trying to score [purchase drugs] and when he was, he’d just shout and throw his weight around” (Paddy, 18 years).

The negative impact of Paddy’s father’s drug abuse not only created tensions and difficulties within the family home but also weakened any emotional attachment to the parent-child relationship. Excessive alcohol consumption by a parent(s) also created stress and invariably led to disruption to family life and strained relationships.

Michael described his family situation where both his parents were alcoholics:

“I can never remember a time when they [parents] weren’t drinking and rowing. They’d [parents] just sat there drinking all day and night, sure there was never a penny, the fucking rows they’d [parents] have were mental” (Michael, 25 years).

Both Michael and Paddy said they reacted to their parent’s addiction by running away leaving the family home in early adolescence which subsequently led to their admission to care:

“I just said ‘fuck this’ and ran away and ended up in care” (Michael, 25 years).

“It just got to a stage where I couldn’t stay in the gaff [house] with him anymore so I ran away then ended up in care” (Paddy, 18 years).

As pointed out by Mongan et al., (2007) parental substance abuse and dependence can have a negative impact on the physical and emotional wellbeing of children and can cause home environments to become chaotic, unpredictable leading to child neglect. Both Michael and Paddy’s physical and emotional needs appeared to take a back seat to their parent’s substance abuse activities usually related to obtaining and using drugs and alcohol. Their parents pre-occupation with drugs and alcohol appeared to affect

their ability to fulfil their role as the ‘primary care giver’. As we know from the literature (Graham, 2006) an important aspect of the primary caregivers relationship with the child is trust. If the child views the parent as unreliable and has let them down, there is no trust in that relationship. Both Michael and Paddy’s parents appeared to put their children’s needs second to their addiction, demonstrating their lack of trustworthiness and reliability as a parent. Their erratic behaviour and mood swings also appeared to do little to provide any security or consistency within the parent-child relationship. The financial status of the family also appeared to have had a strong negative effect on the welfare and the quality of care they received. Both referred to the lack of money available to meet family needs. Their comments are very instructive and consistent with the findings reported in the literature (Butler, 2002; Christoffersen and Soothill, 2003) on the impact of parental substance misuse can have on children which can include neglect, isolation, insecurity and inconsistent parental behaviours.

### **5.2.1.3 Parental Separation**

Three participants recalled how deteriorating relationships with their parents due to parental separation culminated in their admission into care. Gavin explained:

“My ma and da were always arguing. In the end he [father] left. Then my ma started on me [arguing] in the end I ran away. I was sick of the gaff [house] and the fights” (Gavin, 24 years).

Disagreements were also related in some cases to the young people’s own behaviour following their parent’s separation. Both Patrick and Claire said they reacted negatively to the inter-parental conflict they experienced in their respective homes.

According to their accounts both sought solace outside of the family home which ultimately led to their admission into care. Patrick said:

“There was a lot of shit that was happening with them [mother and father] fighting all the time, in the end he [father] left. After he left I started going off the rails throwing benders [a drinking or drugs session] and fighting with my ma. She [mother] got sick of it and in the end got a social worker and I ended up in care” (Patrick, 19 years).

Claire reported that she was twelve when she first went into care:

“My ma and da’s marriage broke down. I know people say when your ma and da split it doesn’t affect you, but it does. I just started going out drinking and not coming back for days at a time. So eventually she [mother] had enough of the fighting and stuff and she told me to go” (Claire, 19 years).

Participants’ accounts of their parent’s separation appeared to have caused major disruption to their daily relationships and routines. All three experienced the loss of their father from the family home and subsequently appeared to have had a less than positive relationship with their mothers who continued to dominate as the primary custodial parent following their parent’s separation. Their recollections of the inter-parental conflict and stress leading to their parents’ separations appears to have had an impact on their ability to cope with the changes in their family circumstances. All three participants appeared to disconnect themselves from their families as much as possible in Gavin’s case by running away, while Patrick and Claire engaged in ‘at risk’ behaviours in which their custodial parent, their mother, was unable to cope with and which subsequently led to their admission into care. The experiences of the participants are consistent with research by Videon (2002) and Bream and Buchanan (2003) which found that it was not necessarily the separation itself but rather, the poor

parent-child relationships and protracted inter-parental conflict prior to and following separation that accounts for the difficulties experienced by children of separated parents.

#### **5.2.1.4 Parental Bereavement**

Currier et al., (2007) reports that the death of a parent represents a profound crisis in the surviving family members and can leave the remaining parent ill prepared to continue in his/her role let alone take on the functions of the deceased. Over a quarter (six) of the sample had lost a parent through death. They reported their parent's death as a major life event and a contributory factor that triggered change in their lives. However, only two participants reported their parent's death as the primary reason for their admission into care. Both Peter and Connor described how they engaged in negative behaviours following their respective parent's death which led to conflict and a subsequent breakdown of the remaining parent-child relationship leading to their admission into care:

“Yeah my da he died. After that my ma just couldn't cope with me, her nerves were at her. She [mother] said I was too wild to manage. I started skipping school and not bothering to come home at night, shit like that so she [mother] put me in care” (Peter, 22 years).

“My ma died, my da sure he was in bits drinking and staying in bed all day. He [father] just couldn't cope. I ran a muck [getting into trouble] it ended up that he kicked me out. One day he just said he had enough and I ended up in care” (Connor, 25 years).

The narratives highlight the vulnerability experienced by both Peter and Connor in the wake of their respective parent's death. The grief that accompanied their loss was

made more complex by the fact that both Peter and Connor had to integrate this loss into their life as part of growing up. Both appeared reactive to their surviving parent's response to the loss which resulted in the family structure, functioning and parent-child relationship becoming strained. Both appeared to have had to deal with their own loss and grief in the context of the grief and morbidity of their surviving parents. This proved too difficult to manage in both Peter and Connor's case and ultimately led to their admission into care.

#### **5.2.1.5 Violence in the Home**

Two of the participants reported experiencing and/or witnessing physical violence.

Joe explained:

"I remember my da [father] always beating the shit out of me. I was only a kid, I couldn't really do anything about it. I'd never know what would set him off, it could be anything. My ma tried to protect me but she couldn't really do much to stop him, when he got going nobody could stop him" (Joe, 25 years).

Andrew recalled memories of his father's violence towards his mother:

"My da used to beat the shit out of her [mother] he'd come home and start throwing his weight around, smashing things. We'd [siblings] have to hide upstairs for fear of getting a box [slap/punch] from him" (Andrew, 20 years).

Both Joe and Andrew's accounts indicate that violence was a common experience in the household and both they and other family members were at risk. Their narratives illustrate the adversity they experienced as a result of violence in the family home. Their accounts of the nature of the violence they endured, and witnessed, offers an insight into the kinds of volatile households they spent part of their childhoods in.

Their recollections indicate that both felt little safety in their respective family homes and both appeared frightened and helpless as a result of their father's violence. In Andrew's case his father appeared to do little to protect him or the other children from seeing or overhearing the violence perpetrated against their mother. Living in constant fear appeared to have denied both Joe and Andrew of a sense of basic trust and security that is the foundation of healthy emotional development. As we have learned from the literature the impact of violence on a child's inner world is complex. As pointed out by Mullender et al., (2002) children who either witness and/or are victims of violence in the family home are affected in terms of their behavioural, cognitive and emotional adjustment.

#### **5.2.1.6 Behavioural and Emotional Problems**

Fahlberg (1994) reports that emotional and behavioural difficulties can impact on the parent-child relationship whereby the parent finds the behaviour too difficult to manage resulting in placement in care. Four of the participants reported behavioural and emotional problems which they attributed for the reason for their admission into care. Although some (3/4) young people described how their behaviour changed after their parents separated or they experienced bereavement Tina chose not to disclose the detail of what was going on in her life at the time her behaviour changed. When asked for her understanding of the reason for her admission into care Tina said:

“A lot of shit was happening for me at the time, emotionally like, I was always fighting with my ole one [mother]. I started staying out late at night not going to school. I came home one day and she [mother] had my bags packed and a social worker was there and I ended up in care” (Tina, 19 years).



According to Tina her ‘behaviour’ during early adolescence, which included staying out late, drinking and so on caused tension at home and appeared to exacerbate an already fragile relationship with her mother. This in turn led to Tina being placed in care at the request of her Mother. Overall, the narratives of the participants provide the best illustration of the diversity of factors that led to their admission to care. Most depicted their admission to care in negative terms. In most cases the event precipitating their admission was closely related to other issues or home situations and, even if a specific crisis acted as a catalyst, admission to care was most often the end point of a prolonged period of disruptions and difficulties. Table 5.1 presents a summary of key findings in the participant’s admission to care

Table 5.1 Summary of the Key Findings in the Participants Admission into Care

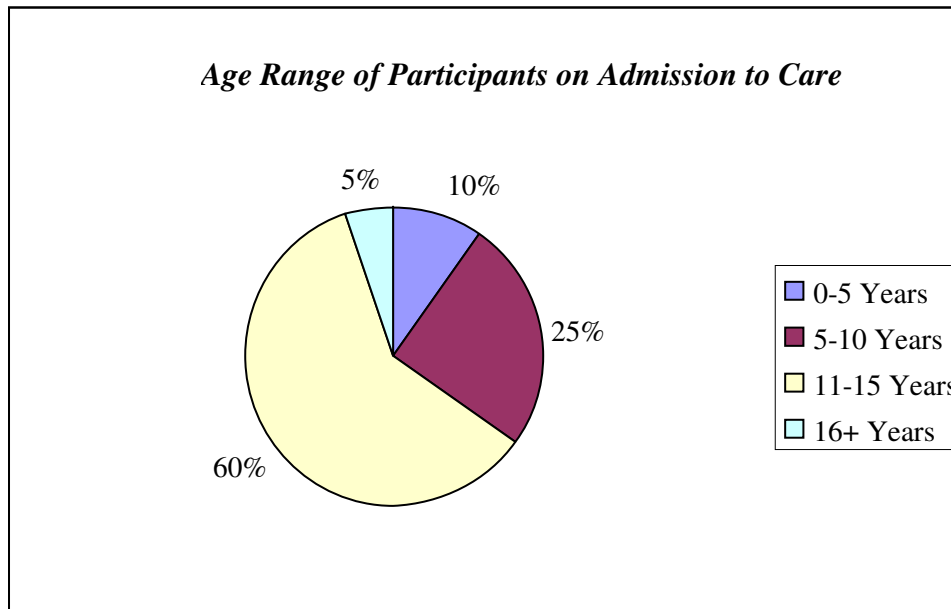
<b>Summary of the Key Findings in the Participants Admission to Care</b>
<ul style="list-style-type: none"> <li>• Insecure attachments</li> <li>• Lack of emotional security</li> <li>• Loss and Grief</li> <li>• Fear and Confusion</li> <li>• Frustration, Anger and Helplessness</li> </ul>

As pointed out by Graham (2006), parental emotional involvement with a child is vital to the development of secure attachment and emotionally healthy children. In other words for optimal emotional, social and psychological development, to occur, children need a warm, secure, affectionate, individualised, continuous experience of care from a primary care giver who interacts with them in a sensitive way. During a

time when children should be certain in the knowledge that the foundation of their families are secure, many of the participants in this study were living in circumstances which were not conducive to meeting neither their physical safety nor developing their emotional and psychological needs. Their recollections of their early childhood point to an absence of attachments and supports. This is consistent with findings in the literature which report that inadequate parenting, especially inadequate availability of the attached figure(s) due to maternal depression or parental alcohol/drug dependency can predispose the child to insecure attachment and in more extreme cases to impairment and/or breakdown of the child's whole attachment system (Foreman, 1998). The findings in this study show that even in middle childhood and adolescence the participants' feelings of security were strongly determined by their perception of the availability of their attachment figure(s) and threats to the availability of attachment figure(s) provoked profound feelings of anxiety, anger and despair. Many of the participants (19/20) did not appear to have had access to a sensitive, responsive caregiver who offered consistency, predictability, security and affection. This resulted in unmanageable behaviours which in turn exacerbated an often already fragile or mis-attuned parent-child relationship. According to their narratives many of the participants (19/20) received harsh, inconsistent parenting or permissive parenting with no specific expectations or limits which resulted in many (8/20) reacting with demanding, disruptive or attention-seeking behaviour. While some participants referenced their negative behaviour as the reason for admission into care in almost all cases this behaviour was related to incidents of profound loss and grief due to their parent(s) inability to cope resulting in their admission to care. Figure 5.2 presents the age range of participants on admission to care.

### 5.2.2 Age Range of Participants on Admission to Care

Figure 5.2 Age Range of Participants on Admission to Care.



Just over a quarter, (seven cases) reported their first admission to care at age ten years or under. Of those entrants, two said that they were placed in care under the age of five years and five were aged between five and ten years. The most common age range for admission into care in this sample was eleven–fifteen years representing over half of the study’s participants (twelve). Only one of the participants entered care when he was sixteen. This is a similar finding to Biehal et al., (1995) who found that sixty two per cent of their sample of one hundred and eighty three entered care between the ages of ten and fifteen years. Of the seven cases who entered the care system aged ten years and under, two said that they were admitted on full care orders under Section 18 of the Child Care Act, 1991, while five said that they were placed under voluntary care orders under Section 4 of the Child Care Act, 1991, however full

care orders were sought and granted in all five cases. The remaining thirteen entered the care system via the Out of Hours Service (OHS) under Section 5 of the Child Care Act, 1991.

### **5.3 Placement Histories**

This section explores retrospectively the placement histories of the participants. It traces their patterns of movement across different placement settings. Residential care was the most commonly reported placement type experienced by all twenty of the participants. However, some participants reported that when they initially entered the State care system they were placed in foster care.

#### **5.3.1 Placement in Foster Care**

The study found that those that entered foster care tended to be younger in age than those who entered residential care. Five participants reported being ten years and younger when they first entered the foster care system. The participants who reported being placed in foster care had experienced a number of foster placements prior to their entry to residential care. The main theme to emerge from the narratives to describe their time in foster care was one of a time of instability.

### 5.3.1.1 A Time of Instability

Participant's spoke of moving from one placement to another and of not being able to get close to anyone. Feelings of instability, loneliness and feeling unwanted were mentioned by some participants when speaking of their time in foster care. Peter recalled his experience of the foster care system:

"I first went to foster care when I was seven. It was strange living somewhere else with people it never really felt like a home. I was moved soon after. I had a few more foster placements but they never seemed to work out. I never knew how long I'd be staying in any one place. I always had to go I didn't know what I was doing wrong. I always seemed to be on my own moving around" (Peter, 22 years).

Upon entering foster care, none of the participants found a stable placement. Instead they embarked on a cycle of movement between successive foster families returning periodically, as in Liam's case, to the family home:

"The first time I was put in foster care I was there for three weeks, I went back to live with my ma but then she got sick again so I had to go back to foster care but to another family. I was with that family for about seven months and I thought it was going well but then they moved me to another family. I think I was there for about a year. I just don't think I fitted in I just never knew why? I never seemed to know what went wrong. I just always seemed to be packing up and moving on you get to a point where you don't care anymore" (Liam, 22 years).

Andrew was placed in foster care when he was ten and within twelve months had experienced two failed placements:

"I went into foster care when I was ten. I was with the first foster family for three months. The second one I was there for eight months, it didn't work out either. After that I just gave up sure what was the point it felt like nobody wanted me" (Andrew, 20 years).

