

**'THE THEORY DOESN'T WORK HERE':
AN EXPLORATORY STUDY OF CHILD CARE PRACTICE IN
A 52 – WEEK RESIDENTIAL SPECIAL SCHOOL**

BY

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ABSTRACT

This thesis reports an exploratory study of a residential unit in a special school for young people with complex learning disabilities and challenging behaviour. The study, which draws on ethnographic research methods, describes a relational approach to care based predominantly on 'common sense' explanations of behaviour rather than on a coherent knowledge base. Residential carers drew largely on informal models of care and the nature of the child care task was constructed predominantly from the prevailing staff culture of 'how we do things here'.

Staff made very little use of formal planning mechanisms, partly because documents were inaccessible to them, partly because documents were poorly completed and did not always match the observable skills of the young people. Such plans were often predicated on a much higher staff: student ratio than was actually available, and the way shifts were organised made their execution difficult to achieve.

The construction of the child care task is illustrated in depth by a detailed examination of two micro-practices: providing meals and using bedrooms. In both cases, the research demonstrated that staff were working in a complex context of conflicting ideas, principles and instructions from a variety of competing sources. However committed to the principles of ordinary living, of choice and control, or to learning from everyday life, given the severity of impairment of some young people, the complexity of the context and the shortage of staff, residential workers had to improvise and often decide for themselves how tasks were to be undertaken, without reference to such plans and programmes as were available.

The research suggests that the staff operate in this way because of the anomalous, even liminal, position of the residential special school in relation to mainstream child care practice and the challenges that this poses for staff, school managers and placing authorities.

DECLARATIONS

DECLARATION

This work has not previously been accepted for any degree or award at this or any other university or place of learning nor is being concurrently submitted in candidature for any degree or other award.

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STATEMENT 1

This thesis is being submitted in partial fulfilment of the requirements for the degree of Doctor of Social Work.

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This thesis is the result of my own independent work/investigation, except where otherwise stated. Other sources are acknowledged by explicit references. The views expressed are my own

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This thesis is not only the fruit of six years study on the Doctor of Social Work programme but the culmination of an adult lifetime working as a social worker with disabled children. I would like to pay tribute to all the children, families and staff that I have worked with in Oxfordshire Social Services, the Children's Society (especially everyone associated with the Western Corner Project) and Norwood (especially the staff and pupils of the former Annie Lawson School who taught me how to be a Head of Care). I have also had the privilege of working at a number of universities, and many of the ideas in this thesis have been developed in the course of teaching. My thanks go to former students and staff on the social work programmes at Oxford Brookes University and the Universities of Winchester and Gloucestershire.

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Soli deo gloria

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This thesis reports an exploratory study of child care practice in a 52 week residential special school for children with complex learning disabilities and challenging behaviour.

Residential special schools have been and remain controversial for a number of different reasons. Firstly, however much valued by their proponents, pupils and parents (Cole, 1986, Jackson, 2004, McGill et al., 2006, Saunders, 1994), they stand in opposition to avowed Government and professional commitment to inclusive education (DfES, 2001a)¹.

Secondly, they are a sharp reminder of the failure of local education and care services to respond sufficiently to the needs of unique, complex and challenging individuals. Most young people enter a residential special school as a last resort after prolonged attempts by parents and carers to obtain appropriate local services (McGill et al., 2006, Abbott, 2001, McGill, 2008).

Thirdly, they raise fundamental questions about special education itself. What is so 'special' about it? To what extent does such provision offer better (or more appropriate) educational opportunities to pupils than can be obtained in mainstream settings? Are concepts like 'holistic development' (Aird, 2001) or 'the 24 – hour curriculum' (Abbott, 2000, 2001) meaningful or are they an excuse for excluding challenging children from the mainstream, or meeting the support needs of families without the stigma of entering the 'care' system? Are they, in reality, the same kind of bleak 'special' institutions that the late Maureen Oswin described so eloquently a generation and more ago (Oswin, 1971, 1978).

¹ But note that although this statement is generally true of all recent UK governments, the Coalition Government has not wholly endorsed Article 24 of the UN Convention on the Rights of Disabled People 2006, which concerns the principle of inclusive education. For details see the report of the Equality and Human Rights Commission March 2012 <http://www.equalityhumanrights.com/human-rights/our-human-rights-work/international-framework/un-convention-on-the-rights-of-persons-with-disabilities/>

Lastly, residential special schools raise the spectre of institutional abuse. Partly this reflects the extreme vulnerability of children with severe disabilities living away from home (Paul and Cawson, 2002, Westcott, 1993, Westcott and Cross, 1996, Paul, 2004). However, it also reflects the rather ambiguous legal status of children and young people in such schools, the varied performance of Children's Services' authorities towards them (Abbott, 2000, Abbott and Heslop, 2009, Abbott et al., 2002, Morris et al., 2003, Department of Health, 1997) and a real past history of institutional abuse (Brannan et al., 1993, Corby et al., 2001).

Behind all of these critical concerns lies a single reality – that there has been very little systematic evaluation of services provided by residential special schools, of the experiences of children within them or of the longer term outcomes that they generate.

Whilst this is generally true of residential special schools, it is even truer of the specific contribution of residential child care practice in such environments than it is of the educational provision. With the rather elderly exception of Cole (1986) (writing largely about schools for children with emotional and behavioural difficulties), there is no systematic study of residential child care practice to set alongside the studies of classroom practice (Aird, 2001). As a consequence, we have remarkably little knowledge of child care practice in such schools, nor any real evidence of how such care practices are received and perceived by resident children and young people, despite the vulnerability of children and young people using 52 – week residential special schools, and the very high cost of such provision.

A former Head of Care in a residential special school myself, I set out in this thesis to address some of the gaps identified above. The study itself is an exploration of a single residential unit in a single residential special school which is based on six weeks non- participant observation in the autumn of 2010. With all the limitations implied by this description, the thesis attempts

to explore the nature of the child care task as it is understood and carried out by the child care staff themselves.

In the course of this exploration, the thesis draws on a range of linked theoretical approaches most of which are drawn from ethnographic research into residential and institutional settings. These include ideas from psychodynamic organisational theory, particularly those derived from the 'socio-technical' studies carried out by researchers at the Tavistock Institute in the 1950s and 1960s (Trist and Murray, 1990, Menzies Lyth, 1988a, Obholzer and Roberts, 1994), the extended understanding of 'liminality', first proposed by van Gennep (1960) and Turner (Turner, 1967, 1995), but used in this thesis in the form developed and applied by Mary-Jo Deegan (Deegan, 1975, Willett and Deegan, 2001) and Robert Murphy (Murphy, 1987, Murphy et al., 1988), and the understanding of the contested nature of 'care' itself emerging from feminist writings on the 'ethics of care' (Sevenhuijsen, 1998, Orme, 2002, Meagher and Parton, 2004, Holland, 2010, Barnes, 2012).

As a former Head of Care I brought a number of key assumptions to the research. These assumptions were drawn from long experience as a social worker, manager and teacher in the childhood disability field including nearly four years as Head of Care in a similar (but smaller) residential special school between 2001 – 2004. I am of that generation of social workers who were trained psychodynamically, but whose practice was shaped by the move away from relationship-based practice towards a more outcome focussed ('managerialist') approach in the 1980s, an approach that was sharpened by the (then) new Children Act 1989 and its emphasis on assessment, planning, review and the identification of measurable outcomes. Moving to a failing residential special school in 2001 as Head of Care meant an opportunity to introduce a care practice that drew on the best of residential child care approaches to 'ordinary living' within the context of a systematic, planning framework focussed on measurable outcomes. I assumed that the kind of interests that I had had, and the kind of battles that I had fought would be the same ones in any residential special school, and

that the focus of the research should be on the strategies used by a school or schools to introduce what I then called 'good child care practice'.

The discerning reader can still see traces of that initial set of assumptions in the emphasis given in the literature review to the research conducted by Eric Emerson and his colleagues at Beech Tree House (Emerson et al., 1996, Robertson et al., 1996) and to that produced by Alaszewski and his colleagues (Alaszewski and Nio Ong, 1990). These are clear examples of what I would have called 'good child care practice' and was expecting to observe in some detail in the research site.

This is not what the research demonstrated. Instead what I saw was a humane, nurturing approach to care that was highly relational in nature. This approach paid very limited attention to the formal planning framework in place in the school, and required a constant adaptive response to challenging circumstances by staff members that drew much less on any formal understanding of the developmental needs of their residents and much more on tacit and lay forms of knowledge and understanding. This tacit knowledge was shaped and re-shaped in interaction both with the residents themselves and with other staff members, especially, but not exclusively, within the three 'shift teams' which made up the organisational structure of the residential staff experience. This is why, when one of my informants told me of her professionally qualified Polish colleagues arriving in the school and finding that 'the theory didn't work' in the school, it struck a real chord for me. For me, all of my assumptions were turned upside down by this research, and the rest of the thesis is an exploration of what I saw, and the sense that I have tried to make of it.

As such, it will make an original contribution to the understanding of an important, but neglected, part of the child welfare services in the UK, raise important questions about our understanding of practice across the residential child care sector as a whole, and contribute to contemporary debates about the contested nature of care itself.

Structure of the thesis

The thesis is divided into ten chapters, the contents of which are broadly outlined below. The rest of **Chapter 1** is introductory, and addresses some broad theoretical and definitional issues. **Chapters 2** and **3** locate residential special schools for children with complex learning disabilities and challenging behaviour in the policy debates concerning both special education and residential child care practice and review the relevant research literature underpinning the study. **Chapters 4** and **5** discuss the methodology of the study, review some key ethical challenges and the approaches adopted for addressing them, and describe the research site, its basic structure, organisation and daily routines.

The next four chapters report the key findings of the study as follows:

- **Chapter 6** explores the way in which child care staff come to understand the impairments of the young people they are working with, and the communication strategies they adopt.
- **Chapter 7** discusses the way in which child care staff make sense of the child care task and turn plans into practice
- **Chapter 8** considers one very specific aspect of residential child care practice – that of food practices and mealtime routines
- **Chapter 9** reviews another specific aspect of residential child care practice - the complexities involved in the furnishing, decoration and usage of residents' bedrooms

Chapter 10 is a concluding chapter that summarizes key themes and briefly outlines some policy implications. The remainder of this first chapter deals with the wider context of the study. It begins with an attempt to define more closely what is meant by 'complex learning disabilities' and 'challenging behaviour', (and thus the population at the core of this study). This attempt at definition is discussed in the context of the theoretical, methodological and political complexity of the field of disability studies. Finally, the chapter

concludes with an attempt to identify the core population of 52 – week residential special schools.

‘Learning disability’, ‘challenging behaviour’ and models of disability and impairment

The term ‘learning disability’ is a label used widely by the health and social care sectors in the United Kingdom as an alternative to the internationally used term ‘intellectual disability’. It was introduced by Government ministers in the early 1990s as a more respectful alternative to the prior term ‘mental handicap’ and to avoid confusion with the term ‘learning difficulty’ or ‘learning difficulties’ used in the education field in the United Kingdom to cover a wider field of impairment than ‘intellectual disability’ including ‘specific learning disabilities’ such as dyslexia, dyscalculia and dyspraxia. It is worth noting that advocacy organisations for people with intellectual impairments tend to prefer the term ‘learning difficulties’ to ‘learning disability’ as it is claimed to be a more positive and respectful term (Williams, 2009 pp. 1 - 16).