Participants' recollections of their experiences of foster care depict a sense of drifting from one placement to another without any real explanation to help them understand why they were continuously being moved. This lack of understanding appeared to have led to feelings of uncertainty, powerlessness and of wondering 'what went wrong'. Indeed, there appears to have existed an underlying expectation and fear of being removed and placed elsewhere at any time without explanation. This appeared to be a constant worry in their young lives. Their exposure to multiple carers meant that they did not experience any sense of security which is generally associated with the unique and exclusive long-standing relationship of that between a parent and child (Iwaniec, 2006). Few opportunities appeared to have existed to trust any one person because these relationships were interrupted and consistently unreliable. Each foster care placement appeared to undermine their already fragile sense of self. They remembered their foster care experience as a time of feeling 'unwanted' and they seemed to internalize this rejection by questioning what was wrong with them, or wondering what they did that 'caused' them to be moved. This in turn appeared to cause them to renounce any further attachments in other placements which is in keeping with the literature on insecure attachments and how this can result in an inability to trust (Green, 2003). Rejection appears to have become familiar for all three participants with experience of foster care and provided the only sense of certainty in their lives. Indeed, the familiarity of rejection appeared to create a vulnerability in them that came with hoping that things would work but at the risk of being let down again. This in turn undermined stability in subsequent placements and a cycle of movement and rejection was created which included being moved from the foster care system and placed within the residential care system.

### ***5.3.2 Placement in Residential Care***

In the Irish child care system residential care is made up of mainstream residential centres otherwise known as group homes. These centres typically cater for an average of four to five children and are generally located in ordinary domestic houses in local neighbourhoods. They can provide short-term placements which can last two/three months and/or long-term placements which can last for two or three years or longer or for the duration of the young person's time in care. Of the twenty participants, only two reported having relatively long-term placements in a residential group home. The theme to emerge from their narratives was one of connecting with people.

#### **5.3.2.1 Connecting with People**

Both Matt and Harry's recollections of their time spent in residential care was of positive memories of nurturing and caring adults that provided a source of stability during their formative years. Matt recalls his memories of his time in two group homes:

“We [Matt and his siblings] were in the first home on and off for five years. I don't remember much about that because I was so young but I do remember the staff teaching me how to swim when I lived there. We [Matt and his siblings] moved to another home when I was seven I think we were there for six years, I had a lot of mates at school when I was there. I remember we used to play football with the staff. We were all still living together and I was glad of that” (Matt, 19 years).

Matt's narrative illustrates the significance of having his brothers with him which seems to have provided some sense of familiarity. Moving placements accompanied by siblings provided an emotional or psychological buffer to the effects of the many

losses that can be felt during a placement move (Biehal et al., 1995). Like Matt, Harry, who entered residential care when he was nine, had two long-term residential placements over a five year period. He spoke of happy times spent with staff and how he felt welcome:

“I went to a group home when I was nine. I spent two years there then I moved on to another group home. I was there for three years. It was weird at the beginning living with strangers because I was shy back then so it was difficult but they [staff and residents] made an effort to make me feel welcome. I soon got used to it and settled in and made friends at school, I remember the staff bringing us to the beach and on bike rides, they were happy times for the most part” (Harry, 20 years).

From what Matt and Harry said, their respective placements provided some level of stability for a number of years however, on reaching their adolescent years both of them reported a breakdown with these placements:

“I think I was about thirteen when I started to think about why I was put in care. I became angry all the time, nothing seemed to matter to me anymore, I became more guarded, I automatically thought they [staff] wanted something from me so I started rebelling and lashing out at them [staff]. In the end I suppose they [staff] couldn't manage me and I got kicked out” (Matt, 19 years).

“I was around fourteen things just changed inside me I became really defensive and didn't trust any of them [staff and social worker] anymore. I was angry about what had happened to me. I started acting out, going missing and getting into trouble that's how I got kicked out. I don't think the staff knew what to do for me anymore” (Harry, 20 years).

The picture painted by both Harry's and Matt's narratives is that their placement in residential care were reasonably stable up to adolescence but became increasingly unstable during this period. The onset of adolescence seemed to trigger emotions that were linked to hurtful memories of their past. Issues of trust began to emerge. Both



Matt and Harry appeared to reach a point of giving up or disconnecting from the staff who were looking after them. It seems that withdrawing became a defence mechanism or perhaps a consequence of the underlying losses they already experienced prior to entering residential care. Their narratives demonstrate the emotional cost involved in placement breakdown for young people and the struggle that young people have during this developmental stage in their lives. Their accounts also highlight the challenges that their behaviours presented to the staff and the difficulties that this type of behaviour and need presents for residential care providers. As we have learned from the literature, emotional and behavioural difficulties tend to be recognised as contributing to placement breakdown for older children (Sinclair and Gibb, 1998). Indeed, placement breakdown can make existing behavioural difficulties even worse resulting in a vicious circle of repeated placement failures (Mayock, Corr and O'Sullivan, 2008). Following their placement breakdown both Harry and Matt reported that they had to present to the Youth Homeless Services otherwise known as the Out of Hours Service. The remaining sections of this chapter explore this service and what part it played in the lives of the participant's journey through care.

### ***5.3.3 Placement in the Out of Hours Service***

As outlined earlier in the thesis the Out of Hours Service (OHS) is a crisis service set up to respond to the accommodation and care needs of homeless youth under eighteen years. The service has access to a total of fifteen residential beds distributed among five residential units in Dublin. Young people can access the service by going to a Garda station after 8pm. It is then the duty of the Gardai to contact the Out of Hours social work team who will determine where to place the young person in the

emergency service if returning home is not an option. Beds in the Out of Hours Service are allocated on a night by night basis which requires young people to present nightly at Garda stations, however, Friday night places are allocated for the weekend. Therefore it is not necessary for the young person who has been allocated a place to return to the Garda station on Saturday or Sunday. At the time of interview all the Out of Hours hostels were located in, or adjacent to, the city centre. The Out of Hours Service played a pivotal role in the lives of many of the participants in this study. Both Paddy and Claire recall their first night presenting to the service. Both accessed the service via a Garda station:

“I don’t really know how I found out about the Out of Hours. Somebody just told me to go to the Garda station. I was about twelve the first time I went. He (social worker) interviewed me and later got my ma and da to sign the forms [parents written consent to place their child in voluntary care] to put me into care then the social worker took me to a hostel where I got a bed for the night ” (Paddy, 18 years).

“You usually have to wait a long time for the social worker to get the paperwork done [parent’s written consent to place their child in voluntary care]. After that she [social worker] took me to a hostel where I was to stay for the night” (Claire, 19 years).

Two major themes emerged from the narratives that describe how the study’s participants remembered their first nights in an Out of Hours hostel. The first theme was one of fear and uncertainty. The second theme communicated by the participants was one of a sense of loss.

### **5.3.3.1 Fear and Uncertainty**

Participants’ recollections of their first night in the Out of Hours hostels almost always referenced feelings of fear and uncertainty. Some participants appeared to

have little understanding of what was happening. This is demonstrated in both Liam and Paddy's accounts of their first night in an Out of Hours hostel:

"I barricaded myself in the room the first night. There were bars on the windows and when you looked out the window you could see the Joy [Mountjoy Prison]. I was shitting myself [frightened]. All you could hear was noise and people shouting and banging on doors. I didn't know what to expect those first few nights" (Liam, 22 years).

"The first few nights I was there I was scared of the uncertainty of it all, not knowing the rules, not knowing what to expect, the suddenness of it all, I had no time to think about what was happening to me" (Paddy, 18 years).

The feelings of fear and uncertainty were compounded for participants whose first language was not English. Adam was classified as an unaccompanied minor and placed in the care of the State. He was taken by the social worker to one of the Out of Hours hostels. Adam explained:

"I was fifteen when I came to Ireland. I didn't have any English. The social worker brought me to a hostel. I couldn't eat or sleep for two days. I was scared to death. I thought I was in a mental hospital for young people" (Adam, 21 years).

Participants' fears were not unfounded because they sometimes described how being new to the Out of Hours scene made them susceptible to bullying. Both Jim and Tina reported being bullied while placed in the Out of Hours Service:

"One of the first nights I woke up and they [other service users] were pissing in my wardrobe. Next time I woke up they were trying to smother me with a wet towel" (Jim, 23 years).

"I hated it there [Out of Hours hostel] they [other service users] would soak my bed with water and stuff and said I pissed in it" (Tina, 19 years).

A second theme that emerged from the participant's narratives was one of a sense of loss. Most remembered their time in the Out of Hours Service as a time of profound loss whereby loss was felt in a number of different areas.

### **5.3.3.2 A Sense of Loss**

Some participants spoke of their loss of power over their personal destiny. They remembered this time as an experience in which they had little or no control or influence in decisions or events in their lives especially with regard to the choice of placement or with whom they lived with. This was made evident when the participants spoke about having to present at a Garda station on a nightly basis in order to access a bed and not being sure what hostel they would be placed in. Paddy recalled:

“I went on a night to night basis for a bed [presented nightly at a Garda station]. You were never guaranteed the same bed in the same hostel that was shit especially if you liked the place, you were always moving around” (Paddy, 18 years).

Peter and Gavin described how moving from one hostel to another was an experience into the unknown, but nevertheless a core part of the system:

“You didn't know who, what, where, when or why it was happening its just the way the system works, you had no choice you had to go where you were placed it was just mad” (Peter, 22 years).

“You never knew how long you were staying somewhere or what you were walking into or what the people were like, it seemed you were always living in chaos and just surviving” (Gavin, 24 years).

For many of the participant's (16/20) placement in the Out of Hours Service disrupted ties to friends. The loss associated with friendships affected both established friends left behind, as well as perceived opportunities to make new friends due to the temporary nature of the placement. Tina recalled:

“When they [social worker, parents] put me in the care it felt like they tore me away from everybody I knew, I had no time to say goodbye to me mates. I didn't know anybody when I was put in them Out of Hours hostels. It was hard to make friends sure what was the point you'd never know where you'd be placed” (Tina, 19 years).

The client turnover in the Out of Hours hostels also compounded the challenges of keeping old friends and making new ones as these relationships could be abruptly broken when people moved onto other settings. For most of the participants the lack of stability in the Out of Hours Service meant continuous disruption in their young lives. Liam commented:

“Everyday there was someone different there [young people] and different staff [on duty]. Sometimes you might get lucky and get to stay on in one place [hostel] for the whole weekend. Then you might get to know the faces but usually it was a merry-go-around of people coming and going” (Liam, 22 years).

Other participants remember losing personal belongings during their time in the Out of Hours Service or recalled the risk of having their possessions stolen or end up missing. For children in care who are constantly on the move personal possessions can act as memory keepers and when an item is lost so too is the potential to trigger any memories associated with it:

“When you have to move all the time there's no point in taking everything with you there's nowhere to put it and you can't guard all your stuff all of the time, so you end up losing things or leaving things behind because you have to move on to another bed in another hostel” (Tom, 19 years).

“I had a photo of me and my family when we were little and all living together. I used to carry it in around with me in my pocket all the time. They moved me one day and I hadn’t time to get all my stuff together and it got left behind in a pair of bottoms [tracksuit bottoms]. By the time I cottoned on [realised] it was too late someone had nicked [stolen] me bottoms and the photo was gone. It was the only one I had” (John, 22 years).

Some participants commented about how being in the Out of Hours hostels added to the stigma they felt of being in care. The narratives suggested that not only did they feel different from ‘normal’ but that they were also living outside the range of normal:

“When you see other people your age doing normal things it hits you that you’re not like that, its not normal packing up and moving from hostel to hostel having no real mates or family who give a shit about you” (Gavin 24 years).

“You’re put in shitty hostels, moved around, that’s not normal that’s not caring for someone, I didn’t ask for that life. I just learned to lie about where and how I lived, I didn’t want people thinking I was different or that I wasn’t normal like them, with a family and house and shit” (Fergal, 24 years).

Overall, the strongest theme to emerge from the narratives of the participants was that of a profound sense of loss in their early years of care, the loss of friends, the loss of personal property and a loss of normalcy were all very prominent features in their recollections. The significance of the loss of personal possessions alone and the very real effect the loss can have not only with regard to the item itself but also to the links to memories associated with those possessions were very powerful. Indeed, losing their personal possessions had the effect of almost losing a part of themselves. Table 5.2 presents a summary of the key findings in the participant’s journey through residential care.

Table 5.2 Summary of Key Findings in the Participants Journey through Residential Care

<b>Summary of Key Findings in the Participants Journey through Residential Care</b>
<ul style="list-style-type: none"><li>• Profound sense of loss</li><li>• Mistrust in the care system</li><li>• Instability</li><li>• Lack of continuity</li><li>• Lack of attachments</li><li>• Lack of agency and choice</li></ul>

Mistrust and a lack of trust in the ‘system’ was also a strong underlying theme when they spoke about early years in residential care. Many participants spoke about trust issues by describing ways in which they maintained a level of distance or detachment in their interpersonal relationships with others which resulted in many not making any permanent connections with significant others during their time in the Out of Hours. Consequently, their recollections are of quite a lonely and isolating experience. Quite often the participants appeared ambivalent as a result of the lack of instability surrounding their situation. They felt little point in establishing new friendships and making connections with people especially as they struggled to hold on to existing relationships. The experiences of the participants are consistent with the findings of Mayock, Corr and O’Sullivan (2008) who reported that children and young people who have experienced high levels of instability learn not to expect to form lasting friendships in order to avoid the pain of losing them when moved on. The message

from the participants was clearly that following first contact with the Out of Hours Service the initial days and weeks were challenging times in their lives with many negative memories. For the majority of the participants (18/20), their experience of the Out of Hours Service rather than providing a secure and stable placement seemed to create instability and uncertainty. The extent of the participant's movement in and out of the various Out of Hours hostels meant that many had a repertoire of living situations and experiences while only in their mid-teens. Rather than imposing a sense of structure on their often chaotic lives, the Out of Hours hostels served an opposing function for at least some of the participants by diminishing their social networks and limiting them to contact with other homeless youth. It marked their official entry into the network of youth homelessness and for many it was to be the onset of a process of displacement and exposure to a street culture that appeared to embrace drug use and criminality. The following section pays particular attention to the participant's perspective of life on the streets and the dynamic relationships that they formed for survival.

#### **5.4 Life on the Streets**

A serious implication of the limited number of beds on offer for young people availing of the Out of Hours Service is that some young people have to spend the night on the streets. This was the experience for many of the participants in this study. They identified a number of alternative places in which they had to sleep in lieu of securing an Out of Hours bed. Gavin and Andrew explained that finding somewhere safe to sleep was always a priority:



“When I couldn’t get a bed [in the OHS] I slept in doorways, behind shopping centres or in the park. I was shitting myself [afraid] as most nights you just don’t know what crazy people are around watching you. You can’t trust anyone not for a second not when you’re on the streets” (Gavin, 24 years).

“There was loads of times I couldn’t get a bed [in the OHS] I slept in buses, cars in train stations. It was safer not to be sleeping on the street” (Andrew, 20 years).

In other cases, participants did not report to the Garda Station to access the Out of Hours hostels but instead found their own places to sleep. These participants reported sleeping in squats intermittently. According to the participants, the squats they occupied were usually located in, or adjacent to, the city centre in vacated old derelict buildings. For many of the participants (11/20), squatting did not merely provide a place to sleep but represented a ‘home’ in a way that the Out of Hours hostels did not. Squatting appeared to be a way of obtaining a place of one’s own as described in Liam’s account:

“We had a squat, our own little gaff [house]. It had a couch and a couple of beds we had everything we wanted. The young ones [girls] would do the cooking, it was like our own little happy family” (Liam, 22 years).

The ‘freedom’ associated with squatting was also emphasised by participants, many of whom felt their lives were restricted by the rules placed on them in the Out of Hours hostels. Claire explained that she had stayed in a squat for a while:

“There was a few of us, it was our own place. We could do what we wanted. I liked the freedom of not having anyone telling me what to do, and when to do it. We just did our own thing when we wanted” (Claire, 19 years).

When on the streets, even for a short period of time, many of the participants reported losing whatever contact they had had with their families and communities. Once out of home, the street quickly became a way of life and with this a process of acculturation appears to have begun. The participant's peer networks appeared to become concentrated amongst other homeless people in a similar position to themselves. Many of the participants (15/20) spoke about the group with whom they 'hung around with' their narratives described how they spent their time and the nature of these associations. A repetitive theme that surfaced from the participant's recollections was one of a sense of belonging.

#### **5.4.1 A Sense of Belonging**

The events that reportedly led to the formation of these groups were sometimes simply random and spontaneous occurrences as reported by Michael:

"I just started to just hang around with this group of lads. I began to spend more time on the streets with them. We'd stick together because we were away from our families. It was like we became one big family. We would all watch each others backs and it was a good feeling, we did everything together" (Michael, 25 years).

Fergal's narrative reflects the type of relationships that were established while on the streets:

"You'd just get to know other lads like in the same position and start to hang around with them, they'd introduce you to other people. It just goes like that. You'd just hang out sure there was nothing else to do, nowhere else to go, you'd become tight [close], you'd have each others back [look out for each other] you knew where you stood with them, they were like brothers you know what I mean?" (Fergal, 24 years).

While all of the participants had diverse reasons for spending time on the streets they did share a common need for acceptance and support from other people who were hanging out or living on the streets. Ann spoke about the peer group which she ‘hung around’ with. She described the bond that emerged between her and other girls who shared similar backgrounds and street experiences:

“We’d hang around together a few of us we’d look out for each other we were sisters when it came down to protecting each other you’d take no shit, some of the older ones [girls] you could talk about anything to them, you know if you had a problem like” (Ann, 20 years).

Not only did Ann’s peers provide companionship but they also provided instruction and guidance in how to survive on the streets:

“If you were stuck for a place to sleep you’d tell each other where was safe to go, who to watch out for, what places were the safest to sleep what ones to stay away from” (Ann, 20 years).

These types of group dynamics offered a kind of role identity which helped young people in making the various aspects of survival on the streets more manageable. These roles were not necessarily contingent on age, seniority and resources but were determined by the emotional and psychological support that they provided. Some participants suggested that the group they hung out with provided the emotional support that they expected from their families, but which they did not receive.

Andrew made this point:

“We found what we wanted in each other, you know, like, you knew where you stood and knew they’d [group] back you up no matter what. Like don’t get me wrong we were shitheads at times to each other, but you know, I mean, we would never fuck each other over not like your so-called family would, we would never do that, never” (Andrew, 20 years).

Participants frequently noted that above all else these groups were a source of companionship that helped to mitigate the loneliness and isolation of street life.

Patrick’s narrative captures this sentiment:

“We hung around together we were always there for each other. It’s like when you’re on the street you really learn what friendship is. If I need them, they’re there for me. That’s what it’s all about, someone that’s going to be there when you need them” (Patrick, 19 years).

These groups appeared to provide the participants with the resources and social networks needed to survive the dangers and challenges inherent in their transient and fragile existence. They now had a ‘safety net’ upon which they could depend on and this generated feelings of security. Table 5.3 presents a summary of the key findings of the participants’ experiences of life on the streets.

Table 5.3 Summary of Key Findings of the Participants’ Experiences of Life on the Street.

<b>Summary Of Key Findings of the Participants Experiences of Life on the Streets</b>
<ul style="list-style-type: none"><li>• A Sense of Belonging</li><li>• A Sense of Acceptance</li><li>• A ‘Safety Net’ of support</li><li>• Replenishment of ‘social capital’ that had been absent or lost from their pre-care and in-care lives.</li></ul>

For the participants these peer networks were important because they had established an attachment which provided unconditional acceptance. Some participants (15/20) felt cared for within these social networks because of the camaraderie and nurturing they reportedly received from them. While many of the participants (11/20) were not necessarily opting to be homeless per se, they selected the more welcoming environment other than that provided either in their familial home or in the Out of Hours Service. They sought out companionship and acceptance from other young people who came from similar backgrounds and this provided a sense of belonging.

#### ***5.4.2 Survival Strategies***

Regardless of the structure or roles that characterised these social networks most participants emphasized that several basic needs prompted the formation and maintenance of these groups. One primary issue was survival. Harry explained:

“We couldn’t get welfare because we were too young so we’d go on the rob [stealing]. We did it to survive do you know what I mean?. I was fifteen on the streets never guaranteed a bed [in the OHS] so I started snatching handbags, then phones anything really that I could get money for I’d rob then you’d share” (Harry, 20 years).

Without any source of income, alternative forms of income-generation were necessary for many of the study’s participants (13/20). Theft was reported as the most common solution in the search for money. ‘Snatching’, ‘nicking’ and ‘dipping handbags’ were the terms used by participants as a means of describing the activities they engaged in. Michael’s narrative emphasized the importance of various people’s expertise in meeting their needs while on the streets:

“There used to be a crowd of us all hanging around together. We would just split into two groups and go off and rob, some of us were good at dipping handbags, others at shoplifting you know stuff like that. It was a means to an end, for surviving like, we were living on the streets, we had to do what we had to do to get by” (Michael, 25 years).

Although the peer networks they belonged to on the one hand served as a function for friendship and support, on the other hand they introduced or accelerated some of the participant’s involvement in substance abuse. The participants reported a wide variation in the type and frequency of drugs imbibed while on the streets. This ranged from experimental use to episodic and recreational styles of consumption right through to problematic drug use. The most commonly used substance reported by the participants was cannabis. Cannabis use was considered a cultural norm among the participants. It played a significant role in their communal life while on the streets and was something they used recreationally, as well as for self-medication for anxiety, depression and fear. Gavin explained:

“Everybody did it. We’d spend most days smoking weed [cannabis]. It helped pass the time away. You could forget about what was going on for a couple of hours, forget about how shitty life was, you could pretend everything was okay for a while” (Gavin 24 years).

James reported a similar experience:

“I hung around with a group of lads when we couldn’t get a bed and ended up on the streets for the night we’d just smoke hash [cannabis] and get stoned [under the influence of illicit substance]. It used to take away all the bad feelings, you could chill out for a while forget about all the crap [problems] that you had, I didn’t give a shit about things like getting a bed when I was stoned” (James, 18 years).

Taking drugs appeared to soften the discomfort of their homeless lifestyle. However, for some participants drug use became more persistent and problematic when heroin was involved. Heroin was readily available on the streets as Patrick pointed out:

“I used to smoke hash but then started on the gear [heroin] that’s when things got worse for me, the more I smoked the more I needed, it was everywhere there was no escaping it, everyone I knew took gear [heroin], I suppose that’s how I got involved” (Patrick, 19 years).

For some participants the use of heroin helped them to escape the realities of their homeless situations:

“I just wanted to forget, the gear [heroin] it brings you to a different world you forget the shitty world you’re in for a while only for a while that’s how come you want and need more and more of it to get back to that world” (Peter, 22 years).

Peter advanced to snorting heroin and this rapidly progressed to intravenous (IV) use. He reported that his daily dose of heroin was ‘ten to twenty bags’ per day. As a result of his spiralling addiction Peter began to sell drugs in order to support his own drug use:

“Once you’re hooked, you’re fucked. There was a time I needed at least ten to twenty bags a day. Selling drugs was the only way I could get the money. I’d have to sell enough everyday to get me my own gear [heroin]. I didn’t love it, it’s just that I had to have it and if I didn’t have it I’d be sick” (Peter, 22 years).

For many of the participants (15/20) like Peter the continued demands of their drug use meant that raising money remained a priority of a typical day. The overriding focus was on the immediate situation, if they were to avoid the sickness associated with withdrawal, they were compelled to raise significant amounts of money. For some participants the business of raising money offered a sense of purpose and

structure to the day. Connor compared his drug dealing to the structure of 9am to 5pm employment:

“Its like an every day job, you wake up in the morning, you’ve got people to meet, who you do the business with, that you sell to, or like delivery too, you have to do it its simple you need the hit [heroin] else your sick” (Connor, 25 years).

The elements of the street culture of homelessness that many of the participants experienced were identified in their narratives along with the survival strategies they utilized to navigate the tumultuous environments in which they existed. Their recollections illustrate their unique capacity for coping with the numerous challenges associated with street living. Table 5.4 presents a summary of the key findings of how the participants survived on the streets.

Table 5.4 Summary of the Key Finding of how the Participants Survived on the Streets.

<b>Summary of Key Findings of How Participants Survived on the Streets</b>
<ul style="list-style-type: none"><li>• Relationships that emphasized survival and resilience through exchange of social and economic capital</li><li>• Involvement in informal economic and illicit activities</li><li>• Introduction to or acceleration of substance misuse/abuse</li></ul>



### 5.4.3 Summary

The narratives paint a grim picture of the daily lives of the participants during their adolescent years. They illustrate the unstable and precarious environments the participants found themselves in. Although most young people during this period are investing a large part of their daily energies in educational settings, the participants in this study were spending most of their time less profitably and more dangerously on the street and in parks, squats and abandoned buildings. Together with 'friends' they had acquired on the street, they spent much of their time looking for shelter and money. They fashioned a defined culture of unprecedented freedom and complexity, a culture with rules but little structure, with values but questionable morality. For many they became enmeshed into a street culture that appeared to embrace drug use and criminality. Both emerged as central behavioural adaptations to their living situations. These findings are similar to the findings of Mayock, Corr and O'Sullivan (2008) who found that homeless youth are reportedly more likely to engage in drug use and criminal behaviour compared to other young people their own age because the lives of homeless young people are frequently played out in social spaces that bring them into contact with potential offenders, and other homeless people with serious substances abuse (Mayock, Corr and O'Sullivan, 2008). Although no Irish study claims to provide a comprehensive analysis of the relationships between criminal behaviour, drug use, and State care, it is evident that a strong connection does exist between time spent in State care, multiple placements, homelessness, drug use and criminal activity. In their study, Mayock, Corr and O'Sullivan (2008) demonstrated the interconnection of youth homelessness, drug use and criminal careers. They argued that homelessness exacerbates the risk of young people becoming more deeply entrenched in both drug

use and criminal behaviour and those who got caught up in a cycle of using emergency services and short-term hostels were most at risk. They concluded that emergency interventions such as the Out of Hours hostels were one of a range of State sponsored institutions in which young people accumulated the street competency to enable them to survive which often times included involvement in criminal activity and problematic drug use. The findings from this study demonstrate that the very interventions designed to meet the participants' needs inadvertently facilitated their descent into a culture of homelessness, drug use and criminality during a time when they needed and required protection from such elements.

## **5.5 Conclusion**

This chapter focussed on exploring the first of the study's research questions by examining the experiences of transition for young people who journeyed into and through the residential care system. The chapter found both similarities and differences with regard to their respective and unique journeys into the care system including the multiple forms of child maltreatment, family alcoholism/drug use and mental health issues which characterised the early family histories of many of the participants. The extent of their movement in and out of the various residential settings meant that many had a repertoire of living situations and experiences while only in their mid-teens.

To survive many of them resorted to a myriad of high risk activities such as drug use and criminality. The series of transitions personal, emotional and familial the participants experienced prior too and during their time in State run residential settings is crucial in understanding the participant's present life pathways and in finding an answer as to how some young people fare better than others after leaving residential care? And what factors are linked to those who do well compared with those who do less well?

## **CHAPTER SIX**

### **THE NATURE OF THE PARTICIPANTS' TRANSITIONS FROM RESIDENTIAL CARE**

#### **6.1 Introduction**

Every year a proportion of young people formally leave the care of the State, most to establish independent lives as young adults in the community. In doing so, the burden of expectation placed upon their shoulders is large. As the narratives below suggests, these young people tend to make a series of overlapping transitions on the journey to adulthood and, for many, these are compressed into the first few months of leaving care. It is a testimony to the resourcefulness and resilience of many young people that they manage this process quite successfully. Others, however, struggle under the challenges and responsibilities they face in attempting to establish a foothold in the adult world. The focus of this chapter is to understand more about why this is so. The chapter begins by exploring the participant's perspective of the leaving care process. It looks at the different sources of support, formal and informal, that the participants received when they were attempting to establish independent lives, as well as their destinations and outcomes. Three broad groups were identified. Those who had a relatively smooth or successful transition from residential care, those who struggled but whose circumstances improved over time and those who experienced a volatile or considerably more problematic transition. The narratives are especially revealing in identifying some of the features that appear to be crucial in navigating a successful transition from residential care to independent living and for navigating a way out of

the often damaging social circumstances young people can find themselves in after leaving residential care.

## **6.2 Understanding the Leaving Care Process**

Despite the wealth of evidence in the literature about the key elements supporting effective transitions for young people leaving care, and the legislative and policy frameworks existing within many countries, many young people leaving care do not receive adequate assistance during the transition period to establish stable social and economic independence into the future. This is due to a number of factors, including the often rapid, uneven and compressed transitions they experience which also involves further movement and disruption, homelessness, lost attachments with families and dependency on social welfare (Biehal et al., 1995; Broad, 1998; Stein, 2008). International research studies consistently alert us to the complex and multiple disadvantage characteristic of many care leavers which can directly impact upon their ability and willingness to engage constructively with support services and to sustain effective relationships, without support (Cashmore and Paxman, 2007; Mendes, Johnson and Moslehuddin, 2011). This was true for many (18/20) of the participants in this study, many lacked trust and felt alienated by a system that had not always given them the stability or sense of belonging that they needed to thrive. Many were further alienated by a community that they were unable to relate to. This was often compounded by their poorly developed social and emotional skills as a result of their pre-care and in-care experiences. For many of the participants (16/20) in this study their experience of leaving residential care had similar components to that of their admission to care. It took them from the known to the unknown and most often followed periods of great instability. The participants expressed a variety of emotions

when characterising how they felt about leaving residential care. Some were frightened others recalled feeling a sense of dread and panic at the thought of the prospective changes. Two major themes emerged from the narratives that describe how the study's participants remembered their transition from residential care. The first theme was one of a sense of abandonment. The second theme communicated by the participants was one of a sense of loneliness and isolation.

### **6.2.1 *A Sense of Abandonment***

Children and young people who come into residential care already suffer a deficit of factors that would have been protective of their safety and development. Their primary relationship of trust, love and protection has been damaged or lost, or has perhaps never developed. Most have suffered from a sense of abandonment and/or rejection, which has interfered with their development. An abandoned child becomes a vulnerable human being, exposed to physical, cognitive, psychological, affective emotional and socio-relational cumulative risks, where the malaise symptoms and the behavioural affects such as rejection, resistance to relationships and lack of self-esteem becomes poorer as time goes by, until the child decides to break away from any form of trust and availability towards other people and adults (Fahlberg, 1994). Going into care is for many young people a difficult and traumatising experience, if young people experience a series of failed placements their original feelings of abandonment can be exacerbated. Leaving care, however, can be just as, if not more, difficult as entering care. It is not surprising, therefore, that they can experience leaving care as a 'second abandonment' (Yates, 2001). Little attention is often given to preparing young people emotionally for the changes that leaving care can mean including leaving behind carers and friends they have built a relationship with. Upon

reaching their eighteenth birthday they are being told that this has to end, and they are not allowed to come back and see them. The participants' recollections of leaving residential care almost always referenced a sense of abandonment. Some participants appeared to have little understanding of what was happening at this pivotal point in their lives. This is demonstrated in both Peter and Harry's account of their recollections of their transitions from residential care. Both expressed a sense of abandonment by a system that was there to care for and protect them:

“Once I turned eighteen I felt they (HSE) had washed their hands of me, just abandoned me. I felt let down, like someone put a dagger in my heart. It's not a nice feeling knowing that there's nobody to turn to or that nobody cares about you they [HSE] were supposed to be looking after me then they [HSE] just stopped” (Peter, 22 years).

“I was dreading the day I turned eighteen I knew I'd be out of the system they [HSE] don't care about you anymore you're supposed to just go and look after yourself what a fucking joke. I was on the streets. I was still only a kid like. Anything could have happened to me, do you know what I mean?” (Harry, 20 years).

Despite preparation for leaving care being recognised as an ‘integral part of the care process’ (Kennedy Report, 1970) requiring planning, many of the participants stated they had no ‘plan’ or time to prepare when it was time to leave their residential care placements. Connor recalled having no leaving care plan or any understanding of what was entailed in such a plan:

“Plan? what plan? I was shown the door that was the plan, are you having a laugh they didn't help me I was one less head on a bed for them to worry about, once your eighteen your no-body's concern they just dump you”(Connor, 25 years).