There are three internationally accepted definitions of ‘learning disability’: those of the World Health Organisation’s *ICD – 10*², (WHO, 1992) the American Psychiatric Association’s *DSM - IV(TR)*³ (APA, 2000) and the American Association of Intellectual and Developmental Disabilities’ *AAIDD – 11*⁴ (AAIDD, 2010). A full comparison of the three different definitions can be found in Carr and O’ Reilly et al. (2007)⁵, but the key differences to note are between those that are based on the measurement of IQ, and those that are based on an assessment of adaptive functioning. The *ICD – 10* and *DSM - 1V (TR)* approaches are based on IQ measurement and although there are differences in detail, the overall framework is much the same. Thus *DSM -1V (TR)* describes ‘mental retardation’ as:

² 10th edition of the *International Classification of Mental and Behavioural Disorders*

³ 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (Text Revision)*

⁴ 11th edition of the *AAIDD Definition Manual*

⁵ Note that Carr and O’Reilly refer to the 10th edition of the AAIDD (formerly American Association on Mental Retardation) definition but the changes between the 10th and 11th definitions are mainly ones of language.

significantly sub – average mental functioning shown by an IQ of approximately 70 or below on an individually administered IQ test with concurrent deficits or impairments in present adaptive functioning in at least two of the following areas: communication, self – care, home living, social & interpersonal skills, use of community resources, self – direction, functional academic skills, work, leisure, health and safety. The onset must occur before age 18 years. (American Psychiatric Association 2000 pp.41 – 2)

In this definition there are four levels of ‘retardation’ described as follows:

- Mild: IQ level 50-55 to 70 (approx)
- Moderate: IQ level 35 – 40 to 50 -55
- Severe: IQ level 20 – 25 to 35 – 40
- Profound: IQ level below 20 – 25 (pp.42 – 44)

Both the ICD – 10 and DSM IV manuals are currently undergoing revision and many commentators have argued for a move away from IQ based definitions on the grounds that ‘learning disability’ represents points on a continuum rather than a measurable entity (Whitaker, 2008) and that it would be better to think less in terms of diagnosis and more in terms of utility and the support needed by individuals (Webb and Whitaker, 2012)

To some extent, in the third definition, the American Association on Intellectual and Developmental Disabilities (formerly American Association of Mental Retardation) has been moving away from measurement based approaches, focussing instead on a definition centred on adaptive ability and social functioning. Intellectual disability, they say, is:

characterized by significant limitations both in intellectual functioning and in adaptive behaviour as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18. The following five assumptions are essential to the application of this definition:

- i. Limitations in present functioning must be considered within the context of community environments typical of the individual’s age peers and culture
- ii. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor and behavioural factors
- iii. Within an individual limitations often coexist with strengths
- iv. An important purpose of describing limitations is to develop a profile of needed supports

- v. With appropriate personalized supports over a sustained period, the life functioning of the person with intellectual disability generally will improve (AAIDD, 2010 p. 1)

Particular concern has been expressed at the difficulties in fine discrimination between levels of impairment based largely on IQ measurements for which there is insufficient supporting statistical evidence (Leyin, 2010, BPS, 2000). Consequently, in most UK contexts, the four fold classification has been replaced by a two-fold distinction between 'moderate learning disability' (IQ 55 – 69) and 'severe learning disability' (IQ below 55), although, as Clement and Bigby point out, this can cause difficulties for understanding the needs of the most profoundly impaired members of the population (Clement and Bigby, 2010 p.17), who are the focus of concern in this thesis.

But isn't this putting the cart firmly before the horse? These three definitions all share a basic set of assumptions: that there is something concrete that we can call a 'cognitive impairment', that that 'something' can be measured (whether in terms of IQ or adaptive behaviour) and that there is a relationship between the 'cognitive impairment' and the experience of disability. All of these assumptions have been challenged in recent years by disability theorists. Whilst the range and complexity of ideas generated would require more space than is available to review adequately, it is important to at least explore the major reconceptualisation of disability (including learning disability) that arose as the result of the work of Paul Hunt (1966), Vic Finkelstein (Finkelstein, 1980) and Michael Oliver (1990, 1996) from 1970 onwards, all of whom argued for a distinction between *individual* and *social* models of disability.

For writers in this tradition, the definitions of learning disability explored above are based on an 'individual' model of disability. In this model, any impairment is a 'personal tragedy' for the individual and his/her family and friends, which calls for an individual adaptive response. The 'individual model' of disability puts the emphasis on the disabled person's need to adapt

to the society in which they live and maximise the opportunities available to them.

There are two fundamental points that need to be made about the individual model of disability. Firstly, it locates the 'problem' of disability within the individual and secondly it sees the causes of this problem as stemming from the functional limitations or psychological losses which are assumed to arise from disability. These two points are underpinned by what might be called 'the personal tragedy theory of disability' which suggests that disability is some terrible chance event which occurs at random to unfortunate individuals. Of course, nothing could be further from the truth. (Oliver, 1996 p.32)

By contrast, the disabled people's movement has adopted a 'social model' of disability. The social model, while accepting that impairment is a normal part of human existence, argues that the specific degree to which impaired people can participate or not in the life of the community is a function of the social structure and organisation of that community. The degree to which any society puts up barriers that exclude is a consequence of the social and economic structure of the society and its cultural and ideological underpinnings. The task for the disabled person, then, is not to seek an individual adaptation, but collectively to challenge social exclusion either by direct political action, or by cultural critique;

disability, according to the social model, is all the things that impose restrictions on disabled people; ranging from individual prejudice to institutional discrimination, from inaccessible public buildings to unusable transport systems, from segregated education to excluding work arrangements and so on. Further, the consequences of this failure do not simply and randomly fall on individuals but systematically upon disabled people as a group who experience this failure as discrimination institutionalised throughout society (Oliver, 1996 pp.32 - 33)

To be accurate, there is more than one 'social model', and there is a lively debate within the disability movement over the merits and demerits of particular conceptualisations. At the risk of doing violence to the positions of different authors, it is sometimes helpful to distinguish between the positions of authors from North America and from the UK. The North American position tends to view disabled people as one of a number of minority groups excluded from, or marginalized by, a dominant cultural elite who are

characterised as, white, male, heterosexual, able-bodied, Anglo-Saxon and Protestant:

disabled men and women have been subjected to the same forms of prejudice, discrimination and segregation imposed upon other oppressed groups which are differentiated from the remainder of the population on the basis of characteristics such as race or ethnicity, gender and aging (Hahn, 1997 p. 174 cited in, Williams, 2001 p.134)

The political direction therefore is dominated by the concept of equal civil rights and access for disabled people to participate on equal terms with other social groups. This strategy underpinned the campaign that resulted in the Americans with Disabilities Act of 1990.

British writers tend to view disability within the context of wider processes of social exclusion. The emphasis here though is not on equal access to an otherwise benign social order but on transformation of the social order as a necessary pre-requisite to the development of an inclusive society:

Proponents of this 'social model' turn the conventional models of those working in rehabilitation on their heads, arguing that if you change society, disability will disappear (Williams, 2001 p.135)

The question of what needs to be transformed differs between commentators, and can be broadly characterised as either 'social creationist' (materialist) or 'social constructionist' (idealist) approaches. Of course, this is far too simplistic a categorisation as social constructionists accept some aspects of social creationism and vice versa. However, broadly, social creationists see the development of disabling barriers as inherently linked to the development of capitalist, industrial society, with disabled people being necessarily excluded as part of the capitalist drive for productive efficiency:

Whatever the fate of disabled people before the advent of capitalist society and whatever their fate will be in the brave new world of the twenty-first century, with its coming they suffered economic and social exclusion. As a consequence of this exclusion disability was produced in a particular form: as an individual problem requiring medical treatment. Old age suffered a similar fate. (Oliver, 1996 p.127)

In this approach, contemporary approaches to impairment and disability characterised as 'the individual model' form part of the ideological underpinning of social and industrial exclusion aimed at diverting attention from the true sources of both impairment and oppression. The strategy for the disability movement is therefore to make common cause with the political left in overseeing the transformation of a capitalist society into a socialist society in which disability (but not impairment) will disappear.

Social constructionists tend to see a more deep-seated problem, which while manifesting itself in a particularly sharp way in contemporary capitalist society has deeper origins within the historical development of Western society. In this view, all societies maintain social order by distinguishing between 'insiders' and 'outsiders' and by characterising some people as 'other' – as people whose existence poses a threat of danger or disorder:

In all societies some set or sets of individuals are excluded, and this is often assumed to occur in order that the main body of the group can better define itself.... Thus, in all social groups there will be a concept of 'otherness'. Whoever is unwanted, for whatever reason, is liable to be labelled by the dominant population as 'other' and when a category is thus formed, it will be vested with a mythology and a set of rules regarding who is to be excluded or not. (Hubert, 2000 p.3)

In Western society, so the case is presented, it is people with impairments who have been substantially cast into this role:

Disabled people are scapegoats. It is not just that disabled people are different, expensive, inconvenient or odd: it is that they represent a threat - either...to order, or, to the self-conception of western human beings - who, since the Enlightenment, have viewed themselves as perfectible, as all-knowing, as god-like: able, over and above all other beings, to conquer the limitations of their nature through the victories of their culture (Shakespeare, 1994 p.300)

The strategy in this case is therefore the development of a sustained cultural critique aimed at exposing and challenging the cultural roots of a disabling society.

In recent years, there have been a number of challenges to social model approaches (Barnes 2012) beginning largely with feminist writers (French,

1993, Crow, 1996), who have argued that making a sharp distinction between disability and impairment, whilst politically useful, underplays the way that some impairments are themselves disabling and would remain disabling even if all the (desirable) social and political changes that disability advocates campaigned for were to happen. Shakespeare calls this an 'interactional approach' (2006 p.55) and says of it:

disability is always an interaction between individual and structural factors. Rather than getting fixated on defining disability either as a deficit or a structural disadvantage, a holistic understanding is required. The experience of a disabled person results from the relationship between factors intrinsic to the individual, and extrinsic factors arising from the wider context in which she finds herself. Among the intrinsic factors are issues such as: the nature and severity of her impairment, her attitudes to it, her personal qualities and abilities and her personality. Among the contextual factors are: the attitudes and reactions of others, the extent to which the environment is enabling or disabling, and wider cultural, social and economic issues relevant to disability in that society.

Shakespeare argues that this model acknowledges the importance of environments and contexts without defining disability solely as external disabling barriers or oppression. At the same time, in contrast to the medical model, whilst he accepts that impairment is a necessary factor in defining disability, it is not sufficient to describe disability solely in terms of personal limitations. Thomas, while disagreeing with Shakespeare's suggestion that the social model may have outlived its usefulness, has reached similar conclusions in what she has called a 'social relational model' of disability which recognises the importance of 'impairment effects' and 'psycho – emotional disability' alongside the material barriers of the classical social model (Thomas, 1999, 2004, 2007, see also Connors and Stalker, 2003, 2007)⁶.

But what of 'learning disability'?⁷ Stalker in a recent review of the place of learning difficulties in disability theory (Stalker, 2012 p.122) suggests that

⁶ It is important to note that whereas both Shakespeare and Thomas have acknowledged similarities in their approach to disability (see SHAKESPEARE, T. 2008. Debating Disability. *Journal of Medical Ethics*, 34, 11-14, THOMAS, C. Ibid. Disability: Getting It "Right". 15-17.), Thomas has argued that their positions are 'on different sides of epistemological, political and moral divides' (ibid. P.17)

⁷ The discussion on pages 13 – 15 draws extensively on both Stalker's excellent review of the place of learning disability in disability studies (STALKER, K. 2012. Theorizing the position of people with

there have only been limited attempts to include people with such impairments in mainstream disability studies. This position is echoed by a number of other writers who suggest either that disability theorists have ignored learning disability, or that the social model fails to address the specific barriers encountered by people with learning difficulties or, more seriously, that cognitively impaired people are not seen as part of the disability movement (Aspis, 1999, Chappell, 1998, Chappell et al., 2001, Boxall, 2002).

Where disability theorists have sought to apply the social model to learning disability, this has usually taken the form of a social constructionist approach where the existence of cognitive impairment is either denied altogether or significantly underplayed in contrast to the importance of a label of 'learning disability' being constructed in social and (especially) linguistic interaction (Nunakoosing, 2000, 2012)

The extent to which learning disability is seen as socially constructed varies from writer to writer. Manion and Bersani (1987), for example, in a substantial review article, argue that there is no such transhistorical or transcultural entity as "learning disability" (or, as they called it, 'mental retardation'). The concept, they say, has no absolute meaning, but can only be understood in the historical and political context of the time. They

learning difficulties within disability studies: progress and pitfalls. In: WATSON, N., ROULSTONE, A. & THOMAS, C. (eds.) *Routledge Handbook of Disability Studies*. London and New York: Routledge.) and on the recent work of Simo Vehmas (VEHMAS, S. & MAKELA, P. 2009. The ontology of disability and impairment: a discussion of the natural and social features In: KRISTIANSEN, K., VEHMAS, S. & SHAKESPEARE, T. (eds.) *Arguing about Disability: Philosophical Approaches*. Abingdon New York: Routledge, VEHMAS, S. & MÄKELÄ, P. 2008. A realist account of the ontology of impairment. *Journal of Medical Ethics*, 34, 93-95, VEHMAS, S. 2010. The Who or What of Steve: Severe Intellectual Impairment and its Implications In: HAYRY, M., TAKALA, T., HERISSONE - KELLY, P. & ARNASON, G. (eds.) *Arguments and Analysis in Bioethics*. Amsterdam and New York: Editions Rodopi BV.)

demonstrate this by showing how the understanding of 'mental retardation' has varied over historical time. The present understanding that is focused on the ability to participate in industrial society and to have the necessary skills to function as a member of a productive work force is specific to Western industrial society, and they produce historical evidence to support this. They suggest, though, that to say that learning disability is only a product of western industrial society is to overstate the position, not only because the historical evidence contradicts it, but also because anthropological studies show evidence that all societies have known individuals with cognitive impairments.