Matt expressed a similar experience:

“No I didn’t have a plan, I didn’t have any choice about leaving, when or how it was going to happen, well I knew that when I turned eighteen I’d be out of the system but you don’t expect them to just do it so quickly, there was nothing really organised for me if that’s what you mean by a plan that was it I was on my own” (Matt, 19 years).

As we have learned from the literature transitioning to independence is a major life event for any young person and for most, the process is gradual, well supported and occurs over a prolonged period (Arnett, 2006). Typically, a young person within a family setting, continues to receive support and guidance to develop the necessary social skills and networks to support their move from dependence, to interdependence and finally, to independence. In most cases, families provide a ‘safety net’ allowing the young person to return to the family home and/or an offer of support if needed referred to in the literature as ‘social capital’ (Coleman, 1998). However, many of the participants in this study could call on little, if any direct family support to ease their transition to independent living and many did not have the option of returning home.

Matt reported:

“I was left to fend for myself, my family didn’t care sure my ma hadn’t been around she couldn’t cope when they [HSE] took us off her, so I could hardly go home to her so I was just left, dumped do you know what I mean” (Matt, 19 years).

Like many of the respondents in Biehal et al.’s (1995) study a number of participants in this study left their residential care placement in what is described as a ‘crisis move’ (Biehal et al., 1995 cited in Simon 2007: 94) that is, when young people experience an abrupt end to their care placement with no permanent accommodation organised to move onto. Andrew explained:



“I was discharged from care after my eighteenth birthday with no-where to go and nobody to go too. I was on the streets, it was fucking miserable. I couldn’t go home they [family] didn’t want me. That’s why I was in care in the first place they didn’t want me then and they don’t want me now nothing changed” (Andrew, 20 years).

These findings echo the findings of Raman et al., (2005) who found that while many of the care leavers in their survey had attempted to reconnect with their families of origin they soon discovered that the same issues and dysfunction that separated them in the first place still existed resulting in little or no help forthcoming for over half of the care leavers. Participants in this study who found they had no-one to support them often ended up feeling lonely and isolated.

### ***6.2.2 A Sense of Loneliness and Isolation***

Many of the participants reported feeling lonely and isolated and this appeared to have impacted negatively on their emotional wellbeing. Loneliness was characterised as being a subjective, negative feeling associated with loss. Experiencing loneliness meant some important parts in the young person’s life were missing. Isolation referred to the absence of relationships with other people or the lack of interaction with individuals within their normal social network and generally a low level of involvement in community life. Isolation has been defined as ‘a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and is deficient in fulfilling and quality relationships’ (Nicholson, 2008). Young people leaving care often do not fully understand just how lonely their life is about to become. For some, their lives have changed from living with and being around people to being, for much of the time, on their own. It is not a life that many leaving care choose to have, but it appears to be a

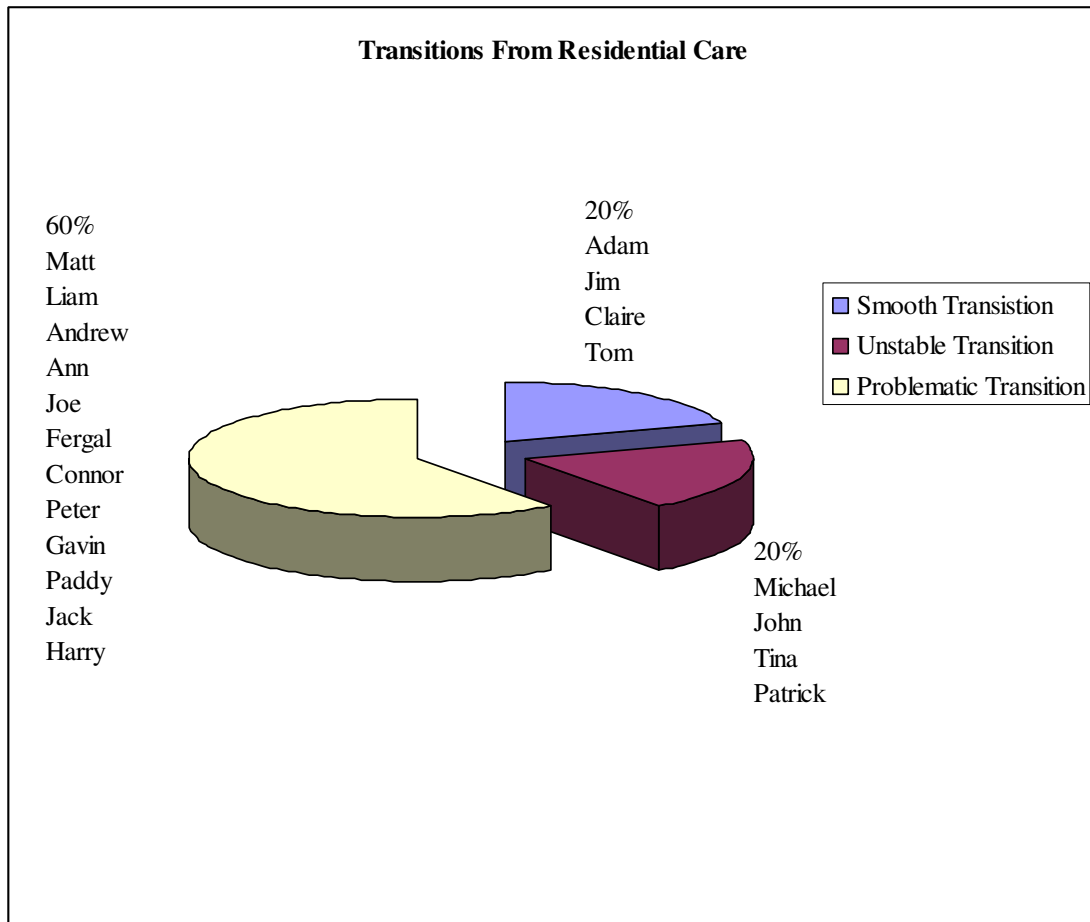
life of isolation that many see themselves as forced into. Both Tina and Patrick recalled struggling with feelings of loneliness and isolation:

“I moved into like a bed-sit type place. It was so difficult, I was on my own for the first time in my life I was never not around people before, I had no-one to talk too when I came home at night. The silence was deadly I didn’t know anybody there I was miserable and lonely” (Tina, 19 years).

“I was moved into like a bed-sit. I became very depressed I didn’t want to live on my own. I hated it with no-one to talk to I was used to the hustle and bustle of the hostels [OHS] from that to hearing nothing, talking to no-one sometimes for days at a time, that’s not normal” (Patrick, 19 years).

Loneliness and isolation were feelings that many of the participants struggled to cope with having spent years living with others in residential care. Their narratives are instructive and consistent with findings by Dixon et al., (2004) who found that the transition from care can adversely affect health and well-being. They found that feelings of profound isolation and loneliness were significant issues for care leavers who had no-one to support them. As we have learned from the literature (Stein, 2008) without ongoing, reliable relationships and stable accommodation, many often end up isolated and disconnected from their local community. For the participants in this study whose past had been marked by instability, abuse and emotional distress, the assumption of full adult responsibilities represented a severe test and for some of the participants it hindered their capacity to make a successful transition. According to the narratives there existed marked differences in how the participants in this study experienced their transition from care. Figure 6.1 presents the participants transition from residential care.

Figure 6.1 Transitions From Residential Care.



The findings indicate that while a proportion of the participants experienced a planned and supported transition and achieved positive outcomes, a significant proportion did not. There were cases where participants were doing well following a planned and relatively smooth transition, others who were doing well after periods of instability and some who were doing very poorly. The following sections will explore each of these outcome groups in terms of the housing/accommodation, financial/practical supports and familial supports that were available to them when leaving their residential care placement.

### **6.3 Smooth Transitions**

This section discusses the experiences of young people whose transitions from residential care was relatively smooth and trouble free. Although in a minority and not generally representative of the experiences of the other participants there were four participants whose transitions from residential care could be characterised as smooth. Their transitions were less fraught and incorporated meaningful strategies for post-care life, including identifying and securing post-care housing.

#### **6.3.1 *Housing/Accommodation***

Two of the four participants in this category moved directly from their residential care placement into the private rental sector. Claire and Adam's accounts illustrate how a planned and assisted move from their residential care placement enabled them both to transition successfully:

“I was happy I was leaving care and setting up on my own but at the same time I was nervous but once we [staff and Claire] sorted out a plan and I knew who was doing what and what help I was going to get from everyone [staff] it made it easier. I went straight from my care placement and into my apartment after my eighteenth birthday. I had been looking for a couple of months at different places and locations with the staff and by the time I was ready to move everything was set up” (Claire, 19 years).

“When it was nearing my eighteenth birthday we [staff and Adam] went looking for a flat. I knew that's what I wanted and they [staff] were around to help me. They [staff] came with me and spoke to different people [landlords] because I didn't know what to

be saying to them [landlords]. Then I picked a nice one bed-roomed flat in the area” (Adam, 21 years).

Both Claire and Adam’s move from residential care appeared to be part of a well organised plan and knowing where they were going after they left residential care was important for a number of reasons. Not only did it reduce the anxiety of leaving their residential care placement per se, but it also gave them the opportunity to think about the future and also what supports they might require. Two participants reported moving into a residential aftercare housing project. This type of arrangement provides accommodation, guidance and support to young people leaving residential care and transitioning to independence. According to Jim, his aftercare residential project allowed him to gain his independence in an environment that still provided access to a supportive network which the literature reports is often craved by young people leaving care (Broad, 2005). Jim found it to be an important source of not only practical but also emotional support:

“After I left care I went to an aftercare placement [residential]. It’s a good service helps you to learn things you need to know. It’s like having your own place but knowing you’re not on your own. I know there’s someone there if I need to talk things out with and it gives me time to plan for the future and what I want to do” (Jim, 23 years).

The findings mirrors the existing literature which asserts that assisting care leavers with their housing needs is a critical element in the overall process of improving outcomes and making successful transitions to independent living (Cashmore and Paxman, 2007; Stein, 2008). Indeed the importance of a leaving care plan was highlighted by Raman et al., (2005) who reported positive outcomes in terms of housing for those in their sample who reported having a leaving care plan. According to the participants in this study other factors which appeared to be instrumental for

these participants in achieving a smooth transition from their residential care placement was the existence of financial support and a strong social network which proved to be an important source of emotional and material support and central to young people's ability to successfully negotiate the transition to adulthood (Beer and Faulkner, 2009).

### **6.3.2 Financial and Practical Supports**

The narratives demonstrate that those participants who managed their own accommodation did well if they received both financial and practical support. Claire commented:

‘Ya they [staff] helped me with my baby’s crèche fees [Claire became pregnant while in care] so I could keep going to school and they [staff] helped me apply for rent allowance<sup>1</sup>. I’m planning to go to college this year and they’re [HSE] going to help me financially. They [staff] taught me everything I needed to know about looking after the baby and keeping me flat and paying the bills you know things you need to know about’ (Claire, 19 years).

The offer of practical assistance and maintaining ongoing contact also appeared to provide a sense of continuity and security to these participants. Tom describes the support he receives in the aftercare residential project he resides in:

‘I knew I needed more time to prepare and sort myself out before I got a place of my own. So I decided to move here [aftercare residential project]. They [staff] help me with stuff so I can keep going to school and get my Leaving Certificate. When I need help with my study all I have to do is ask or if I run short of food and stuff they sort me out. If I get college they [staff] will help with that too. This is what I need for a while then when I feel ready I’ll get a gaff [house] of my own’ (Tom, 19 years).

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<sup>1</sup> Rent allowance is financial help with rent payments given by the local Community Welfare Office to someone who is on low income.

The last sentence of Tom's quote highlights the agency Tom felt in his choice of accommodation and the importance of the supports it provided. This supported environment appeared to have created a sense of surety for Tom and provided a stable platform in which he could make future plans. It reiterates the findings of previous research that suggests leaving care support services do best when they are focussed on accommodation, professional support and the financial needs of the care leaver (Biehal et al., 1995; Moslehuddin, 2010).

### ***6.3.3 Familial Support***

On-going relationships with a parental figure were also identified by the participants as an important source of support. For the participants in this group who had struggled with familial relationships prior to and while in residential care, it was notable that relationships with their families had gradually improved since they left residential care which in turn had a positive impact upon their lives. Claire reflected on the fact that, unlike the past, she could now rely on her family to provide her with assistance should any problems emerge:

“Me and my ma we get on much better now that I'm out of care and have my own place. I just wanted to put the past behind us and move on, it's different now I'm a parent. She's [mother] around now to help me like with the baby I can ring her anytime I need help or just to have a chat if I have a problem” (Claire, 19 years).

Adam's sister moved to Ireland shortly before he left his residential care placement. Before this Adam had no family whatsoever in Ireland, his sister's presence meant a great deal to Adam at a time when he was finding his feet:

“I was fifteen when I left [country of origin] I missed my family so much but now my sister is here. We see each other most days, we help each other like family is suppose to, it makes it easier for me that she is here it is a comfort thing, I know I’m not on my own” (Adam, 21 years).

This is not to say that all family problems and difficulties had necessarily been resolved. On the contrary, the background for some of the participants in this study was one of strained and often innately difficult family relationships. Some like Tom recognised that there were limits in how far relationships could be improved. Tom explained:

“I wanted to be back talking to my family. I still won’t forget the stuff that’s gone on but I just want to put things behind us and move on. It’s a slow process and I’m taking it as it comes” (Tom, 19 years).

Yet Tom acknowledged that relationships with his family had gradually improved, which, in turn, had been a positive step in moving on:

“They [family] come and visit and bring my little brother over and stuff. Before I wasn’t really allowed see him much. I am getting on better with my older brother and sister now too we keep in touch now and meet up regularly” (Tom, 19 years).

When the participants were able to reconnect with their biological families and build on and maintain professional networks, their transition from residential care appeared to run smoothly. These relationships also appeared to be instrumental in helping them achieve and sustain positive housing outcomes. The experiences of the participants support the findings of Cashmore and Paxman, (2007) who found that those respondents in their study who re-established supportive familial networks around them in the period after leaving care fared better in the long-term. As we know from the literature young people who experience supportive and ongoing positive



relationships with significant others are far more likely to overcome the adversities resulting from their pre-care and in-care experiences and prosper when they leave care (Biehal et al., 1995).

#### ***6.3.4 Summary of Key Findings for those participants who had a smooth transition from residential care.***

According to the literature the transition from care may be successful or unsuccessful depending on the degree of preparation and disruption involved in the leaving care process (Stein, 2004, 2008). For these four participants the leaving care process appeared to signify a new phase of their lives and a ‘putting behind’ them some of the difficulties that existed in their childhood years. Their transitions from care were relatively unproblematic. They felt involved in the planning process and appeared to have a strong sense of the need to take control and of wanting to succeed. Their accommodation choices were appropriate to their needs. The extent to which they were able to exercise meaningful agency was heavily dependent upon broader circumstances, in particular the opportunity to access appropriate external supports. Table 6.1 provides a summary of the key findings for those participants who had a smooth transition from residential care.

Table 6.1 Summary of Key Findings for those Participants who had a Smooth Transition from Residential Care.