For other writers, however (e.g. Bogdan and Taylor, 1994, Goodley, 2000, Goodley and Rapley, 2002), the very idea of an independently existing cognitive impairment is nonsensical. Bogdan and Taylor write:

It is a reification – a socially created category which is assumed to have an existence independent of its' creators' minds ... Mental retardation is a misnomer, a myth (p.7)

Rapley (2004) and Goodley (2001) see the concept 'learning disability' as being constructed out of flawed medical and psychological diagnostic testing, amplified by social labelling and abusive and restrictive environments. Such a position is somewhat out of line with the more relational approach to the social model of disability outlined above, and it also raises a number of philosophical problems about the definition of impairment and disability, which are particularly critical when we come to consider 'complex learning disability'. Drawing on Searle's (1996) distinction between 'brute facts' and 'institutional facts', Vehmas and Mäkelä (2009) argue that an approach to disability which recognises both biological impairment and the relational nature of disability does much better justice to the nature and experience of impairment than does any pure social constructionist approach. Applying this approach to the experience of a 10 year old boy with severe physical and cognitive impairments, Vehmas (2010) shows how it makes much better sense of the boy's everyday life and his place in the community than do either of the social creationist or social constructionist approaches. Vehmas

and Mäkelä (2009) describing themselves as ‘philosophers with realist leanings’ (p.45), argue that such an approach may prove more powerful than conventional models of disability in addressing disadvantage and distress (see also Vehmas and Mäkelä, 2008).

Endorsing their position, Stalker cites the comment of the critical realist philosophers, Bhaskar and Danermark (2006):

To weak constructionism, which involves the idea that there is a necessarily interpreted element in the construction of any theoretical understanding and any social object, a critical realist has no objection. However, if this is taken to imply that the phenomenon investigated is *just* (emphasis original) a theoretical interpretation or cognitive construction, or that a social phenomenon such as some specific form of disability exists *only* (emphasis original) as an idea or belief, then it is clearly false (pp. 283 - 4, cited in Stalker, 2012 p. 130).

One advantage of adopting a critical realist approach to the definition of learning disability is that it allows us to take seriously all of the lived experience of even the most seriously impaired young person (Vehmas, 2010, Klotz, 2004, see also Watson, 2012), by contrast with the advocates of a social constructionist understanding who tend to draw most heavily on the experiences of the most mildly impaired, especially those engaged in the self – advocacy movement (Bogdan and Taylor, 1994, Goodley, 2000).

Another advantage is that it lays the foundation for the resolution of the theoretical tension between social models of disability and social role valorisation (SRV) (often, and often incorrectly, called ‘normalisation’⁸). SRV is a social scientific theory of devaluation, and particularly of the contribution made by human services to the devaluation of vulnerable and disadvantaged people (Wolfensberger, 1983). Building upon earlier theories of normalisation (Wolfensberger, 1972, Nirje, 1999), SRV was widely taught in the 1980s and

⁸ The history of the usage of the terms normalisation and/or SRV is quite complex. Briefly, ‘normalization’ was an approach to service delivery for people with learning disabilities and mental health service users that originated in Scandinavia in the 1960s. The core ideas were adopted, adapted and extended in the United States by the late Wolf Wolfensberger. In 1983, Wolfensberger reconceptualised his work, no longer as a set of service principles, but as a social scientific theory of devaluation, which he called SRV and it is in that sense that the term is used in this thesis.

early 1990s in workshops for professionals in both learning disability and mental health services, and incorporated into a series of assessment tools used to evaluate services and promote service change and development (Race, 1999, Pilling and Watson, 1995). Stalker rightly says (2012 p.122) that SRV (which she calls 'normalization') was the 'dominant theoretical framework' within the academic study of learning disability right through to the 1990s and remains important in both North America and the Nordic area.

In the UK, though, it came in for heavy criticism by proponents of the social model of disability, because of the lack of distinction made between impairment and disability, the lack of emphasis on the collective action of disabled people, and its theoretical underpinnings in functionalist and interactionist sociology (Wolfensberger, 1995, Walmsley, 2001). Race and others (Race, 2002, Race et al., 2005) have argued that the differences between the various social models and SRV are essentially ideological and political in nature, rather than reflecting substantive theoretical differences and that SRV continues to make a significant contribution to our understanding of the experience of devalued and disadvantaged people (Stalker, 2012, see also Sinclair, 2007).

Drawing the threads of this part of the argument together, a critical realist understanding of learning disability (upon which this thesis is founded) accepts the reality of cognitive impairment, often biomedical in origin, and potentially measurable in terms of IQ, of developmental attainment or adaptive ability but recognises that the way in which such impairment is understood, contextualised and responded to is socially and culturally constructed not only in specific historical contexts but in all the interactions in which a person with a learning difficulty finds themselves located.

Co-morbidity and Complex Learning Disability

But learning disability, however defined, does not always stand on its own. Carr and his colleagues (Carr et al., 2007 pp. 3 - 49) emphasise in particular the extent to which intellectual disability coincides with pervasive

developmental disorders such as autism, sensory and motor impairments, epilepsy and complex or challenging behaviour. These (what Carr et al. (2007) call 'co-morbid') conditions are particularly common in individuals at the severe end of the intellectual disability spectrum and make up what in this study is called 'complex learning disability'. As we shall see, it is this combination of conditions that also characterises the pupil population of residential special schools.

Amongst this group of co-morbid conditions, autism is the most dominant additional condition. As with learning disability, there is significant debate over the nature, extent and origin of autism, but the debate covers many of the same issues – essentially the question of whether there is a core impairment in cognitive functioning or whether the very concept of autism is socially constructed (Grinker, 2009, Bagatell, 2010, Eyal et al., 2010, Solomon and Bagatell, 2010). These issues are not explored here, but for clarity, the thesis takes the same 'critical realist' or 'weak constructionist' approach to autism as it does to learning disability – that is, it accepts in principle that an impairment exists and is biomedical in origin (Baron - Cohen, 2008, Howlin, 2002). Most standard definitions of autism acknowledge a wide spectrum of impacts ('the autistic spectrum') clustered around three principal deficits:

- a. difficulties in understanding, initiating and managing reciprocal social interaction
- b. difficulties in understanding, initiating and managing communication with others
- c. fascination with repetitive activities and narrow interests (Frith, 2008 pp.8-11)

The particular combination of autism and severe and complex learning disability poses a significant challenge for parents and professional carers as Frith (2008 pp.26 - 7) describes:

autistic children with superimposed intellectual disability ... tend to be very delayed in speaking and may never speak at all. They often appear to be locked into repetitive behaviour, such as rocking, and into routines that are difficult to break. They are more likely to suffer from additional neurological disease, in particular epilepsy. They are also likely to be less attractive in appearance and they may well exhibit highly unattractive behaviour.

What Frith calls 'highly unattractive behaviour' is a common co-morbid condition associated with pervasive developmental disorders. More commonly called 'challenging behaviour' or (perhaps more correctly) 'behaviour that challenges services', it is particularly associated with extremely vulnerable individuals. Like learning disability and autism, there has been considerable academic debate about the nature and origin of challenging behaviour but unlike the other two core concepts, the movement has been in an 'essentialist' direction.

Challenging behaviour was originally conceptualised as a social construct – as a way of describing the interaction between an individual's behaviour, the services they use and those who staff them (Emerson, 2001, Clements and Zarkowska, 2000, Hewett and Nind, 2006), and as a framework for identifying both the functions served by the behaviour and the strategies to enable an individual to gain better control.

Over time it has tended to be adopted as a diagnostic term with attempts to understand its origin in terms of personal aetiology, rather than functional adaptation to the environment. A recent joint report by the Royal College of Psychiatrists, British Psychological Society and the Royal College of Speech and Language Therapists (RCP, 2007) strongly recommends a return to the earlier practice and offers the following as a working definition:

Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive, or result in exclusion (p. 10).

Rather than being seen as a diagnosis in its own right, 'challenging behaviour' is a way of describing a negative interaction between the person

and the environment. Such an interaction may originate in personal development (and explanations range from the developmental through behavioural to psychodynamic, (Emerson, 2001, Hewett, 1998, Hewett and Nind, 2006, Sinason, 1992)) or in life experiences, or may arise from poorly designed and managed services. However, as the RCP report makes clear, people who manifest behaviour that challenges services are much more likely to be excluded from such services and so it would not be surprising to find such children and young people over-represented amongst the pupils in residential special schools. But what do we know of the population of such schools?

Complex Learning Disability and the Residential Special School Population

Whilst the size of the residential special school sector has been steadily declining (from approximately 22,500 pupils in England and Wales in 1984 (Cole, 1986) to 5034 in England in 2007 (McGill, 2008)) this decline has been uneven, being fairly rapid amongst pupils with physical and sensory impairments or moderate learning difficulties, whilst numbers of pupils with severe learning difficulties or with emotional and behavioural difficulties have been much slower to fall (Pinney, 2005).

Understanding the characteristics of the residential special school population is not easy. Part of the problem, as Morris demonstrated in an important set of reports in the mid – 90s (1995, 1998b), was that until very recently, even basic information about who was attending such schools was largely missing in terms both of absolute numbers, and key characteristics (age, gender, impairment etc.).

The recent introduction of the Pupil Level Schools Annual Census (PLASC) (Pinney, 2005) has partially rectified this by substantially improving the available data for maintained and non-maintained residential special schools. However, approved independent special schools (who make up the majority of providers of 52-week schools for children with autism and challenging

behaviour) are not required to complete PLASC, but return a less rigorous set of data (the School Level Annual Census) (Pinney, 2005, McGill, 2008). These sources of data were supplemented by surveys conducted by the former SEN Regional Partnerships (McGill, 2008, Pinney, 2005) but there is still a great deal of interpretation to be done, and the residential population of approved independent schools is particularly problematic.

McGill's analysis (2008) is the latest and most comprehensive and he estimates that in 2007, 678 young people with learning disabilities attended 52 – week residential special schools. Overwhelmingly, these young people were male (over 80%), aged between 11 and 19, and had a pervasive developmental disorder (predominantly autism) combined with behaviour that challenges services (predominantly aggression).

Some further light is cast by an earlier study by Pilling and his colleagues (Pilling et al., 2007) who surveyed all known schools approved to provide 52 week boarding education to children and young people with severe learning disabilities and challenging behaviour⁹. This study identified a number of key characteristics that are consistent with data from other sources (Pinney, 2005). Overwhelmingly, the population was male (75%), adolescent (mean 15.1 years) White British (62%)¹⁰ and autistic (75%). Pupils were largely independently mobile (88%) but the majority had restricted (28%) or no (46%) verbal communication and hence schools used a variety of systems of non-verbal communication. All demonstrated a wide range of challenging behaviour including hyperactivity (72%), aggression (91%), inappropriate sexual behaviour (77%) and self-injury (84%).

⁹ It is, however, important to note the limitations of this study. Of the 16 schools identified by the researchers, only nine agreed to take part in the study. Questionnaires were sent out for completion on 234 pupils resident at these nine schools, but only 156 were returned. As a consequence, although this is by far the most comprehensive study yet undertaken, the data was only collected from 33% of the original target population and, given the small and idiosyncratic nature of the sector, it is not known whether this limited sample is significantly skewed or not.

¹⁰ A figure of 62% White British means, of course, that the resident population has a much higher proportion of members from black and ethnic minority communities than the general population although this has not, to my knowledge, been the subject of any sustained research.

Such young people, most of whom have limited or no verbal communication, are amongst the most vulnerable young people in society (Paul, 2004, Department of Health, 1997) and this was highlighted in the research undertaken for The Report of The Review of The Safeguards for Children Living Away from Home People Like Us (Department of Health, 1997) which identified the major sources of vulnerability in severely disabled children (apart from living away from home) as being:

- physical and social isolation
- lack of choice
- reliance on multiple carers
- risk of over-medication
- poor feeding and toileting arrangements
- lack of stimulation
- inappropriate restraint strategies
- communication difficulties (pp. 82 – 3)

These, along with other characteristics which Westcott called 'constructed vulnerability' (Westcott, 1993 p.33) are, of course, particularly present in the most severely intellectually impaired youngsters.

Having defined and explored the concept of 'complex learning difficulties' and established that the definition covers a group of highly vulnerable young people who together largely make up the population of 52 – week residential special schools, Chapter 2 explores the origin and development of such schools and locates them in contemporary education and care policy.

CHAPTER TWO THE POLICY CONTEXT

This chapter is an exploration of the policy context within which residential special education is located, exploring how such schools relate to the policy context; how they have changed their focus over time, and the justifications for their continuance as part of contemporary special educational provision.

Given the challenges faced by the small group of children and young people described in Chapter One, it is not surprising, as the Royal College of Psychiatrists report makes clear (RCP, 2007), that such young people are much more likely to be excluded from services:

People with learning disabilities (the report argues) who present behavioural challenges are often marginalised, stigmatised, disempowered and excluded from mainstream society. (p.9)

Nor is it surprising to find such children and young people over-represented amongst the pupils in residential special schools as the research presented in Chapter One suggests. However, the usage of residential special schools for young people with complex learning disability has not been the policy position of any UK government in the last three decades.