<b>Summary of the Key Findings for those Participants who had a Smooth Transition from Residential Care.</b>
<p>The research found that those who had a Smooth Transition from residential care:</p> <ul style="list-style-type: none"><li>• Felt involved in the planning process</li><li>• Felt that they were better prepared for leaving their residential care placement</li><li>• Spoke favourably about the transitional arrangements</li><li>• Identified the quality of the accommodation and support as a critical factor</li><li>• Had important, reliable and consistent social attachments that provided resources that enabled them to access and maintain their accommodation</li><li>• Were able to use their stable housing as a base from which to start engaging with educational opportunities.</li></ul>

All four of the participants had a secure, reliable and consistent attachment sometimes with members of their families and some with their aftercare workers which provided a sense of security. These relationships allowed them access to supports which provided critical social and economic resources that the participants could draw on to resolve any problems that emerged during their transition. As a result their subsequent housing experiences were characterised by little housing instability, planned transitions and no evidence of homelessness (although many had experienced

homelessness while they were in residential care). These findings concur with Rutter (1999) who found that in terms of good outcomes those who are successful have reciprocally positive connections to their community within which there are supportive and caring relationships. Where there was at least one reliable adult responsive to the care leavers needs in terms of advice and tangible support for dealing with problems, care leavers were more likely to be successful in their transition (Rutter,1999). It seems evident from the findings in this study that the supports available to the participants played a vital role in helping them in overcoming the adversities resulting from their pre-care and in-care experiences and enabled them to prosper when they left their residential care placement. Without such supports, young people leaving residential care are often far more vulnerable to housing instability and homelessness as demonstrated by the participants in the next group.

#### **6.4 Unstable Transitions**

This section discusses the experiences of four participants whose transition from residential care was characterised as unstable. While it has been noted in the previous section the importance of preparation and planning regarding first post-care housing/accommodation this was not necessarily the case for the participants in this group.

### **6.4.1 Housing/Accommodation**

In contrast to the participants who experienced a smooth transition and felt empowered and encouraged by their leaving care plans, those in this group did not appear encouraged to enter into dialogue with professionals in identifying their leaving and aftercare needs. Their narratives suggest they were given little choice with regard to their post-care housing/accommodation. All four participants appeared to have been swept along by the fast pace of change required of them when they turned eighteen. All four participants were required to live independently shortly thereafter with little time to adapt. Michael explained:

“I was just told in a meeting that I was going to [aftercare project] a few days after my eighteenth birthday. There was no discussion it was like accept what’s on offer or nothing at all sure they [HSE] knew I had to take what they [HSE] offered I had no choice I couldn’t afford a gaff [house] of my own it was that or back on the streets again” (Michael, 25 years).

These 'forced choices' resulted in some participants feeling isolated and lonely, often in accommodation and communities in which they felt lost and afraid as reflected in

Tina’s comments:

“They [HSE] moved me into like a bed-sit type [aftercare accommodation] over the far side of the city away from everything I was used to. They didn’t give me a choice, they just told me that’s where I was going. I was totally cut off from all that I knew I was lost like if you had put me in another country like” (Tina, 19 years).

Of course, moving to a new area may be a welcome development and provide some young people with a fresh start however, for the participants in this group moving to a new area presented difficulties in building up support networks and created a sense of isolation as they felt dislocated from their home area:

“When my time was up in care they [staff] moved me to this project (aftercare accommodation). I didn’t have a choice. It was miles from where I used to live. I didn’t know anyone it was like starting all over again. I missed my friends and just stayed inside all the time I didn’t see the point in going out sure I knew nobody” (John, 22 years).

Not only were the accommodation options for the participants unsuitable in terms of location, but also in terms of the way they were configured. Most aftercare accommodation that has been set aside for care leavers often involves sharing facilities. While these arrangements may work well for some, for others they may well be inappropriate. Some participants (2/4) had experience of sharing facilities. Tina’s comments were typical of the difficulties that arose when having to share facilities:

“I had my own bedsit but had to share the bathroom that was a pain. There were always arguments over who was to do the cleaning or half the time your stuff would go missing if you left it behind it was horrible at the time. I just wanted my own privacy” (Tina, 19 years).

Sharing arrangements were highly problematic for some of the participants as it often led to conflict which undermined their need for safety, privacy and a sense of control over their environment. Patrick explained:

“There were like five different bedsits in the house and there was one main front door which was used by everybody. That was the problem there was always strangers you’d be bumping into in the hall you never knew who was in the gaff [house]” (Patrick 19 years)

The participants also commented on the rules and regulations that governed their placement in this type of accommodation. Some like Michael felt the rules were

applied too rigidly, irrespective of their needs, age and experience. Michael reported that:

“There were rules you had to follow, you had to be doing something during the day [employment/education], pay your rent weekly, cook, shop, no drugs or shit like that it was like being in the fucking army. I wasn’t a child anymore, I needed help but it was all too much too soon” (Michael, 25 years).

None of the participants were actively involved in the planning of their post-care accommodation and subsequently appeared to be inappropriately placed in accommodation that they struggled to maintain. The difficulties that these participants experienced were further compounded by the lack of financial and practical supports available to them.

#### ***6.4.2 Financial and Practical Supports***

The participants in this group had attained lower levels of education, comparative to those who had a stable transition, thus limiting their abilities to secure employment. As a result, all four participants reported that at the time of leaving residential care they were unemployed and receiving unemployment assistance. Care leavers are statutorily entitled, as any young person, on reaching eighteen (who are not in full-time employment) to a minimum weekly income under the provisions of the Social Welfare Consolidation Act, 2005<sup>2</sup>. This weekly income provides their living allowance and is generally the only source of income available to them. It appears from the narratives that the participants in this group struggled with the changes that leaving care brought about including coping with the strains of managing their own

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<sup>2</sup> With the exception of asylum seeking non-Irish national(s).

budget and caring for themselves. A sense emerged from the narratives that this was often too much for them to handle. Patrick highlighted the difficulties he encountered:

“I never learned to budget my money sure I was used to spending it as soon as I got it. I never had to think about rent and bills and shit before, the staff did all of that when I was in care. I didn’t bother going to school when I was in care so there was fuck all I could do for work like after I left care” (Patrick, 19 years).

John pointed out the difficulties he experienced with day to day practicalities:

“You’d have to spend the day looking for work then come back and cook and shop with fuck all money to your name. I had never done any of that shit before staff did all of that. I just wasn’t ready and that’s what fucked it up for me” (John, 22 years)

Tina reported a similar experience:

“I had no-one to show me how to live on my own, I wasn’t ready for it, I was like hold on I don’t know how to do anything and they [HSE] expected me to do this on my own, its not normal to be shopping, cooking, pay bills and living alone at eighteen, you feel stupid saying you don’t know how to do them things” (Tina, 19 years).

Having difficulty managing financially on limited income was not a unique finding of this study. Previous studies have highlighted the financial difficulties and hardship of young people after they leave residential care, due in most cases, to inadequate incomes, poor living skills, lack of experience in budgeting and limited supports to fall back on when they need extra (Biehal et al., 1995; Broad, 1998, Stein and Carey, 1986). For the participants in this study negotiating the changes and challenges in their lives after residential care particularly in the absence of consistent and effective support networks appeared to be overwhelming. Their narratives illustrate little if any real preparation for their post-care lives. Indeed, the absence of practical supports

could reflect an absence of any ongoing relationships with professionals. Their recollections reveal a disquieting picture of their life where they appeared to be adrift and alone within a relatively short time of them leaving the residential care system. These findings echo the findings of Moslehuddin (2010) who found that over half of the twenty care leavers in his study reported a range of problems and unhelpful experiences similar to the ones reported by the participants in this group including limited independent living skills, little opportunity to be involved in the discharge process, lack of emotional preparedness and maturity, and the absence of basic necessities including housing. Similar to the experiences of the participants in Moslehuddin's study many of the participants in this study felt confused, uncertain and scared, which negatively affected their ability to successfully transition to independence.

#### **6.4.3 Familial Support**

When asked about what type of contact or support if any was forthcoming from their families two of the participants reported that they had lost all contact or severed contact with their families while two reported some contact but no support. As Biehal et al., commented, '*the history of the relationship and the pain of rejection often resurface in young people's disappointment in their parent's incapacity to admit to the earlier difficulties*'(1995: 87). Patrick and Tina for example, expressed their disappointment and resentment in the following ways:

"I don't want to have anything to do with any of them [family], I wouldn't be in this shit if they [family] had looked after me properly what the fuck would I want from them [family], there's nothing they [family] have that I want I'd rather live on the streets then go back" (Patrick, 19 years).



“Yeah I ring them [parents] and see them sometimes but I manage on my own I wouldn’t ask them [parents] for anything I’ve been looking after myself now for a while well since she [mother] put me in care so why would I ask her for help now there is no point” (Tina, 19 years).

Given that transitions from residential care are found to be shaped by the resources and opportunities young people have on the point of leaving care (Biehal et al., 1995; Cashmore and Paxman, 2007) it is perhaps unsurprising that all four of the participant’s placements broke-down within the first few months of leaving their residential care placement. Feeling isolated and lonely as a result of living alone in unsatisfactory accommodation often with little money, no work, minimal if any professional or familial support and little prospect of improvement in their circumstances these participants began moving between tenuous housing circumstances or directly into homelessness.

#### **6.4.4 Homelessness**

When the participants lost their accommodation they experienced periods of instability and moved in and out of homelessness. Participants in this study who classed themselves as homeless are those categorised as homeless by the Local Authority under the provisions of the Housing Act, 1988, for example, those living in temporary accommodation or those who use the adult homeless services. Once they were homeless their circumstances often got worse and finding any form of housing was particularly difficult. The participants in this group resorted to a range of stop gap measures including ‘couch surfing’. Participants used this term ‘couch surfing’ to describe staying on friend’s couches. However, staying with friends did not prove to

be a sustainable option for many as it often put pressure on these relationships and placed them in danger of social isolation where they don't stay their welcome as described in Michael's narrative:

“After I lost my placement [aftercare accommodation] I started staying between friends and at my girlfriend's gaff [house]. That lasted a couple of weeks but it began to cause problems so I couldn't stay there anymore. There was no point in going home sure I hadn't seen or spoken to my family since I went into care” (Michael, 25 years).

John reported a similar experience:

“When I lost my placement [aftercare accommodation] I went to live with my sister for a while but that didn't last long we kept arguing. She was the only family I had so when that broke down I ended staying with friends but you can only do that for so long” (John, 22 years).

The participant's pattern of instability and the reasons for this instability were very similar to those reported by Biehal et al., (1995). A third of the young people in their study had moved to or from temporary stops with friends or relatives at some stage after leaving care. These moves were often triggered by a crisis which resulted in their eviction or there being asked to leave. Similarly some of the participants (3/4) in this study were asked to leave their accommodation following continuous breaches to the terms of their lease. Patrick reported:

“I was so miserable there I just gave up I didn't want to do anything I just spent my money on hash [cannabis] and spent my days smoking that. They [aftercare providers] said I wasn't engaging and so that was that I was in breach and had to go” (Patrick, 19 years).

With no-where else to go this often led participants to access adult homeless hostel accommodation and consequently to associate with other homeless people where their

drug use became problematic. For some of the participants (3/4), using drugs was a way to escape from the day to day reality of their homeless situation. Drug use was a means of coping with being homeless as demonstrated in both John and Patrick's comments:

“Once I was homeless I just didn't care. All I wanted to do was get stoned [under the influence of a substance]. I'd wake up in those fucking homeless hostels and do the same fucking thing all day, every day, it helped block all the shit out I didn't want to remember the shit I had been through” (John, 22 years).

“Once I was homeless again I started smoking the gear [heroin]. All I cared about was getting my next hit [heroin] I didn't give a shit about anything else why should I nobody gave a crap [cared] about me. I didn't care about getting a place anymore, I wasn't able too I just started drifting in and out of those hostels [adult homeless hostels]” (Patrick, 19 years).

Ward et al., (2003) also found increased levels of drug use were reported by care leavers during periods of transition and among those whose movement to independent living was premature or poorly planned. The authors reported that some had turned to drugs as a means of compensating for the negative experiences of loss and rejection encountered in the past as did the participants in this group.

#### **6.4.5 *Moving On***

While the combined effects of their pre-care, in-care and post-care experiences left the above mentioned participants vulnerable to periods of instability and acute social exclusion the findings show that after a rough start these participants moved on with their lives and successfully navigated a route to independence. One of the main reasons cited by the participants (3/4) that enabled them to 'move on' was their ability to address their substance abuse issues. When the participants addressed their

substance abuse issues, they found that they had the capacity and the opportunity to build meaningful social relationships with friends, their families and professional supports. Not only did their housing circumstances improve there were notable improvements in their involvement in training and education as demonstrated in John's comments:

"I was fed up feeling like shit all the time, I started wanting a normal life so I did a programme [drug rehabilitation programme]. After that I got into an aftercare residential project. Now I'm doing a course during the day which I like going too, it gives me a purpose I feel I'm ready now to make decisions. When I left care I was too young to know any better" (John, 22 years).

When the participants addressed their substance abuse issues and experienced continuity, stability and good support there was a noticeable improvement in other areas of their lives. Patrick noted how his self-esteem and confidence had grown since he had been 'off the gear' [heroin]:

"Once I was off the gear [heroin] I started to feel better in myself and began trusting people and not being so paranoid. I know people are there to help me. I'm on a methadone programme now and going to a course where I'm earning my own money and have a place to stay" (Patrick, 19 years).

Sometimes there was a pivotal moment or experience that encouraged the participants to actively seize control over their lives and their circumstances. Michael reported:

"When I knew I was going to become a dad that was it, I wanted to make a better life for my son so I had to get off the gear [heroin]. I had to sort myself out and to have a normal life with my son. I did a detox [drug rehabilitation programme] and got clean [off the drugs] I have a flat now and do a part-time course" (Michael, 25 years).

Among those who addressed their substance abuse issues there was a strong desire to stop using drugs. A sense of wanting something better and having a 'normal life' was a primary motivation in their decision to address their substance abuse issues. However, abstinence only occurred when there was access to appropriate drug services and appropriate housing available to meet their needs. Some of the participants (3/4) continued to be involved with drug and addiction services and two of the participants continued to be on a methadone programme. Securing education was also a key feature of moving on for these participants. Securing a course brought not simply financial rewards, but also broader benefits such as stability and security. Coupled with increasing self-confidence and an improved sense of self, the participants in this group were starting to flourish. While each individual's motivation to change was different, it is noteworthy that most aspired to having a normal life, a job, an education and family, circumstances that are often readily available to most young people in society.

#### ***6.4.6 Summary of Key Findings for those Participants who had a Unstable Transition from Residential Care***

There appears to be marked differences in the level of preparedness between those who experienced a smooth transition and those who had an unstable transition from residential care. Some found managing their own housing more complicated and stressful than they had imagined because they had little or no support and little experience living on their own unlike those who experienced a smooth transition who appeared well prepared and secure with their move.

Table 6.2 provides a summary of the key findings for those who experienced an unstable transition from residential care.

Table 6.2 Summary of Key Findings for those Participants who had an Unstable Transition from Residential Care

<b>Summary of Key Findings for those Participants who had an Unstable Transition from Residential Care</b>
<ul style="list-style-type: none"><li>• Did not feel involved in the planning process</li><li>• Been discharged into inappropriate accommodation</li><li>• Poor experiences of supported/transitional accommodation and specifically, being forced to share.</li><li>• Experienced a lack of privacy, safety and control over their accommodation.</li><li>• Had difficulties coping with newly found autonomy and independence.</li><li>• Substance abuse and mental health problems destabilising their housing.</li><li>• Poor relationships with their family</li><li>• Addressed their substance abuse issues.</li><li>• Found the right sort of support.</li><li>• Developed improved relationships with their family.</li><li>• Were able to use stable housing as a base from which to start engaging with training and education opportunities.</li></ul>

They experienced instability and homelessness within months of them leaving care. For some of the participants breaking the cycle of housing instability and homelessness was heavily compromised by their substance abuse issues and this was often the most significant barrier they faced to moving on. Nonetheless, all those who experienced an unstable transition eventually overcame their difficult starts and successfully managed their transition to independent living. They displayed determination, persistence and resilience to turn their lives around. Moving on was often connected to a strong desire for a better life and securing appropriate supports and stable housing was a crucial ingredient for these participants in overcoming the issues that had made their lives so challenging. There was a strong recognition in the narratives that opportunities to access appropriate external supports were necessary in assisting the participants in their transition to independence. This appeared to be instrumental in delivering positive outcomes for these participants. These findings are in keeping with the findings of Stein (2008) who found that aftercare supports have the potential to provide a number of resilience-enhancing opportunities. In the absence of such supports it is clear that, compared to their peers care leavers opportunities are much more limited and the chances of experiencing poor outcomes much higher as demonstrated in the narratives of the participants who experienced a problematic transition from residential care.