Special education policy today

The clearest statement of government policy¹¹ can be found in statutory guidance issued by the then Department for Education and Skills under the title Inclusive Schooling: Children with Special Educational Needs (DfES, 2001a):

Like most countries in the world the United Kingdom supports the Salamanca Statement, the statement drawn up by a UNESCO world conference, held in Salamanca (Spain) in 1994 [which] called upon all Governments to “adopt as a matter of law or policy the principle of inclusive education, enrolling all children in regular schools, unless there are compelling reasons for doing otherwise” (p.3).

¹¹ Note that this policy applied only to England and Wales, not Scotland or Northern Ireland

This policy commitment is enshrined in statute in Section 316 (subsections 2 & 3) of the Education Act 1996 as amended in 2001.

316 Duty to educate children with special educational needs in mainstream Schools:

(2) If no statement is maintained under section 324 for the child, he must be educated in a mainstream school.

(3) If a statement is maintained under section 324 for the child, he must be educated in a mainstream school unless that is incompatible with –

(a) the wishes of his parent, or

(b) the provision of efficient education for other children.

This policy statement is turned into practice in a complex system that originated with the Warnock Report (DfES, 1978) and has been largely unchanged since then^{12 13}.

The policy is based on the assumption that all children will attend mainstream education, that special educational needs will be identified within the mainstream school, and that additional resources and revised teaching strategies will be identified for such children, until such a time when a child's needs are so complex that they cannot be met within the mainstream setting.

A three stage identification process is in operation in mainstream schools, managed by a specialist teacher known as the Special Educational Needs Coordinator (or SENCO). Stage One (called in the SEN Code of Practice 'School Action'), allows for the assessment and recording of a child's special needs and the identification of support and revised teaching strategies from within the school's existing resources. Stage Two (called in the SEN Code of Practice 'School Action Plus'), allows the school to call on resources maintained centrally by a Local Education Authority to support the child in the

¹² The SEN Green Paper 'Support and Aspiration: A New Approach to Special Educational Needs and Disability (London: Department for Education) was published in 2011, and its recommendations are intended to be incorporated in a new Children and Families Bill in 2013, with the introduction of a modified system in 2014. Some of the detail of the policy and procedure described no longer applies to academies and free schools.

¹³ It should be noted that the policy framework described here is English, and the research site is in England. Education, including special education, is a devolved matter, and whilst the systems in Scotland, Wales and Northern Ireland share broadly the same principles and processes, they do differ in detail.

school. Such support might include assessment and treatment by an educational psychologist, speech and language therapist, autism specialist, or any other of a range of professionals who can be called to provide short-term structured intervention (DfES, 2001b).

Where a child's needs exceed the resources of these two stages, a full, external, multi-disciplinary assessment is undertaken, resulting in the development of a Statement of Special Educational Needs. This document identifies the child's special educational needs; the learning outcomes for the child; the teaching and learning strategies to be adopted with the child and the type of school needed to provide the identified teaching and learning strategies. There is also an opportunity in the process to identify additional health and social care needs and resources to address them (DfES, 2001b).

Statemented children can call on additional financial support from Local Education Authorities whilst remaining in a mainstream setting, or can be taught in a specialist unit attached to a mainstream school, or attend a community special school. A small proportion of pupils whose needs are deemed to be unable to be met may be referred to resources outside the provision of a Local Education Authority, including residential special schools and most pupils in such schools arrive there having exhausted all available local provision.

Educational approaches to complex learning difficulties, autism and challenging behaviour

Although there are a range of philosophical and theoretical approaches to special education, they share a great deal in common. Firstly, the curriculum is severely reduced and all National Curriculum assessments are disapplied. In most special schools, pupils are described as 'working towards Key Stage 1', and most schools work within the 8 – step framework of the 'P' levels' developed by the Qualifications and Curriculum Authority (2001) and endorsed by the Department for Education and Skills and its successors.

This reduced curriculum focuses on basic skills in English, Maths, Science and ICT differentiated to very early developmental levels and focussed on skills such as early language development, symbol recognition, and very simple tasks. The curriculum focuses as much on the social skills required to be in the classroom (dressing appropriately, sitting down, concentrating, listening and speaking/signing, eating and drinking, managing behaviour etc.) as in any traditional academic learning.

The second key feature is a high staff –pupil ratio, where a typical special school classroom may have up to 8/9 pupils with a class teacher supported by teaching assistants to provide a staff – pupil ratio of anywhere between 1:1 and 1:3. Such a staff ratio allows for a high level of 1:1 and small group interaction and learning.

The third feature is a highly structured teaching approach where each part of the day is broken down into very small sections, and learning activities are broken down into very basic steps. In some approaches, for example, TEACCH (Mesibov et al., 2004), the programme for the day is clearly signed with pictures and/or symbols so that a student knows exactly what is coming next. All learning activities will be individualised and tailored to the specific learner in an Individual Education Plan (DfES, 2001b).

The fourth feature is the attention paid to encouraging basic language skills usually supported by a speech and language therapist. Provision varies from school to school, but most adopt a ‘total communication’ strategy involving elements of speaking, listening, signing (most commonly Makaton¹⁴ signs) and the exchange of symbols or pictures as in the system called PECS (Picture Exchange Communication System) (Bondy and Frost, 2002). More severely impaired young people may be encouraged to develop eye-pointing (Buckley and Latham, 2008) or the use of ‘objects of reference’ (Park, 2002).

¹⁴ Information on Makaton can be obtained from www.makaton.org.

The final core element is the management of challenging behaviour. All schools will have a clear policy framework and training programme. A number of different providers offer slightly different approaches but most are based on applied behaviour analysis, with its emphasis on understanding both the function of challenging behaviour and its communicative nature (Emerson, 2001). Most schools operate within a 'positive behaviour management' (Allen, 2009, Ashman et al., 2010) framework with a strategy that involves behaviour contracts, looking for and rewarding positive behaviour, individualised intervention plans, de-escalation strategies, breakaway techniques and, if all else fails, safe physical intervention.

Where into the special education system, then, do residential special schools fit?

Residential special schools

These institutions have a long and complex history, perhaps rather neatly illustrated by the history of what is now known as the David Lewis Centre in Cheshire, a national specialist resource for children with epilepsy and complex learning disabilities¹⁵, which began life over one hundred years ago as the Sandlebridge Colony 'to provide permanent care for the feeble-minded' and was founded by one of the most prominent early eugenics campaigners, Mary Dendy (Jackson, 1996 p.161).

Schools have multiple origins: as Poor Law boarding schools, Industrial Schools, schools for delicate children, colonies for the 'mentally defective' and many others and were started by local authorities, by charitable organisations and by campaigners. (Cole, 1989, Thomson, 1998, Sutherland, 1984, Hurt, 1988). As both Cole (1989) and Hurt (1988) document, there was, from the latter half of the nineteenth century no systematic drive towards segregation of children from mainstream school, despite the efforts of influential lobbyists. Residential special schools existed alongside day

¹⁵ Information about the David Lewis Centre from www.davidlewis.org.uk

provision of both special schools and special classes within mainstream elementary schools. The existence and development of such schools varied from authority to authority and was affected by, amongst other factors, the particular views of local authority education and public health officials, and the costs of provision.

As far as children with complex learning disabilities were concerned, they tended not to be in residential special schools prior to the 1960s partly because few survived beyond the early years, and partly because those that did were largely provided for in what were then known as 'mental handicap hospitals'. Indeed, under the 1944 Education Act (Hurt, 1988), such young people were formally termed 'ineducable' and were consequently the responsibility of local authority public health or mental welfare committees, rather than education authorities, with some being accommodated in 'junior training centres' and others in hospital settings.

The major change came with a cluster of developments in the late 1960s and early 1970s. These included: the Education (Handicapped Children) Act of 1970 which revoked the category of 'ineducable' and converted 'junior training centres' into schools for children with severe learning difficulties; the progressive closure of the older 'mental handicap hospitals' (DHSS, 1971) following the Ely (DHSS, 1969) and Normansfield scandals (Butler and Drakeford, 2005 pp 33 - 59; 113 - 140) and the drive towards inclusive education advocated in the Warnock Report (DfES, 1978), and enacted in the Education Act 1981. Taking all these developments together, there was a steady decline in the numbers of children being educated in residential special schools throughout the 1980s and early 1990s, with a particularly sharp decline in provision for children with physical or sensory impairments who were increasingly catered for in mainstream schools, and for children with moderate and severe learning disabilities who were provided with a developing framework of day provision including integration into mainstream day schools, specialist classes attached to mainstream day schools and local authority special schools. At the same time, the population of the remaining residential special schools changed to increasingly accommodate those most

severely impaired young people who had previously been in hospital care. There was also a general shift in the ownership of residential special schools with a steady reduction in local authority schools and those run by the major children's charities in favour of the private sector, and smaller charities with very specific remits including autism and challenging behaviour (Pinney, 2005, Pilling et al., 2007, OFSTED, 2009, McGill, 2008).

The residential special school today

Chapter 1 argued that, although there are significant gaps in our knowledge of the pupils of residential special schools, especially the 52 – week boarding schools run as approved independent schools, a significant part of the population of such schools was now made up by that group of young people described in this thesis as pupils with complex learning disabilities and challenging behaviour.

If our knowledge of the pupil population is limited, our understanding of the reasons why such pupils end up in a residential special school placement is even more so. In the limited studies we have of parents' views (McGill et al., 2006, Abbott, 2001, Morris et al., 2002b), the emphasis is on the complex needs of the individual child and the shortcomings of local education and social care services. Typically, parents studied talk about having a long, stressful and distressing process of fighting for what they consider to be the needs of their child.

The only significant study of local authority views (Abbott, 2001, Abbott, 2000, Abbott et al., 2002, Morris et al., 2003, Morris et al., 2002b) tends to support this position, with an emphasis on social care and education professionals' philosophical commitment to inclusion running in tandem with a concern to maintain control of restricted budgets. Qualitative interviews with senior managers (Abbott, 2000) emphasised the reluctance of managers to agree to placements and, in terms of social care managers, the concern was expressed that residential special education was being used by

parents as a 'respectable' alternative to asking for a child to be accommodated.

Perhaps not surprisingly, the consequence of this is that no clear criteria for admission to residential special schools appear to exist and placement decisions are taken on an individual basis, often after months (or even years) of negotiation and/or appeals. As a result, the numbers of children placed by authorities varies widely with Abbott and his colleagues (who studied 21 authorities) finding a range from 8% of pupils with SEN statements down to 0.2% (Abbott, 2000).

One of the consequences of the developments outlined above is that residential special schools for children with complex learning disabilities tend to fall outside government educational policy frameworks. The thrust of policy was the promotion of inclusive education, and where that was not possible, the provision of local day special education provision. As Abbott and others pointed out in their studies (Abbott, 2001, Abbott and Heslop, 2009, Abbott et al., 2002, Morris et al., 2003), local authorities varied widely in the criteria used in making decisions as to whether to fund places, and these variations were made up partly of a firm commitment to inclusion and local provision, and partly on grounds of cost.

In many ways, prior to the Care Standards Act 2000, residential special schools tended to be neglected in terms of policy and regulation, with no specific inspection and regulation under the 1989 Children Act, other than the general bi-annual obligation on local authorities to inspect boarding schools under Section 87 of the Act, and the associated Welfare of Children in Boarding Schools Regulations. The fact that many schools were non-maintained and/or approved independent schools also reduced the responsibilities of central and local government to regulate and inspect schools, or for schools to meet national standards for education and care.

The problem was not only that residential special schools have sat outside national and local policy for special education, they have also sat outside the

framework of child care practice towards children 'in need'. Since the early 1960's the emphasis in child care practice has moved towards preventing children from coming into the care system in the first place, and the use of fostering or adoption as the provision of choice (Bullock, 1999, Hendrick, 2003, Heywood, 1959, Holman, 1998, 2002, Younghusband, 1978). With the withdrawal of many of the major voluntary organisations from residential child care provision, and the drive for fostering and family permanency, residential child care was relegated to being a 'cinderella' service, with many local authorities closing all provision. This was compounded by a sequence of major child abuse scandals in residential homes and schools in Shropshire, Staffordshire, Leicestershire and North Wales amongst others, many of which led to widely – publicised public inquiries (Corby et al., 2001). Crimmens and Milligan (2005 p.19) argue that:

at the beginning of the 1990s residential child care was not only waning, it appeared to be in terminal decline.

Amongst the factors they identify are a general critique of institutional care; a marked preference for substitute family care; a concern over the costs of residential provision and the limited training and competence of residential child care workers (pp. 19 -24).

However, even at its lowest point, there was government recognition that residential child care needed to be an option for a significant number of children, and that the sector in its current condition was neither large enough nor healthy enough to respond to need (Crimmens and Milligan, 2005 pp. 22 - 24). As a consequence, the UK Government commissioned a number of critical reports into the needs of the sector. These included for England and Wales, Children in the Public Care (Department of Health, 1991); Choosing with Care (Department of Health, 1992) and People like Us (Department of Health, 1997). For Scotland, there was Another Kind of Home (Skinner, 1992) and the Children's Safeguards Review (Kent, 1997).

All reports emphasised the highly specialised role that the residential sector needed to play in addressing the needs of vulnerable and damaged children, the importance of recruitment and retention of high quality staff and the critical role of training. Alongside the formal reports went a programme of specialist training for children's homes managers (Hills and Child, 1999, Karban and Frost, 1998), the commissioning of research into effective residential child care practice (Brown et al., 1998, DoH, 1998, Little, 1999, Sinclair and Gibbs, 1998, Whitaker et al., 1998) and the establishment of the Support Force for Children's Residential Care in England and Wales to promote best practice in the sector. None of this was directed at residential special schools.

From time to time, a child abuse scandal such as Castle Hill (Brannan et al., 1993, Corby et al., 2001) raised public concern and prompted Government enquiry (Utting, 1997) but it wasn't until 2000 with the passing of the Care Standards Act, with publication of regulations specifically for residential special schools and the classification of schools for children living away from home for more than 48 weeks as 'children's homes' that a proper regulatory framework was established.

So it is perhaps no surprise that when Morris in the mid – 1990s (Morris, 1995, 1998b) explored the world of the residential special school, she entitled her findings 'Gone Missing' as a way of drawing attention to a small and vulnerable group of children and young people who were largely missing from the policy and legislative framework in place when she wrote, and all the more vulnerable because of that.

This was compounded by the reluctance of many local authorities to treat children in residential special schools (despite many of them effectively living permanently on site) as 'looked after children' within the meaning of Section 20 of the Children Act 1989 and discharging their responsibilities in relation to planning, reviewing and monitoring the welfare of such children (Abbott, 2001).

The legal situation for young people in residential special schools was clarified as a result of changes to the 1989 Children Act made by the Adoption and Children Act 2002 and notified to local authorities by Local Authority Circular 2003 (13). As a consequence of this, some placements were re-classified as placements under section 17 of the 1989 Children Act, and hence no longer requiring the local authorities to treat such young people as 'looked after'.

Recent case law, however, especially *R (O) v. East Riding of Yorkshire Council* [2011] EWCA Civ 196, supported by changes introduced in sections 17 & 18 of the Children and Young Persons Act 2008 and in the Visits to Children in Long Term Residential Care Regulations 2011 (which came into effect in April 2011) has largely reversed that development and the default position is that any young person living away from home in a residential special school should now be treated as a 'looked after child'¹⁶.

Given that residential special schools sit outside the basic thrust of Government special educational policy, providing for a small group of very vulnerable young people at a very high cost, what is the rationale for keeping them open?

The arguments for residential special education

As long ago as 1986, Cole summarised the arguments against continuing with residential special schooling. Placement, he argued, separates the child from his family and interferes with the natural pattern of a child's growing up with his parents, brothers and sisters. It also isolates a child from her local community and denies a pupil a normal childhood, mixing and growing up with local children in an ordinary day school.

Such placement cannot provide the width and variety of the ordinary secondary school curriculum, and therefore limits the educational

¹⁶ The research reported in this thesis was completed in November 2010, therefore the legal position referred to in this paragraph did not apply either to the school, or to placing local authorities at the time the research was conducted.

opportunities and achievements of their pupils. Additionally, residential schools can be uncaring and institutionalised, with the result that children's social and emotional needs are neglected. Finally, and importantly for placing authorities they are too expensive (Cole, 1986 pp. 142 - 152)

Some of these concerns have been picked up by other commentators (McGill, 2008, McGill et al., 2006, Morris et al., 2002a). Both Morris and McGill, however, point out the continued existence of the residential special school arises from the failure of local, community based special education and family support services (Wodehouse and McGill, 2009). However, an argument from failure is not a strong argument and a number of commentators have suggested more positive arguments. Jackson (Jackson, 2004), for example, sees the critique of residential special schooling to be part of the British failure to value residential approaches to the care of vulnerable young people and contrasts this with the much more positive social pedagogy tradition in many European countries (Petrie, 2003, Jackson, 2004, 2006b, Petrie, 2001, Petrie et al., 2006, Cameron, 2004).

Jackson (2004) points out also that many of the young people who end up in residential settings have been excluded from school and isolated from their communities and that residential schooling offers new opportunities for new relationships. He argues, with Aird (2001) that the residential school offers an holistic solution to the education and care needs of very vulnerable young people, offering an educational experience that spans the whole of a young person's life building in consistency and continuity – what Saunders calls 'the 24 hour curriculum' (Saunders, 1994).

Whilst McGill is sceptical about the advantages of residential education, arguing that the best aspects could be, and should be developed at the local community level, he points out that the best residential special schools offer genuine expertise in the education of some of the most challenging and vulnerable young people in the community: expertise that might otherwise be lost (McGill, 2008 p.10).

In summary, then, residential special schools have sat on the margins of local and national government policy in relation to both special education and child care practice, despite the strong arguments made for their continuing value for a small number of young people. What does the research evidence say? Chapter 3 will explore the literature base and work towards a theoretical framework for understanding the experience of residents and staff in such a setting.

CHAPTER THREE THE RESEARCH LITERATURE

Chapter 2 looked at the place of the residential special school in SEN and child care policy, and briefly reviewed the arguments in favour of a continuing role for such schools. Chapter 3 reviews the research literature with the aim of understanding the strengths and weaknesses of residential special education as it has developed and changed over the last few decades, and of identifying both what is known and what is not known about the impact of residential education on young people with complex learning difficulties, and those who work most intimately with them. Building on this research literature, the chapter concludes with a discussion of the elements of a theoretical framework for understanding the institutional culture of the school at the centre of the current study.

Research studies on residential special education

As we have seen, the development of the residential special school for children with severe and complex learning disability is a relatively recent phenomenon, affecting a very small group of very vulnerable young people. Consequently, research into the experiences of children living in them, and the educational and care practices used with them is very thin. That said, there is research evidence from earlier institutional and hospital studies, from residential schools for children with emotional and behavioural difficulties, and from residential child care more generally that can orientate us to critical issues. There is also a solid body of evidence of effective interventions to promote teaching and learning in such severely impaired populations. The next part of this chapter reviews this evidence, before going on to look at the limited body of specific research, and concluding with some more general observations from wider research into public care facilities for vulnerable groups.

Institutional studies

The earliest significant studies of residential care for children with complex learning disabilities were rooted in the deinstitutionalization movement of the 1950s and 1960s (Kugel and Wolfensberger, 1969, Wolfensberger, 1975, Whitehead, 1992), are linked to the sociological interest in institutions generated by Goffman's Asylums (1961), in particular his concept of the 'total institution' (Penguin 1968 edition pp. 13 – 115) and were influenced by a range of critical Government reports on standards of residential care (e.g. DHSS, 1969, Butler and Drakeford, 2005). The work of four pioneer researchers: Jack Tizard, Maureen Oswin, Pauline Morris and Andy Alaszewski is briefly reviewed here. The first of these, Tizard, working with Neil O'Connor from 1948 onwards, identified that a significant proportion of young people living in 'mental deficiency' hospitals did not have a learning disability at all and of those that did, a large proportion could undertake sheltered work if given appropriate training (Tizard and O'Connor, 1952, Williams, 2005, Tizard, 1983).

From this early work, Tizard moved on to look at the institutional care of children with severe learning difficulties. In his famous 'Brooklands' experiment (Tizard, 1964, Williams, 2005), Tizard took 16 children from the (now closed) Fountain Hospital and transferred them to a smaller unit run on the lines of a residential nursery, and then compared the outcomes with a control group remaining in the hospital setting. Although some of the results were inconclusive (Tizard, 1964 pp.130 - 137), there was sufficient clear evidence both of improvement in verbal skills, and in general behaviour, to warrant the conclusion that children with learning disabilities were better cared for in smaller, non – institutional environments than in hospital settings. In later work, Tizard and colleagues (King et al., 1971) systematically compared large and small institutions for children with learning disabilities (including hospitals, hostels and children's homes). The research, which included four substantial 'field studies' undertaken along ethnographic lines, supported by a larger survey, concluded that whilst units run on 'child care' lines were generally associated with better outcomes and happier children,

there were a number of features of staff organisation and management that contributed to the development of child care practice. These included:

- a. scale (smaller units were more conducive than larger ones)
- b. child care training (at least for the manager and preferably for the staff)
- c. sufficient numbers of staff to meet the needs of children
- d. continuity of staff: child relationships
- e. high levels of delegated management responsibility to the Unit head
- f. a 'hands – on' approach to management by the Unit head, who should spend significant amounts of time in direct interaction with residents.

The authors concluded that merely moving young people out of large institutions into smaller ones does not necessarily improve things. Small units can be run on institutional lines just as much as larger ones (King et al., 1971 pp. 191 - 204).

One of Tizard's collaborators was Maureen Oswin. She developed a research study that involved participant observation of weekend life in a variety of different units for children with severe learning difficulties. Her observations were then written up as ethnographic case studies, with an emphasis on describing the daily routine of severely impaired children at the weekend. Four of these case studies were published in Oswin's first book The Empty Hours: A Study of the Weekend Life of Handicapped Children in Institutions (1971) and they contrasted life in two residential special schools and two hospital wards. The contrasts she drew were very powerful, between two units which were child-centred, stimulating and enjoyable to be in, and two units that were rigid, institutional and above all, boring. She concluded that four features of hospital organisation made them inherently unsuitable for caring for children: the poor quality environment ; a daily timetable that focussed predominantly on the physical care of children whilst ignoring their emotional needs; changes of staff and fragmentation of care, which deliberately prevented the development of relationships between staff and children; decisions about children's welfare being made by administrators

and managers who were not in daily contact with the children (pp. 197 – 198). The overlap with Tizard's earlier findings are clear.

Oswin followed up her 1971 study with a longer and more detailed review of Children Living in Long Stay Hospitals (1978), exploring the experience of children with complex learning difficulties. The study involved 223 children and young people living in 'special care' wards in eight hospitals, where they had been resident for periods between two weeks and 27 years. Her findings were that the young people living in the hospitals were living lives of bleak deprivation.

Contrary to the very notion of a 'special' hospital or school, residents had less access to support services (physiotherapy, occupational therapy, speech therapy, psychology, medical care) than similar children living in the community. Social workers took little interest in the care of long term resident children. Nursing staff were over-stretched, demoralised and focussed solely on the physical care of young people. The children themselves lived bleak lives, with very little in the way of emotional warmth or 'mothering' and staff made little or no response to young people's attempts to communicate. Oswin came to the bleak conclusion that 'on average', each child received 5 minutes 'mothering' in every 10 hours (p.100).

Oswin's findings were widely publicised and fed into three major Government enquiries in the second half of the 1970s: the Court Report (DSS and DfES, 1976); the Jay Report (DSS, 1979) and the Warnock Report (DfES, 1978), and contributed to the ultimate closure of hospital wards for children with complex learning difficulties, and the increasing inclusion of disabled children in mainstream child care services.

However, research into hospital care of children with complex impairments was not limited to Oswin's work. Pauline Morris's Put Away: A Sociological Study of Institutions for the Mentally Retarded (Morris, 1969) was a detailed study of 35 hospitals for the 'mentally subnormal' and 27 community homes. The study covered the entire age range with about 12 percent of the

participants being children. The study was based upon interviews with senior and ward staff (or equivalent) supplemented by a detailed observational study of two hospitals. As with Oswin's work, Morris and her colleagues noted a sharp differentiation between the hospitals and the community units, with hospitals being focussed largely on physical care, rather than on meeting developmental needs, or undertaking anything that might be described as 'treatment'.

Morris concluded that the hospitals were effectively 'total institutions' (Goffman, 1961), physically isolated from the community and intellectually isolated from developments in care practice. She recommended a focus on community based services, with such hospitals as remained being staffed with trained staff, up to date with current best practice and interacting with the rest of the healthcare sector. Morris' work, along with the major scandals of the early 70s, fed into the Government strategy Better Services for the Mentally Handicapped (DHSS, 1971).

With the progressive closure of hospitals as appropriate accommodation for children with complex disabilities, Alaszewski and his colleagues conducted a detailed study of the impact on children and young people of moving from a hospital setting into small children's homes in the community (Alaszewski and Nio Ong, 1990). A project developed by Barnardos resulted in 12 children moving into four bungalows on ordinary housing estates in Liverpool and these were followed up in terms of their quality of care (pp.227 – 248), psychological development (pp. 205 – 226) and their engagement with the local community, including their own parents (pp. 160 -181).