### **6.5 Problematic Transitions**

The third group describes the experiences of over half of the participants (twelve which makes up the majority of the participants in the study). In contrast to those who experienced a relatively smooth transition from residential care this group had

experienced more complex and chaotic circumstances since leaving residential care, with periods of instability in social relationships and housing, interspersed with periods of acute instability and homelessness which had serious implications for all aspects of their lives.

### **6.5.1 *Housing/Accommodation***

Of the twelve participants in this group six reported having post-care accommodation, five reported moving into transitional housing, one young man moved directly into the private rental sector, while six reported having no permanent accommodation organised upon leaving care and subsequently were officially placed on the homeless register<sup>3</sup>. Those with housing struggled with independent living and within a relatively short time, all six participants had subsequently left or been evicted from their accommodation. A number of reasons why their tenancies were unsustainable were identified in the narratives. Participants reported feeling unable to cope with the responsibility of managing their own lives with many struggling with ‘having to do everything themselves’. Some of the participants reported having had no preparation to help build the skills needed to live alone, such as budgeting and cooking skills, while some participants found the guidance they had received during their time in residential care to be lacking as described by Ann and Joe:

“It was a big shock for me I hadn’t a clue how to manage. I never had to do all that stuff before. Staff always did the cooking. All of a sudden you’re supposed to know all this shit about bills and rent and having to do everything by yourself. It just didn’t work out for me” (Ann, 20 years).

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<sup>3</sup> When you are classified as homeless under the Housing Act, 1988, you are placed on a homeless register with one of the four Local Authority Areas in Dublin.



“They [staff] showed me a few things but mostly I think they [staff] assumed I knew things and I wasn’t going to let them [staff] think I was stupid so I just didn’t bother and lost the place [Aftercare residential placement]” (Joe, 25 years).

Peter found managing his own accommodation [private rental] more complicated and stressful than he imagined. He reported a lack of knowledge and little experience living with others as the main difficulties he encountered:

“I was house sharing [private rental]. I had my own room but had to share everything else, I hated it. Nobody tells you what to expect, I didn’t want them knowing my business, like I was in care and shit, I couldn’t talk to them I wasn’t like them I just couldn’t cope with all that shit so I just left” (Peter, 22 years).

The findings in this study echo the findings of Johnson et al., (2010) who found that the lack of attention given to preparing the participants in their study for life after care was a major deficit that exacerbated the challenges involved in accessing and maintaining housing. Similarly the findings in this study suggest that the participants required more practical assistance in a range of areas, including living skills such as cooking and budgeting, locating suitable accommodation and understanding the challenges of living alone. Unlike the participants in the latter two groups, who seemed to have developed better coping strategies that included a network of support such as family they could turn to in times of crisis this was not the experience for the participants in this group.

### **6.5.2 *Familial/Professional Support***

Although reunification with biological families was relatively successful for some of the participants this was usually not the situation for this group of participants. As we have learned from the literature the transition to independence is generally premised

on the view that young people will be supported through the process by their families in a stable environment (Biehal et al., 1995; Broad, 2005; Stein 2008). While this is the case for most young people, the notion was problematic when applied to this group of participants particularly for those who had no home to return too and had little if any family support. Paddy explained:

“I don’t talk to my family anymore. I went home for my ma’s birthday but my da started on me [arguing] so I had to leave. I haven’t gone back since. There’s no point I couldn’t live there with them [family] they don’t want me and I fucking don’t want them it just that simple like” (Paddy, 18 years).

Indeed many (10/12) of the participants were dismissive of the idea that they could turn to their families or professionals for help Connor simply and briefly said:

“No, there wouldn’t be any point, none that I can see anyways nobody cares you just get thrown into the world like do yeah know what I mean sink or swim” (Connor, 25 years).

Connor’s narrative is notable for the absence of any discussion on his connection to or engagement with professionals or relationships with others. Their significance lies in their absence. There was no sense that people or services were integrated into his life. While, isolation from their family, friends and former social worlds affected the participant’s self-confidence and identity and created a sense of dislocation, some participants however had become completely isolated, reporting that they had no one with whom they could talk too. Fergal commented:

“When I feel low, I feel low, you know what I mean, I try hard not to beat myself up, I just go and sit somewhere and just think and think and think, and I say to myself no I shouldn’t be thinking like this, and I go for a walk and try to forget about it then, you know what I mean its lonely like” (Fergal 24 years).

The lack of support from family and professionals prompted some participants to make friends amongst other care leavers who had left the care system. As we know from the literature there is a tendency to befriend those in similar circumstances to oneself (Mayock, Corr and O'Sullivan, 2008). While these relationships can provide some predictability in an otherwise chaotic world there is nonetheless always a degree of caution and wariness about these friendships. Studies have shown that these type of friendships are opportunistic in nature and do not provide the depth of emotional support that characterises good friendships (Ballintyne, 1999). For some (7/12) participants there was a sense of belonging and some level of trust in the friendships they formed as described in Paddy's narrative:

“I still hang out with the gang I met in the [OHS]. When you have no family you have to depend on your mates that's all that is left you got to trust that they'll look out for you, have your back when shit happens” (Paddy, 18 years).

However the issue of trust/distrust was raised by other participants (5/12) when speaking about the young people they associated with:

“I don't trust no-body. I hate saying that, I should trust somebody but I don't, I can't. I won't let myself do it maybe when I was younger and with me mates in the [OHS] but it's a different ball game [situation] now” (Andrew, 20 years).

### **6.5.3 Homelessness**

All of the participants in this group were homeless at some point. There were those who found themselves homeless when their housing circumstance did not work out (6/12) and there were those who exited directly from residential care into homelessness (6/12). Hostel accommodation remains the basic element in the

provision of services for those who find themselves homeless (O'Sullivan, 2008).

Many of the participants (8/12) reported feeling trapped in this form of emergency accommodation, moving between different hostels. Harry explained:

“I had no choice but to take what they [Adult Homeless Services] gave me, go where they tell you to go. I've lost count the number of times they [Adult Homeless Service] have shifted me from one hostel to the next” (Harry, 20 years).

Similar to their experience of the Out of Hours these adult homeless hostels also created a great deal of uncertainty for the participants and often added to an overall feeling of restlessness and an inability to settle down. Matt, who has been homeless for the past twelve months and had resided in a number of homeless hostels described his experience:

“You have to follow the system which means ringing up every night to see where you have to go to get a bed, you could be anywhere in the fucking city, you don't get a choice you can't just settle into one hostel your always on the fucking move. You get a bed you get some kip [sleep] and have to leave the next morning by 10am and start the shit all over again” (Matt, 19 years)

Some participants (4/12) expressed the view that their lives 'were on hold' while they were homeless. They were unable to get on with their lives in their present situations.

Quite worryingly, most of the participants (9/12) had spent most of their young lives moving around the hostel 'circuit'. Jack explained:

“I was shunted about those hostels [OHS] for years that does nothing for you, you don't know where you're going, nobody really wants you, then you get dumped into this shit, more hostels [adult homeless hostels] its like a fucking circuit, what can I do I'm stuck in this shit now” (Jack, 21 years).

Gavin expressed a similar experience:

“For the most part it has been the Out of Hours hostels then the adult homeless hostels or the streets that’s all I know now. I never got a chance to have a gaff [house] fuck all chance of one coming soon its just the same shit different day, nothing changes for me you could say my life’s on hold because there’s fuck all I can do to change this shit” (Gavin, 24 years).

For some participants (8/12) living on streets was physically and emotionally taxing. Some participants were simply weary and exasperated by their experiences as demonstrated in Andrew’s comments:

“I’m miserable I hate being like this [homeless] I’m just tired of all the shit over the years” (Andrew, 20 years).

Many of the participants (10/12) had tried, often repeatedly, to exit homelessness but with limited success. There is, as some of the participants made clear, a powerful stigma attached to being homeless and this affected their ability to get out of homelessness and further isolated them from society in general as well as from their families and friends. A number of the participants begged or ‘tapped’ for money but found peoples’ attitudes difficult to cope with. Matt explained his experience:

“If your sitting there tapping [begging] on the street and some woman walks past, she’ll grab hold of her handbag I’m used to all that now, I don’t mind it at all they think you’ll rob the eyeballs out of their head, you know what I mean” (Matt, 19 years).

While begging was found to be a good source of income it was also a source of social contact. Some participants like Joe and Harry recalled experiencing kindness as well as rejection:

“There is a lot of shitty people around but every now and then you come across a nice person out there they’ll wake you up and give you a cuppa” (Joe, 25 years).

“Most people just ignore you as if its your fault you’re in this shit then there’s others you get to talk to who would just sit down and talk to you and go up and buy you a McDonald’s and all, even if someone threw a euro into me cup at least you feel that they noticed you” (Harry, 20 years).

Surviving homelessness for the majority of participants involved retaining a sense of hope that they would escape from their homeless situation:

“I know what I want from life, and that’s why I’m going to make it happen, I’ll just try and get a job, get me own flat, I’ve been trying these things, but the thing is they just don’t seem to fall into place. Hopefully one day it’ll fall into place I just have to take it day by day. I’m not going to plan the future because every time I plan the future it doesn’t seem to work for me” (Gavin, 24 years).

With little social and economic capital to draw on, young homeless adults often struggle to find a way out of their circumstances. As we have learned from existing research drugs are a major influence on care leaver’s life course, their access to housing, and ultimately their capacity to get out of homelessness can be severely compromised (Ward et al., 2003).

#### **6.5.4 Substance Misuse**

Among the participants whose transition from residential care was particularly problematic all identified that they had substance abuse issues at some stage in their lives compared to those who had experienced a smooth transition from care. Some participants (7/12) had started using drugs at a young age and had used a variety of drugs, often moving from smoking cannabis to injecting heroin by sixteen or

seventeen. Hence many (7/12) have been addicted to some substance for a substantial period. Like participants in Mayock, Corr and O'Sullivan's (2008) study, it was found that drug use escalated for the majority as their careers in homelessness progressed. Many of the participants (9/12) in this study reported that their drug use was an escape from their circumstances 'a way of getting out of it all':

"I can't be thinking of my life and how I got here, it's too hard. The drugs help to block it out it's a way of getting out of all the shit, not thinking about it. I do what I have to, to make sure I get my gear [heroin] everyday. The longer I was homeless the worse it got. I've been taking it [heroin] for so long now that I can't go a day without it" (Harry, 20 years).

"It's hard to explain, I just done it, you know to escape from it all or something once you start on it that's it, it takes over, there's nothing else" (Jack, 21 years).

"Staying in those hostels [adult homeless] you end up where there are so many drugs it's in your face all the time the longer you're in it [homeless] the worse it gets" (Connor, 25 years).

Over time as their substance abuse problems became more pronounced, participants came to rely on the streets more and more. Participants reported 'learning the ropes' on how to access a daily supply of heroin as Liam reported:

"You need to learn the roles very quickly when it comes to drugs, it's a business pure and simple that's the way you need to operate if you want to get your gear [heroin] every day you need money" (Liam, 24 years).

For the majority of the participants (10/12) their addictions were linked to ways of making money, usually involving theft. Stealing was viewed as a necessary part of

their homeless lives. Many of the crimes committed by the participants were directly linked to obtaining a daily supply of heroin:

“When you are on heroin it’s like a demon inside you, you have to feed it everyday so you got to do what shit you can to get your gear [heroin] if that’s means nicking [stealing] shit from people well that’s what you gotta do that’s life” (Fergal, 24 years).

“You do what you have to you know what I mean. Nobody’s going come and help you. You have to help yourself and get what you need to get through the day for me that means getting enough gear [heroin] I’m past caring what I do to get it” (Andrew, 20 years).

The findings in this study are in keeping with the findings in Mayock, Corr and O’Sullivan’s (2008) study which found that many of the respondents in their study were propelled into daily criminal activity due to the demands of their drug consumption. The process of ‘moving on’ for young people in this group who experienced profound and often long periods of social and economic exclusion can vary significantly depending on the individuals circumstances and experiences. As we have learned from the literature moving on is often an arduous process where numerous obstacles and set-backs have to be overcome. However, in the absence of support the chances of care leavers ‘moving on’ are significantly lowered (Stein, 2008).

#### ***6.5.5 Summary of Key Findings for those Participants who experienced a Problematic Transition from Residential Care***

For the majority of the participants (12/20) in this study the transition from residential care was not smooth but problematic, marked by instability in their social relationships and housing. Their experiences were chaotic. Many had experienced



numerous placements and had little trust in the system and other people. Table 6.3 provides a summary of the key findings for those participants who experienced a problematic transition from residential care.

Table 6.3: Summary of Key Findings for those Participants who Experienced a Problematic Transition from Residential Care.

<b>Summary of Key Findings for those Participants who Experienced a Problematic Transition from Residential Care.</b>
<ul style="list-style-type: none"><li>• Rarely had a leaving care plan</li><li>• Left residential care in crisis</li><li>• Been discharged into inappropriate accommodation or homelessness</li><li>• Lack of professional support.</li><li>• Lack of familial support</li><li>• An absence of relationships offering resources that could be used to access and maintain housing.</li><li>• Their social networks were comprised of homeless and other marginalised young people, and many experienced profound difficulties in maintaining relationships.</li><li>• Participants in this group were also mistrustful of statutory care system.</li><li>• Lost accommodation because of substance abuse.</li><li>• Participants in this group were all currently homeless.</li></ul>

Participants in this group typically left their residential care placements in crisis with no real planning for their post-care lives. The abrupt end to their residential care placement and the absence of any follow-up supports reflects the absence of any ongoing relationships with professionals, or family. Most experienced chronic instability and homelessness. For these participants, breaking the cycle of housing instability and homelessness was heavily compromised by a lack of both economic and familial support. The preceding accounts suggest that there were few attempts to manage the participants' transitions from within the State care system. Instead, many of the participants were often left to find their own way by drawing on their own limited supports. Many felt confused, uncertain and scared, which negatively affected their ability to successfully transition to independence. Not only did these young people feel unsupported they also felt rejected by those who assumed a responsibility for their care and protection. These unhelpful experiences were found to be still unresolved for some of the participants at the time of interview, and therefore continued to have adverse effects on their ability to exit homelessness.

## **6.6 Conclusion**

The participants whose stories are presented here are all different but similar themes run through their lives. What emerges from their narratives is that a series of difficulties in their young lives personal and familial narrowed their life options as they grew to adulthood. All of the participants had been separated from home, school and their communities and were placed in residential care from an early age. This was often due to a problematic home backgrounds and parenting difficulties. During their time in residential care they often had little, if any, continuity and stability, many

experienced frequent movement, had limited social networks and had few people to rely on. Each participant's journey through and from the residential care system was individual and reflected their specific personal history. The majority of the participants (12/20) did not follow the usual, graduated transitions to independence. The findings show that most struggled with their transitions from the residential care system. Access, affordability, location and the quality of accommodation were all major factors confronting the participants. The impact of these factors was also strongly mediated by the financial/practical and familial supports available to the participants at the time of leaving residential care. While many of the participants (14/20) continued to have conflicting relationships with their immediate families, some of the participants did attempt to 'put things behind them' and renew contact with their families upon leaving their residential care placement. Indeed, the importance of improved family life for offering support and instilling greater stability came through clearly in the narratives. Even fairly small improvements in family relationships often had a significant impact upon young people's ability to successfully navigate their way towards independence. However, the absence of consistent, alternative sources of care and support appeared to be a crucial deficit. The participants' narratives were full of examples where support was inappropriate, insufficient, inflexible or judgmental. Many were angry at a system that they thought had failed them and had failed to understand why their circumstances were as they were. The reliance on social welfare support meant that many of the participants also struggled financially. Without on-going, reliable supports many of the participants often ended up isolated and alone. A consequence of this was that many struggled to maintain their accommodation and subsequently became homeless. Having identified the three transitions undertaken by the studies participants and acknowledging that the

participants in all three groups faced similar disadvantages in their journey to adulthood there were however differentiations in terms of their individual resources and resilience that enabled them to negotiate barriers and opportunities in their post-care lives this will be discussed in the final chapter.