All 12 children demonstrated significant gains in all three areas¹⁷. The researchers drew a number of conclusions about effective residential child care for children with complex disabilities. Such care, they argued, needed a robust child care planning system based around six-month reviews setting medium – and long – term objectives, combined with a goal plan setting

¹⁷ The authors note that the lack of a formal control group amongst hospital residents led to some qualifications as to how much of the developmental gain could be causally attributed to the new setting (p.224).

short – term (day – to – day) goals. Each child also needed a link worker combining the roles of key worker and ‘surrogate parent’, and units needed a participatory style of management with a strong commitment to staff supervision and regular staff meetings.

With the progressive closure of hospital wards as a suitable service for children with complex disabilities, the move of such children into community facilities and the increasing emphasis on social and educational inclusion, research moved away in the late 1980’s from specialist residential facilities for such young people, and focused, at the service level, on respite care (Oswin, 1991) and family support (Burke and Cigno, 1996, Cunningham and Davis, 1985), and, at the level of direct intervention, on new strategies for addressing teaching and learning (Bondy and Frost, 2002, Mesibov et al., 2004) , communication (Hewett and Nind, 2006, Coupe O’Kane and Goldbart, 1998), and the management of complex behaviour (Emerson, 2001, Hewett, 1998, Ashman et al., 2010).

One exception to this, by Beail (1989), did ring some warning bells. In a small study of a service similar to that evaluated by Alaszweski, he noted that it was possible for community based services to slip quickly back into institutional practices. In this study, he carried out a detailed observation of staff: child interaction and concluded that whilst the relationship between staff and children was much more positive than in the hospital setting he had previously evaluated (Beail, 1985), it was still the case that the majority of attempts made by children to communicate were ignored by staff; that children spent long periods of time doing little or nothing; there was a lack of toys and play material and no systematic process of child care planning. It may have been significant, although not commented on by the author, that all the staff were either qualified nurses or nursing assistants, rather than the child care specialists recommended by Oswin and Alaszewski.

Two key themes emerge from these critical studies conducted over a thirty year period. The first is the crucial importance of ethnographic research that gets under the skin of the institution and can study close up the actual

interaction between staff and resident, rather than relying on second hand accounts whether from staff or parents. The second is the crucial importance of a clear 'child care' orientation to care practice – small size, good relationships between staff and young people and a clear sense of purpose and direction.

Residential special education and EBD

Unlike residential special schools for pupils with complex learning disabilities, there is a small but valuable literature on the experiences of pupils attending residential special schools for children with emotional and behavioural difficulties which is relevant to the research topic. Outcome studies have been conducted by Cooper (1993), Gleeson (1999), Wood and Cronin (1999), Polat and Farrell (2002), Farrell and Polat (2003), Smith, McKay and Chakrabarti (2004), Harriss, Barlow and Moli (2008), and Hornby and Witte (2008a, 2008b), covering schools in the US, UK and New Zealand and exploring the views and experiences of staff, pupils and parents.

Although samples are always small, and the total number of schools to have participated very limited, the results are surprisingly consistent, and a number of factors that contribute to a positive experience for pupils are summarised in partial reviews of the literature by Hornby and Witte (2008b) and Harriss et al.(2008). There is no evidence that students make significant educational gains whilst in residential special school, but there is evidence that students learn to manage behaviour, and are able to tolerate challenging situations that might previously have led to serious outbursts of anger or withdrawal from the situation. These achievements are consistently linked to the small size of classrooms and living groups, high staff: child ratios, structured teaching, clarity of expectations about boundaries and behaviour, close and confiding relationships with teachers and care staff and relief from the complexity of relationships at home.

Residential special education and complex learning difficulties

Although there are far fewer significant studies of residential special schools for children with complex learning disabilities, the one school that has been studied in some detail demonstrates outcomes that are not dissimilar to EBD schools. This was Beech Tree House, a specialist unit set up in the grounds of Meldreth Manor School in Hertfordshire in the 1970s and later relocated to Lancashire (renamed as Beech Tree School). Run on what was then known as a 'token economy' basis, and more recently as Applied Behaviour Analysis (Emerson, 2001), Beech Tree House developed a curriculum for resident children with severely challenging behaviour, along with a parent training programme, which aimed to return young people to their own homes and communities after a two –year period of residence.

The first study of the school was a rather anecdotal one by Jones (1983). The study describes the unit, some of the resident children, the programme that was in place, and profiles one child's progress in depth. However, two later studies (Robertson et al., 1996, Emerson et al., 1996), (which were carried out by the Hester Adrian Research Centre at Manchester University) followed up a group of children and young people attending the school

Of these studies, one (Robertson et al., 1996) was an interview study of the parents of 44 children and young people who had attended the school between 1982 and 1993. They were asked to indicate whether, and in what way, their son or daughter's behaviour had improved, and what factors they thought had contributed to any improvement. Overwhelmingly, parents thought that the Beech Tree approach had produced changes in their son or daughter in the following principal areas: reduction in challenging behaviour; improvement in communication; improved sociability and learning of new skills (although a significant number reported that their son or daughter had deteriorated after leaving the school). They attributed these changes to the school's behavioural programmes and techniques; staffing ratios and skills; consistency, routine and structure; intense 1:1 staffing and repetition of teaching and the emphasis on improving communication skills.

In the parallel study (Emerson et al., 1996) an attempt was made to evaluate the progress of 55 former pupils by analysing written records at two points in time (pre-admission and mid – stay) and by interviewing parents (of 44 pupils) and care staff (of 11 pupils). The researchers concluded that during their stay at Beech Tree School, pupils had made significant gains in self – care and communication skills and significant reductions on all indicators of challenging behaviour. These gains were generally maintained, but not improved upon, on leaving the school. The researchers noted that their evaluation was broadly consistent with parental evaluation, but noted a number of methodological limitations, including the retrospective analysis of records, and the possibility of rater bias as raters could not remain blind to the stage of a child in the school and the expectations of progress. The absence of any kind of control group also reduced the credibility of any claim for the effectiveness of the Beech Tree School method.

For nearly twenty years, the three studies of Beech Tree School were the only studies of residential schooling for children with complex learning disabilities, until they were joined by a study by researchers at the Tizard Centre at the University of Kent (McGill et al., 2006). McGill and his colleagues studied the perceptions and expectations of parents of children and young people with learning disabilities and challenging behaviour attending 52 week residential special schools. 73 parents completed a postal questionnaire covering three broad areas: the support parents had received prior to their child’s placement at residential school; the suitability and quality of their child’s current residential school placement and their concerns and hopes for their child’s future (McGill et al. 2006 p. 601). The design was a mixed methods one, predominantly based on a survey questionnaire designed by the authors, with most data collected by way of self-completed 5 – point Likert scales. Additionally, the questionnaire was designed to elicit some free qualitative comment, and a telephone questionnaire was administered to 14 selected respondents to provide additional qualitative data.

The survey method was intended to permit researchers to access a large body of parental response from all 52 week residential special schools and to enable generalisation of findings with a high degree of confidence. However, only 11 of the 16 identified schools agreed to take part, and whilst 214 questionnaires were distributed to parents in participating schools (plus three to parents who contacted the authors directly), only 73 were returned completed. Whilst at 34%, the response rate to a postal questionnaire is not unreasonable, it should be noted that this is only 19% of the originally identified sample and any claim to generalisability should be treated with caution. The reported findings suggested (not surprisingly) a high level of dissatisfaction with support services prior to residential placement; general satisfaction (with some reservations) about the education and care received by children in residential schools. The reservations were about the high turnover of care staff; the youth and inexperience of care staff; the quality of care by care staff and communication between care staff and families. These concerns sit uncomfortably with the findings of the EBD studies and their emphasis on the importance of high staff: child ratios, and good trusting relationships between staff and residents.

This is the sum total of specific research into the type of special school at the centre of this study. Two reports suggesting similar outcomes to those of EBD schools, with similar factors at play, and one report suggesting that in many such schools, successful strategies may be being undermined by poor quality staff and high staff turnover.

Two more general studies of residential special schools also need mention. The first was a multi-dimensional study conducted by a research team based at the Norah Fry Centre at the University of Bristol. (Abbott, 2001, Abbott, 2000, Abbott et al., 2002, Morris et al., 2002a, Morris et al., 2003, Morris et al., 2002b).

Firstly, the researchers interviewed senior managers in a sample of 21 LEAs on the reasons for making residential placements, the decision – making process, legislative framework and inter-agency co-operation over

placements (Abbott, 2001 p.126). Secondly, the researchers conducted a more detailed study of the decision – making process in four of the 21 authorities including interviewing 53 education and social services personnel and observing placement panel meetings (p.129).

In the third part of the study, approaches were made to the parents of the last 10 children placed in residential school by each authority, and this resulted in interviews with 34 parents (p.130). Finally, with parental consent, 33 children were recruited into the final phase of the study, resulting in 18 semi- structured interviews (some with communication assistance) and 14 interviews with a key worker and/or teacher where the young person was deemed unable to be interviewed themselves (p.131).

Of the 32 children included in the research, 11 (31% of the sample) had an autistic spectrum disorder and 10 (29% of the sample) a learning disability. However, the research findings aggregate together all of the children's responses and include responses made by a child and responses made on behalf of a child by a key worker or teacher (p.132).

The children studied were largely positive about their experiences in the school. They appreciated the quality of their education, enjoyed having friends around them, felt homesick on arrival, saw less of their parents than they would have liked and found weekends and holidays boring. However, that brief summary covers a range of highly individual responses with some children being very happy, and others really unhappy. Relationships with staff were also varied, with some excellent relationships and some where children did not feel respected (pp. 48 – 72).

Parental experience of schools was similarly varied. Most felt that the decision to seek a placement was a very hard one to take, but that it was in the best interests of their child. Many reported difficulties in communicating with the school, although some had excellent relationships with key workers and most thought that schools addressed cultural identity well, and provided good quality education (pp.73 – 90).

Local authority views were complex with ideological commitments to inclusion in the mainstream reinforcing tight budgetary constraints and resulting in a lack of clarity over the criteria for agreeing placements, with a consequent broad spread of percentage of children with SEN statements in residential schools ranging from 8% in a London Borough down to 0.2% in Norfolk. Such complexity added to uncertainty for parents and made it all the more likely that a struggle would develop over placement decisions (Abbott et al., 2002, Morris et al., 2002b, Morris et al., 2003, Morris et al., 2002a, Abbott, 2000).

Abbott and Morris's study remains the largest and most detailed research study into residential special schools in the United Kingdom, but its limitations for the purposes of this study are very marked. Firstly, it focuses mainly on the views and experiences of local education professionals and parents. Secondly, the 32 children who took part in the study are from a broad spectrum of impairment and it is difficult to identify the specific experiences of children with complex learning disabilities who appear to have been a minority in the group interviewed. Thirdly, there is no attempt to describe or explore the residential school experience itself, beyond the interviews with young residents and it is not clear what type of schools these were, and what kind of regimes they were running. So although this is the only study to seriously explore the lives of resident children, it doesn't really take us much further forward.

A similar problem affects research conducted by Stalker and her colleagues (Stalker, 2003, 2004) into 'Edenvale' a residential special school that was part of a cross-border (Scotland and England) study into the needs of children with complex health difficulties living away from home. This study explored the needs and experiences of four young people (average age 16). Time restrictions prevented any direct involvement by the young people themselves and involved the children's mothers and their keyworkers. The study explored staff relationships, noting the importance of continuity of care, of understanding the behaviour, moods and needs of the young person.

Keyworkers were closely involved in the day to day care of resident young people, but (despite supporting in school classrooms during the school day) did not appear involved in the education programmes, had not been trained to use any of the communication systems used by the young person and had limited input into future planning. As with Abbott and Morris' study, Stalker's research suggests that the residents' cultural needs were well met and the young people generally well cared for, although they all noted homesickness on arrival from home.

Interesting and indicative though this study is, its small scale and the lack of direct engagement with young people restrict its value. However, in identifying lack of training in core skills and limited input into planning, the research does point up some key issues for future research, some of which are reflected in the findings from the present study.

This review of the literature suggests that we still know very little about residential special schooling for children with complex learning disabilities. We do know quite a lot about why and how local authorities make decisions to place children in such places (Abbott, 2000, Abbott et al., 2002, Morris et al., 2002a, Morris et al., 2003, Morris et al., 2002b). We know a little about parental views as to the suitability or otherwise of the education received by their child (Stalker, 2003, Abbott, 2001, Robertson et al., 1996, McGill et al., 2006). However, with the limited exception of Abbott and Morris's study (Abbott, 2001), the views of children – actual pupils – are almost completely absent. This is especially surprising for, whilst the most comprehensive attempt at eliciting the views and experiences of disabled children – the ESRC 'Life as a Disabled Child' project (Watson et al., 2000) included residential special schools amongst the fourteen schools that made up its research sites, the data from such schools are not separated out nor do any of the 'voices' of children appear to be those of children with the kind of impairments that characterise boarders at 52 – week schools although some of the themes identified by the researchers, especially those relating to the incidence of adult surveillance and the difficulties of maintaining peer-

relationships with non-disabled children, would appear to be highly relevant to residential schools.

Even the recent report by OFSTED's Children's Rights Director (OFSTED, 2009), which included 168 pupils who self-identified as disabled (52% of the survey group) needed respondents to be sufficiently competent in basic communication skills so as to complete a web-based survey, and the report acknowledges that this means that the experience of more severely impaired children and young people will not be represented.

This lack of attention to the voice of the resident young person contrasts sharply with mainstream residential child care (Holland, 2009), where there has been something of a surge in research exploring and representing the views and experiences of children in the care system (Emond, 2002, 2004, 2003b, Dorrer et al., 2011, McIntosh et al., 2010, Punch et al., 2009, Punch et al., 2011). This has definitely not filtered through to looked-after disabled children, residential special schools in particular, and children in 52 – week boarding establishments specifically, although Cocks' unpublished study of a residential respite care service is an excellent example of what can be done (Cocks, 1999, 2000) .

If children's experiences of life in a residential special school are seriously under-represented in the literature, there is scarcely more evidence concerning the nature of the interaction between care staff and resident children. Whilst there are some classic (and controversial) discussions of this theme in relation to children with autism and challenging behaviour written by the psychoanalyst Bruno Bettelheim from the 1950s (Bettelheim, 1955, Bettelheim, 1959, Bettelheim, 1974) and something of a tradition of exploring residential child care roles in schools for children with emotional and behavioural difficulties - for example, the collection of essays by Hardwick and Woodhead (1999) – the only substantial discussion of the role of residential child care staff more generally is Cole's study, published back in 1986. Although Aird (2001) acknowledges the importance of child care staff, there is no significant discussion of their role. Cole, by contrast stressed the

importance of close working relationships between child care and teaching staff and the value of good relational care of resident pupils. His approach to the residential child care task prefigures Ward's 'theory of the everyday' (Ward, 2004) and seems quite prescient.

That this approach has not become embedded in residential school practice is suggested by a study of the 'social ecology' of such a school by Smith and her colleagues (Smith et al., 2007). This was a timed observational study of 18 pupils in the main body of a residential special school for students with intellectual disabilities and challenging behaviour and 5 pupils living in an independent living unit (ILU). Each young person was observed for two 30 minute periods after school during the week. The findings were that in the main school, students received assistance to complete activities for under 6% of the observed time, and were constructively engaged for under 50% of the time. In the lower staffed ILU, students received assistance for less than 1% of the observed time and were constructively engaged for less than 20% of the time.

Although a very small scale study, it generated interesting questions about staff – student interaction, suggesting that the levels of interaction between staff and pupils were generally low and, additionally, in inverse proportion to the need for support i.e. the more dependent the young person, the less likely they were to enjoy appropriate interaction. Active social engagement worked out at only 9.6% of the observed time, and the most common way of students occupying their time was 'disengagement'. This was a very small, time-limited study, as the authors are at pains to stress, and it would be easy to dismiss these findings as an aberration were they not consistent with earlier findings from institutional care research (Beail, 1985, Oswin, 1971, Oswin, 1978, Oswin, 1991, Beail, 1989) or Cole's understanding of the residential child care task (Cole, 1986).

Evidence from residential child care

The limited research into residential special schools contrasts sharply with the range and volume of research conducted into mainstream residential child care for looked – after children. Some of this has emerged as Government - initiated critical reports into the sector, and was reviewed in Chapter 2. More recent reports have emphasised the specialist nature of residential child care, and provided evidence of an increasing complexity of challenge to residential child care workers as they deal with some of the most vulnerable children and young people in the community (Crimmens and Milligan, 2005, DfES, 2006, Ward, 2006c, Milligan and Stevens, 2006) and the emergence of specialised residential practice in respect of such children.

Such specialist challenge is increasingly seen as requiring a specialist knowledge and skill base and some of the recent literature provides evidence of the development of such a knowledge base, and its dissemination through qualifying and advanced training (Mainey and Crimmens, 2006, Karban and Frost, 1998, Moss et al., 2006, Hills and Child, 1999, Mainey, 2003, Milligan, 2003, Smith, 2005a, Smith, 2005b, Smith, 2009, Ward, 2004, Ward, 2006b, Ward and McMahon, 1998).

This, in turn has led to the development of a number of coherent models of practice that underpin good quality residential child care practice. Smith (2005b & 2009), for example points to the critical theoretical and practical emphasis in residential child care on the constructive use of the ‘lifespace’ (2005b p.264), and the key importance of skilled use of everyday life activities with young people (Pike 1999). This conceptual framework is developed in detail by Ward (2004; Ward and McMahon 1998) in his ‘theory of the everyday’.

Towards a theoretical framework for residential child care

Recent research into residential child care practice has not only highlighted the contributions of young residents and child care staff to positive outcomes; it has also begun to explore some of the key issues that contribute to positive

and/or negative outcomes for young people. Particular attention has been paid to the allied concepts of 'structure' and 'culture'. 'Structure', according to the authors of the major Dartington study into the organisation and management of children's homes (Brown et al., 1998 p.15) is the 'written, formally agreed institutionalised arrangements which influence behaviour' including 'the mechanisms by which an institution achieves its goals and the relationships between its different components' (p.16).

'Culture', the authors say 'is more resistant to definition' (p.16). Culture is defined by three other authors in the Dartington research team as:

the totality of values, shared goals, norms, shared beliefs, assumptions and expectations, characteristic procedures, routines and customs, degrees of internal cohesiveness, the stance taken towards people and groups outside its own boundaries and the permeability or rigidity of those boundaries (Hicks et al., 1998 p.365)

Recent sociological research, though, has begun to call into question the distinction between structure and culture, suggesting that some essential features of the residential setting which might at first sight appear to be structural in nature, are profoundly cultural, both in terms of the local culture of the residential unit ('the way we do things here') and the culture of the wider society in which any residential unit is located ('the way things are done'). A core example of this, drawn from research into older persons' homes, rather than residential child care, comes from the work of Willcocks and her colleagues (1987) who point out that, at the heart of the residential care process, are tasks that are part of everyday domestic life (bathing, dressing, providing meals, cleaning and tidying rooms, helping people get ready for bed). Such tasks are laden with 'private', 'domestic' meaning but performed in a public setting for relative strangers, and their new meaning in a new place has to be renegotiated between residents and staff members.

Turning to the child care setting, Pike (2008, 2011) has shown, in her analysis of arrangements for school lunches, how an apparently simple set of daily school arrangements is shot through with complex and conflicting meanings. Punch and her colleagues (McIntosh et al., 2010, Punch et al.,

2011, Punch et al., 2009, Dorrer et al., 2011) have made similar observations about the multiple meanings of meal time arrangements in children's homes.

Whilst such ideas emerge predominantly from extended ethnographic studies and post structuralist sociological theory, this is not the only research tradition to suggest that structure and culture in the residential setting is much more complex than at first appears. Menzies Lyth (1988b) in a pioneering study of nurse organisation and deployment in a major teaching hospital, showed how staff rotas and task allocation systems, although dysfunctional in the longer run, served to protect students from the anxiety aroused by working closely with sick and dying patients and (drawing on Kleinian theory) suggested that many of the structural and cultural patterns that develop in institutions serve at an unconscious level as a defence against a potentially disabling anxiety.

Menzies Lyth's work was extended and developed in a study of residential units for impaired adults in the late 1960s. Miller and Gwynne's (1972) study was controversial when it was first published, and remains so today (Hunt, 1981, Barnes et al., 1999 pp.213 - 214). They called the consequences of admission to the units studied 'social death'. They argued that such residential units, whatever their formal statement of purpose, also had an unconscious social purpose which was to provide a place where people who had failed to establish a valued role in society could remain until they were physically dead (pp. 72 – 90). Drawing on open systems theory within the Tavistock framework (Obholzer and Roberts, 1994), they suggested that although this was the primary task of such residential units, this was an intolerable idea for people who work in such an environment. They therefore developed cultures that made the job psychologically bearable, and adopted philosophies of care that made their role possible.

Miller and Gwynne's analysis was (understandably) abhorrent to the nascent disabled people's movement (Hunt, 1981), although their analysis of the liminal position of disabled people in society was not very different from that

of some disabled sociologists (Shakespeare, 1994) and radical writers like Wolfensberger (1972, 1975, Race, 1999).

The intellectual framework for the study

The approaches to residential child care outlined above suggest a three – stranded theoretical framework in which formal structure, practice culture and unconscious defence mechanisms are entwined together in such a way that all three elements mutually influence each other. Frost describes this as a ‘psychosocial’ approach to human and organisational behaviour, pointing out that:

Most importantly to the whole concept, though, is that the ‘psycho’ and ‘social’ elements are not two parallel paradigms, but represent a whole epistemological shift into theorising the (non-rational) subject, within, saturated by, reflecting of and influencing, impacting on and impacted by their social world (2007 p.246)

‘Psychosocial’ is used here to describe a family of theoretical approaches which focus on the interactions between the inner and the outer worlds of individuals, groups and organisations, between individual psychology and social structure, with the emphasis less on establishing the priority of the one over the other (inner over outer or vice versa) than on exploring the interaction between the two. Hollway and Jefferson in their contribution to psychosocial research methodology describe social actors as:

subjects whose inner worlds cannot be understood without knowledge of their experiences in the world, and whose experiences of the world cannot be understood without knowledge of the way in which their inner worlds allow them to experience the outer world.(2000 p.4)

Psychosocial theory takes its origin from developments within psychoanalysis in the immediate pre- and post – war period including Erikson’s work on identity and personality development (Erikson, 1951, 1959), the development of ‘object relations’ theory as a distinctive school of psychoanalytic thought and practice (Gomez, 1997, Craib, 2001) and the coming together of Kleinian theory with open systems approaches in the work of the Tavistock Institute of Human Relations(Trist and Murray, 1990,

Obholzer and Roberts, 1994, Clarke et al., 2008). In recent years, there has been a developing critical interaction between psychosocial theory, critical sociology and social psychology resulting in important work on gender identity (Frosh et al., 2002, Walkerdine et al., 2001, Hollway, 2006), racism (Clarke, 2003), disability (Marks, 1999), criminology (Gadd and Jefferson, 2007), organisational studies (Obholzer and Roberts, 1994, Hinshelwood and Skogstad, 2000), social policy (Hoggett, 2000, Froggett, 2002, Cooper and Lousada, 2005) and qualitative research methodology (Hollway and Jefferson, 2000, Clarke and Hoggett, 2009) (to name just a few).

Psychosocial theory, whilst out of fashion in social work for many years, was influential in the development of social work theory and practice across a wide range of interventions including residential child care and has become increasingly so in recent years, especially under the guise of 'relationship – based practice' (Ward and McMahon, 1998, Ward, 2006c, Ruch et al., 2010, Trevithick, 2012).

In this study, psychosocial theory underpins my understanding of how child care workers make sense of the child care task. Like everyone else, the participants in the study are conceptualised as being continuously engaged in the construction of identity and meaning throughout their lives and doing so both intra-psychically and intersubjectively. Participants will seek actively to make sense of the circumstances in which they find themselves in relation to their own material circumstances, in relation to their previous life experiences (especially to earlier family relationships), in relation to the organisational culture in which they work and in the network of social relationships in which they are embedded (Stevens, 1996).

'Sense-making' is both an everyday activity and a highly problematic one requiring individuals to both draw upon and actively maintain a social world – that is, a shared understanding of what 'normal' is. A sense of the "normal" is continually refined and redefined in the interaction with one's own life story, and with others in daily life: in the family, in the workplace, in engagement with significant social institutions. In this study, the 'normal' that

is constructed is the understanding of the young people who make up the resident population, and the task of caring for them on a day – to – day basis, and the material that is available for the construction of ‘normal’ child care practice are the individual histories that workers bring with them, the interactions with resident young people, the interactions with other staff, the tasks of the working day, and the organisational context within which staff work. A key aspect of the research is thus the understanding of how the normal child care task is constructed out of these psychosocial elements.

But, deriving as it does from psychoanalysis, psychosocial theory is not just interested in how individuals and groups make sense of the social world that they co-construct, but how that sense-making helps to defend the individual against anxiety. The psychosocial self is a defended self (Hollway and Jefferson, 2000), where the pressures of everyday life can re-awaken the anxieties of infancy and the ego has a critical role in developing ways of defending the self against potential sources of anxiety, both individually, in the way that the individual lives their life and interacts with others, and socially in the way that groups and organisations organise themselves not only to enable the effective performance of task, but also to defend against and manage perceived threats to the self (Menzies Lyth, 1988b, Obholzer and Roberts, 1994, Hinshelwood and Skogstad, 2000).