## CHAPTER SEVEN

### CONCLUSIONS AND RECOMMENDATIONS

#### 7.1 Introduction

The focus of this qualitative study was on exploring ways to improve the chances for young people transitioning out of the residential care system. The main emphasis was on understanding the meaning of the participants' journey into, through and from the residential care system, drawing on their subjective experiences. As the young people communicated their experiences and perspectives of their past and present, it was possible to acquire a multi-layered picture of their journey into, through and from the residential care system. The preceding two chapters have documented a range of findings that are relevant to understanding the participants' lives and their present-day circumstances. The overall picture points to diversity and complexity of experience reconfirming previous research which found that care leavers are not a homogeneous group (Cashmore and Paxman, 2007; Mendes, Johnson and Moslehuddlin, 2011; Moslehuddlin, 2010; Stein and Dixon, 2006). This final chapter will attempt to draw on some of the most salient findings and consider in a broad sense how leaving care can best be framed and understood.

## **7.2 Conclusions**

Specifically the study answers the following three questions what are the experiences of transition of the study group? why do some fare better than others after leaving residential care and what factors are linked to those who do well compared with those who do less well? These three research questions are closely linked and represent a progression in thought and analysis towards the central purpose of the study which is to identify ways to promote positive outcome for care leavers.

### **Q.1 What are the experiences of transition for young people who journey into, through and from residential care?**

The findings of this study are consistent with available literature reporting general negative outcomes for young people leaving the residential care system (Biehal et al., 1995; Cashmore and Paxman, 2007; Kelleher et al., 2000; Stein, 2008). In this study it was clear that the participant's journey from the residential care system was characterised by experiences of profound loss and was perceived by the majority of the participants to have a lasting detrimental impact on their present-day lives. Due to the limits of the study's methodology other possible factors that may also have contributed to how the participants recalled their experiences of leaving care cannot be ruled out. Neither can the residential care experience be isolated as the sole contributor to how the participants perceived their present-day life struggles. For instance, all of the study's participants experienced abuse or neglect by their parent(s) and were subsequently removed from their families and placed in the care of the State. Such traumatic events can be expected to have profound negative effects

(Fahlberg, 1994; Broad, 2005; Iwaniec, 2006). On the other hand, one might argue that the residential care experience did little to relieve the trauma and losses suffered prior to placement in care. These losses were recurring as participants changed from one residential care placement to another. The events and experiences of residential care contributed further to a pattern of disrupted attachments and this effect was identifiable in the participants' narratives. The findings reveal that the experience of placement moves was not only remembered as a series of significant losses but also perceived by participants to have left them with negative emotional scars, particularly in the area of trusting people and building and maintaining relationships. The overall experience culminated in fractured and dislocated relationships which were a distinctive feature of the majority of the participants care histories. The qualitative nature of the study limits generalizations beyond the sample however the findings bring greater understanding to the possible lingering effects of multiple placement moves in residential care on children and young people, as well as providing an insight into the psychological dynamics at play during the process of leaving care. A theory that is relevant to this discussion is attachment theory.

Attachment theory, in its broadest sense, describes how early childhood relationships are formed and sustained. Central to Bowlby's (1973; 1982) theory is the proposition that children learn about life from their main caregiver in terms of their identity and their ability to relate to others (Howe et al., 1999). For the majority of young children, the primary caregiver is the mother and this relationship has been viewed as being fundamental to the child's development (Goldberg, 2000). The security that this relationship can provide has a positive influence on the young child as they develop and grow during their childhood years. Bowlby (1973; 1982) found that a stable

relationship in early childhood can provide the child with the necessary skills in managing relationships in later life, and in effect becoming socially competent. What the literature informs us is that early attachment can have an effect on an individual's on-going development (Falhberg, 1994; Iwaniec, 2006). To be more precise, how an individual's ability to develop relationships and function in society, in essence to be a competent young adult, can be as a result of early experiences particularly in relation to how one experienced attachment to a caregiver. This had clear ramifications for the study's participants who had experienced disruption in early childhood relationships. With the psychological deprivation that some of the participants had experienced in terms of their move away from their family, attachment theory explains how this can affect the individual at various stages in their lives, not only in early childhood. A failure to address this experience of very early childhood trauma can have a detrimental effect on the young person's ability to settle into residential care (Goldberg, 2000). As a result young people can experience placement breakdown in residential care resulting in multiple placements. In terms of the young person's social network, there can be a resulting disruption in this framework, and ultimately, it can have negative effects on the young person's ability to form close relationships. A picture emerged from most of the participants' narratives of repeated moves during their time in residential care with few or no opportunities to develop and build positive relationships. This combined with their own childhood experiences prior to coming into residential care resulted in negative outcomes for over half of the participants (12/20).



The many losses recalled by the participants suggest that their time in residential care was a source of much distress for many of them. Multiple and repeated losses may well have compounded any consequences of stress related to their prior abuse and neglect or removal from their family home. Participants described their emotional states during the different stages of their transitions into, through and from residential care in similar ways to previous research where it was found that complex trauma manifests as problems with attachment, affect regulation, cognition and behavioural problems (Ainsworth et al., 1978; Graham, 2011; Main and Soloman, 1990). Many of the participants remembered their time in residential care as a time of shutting down, and this reaction was described in very similar ways regardless of age, different types and the number of placements both while in residential care and after leaving residential care. This finding does not suggest that multiple placement moves will affect all individuals in the same way rather it reiterates the heterogeneity of care leavers' experiences. Further research is needed to investigate how particular characteristics of individuals or residential care experiences affect perceptions or outcomes related to leaving care. However, the findings point to the possibility that repeated and abrupt changes in living environments after having suffered child abuse and neglect and removal from one's family home may result in a common reaction by individuals who experience this sequence of events. The growing body of research on attachment (Ainsworth, 1978; Bowlby, 1973, 1982; Fahlberg, 1994; Graham, 2006; Main and Solomon, 1990) which describes the types of negative consequences experienced by children exposed to chronic stress, helps explain the reaction described by participants in this study. When young people are not allowed to grieve separation and loss, their ability to cope with change becomes seriously compromised (Fahlberg, 1994).

The findings also align with previous research that shows that young people sometimes leave residential care without the benefit of being properly prepared for the move (Biehal et al., 1995; Broad 2005; Kelleher et al., 2000; Stein, 2008) and this raises doubts about the opportunity that young people are given to psychologically process the impact of their leaving their residential care placement. The significance of using an attachment theory model for understanding the effect of the leaving care transition on young people is that the damage caused is psychological and often leads to lifetime limitations in how one relates to other people, regulates emotions and processes information cognitively. The permanent effects of such stress is supported in this study by the participants' descriptions of lifetime struggles with mistrust, detachment, profound loss and the transient lifestyle that they attributed to having journeyed into, through and from the residential care system. While attachment theory can help us to understand the negative consequences of leaving residential care experienced by many of the participants, the theory of resilience can identify protective factors that can prevent more adverse consequences.

**Q.2 Why do some fare better than others after leaving residential care? What factors are linked to those who do well compared with those who do less well?**

In answering the second research question I wish to focus the discussion on the concept of resilience and its role in the leaving care experience of the study's participants, and specifically to consider, whether, despite their negative pre-care and in-care experiences, can a resilient young person manage to effectively form and sustain independence and achieve positive outcomes post-residential care. Resilience has been described as the ability to achieve despite the experience of adversity

(Gilligan, 2000). Research has focused on its application to a variety of vulnerable groups within society, including young people at risk and in the care of the State (Place et al., 2002, Gilligan, 2000). It has been well documented that young people who have been in the residential care system have experienced adversity in their lives (Gilligan, 2000; Stein, 2008). This may take many forms, including separation from the birth family, experience of abuse and other forms of maltreatment and instability in care placements (Schofield and Beek, 2005). What has focused the discussion on resilience and this study's participants is how, in the case of some of the participants, they managed to achieve positive outcomes despite the adversity they encountered. Much of the discussion has focused on resources and opportunities young people have on the point of leaving care as a means of promoting resilience in young people who have experience of residential care (Stein, 2008). These included the positive effect of supporting young people in preparation for leaving care and in particular, independent skills, the young person's resources, family, interaction with professionals and community resources.

The resilient young person seems more able to link in with individuals and groups to provide social support specific to their needs (Flynn and Byrne, 2004). The findings highlighted that the participants who demonstrated strong resilience had individual, family and community protective factors in common. This access to resources was indicative of positive outcomes for a number of the participants in this study. For the participants who experienced a smooth transition there appeared to be a conceptual overlap between resilience and attachment theory. Their experiences surrounding the transition from residential care provided them with stability and a secure attachment to at least one of their family members or carers and from this secure base, they were

able to avail of opportunities and active encouragement to explore and become confident in the adult world. Their transition from residential care has provided them with a turning point to develop their potential and they have accumulated resilience promoting factors including developing a positive identity, a personal narrative or a developing story. They have connected the past, present and anticipated future and their story provides coherence and continuity. They have pieced together the financial, social, housing and educational supports they required and combined them with their resilience and unique skills set and have created a place for themselves in the adult world

As garnered from the literature, emergent adulthood constitutes a period of major transition, challenge and opportunity (Arnett, 2000). Yet, for the majority of the participants in this study they arrived at the shores of adulthood on waves of disrupted family backgrounds, disjointed residential care experiences and marked vulnerabilities that undermined their ability to adapt and navigate the developmental challenges of emergent adulthood. Their narratives powerfully gives voice to the negative experiences of their transition from residential care, emotionally polarised from dependence to independence, and denied through their experiences of family and residential care, the emotional flexibility to emerge into adulthood. These participants reported feeling ‘abandoned’ by the system. Some expressed no interest in participating in or becoming dependent on a system they felt had failed them. Their reluctance to develop relationships with other professionals impacted greatly on their lives post residential care. On the other hand, the unique personal strengths identified by the study’s participants suggest that there were many ways of overcoming or living with the adverse effects of growing up in and leaving residential care. One could

argue that the 'social networks' and 'street competencies' that many of the participants acquired also reflected a kind of resilience, finding somewhere safe to sleep, building relationships, securing an income all represent competencies that indicated resilience amongst the participants. For the participants in this study their social network was their support system and the individuals from this network were the people they approached when they needed help, when they were upset and when they required advice and direction. The social activities they were involved in were the systems through which they met 'friends' and developed survival strategies. Not all of the relationships in the participant's network could be regarded as positive and at times they had negative consequences but what has been one of the common elements is that it was 'their network' and it consisted of individuals and groups who provided them with a sense of belonging that also contributed to identity formation.

The findings from this study indicate that how well the participants were faring after leaving residential care was a function of a complex interaction of factors relating to their pre-care experiences, their in-care experiences and the circumstances of their transition from residential care, and the extent of the supportive network they had around them in the period after leaving residential care. As with every story told by the participants in this study, the details and nuances of their experiences make them unique. The telling of their stories does not allow us to identify causal relationships, and indeed, one can argue that their transitions from residential care cannot be attributed to the mere presence of a particular factor or factors. Rather, a person's interpretation of that resource and how they decide to use it are the important and changing elements of moving on and achieving positive outcomes for the future.

**Q3. What can be done to improve their life chances and what supports are required in making the transition from residential care to adult independence?**

As outlined earlier, many young people leaving residential care have to negotiate a number of major changes in their lives earlier and in a much shorter period of time than other young people of their age. These include leaving their residential placement, setting up in new accommodation, trying to find work or some other means of support, and managing financially on very limited resources. The significant factors that promote better outcomes for the participants after they left residential care that have emerged from this study are summarised in Table 7.1. The value of these findings for policy and practice relate to those factors that might be amenable to change, especially changes in legislation, policy or practice, and particularly where these changes might lead to better outcomes. The discussion that follows will focus on those factors that are likely to be amenable to change.

Table 7.1 Significant Factors that Promote Better Outcomes

Significant Factors that Promote Better Outcomes
<ul style="list-style-type: none"><li>• Proper Planning and Preparation for Leaving Care</li><li>• Living skills Training</li><li>• Supportive Network</li><li>• Flexible Leaving Care Plans</li><li>• Young person at the Centre of the Decision Making</li><li>• Offering Choices</li><li>• Secure Housing</li></ul>

An important ingredient in improving the outcomes for young people leaving residential care and helping them to adjust to the demands of greater independence is proper planning and preparation for leaving care and living skills training. Young people need to have support in developing independent living skills in caring for themselves including cooking and budgeting. Young people who have spent long periods of time in residential care often have an institutional experience of residential care and have not had the opportunity to develop skills in these areas. The key is to start preparing young people for their change of status some time before the transition, in fact, all that is done for the young person while they are in residential care in terms of encouraging the development of social and practical skills constitutes good preparation for their life after care. Directly addressing the specific issues associated with leaving residential care, however, involves a tricky balance between helping them to prepare for and adjust to the expected changes, and the risk of destabilising the placement by focusing on its ending.

This might, however, be counterbalanced by including in the package of living skills those things that are highly valued by young people as positive indicators of adult status and increasing independence for example obtaining a passport, learning to drive and getting their driving licence. It might also be helped by directly involving the young people and those that they would like to be involved in a discussion of what support they will need and how it might be provided. An important aspect of the findings centred on a lack of familial and supportive networks. Over half of the participants (12/20) left their residential care placement without important social capital to rely on. Many had no-one from whom they could receive advice and/or emotional support. In short, many of the participants had no 'safety net' when they

struggled with their transitions. Many reported suffering from isolation and loneliness. Contact with families has been shown to help to ameliorate the risk of social isolation by providing encouragement, reassurance and a person to turn to in times of difficulty (Biehal et al., 1995). In strengthening, improving or renewing family relationships, young people may need professional support in mediating between themselves and their families. In some instances psychological support may be required in order to prevent patterns of rejection continuing in adult life. Professionals are best placed to encourage and help young people to develop their familial networks. Professionals are in a position to assist young people to maximise the formal and informal support available to them by helping them to identify key people that will provide support at an early stage in the leaving care process.

It is perhaps equally important that each young person has a clear leaving care plan that looks into the future and provides them with a more positive sense of direction, however far ahead the end point may be. If young people are not ready at one point, continuing support, encouragement and flexible forward planning may lead them to return at a later point when they feel more settled. Leaving and aftercare support, therefore, needs to be flexible, targeted and geared to the pace at which the young person is able to engage with. Any leaving care plan must actively involve young people in their own life planning. As noted in the literature (Moslehuddin and Mendes, 2006), it is important that the young person leaving care is both the focus of transition arrangements and is an active participant in their own care planning. Such a notion comes under the rubric of client driven service delivery. In particular this includes client's choice, the right to complain, the right to have decisions reviewed, and the right to be involved in the design and review of services. The participants in



this study expressed a strong desire to exercise some control over decisions that affected them and to re-establish a 'normal life' in which they were more independent and better able to be treated and recognised as an equal citizen, rather than a client who, by definition, is always in an unequal position of power and influence.

Housing is another critical resource that care leavers require. However, to improve care leavers housing outcomes does not simply require the provision of more housing alone it requires better integration between the HSE and the housing authorities. If rates of homelessness and housing instability among care leavers are to be reduced and care leavers are to have the same opportunity as their peers to participate in society the HSE in collaboration with the housing authorities need to invest in a range of integrated services and housing options designed around care leavers' varying needs. It is clear that no one person or agency can ensure that all their needs are met. There must be interconnected and interdependent support provided to the young person. This interdependence means that it is not possible just to 'fix' one set of needs and the others will follow. It means that policy and practice have to be developed as an inter-agency responsibility because no one agency is able to meet all the needs of these young people. As the findings in this study have shown failing to invest in appropriate housing and support services for care leavers comes at a great cost to both the individual care leaver and the community.

### **7.3 Recommendations**

Based on the narratives of the participants in this limited study and the legacy of studies that have gone before (Biehal et al., 1995; Cashmore and Paxman, 2007; Kelleher et al., 2000), the study puts forward a number of key recommendations aimed at improving the experience of all care leavers in their transition from residential care to ‘adulthood’ and ‘independence’.

#### **1. Corporate Parenting to Become a Reality for Care Leavers**

Many of participants in this study often felt they had no choice regarding leaving residential care and many experienced an abrupt end to their residential care placement. This resulted in many of them feeling ‘abandoned’ by the State. This study recommends that the Health Service Executive adopts an organisational position, accompanied by strong advocacy, to not exit young people from residential care at eighteen years without adequate preparation, supports and resources and ensure that this position is clearly articulated and expressed at a Government level.

Most young people receive ongoing support from parents, guardians and other significant family members unconditionally into early adulthood. This does not necessarily and arbitrarily cease at the coming of age. However, despite the policy rhetoric in Ireland at present, that acknowledgement for the need for a flexible approach does not exist. In practice there remains a rigid adherence to discharging young people from residential care at eighteen years. This practice continues to jeopardise many young peoples’ transitions to independent living. On the grounds of

equity, it could be strongly argued that the Health Service Executive's role as 'corporate parent' needs to be equally flexible and supportive in its post-care arrangements, including a duty of care towards providing care leavers with the necessary supports required to transition to independent living. As a corporate parent, the State cannot achieve all that it wishes for its care leavers through policy and regulation and it is unrealistic to believe that it can be a 'forever parent'. What it can do is put measures in place to ensure that all those who share duties of corporate parenting across government departments take that responsibility seriously and talk to each other about how best to support these uniquely vulnerable young people. Greater awareness of young care leavers' perspectives as outlined in this study and previous research (Biehal et al, 1995; Cashmore and Paxman, 2007; Kelleher et al, 2000; Stein, 2008) will assist the professionals/service providers who come into contact with care leavers in their various roles to better target services and supports to the needs of young people.

## 2. Minimum Standards

What the participants' narratives demonstrated was the wide variation in access to and availability of supports. Participants who experienced a smooth transition appeared to have a comprehensive package of supports compared to those who experienced a problematic transition who 'struggled with having to do everything themselves'. This study recommends that the transition from residential care should be managed in a manner that acknowledges differences in circumstances of young people who leave residential care. This study recommends legislative reform that provides a national framework that details the provision of leaving care supports for all young people leaving the residential care system.

No service can work at such a micro level that it will perfectly meet the needs of all of its service users. However, there is ample evidence from the narratives presented in this study that there is considerable room for improvement in the leaving and aftercare services for young people in residential care. There is a clear need to establish consistent standards regarding planning, support and housing to avoid the current problems among populations of care leavers in the future. This study advocates for the commencement of a national data collection system (as recommended in the Ryan Report, 2009) into the outcomes for care leavers. Investment in a consistent data system would allow for more informed and responsive programme resourcing and development.

### 3. Delayed Transitions

For the participants who were experiencing a problematic transition they spoke about their lives being 'on hold' that their drug use was an escape from their circumstances 'a way of getting out of it all'. This study recommends that the transition from residential care be delayed for those who require additional support to successfully move into independent living and an increase in resource allocation to ensure that service delivery is able to adequately respond to an expansion of service provision to the age of twenty five years.

An integral part in planning for young people leaving residential care is identifying and supporting those young people who require extra support. The best 'early' indicators from this study of those in particular need of additional support were instability in their residential care placements and the lack of attachment to carers, associated with behaviour problems and rejection by family members or carers. It is evident from an analysis of the different transitions taken by the participants that those who had substance abuse problems, poor family relationships, limited professional supports and lack of access to training and employment, were most likely to experience poorer outcomes. This group require additional support to address these challenges prior to leaving residential care. These supports should be guaranteed to the age of twenty five years. It would align the corporate parent idea more closely with the relationships that 'natural parents' have with their children. Young adults regularly live at home, or return home after a failed independent living experiment, into their mid-twenties. Even if parents are not providing shelter, they are often called on to provide financial assistance in the early years of independence. Assistance until

the age of twenty five years would recognise the changing nature of the transition to adulthood and in some way may help to contribute to a sense of belonging and inclusion for young people which will enable them to make their way in the world feeling cared for, cared about, significant and valued.

#### **4. Improving Care Leavers' Access to Appropriate Housing**

The narratives highlight the limited housing options available to some participants as a result many felt forced to take up accommodation that was not suited to their needs 'I had no choice I had to take what was offered it was that or back on the streets'. This study recommends that the Health Service Executive adopt an organisational position to not exit young people into homelessness through the provision of increased transitional and supported aftercare accommodation through partnerships between the Health Service Executive and Housing Authorities.

Care leavers require a range of accommodation options to meet their differing needs as no single model will suit every care leaver. One approach that has been successfully tested in the United Kingdom could be to set aside a percentage of social housing specifically for care leavers each year. This would require partnership arrangements between the Health Service Executive and the Housing Authorities as well as the Housing Associations that over the last decade have had an increasingly prominent role in the low income housing landscape. From the transitions identified in the findings of this study, a feasible response for some care leavers would be to have direct access to subsidised housing while for others, dedicated social housing would be the exit point from HSE supported/transitional accommodation once they

were capable of independent living. The supply of targeted housing supply for care leavers would assist in reducing the incidence of homelessness if there was adequate provision of support services to promote sustainability of tenancy.

## **5. A Voice for Care Leavers**

The majority of the participants in this study felt overwhelmed with the realities they faced upon leaving the residential care system. As with their journey into and through residential care many felt they had limited choices over their own future as decisions were made for them regarding their transition from residential care 'I was told in a meeting I would be leaving a few days after my eighteenth birthday'. This study recommends the establishment of a dedicated support service regionally for care leavers which provides a drop-in facility, access to specialist counselling, training programmes, assistance with accessing records, regional support groups and peer mentoring.

Care leavers themselves are imperfect beings and like all of us in the process of growing up need to be permitted to make mistakes without judgement and allowed to be competent and make important choices and decisions in their own lives regarding their own future. These decisions have a momentous impact on care leavers' lives and it is essential that these young people are heard and their voices represented. This can be achieved through the establishment of a dedicated aftercare support service regionally which would provide supports and act as a forum so that their voices may be heard. This practice of listening to what care leavers have to say needs to be widely

shared and built upon if we are to be able to say in future years that care leavers have been truly listened to and their opinions acted upon.

#### **7.4 Conclusion**

On the basis of these findings, this study recognises that there are still numerous gaps in aftercare provision for care leavers leaving the residential care system in Ireland. As identified, the needs of care leavers are many and varied and call for a diverse and responsive service system to better support them and alter their future transitions. There is no ‘one size fits all’ response that will meet all need, but rather a range of responses that target individual needs and promote a greater overall opportunity for intervention. Young people only have one chance to make a successful transition from adolescents to adulthood. All of them, especially those who are leaving the residential care system, deserve to be appropriately supported to make this transition, facilitating them to become independent, self sufficient, confident young adults. The consistency of these findings and findings over time in different countries is persuasive evidence that young people leaving residential care cannot make it on their own.



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## **APPENDIX I**

### **LIST OF ORGANISATIONS**

**Belvedere Social Services**  
**Don Bosco**  
**Focus Ireland**  
**Fr. Peter McVerry Trust**  
**Dublin Simon Community**  
**DePaul Ireland**  
**St. Catherine's Foyer**  
**Y.M.C.A.**  
**St. Vincent De Paul**  
**Health Service Executive**  
**Local Health Offices**  
**Dublin North Central**  
**Dublin North West**  
**North Co. Dublin**  
**EPIC**  
**Sophia Housing**  
**Daisy Housing**  
**Aislinn Aftercare Services**  
**Crosscare**  
**The Los Angles Society**  
**Streetline Hostel**  
**Balcurris Boys Home**  
**Balcurris Girls Home**  
**Mrs. Smyly's Aftercare Service**  
**Lefroy House**  
**An Teallach Aftercare Services**  
**Salvation Army**

## APPENDIX II

### LETTERS TO ORGANISATIONS

**Re: Research Study ‘The Transition to Adulthood and Independence: A Study of Young People Leaving Residential Care’.**

Dear [Managers Name],

I am currently undertaking an MPhil at the Department of Social Sciences with Dublin Institute of Technology. The title of the study is ‘The Transition to Adulthood and Independence: A Study of Young People Leaving Residential Care’. The study intends to focus on the circumstances and experiences that bring about positive or negative outcomes in the living situations of care leavers. The proposed topics for inclusion in the study are: reasons for entry into residential care, the journey through residential care, the leaving care experience and the transition to independence. I have experienced first hand as a social care practitioner the difficulties young care leavers face when reintegrating into the community after years spent living within the residential care system. It is from this viewpoint that I wish to undertake this study. I intend to conduct in-dept interviews with twenty young people, both male and female between the ages of eighteen twenty five years within the Dublin metropolitan area. The focus of the interviews would be centred around the topics outlined above with particular emphasis on the experiences and challenges they encountered while journeying into, through and from the residential care system. As a researcher and social care practitioner I will operate under a strict code of confidentiality at all times. The right to self-determination will be respected and to this end participation will be entirely voluntary and each participant will have the right to terminate the interview at any stage. The identity of each person will not be disclosed in the research and pseudonyms will be used.

I would be grateful if you could inform any of the young people who avail of your service and who fit the above criteria about the study. I am happy to come out to speak with you or any potential participants prior to commencing the study. I would like to undertake the interviews during the coming weeks and appreciate if you could give this letter your due consideration. I will contact you by telephone in the coming days. Alternatively please do not hesitate to contact me on [telephone number] if you require any further information.

Yours Sincerely,

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Mary Kilkenny

**APPENDIX III**  
**CONSENT FORM**

**Re: Research Study ‘The Transition to Adulthood and Independence: A Study of Young People Leaving Residential Care’.**

Dear Participant,

My name is Mary Kilkenny I am carrying out a study of the experiences of care leavers and their transition to adulthood and independence. Particular focus will be given to your journey into, through and from the residential care system. I would like to meet with you and hear your experiences. The interview will be taped and the information that you give will be treated in the strictest of confidence unless you tell me that you are thinking of harming yourself or harming others. Your participation in this study is completely voluntary. There will be no payment for taking part in this study. If you decide to take part and are uncomfortable about answering any of the questions you can stop the interview at any time or not answer particular questions you might find difficult.

Your participation is very important it is only by hearing the experiences of care leavers that we can bring about change and promote better outcomes.

I understand the information contained in this letter

Name: \_\_\_\_\_

Date: \_\_\_\_\_

I am willing/not willing to take part in this study

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## APPENDIX IV

### INTERVIEW QUESTIONS

**Re: Research Study ‘The Transition to Adulthood and Independence: A Study of Young People Leaving Residential Care’.**

#### **Profile:**

Name of Young Person:

Age:

Gender:

Marital Status:

No. Of children

#### **Duration of Time in Residential Care**

- When did you first come into care (date/age)?
- Do you know why you were placed in care?
- How long did you spent in care?
- How many placements (types) you had while in care?
- What are your memories if any of your time in those placements?

#### **Preparation for Leaving Residential Care**

- How did you feel about leaving residential care?
- What preparation did you receive for leaving care?
- Did you have an aftercare worker?
- Did you have a Leaving Care Plan?
- What was the most difficult part about leaving your residential care placement?
- Did you feel ready?
- What housing options were you offered? (flat, bedsit, supported lodging, aftercare residential services or return to family).
- Did you have any family supports or contact with family on leaving residential care?
- How did you support yourself (income)?
- Did you have help from other people outside of your family?

## **Aftercare**

- What do you think about the options that were offered to you when leaving care?
- Since the time you left residential care where have you lived?
- Was there a time that you found yourself homeless?
- What happened that you became homeless? (financial problems, family issues, loss of accommodation).
- What things do you think have led you to where you are today?
- Are you in school, further education/training or employment? If yes what do you?
- How do you support yourself?
- What are your daily routines?
- Do you still have contact with friends from before you were in residential care or from during your time in residential care?
- Do you have contact with your family?
- If no contact, why do you think this is?
- Would you like to have contact with your family?
- What type of accommodation would you like?
- What other supports or assistance do you think would be beneficial to you or other young people leaving residential care in the future?

**Thank You for taking the time to answer all the questions.**



## **APPENDIX V**

### **PROVISIONAL AND FINAL CODE LISTING AND THEMES.**

The interviews were guided by five areas in order to capture the experiences of participant's journey into, through and from residential care. The five areas were;

- Young people's entry into statutory care including their understanding of the reason they were placed in care. Age at entry to care.
- Young people's care histories
- Young people's experience of leaving care
- Young people's experience since leaving care
- General information about key relationships, their finances, housing and support systems.

The five areas assisted in identifying key themes and processes as they were evident in the data rather than imposing pre-existing codes. Through this process, commonalities in in-care and leaving care experiences were identified and categorised participants' experiences as one of three transitions, 'smooth', 'unstable' and 'problematic'.

#### **Reasons for Entry to Statutory Care**

- Provisional coding : Family problems  
Individual Problems
- Final coding : Parental Mental Health Difficulties  
Parental Addiction  
Parental Separation  
Parental Bereavement  
Violence in the Home  
Behavioural and Emotional Problems

## **Journey through Residential Care**

- Provisional Coding: Frequency of movement
  - Insecurity
  - Placement Types
  - Homelessness
  - Drug Use
- Final Coding: Multiple Placements
  - Foster care
  - Residential care
  - Out of Hours Service
  - Life on the Streets
  - Survival Strategies

Themes to Emerge from their Journey Through Residential Care
<ul style="list-style-type: none"><li>• Instability</li><li>• Connecting with People</li><li>• Fear and Uncertainty</li><li>• A Sense of Loss</li><li>• A Sense of Belonging</li></ul>

## **Journey from Residential Care**

- Provisional Coding: Planned exit
  - Abrupt exit
  - Crisis exit
- Final Coding: Smooth Transition
  - Unstable Transition
  - Problematic Transition

Themes to Emerge from their Journey From Residential Care
---

- |   |
|---|
| <ul style="list-style-type: none"><li>• A Sense of Abandonment</li><li>• A Sense of Loneliness and Isolation</li><li>• Availability/Non-Availability of Appropriate Housing/Accommodation</li><li>• Availability/Non-Availability of Financial and Practical Supports</li><li>• Availability/Non-Availability of Familial Supports</li><li>• Homelessness</li><li>• Substance Abuse</li></ul> |
|---|

## APPENDIX VI

### CRITERIA FOR CATEGORISING NARRATIVES AS ‘SMOOTH’, ‘UNSTABLE’ AND ‘PROBLEMATIC’

Transitions were categorized with reference to key patterns in the data that highlight the individual resources and elements in the participants’ experiences of their journey through and from residential care. These included;

- Had or had not security and stability in care
- Number of placements
- Had or had not attachments/relationships/friendships while in residential care
- Had or had not a leaving care plan
- Was or was not involved in the transitional planning process

Felt somewhat prepared, or very prepared or not prepared at all for the transition from residential care with regard to;

- Shopping
- Cooking
- Cleaning and taking care of a house
- Managing money
- Living alone
- Getting a job/course
- Finding housing/accommodation
- Accessing resources
- Accessing welfare assistance

Availability or non-availability of;

- Financial assistance
- Advice
- Employment/Education
- Housing and accommodation opportunities

- Individual resources
- Trusting and ongoing relationships with family members
- Professional support
- Social networks

Experience of;

- Homelessness
- Substance abuse