In this study, this means paying attention to the way in which the child care task is both conceptualised and carried out and to ask the question whether the conceptualisation and execution are themselves defensive in nature, and if so, what source of anxiety is being defended against. The implication of this approach for the study of a residential special school is that in order to understand the nature of the care process, as it is experienced by students and staff, it will be necessary to pay attention to the ordinary day to day tasks of care at several different levels:

At the level of **formal structure** there is a need to explore how any task is shaped by or contributes to the formal goals of the school, or the legal requirements for professional practice. At the level of **workplace culture**,

there is a need to explore how any task is shaped by, and makes sense to the individuals, teams or units that carry them out. At the **unconscious** level there is a need to explore how the task helps to protect the individual, unit or team from unconscious anxiety.

If the core question for the study then is: 'in a 52 week residential special school for children with complex learning disabilities and challenging behaviour, how do staff both make sense of, and carry out, the child care task?', the three dimensions outlined above extend that core question to ask:

- a. how is the child care task structured so as to contribute to the formal goals of the school or residential unit, to the development of the child or the discharge of responsibility of the staff member?
- b. what meaning does the task or activity carry for those involved in it? Is that meaning drawn from the external world, or is it something that has developed as part of local culture 'the way we do things here'?
- c. at the level of unconscious structure and culture: is the child care task organised in such a way as to keep staff from experiencing acute anxiety or does it serve to divert attention from a primary task that is potentially distressing?

Studies conducted using this kind of theoretical framework, whether derived from interpretative sociology, cultural anthropology or object relations theory, have drawn extensively on ethnographic research methods using both participant and non-participant observation, supported by unstructured and semi-structured interviews (Hinshelwood and Skogstad, 2000, Clarke et al., 2008, Clarke and Hoggett, 2009). This study will be no different, and Chapter 4 turns to the methodological approach to the study and the methods of data collection and analysis used.

CHAPTER 4 METHODOLOGY AND ETHICS

Chapter 3 concluded with a summary of the intellectual framework underpinning the thesis, and the observation that the framework had been based on research studies that were largely ethnographic in nature. This study, too, utilises ethnographic approaches, and this chapter begins by arguing that in an institutional setting, ethnographic methods offer the best opportunity of defamiliarising familiar settings and thus generating new knowledge. The chapter goes on to describe how the research was carried out, the methods of data collection and analysis and assesses their strengths and weaknesses, before concluding with an extended discussion of the ethical challenges posed by the research and the strategies used to address them

Why adopt an ethnographic approach?

Peter Berger's (1963) classic introduction to sociology says of the discipline:

the first wisdom of sociology is this – things are not what they seem (p.23).

Berger goes on to describe the essential task of the sociologist as being to 'see through' the 'facades of social structures' (p.31). However, as he acknowledges, the challenge faced by the sociological researcher, that makes the task of 'seeing-through' so difficult is that

he (*sic*) lives in society, on the job and off it. His own life, inevitably, is part of his subject matter (p.21)

and maintaining an ability to critically question the 'taken for granted' world in which we live our everyday lives is a critical skill for the researcher to master. For the sociologist:

It is not the excitement of coming upon the totally unfamiliar, but rather the excitement of finding the familiar becoming transformed in its meaning. The fascination of sociology lies in the fact that its perspective makes us see in a new light the very world in which we have lived all our lives (Berger, 1963 p.21).

The challenge, then, for the sociological researcher, is the pull of the familiar. This is a particular problem for researchers in education, health and social care settings since most of the institutions, agencies and practices that are the focus of our research are deeply interwoven into our everyday lives.

If we are educational researchers, not only have we been pupils in school, but so have our parents and our children. Not only have we been pupils, but we may also have been teachers, classroom assistants, school governors or administrators.

Alongside our own lived experience goes the daily diet of discussion of educational policy and practice at the school gate, in the local and national press and on radio and television. Not only are we deeply familiar with the everyday routine of schools, but we also 'know' what the questions are that we should be asking because they are the questions everybody else is asking. What is true of schools is true of all educational establishments from pre-school playgroups to university lecture theatres.

If we are health researchers, it is also true of settings from the maternity unit, through contact with the midwife and the health visitor, to our regular encounters with the GP and the dentist; the dramatic or planned hospital admission and even the place of the hospice in our final illness.

The present study, of a residential special school, is a less familiar, less mainstream setting, although images of 'mental handicap hospitals' and 'boarding schools' may form part of one's unconscious mental furniture, but in my case, I have been both a manager and a practitioner in such a school for a number of years, and a childhood disability practitioner for much longer, shaped by the same policy contexts and principles that were set out in Chapter 2. In those circumstances, how do I 'unlearn' what I know, avoid finding what I expect to find, and allow the setting and the site to talk to me afresh?

Bauman states the problem and the responsibility of the sociological researcher succinctly:

When repeated often enough, things tend to become familiar, and familiar things are self-explanatory; they present no problems and arouse no curiosity.....

Familiarity is the staunchest enemy of inquisitiveness and criticism and thus also of innovation and the courage to change. In our encounter with that familiar world ruled by habits and reciprocally reasserting beliefs, so sociology acts as a meddling and often irritating stranger. It disturbs the comfortably quiet way of life by asking questions that no one among the 'locals' remembers being asked, let alone answered. Such questions make evident things into puzzles: they defamiliarize the familiar. Suddenly, the daily way of life must come under scrutiny. It now appears to be just one of the possible ways, not the one and only, not the 'natural' way of life. (Bauman, 1990 p. 15)

The problem, as Delamont and Atkinson illustrate in their review of educational research (1995, see also Delamont, 2002), is that failure to address the problem of familiarity results in research that only tells us what we already know and fails to generate any fresh insight into the area of research.

How, as researchers, can we ensure that we are engaged in 'defamiliarizing the familiar' (Bauman 1990 p.15) or 'making the familiar strange' (Delamont and Atkinson 1995 p.7) sufficiently to generate genuinely new insights into the institutions, practices or policies that are the focus of our study, given the inherent difficulty of the task?

Alfred Schutz, in an influential paper, advocated adopting the 'perspective of the stranger' in our attempts to explore the familiar social world (Smith, 1998 pp. 16 - 20, see also Hammersley and Atkinson, 2007) as a way of counterbalancing the pull of the familiar. Unlike the 'person on the street' (Smith 1998 p. 16) or the 'well-informed citizen' who is at home in a particular place, operating through tacit knowledge and getting by without the need for much deep reflection, the stranger 'needs to establish an adequate grasp of existing social relationships in order to get by' (Smith 1998 p. 16). This requires the ability to identify key informers amongst the well-informed

citizenry and the asking of naïve questions. As Hammersley and Atkinson point out (2007 p.9) this approach to sociological research in familiar settings is very similar to the traditional practice of the ethnographer seeking to understand a culture which is different from their own:

[a] key characteristic of ethnography is that it attempts to find a relationship between 'emic' and 'etic' understandings of human behaviour. An emic perspective is one that reflects the insiders' or research participants' point of view, whereas an etic perspective is one that echoes the outsiders' or researchers' point of view....Finding a relationship between emic and etic perspectives is not simply a matter of balance, but rather these two ways of seeing are synthesised to explain particular human phenomena against a broader canvas (Madden, 2010 p.19).

A good example of the emic/etic dilemma in this study can be found in a Field Note from 14th October. The first part of the recording is an 'emic' attempt to portray accurately how an experienced staff member understood the roots of a staffing shortage:

I had lunch with Elaine. She is Bryn's key worker and is a very experienced worker. She first started working at Hill House Farm School about 11 years ago, worked here for 7 years, then took another job for a year before returning to Hill House Farm two- and – a half years ago 'because I missed it'. She has just handed in her notice. 'Are you leaving for positive or negative reasons?' 'A bit of both, really, I am going to a much smaller unit, with less stress and pressure' 'Is there a lot of pressure here?' 'Yes, because we are so short of staff'. 'Why is that?' And Elaine then described what she saw as the three stages by which the current shortage of staff had developed:

1. A management decision to cap the number of hours that any agency worker could work in the school to 40 per week. 'How many were they working before?' 'Some were working up to 70 or 80 hours. So when the cap came in, we were immediately short staffed – 30 to 40 hours a week is one less person on shift. To make it worse, some agency staff left altogether to work in places where they could be paid for longer hours'.
2. Non – payment of the overtime bonus. 'Last year, the bonus was paid one month late and that caused real problems. People had to cancel holidays and abandon plans to buy flats and that caused a lot of resentment. With the ending of the scheme, quite a lot of staff decided not to volunteer for overtime, as it was no longer worth the extra work'.
3. The combined effect was to reduce the number of available staff on shift and make the job much harder to do and so people started to leave 'and it's the

experienced people who are going – so not only do we have less people, they are also less experienced, so this shift today has only 5 staff for 7 residents. Fewer staff members means that fewer activities are undertaken – children are contained rather than developed. This summer was particularly bad.

This was then followed by an 'etic' reflection which draws on my own expectations of how staff would view such changes.

As a former manager, I can see why capping the hours which any staff member can work is in the best interests of staff and children – who wants tired staff working with vulnerable kids? But this side of the equation was not something that Elaine mentioned at all.

A full understanding, then, of how the challenge of staffing the unit is viewed across the school has to both understand what managers were seeking to achieve in relation to high quality child care practice, and how that was perceived (or misperceived) on the ground. At root, it is the question of 'what is normal' that lies at the heart of the different understandings. For senior managers, striving to attain a working week of 40 hours is 'normal', whilst for staff on the ground, a working week of 70- 80 hours with significant financial benefits is also 'normal'.

So what are ethnographic methods? Hammersley and Atkinson (2007) say that they

usually involve.. the researcher participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal and formal interviews, collecting documents and artefacts – in fact, gathering whatever data are available to throw light on the issues that are the emerging focus of inquiry (p.3)

and they go on to suggest a number of key features of an ethnographic approach, including the study of people's actions and accounts in everyday contexts, rather than under conditions created by the researcher and the gathering of data from a range of sources, with a particular emphasis on participant observation and informal conversations. They argue in favour of the collection of relatively unstructured data that does not involve following through a fixed and detailed research design from the start and the

developing of categories for interpreting what people say or do that are generated out of the process of data analysis. They also suggest that the ethnographic focus is usually on fairly small-scale, or single settings or groups of people, to facilitate in-depth study, often at the expense of generalisability, and data analysis that involves

the interpretation of the meanings, functions and consequences of human actions and institutional practices and how these are implicated in local, and perhaps also wider, contexts. What are produced, for the most part, are verbal descriptions, explanations and theories; quantification and statistical analysis play a subordinate role at most. (p.3)

Madden (2010 pp. 15 - 20) adopts a similar approach to Hammersley and Atkinson but adds three additional aspects which are: the importance of the ethnographic researcher participating in the social world that is the subject of inquiry; moving beyond data gathering and interpretation to theory building and knowledge building and committing herself to telling a coherent story. This point is particularly emphasised by Fetterman (2010) who says that ethnography:

is about telling a credible, rigorous and authentic story. Ethnography gives voice to people in their own local context, typically relying on verbatim quotations and a 'thick' description of events. The story is told through the eyes of local people as they pursue their daily lives in their own communities. ..The ethnographer is focussed on the predictable, daily, patterns of human thought and behaviour (p.1).

Given the very limited knowledge of residential special schools, let alone of child care practice within them, an ethnographic approach is an obvious way of beginning to explore the issues identified in Chapters 2 & 3. Such an approach allows one to get inside a small part of an individual school, to immerse oneself deeply in the day - to - day routine, the culture and the relationships between staff and child, and to begin to tell the story of how the child care task is understood and practiced in one particular context.

Access and Sampling

Having decided that a single unit study utilising ethnographic methods was more likely to address the research questions than (say) a larger scale survey (either by post or telephone), the research site was identified from the Department for Education's list of non-maintained special schools issued bi-annually, and the similar list held by the National Association of Independent Schools and Non – Maintained Special Schools¹⁸. The site was chosen because it met a number of key criteria. Firstly, it was a school with which I, as researcher, was unfamiliar. Secondly, its OFSTED reports suggested that the school was 'satisfactory' and thus might reasonably be considered to be 'typical', as might not be the case in a school which was either 'outstanding' or in special measures. Thirdly, it was small enough for a single researcher working in a restricted timeframe to be able to get to know reasonably well. Fourthly, its core pupil population fell firmly within the area of interest of the study, and lastly, it was close enough to my home area to make travelling to and fro practical.

An initial approach was made in writing to the Head Teacher and an initial positive response resulted in several preparatory visits to discuss the research proposal, visits that included discussions with the Head and the manager of the unit where I was to be based. These discussions, along with obtaining an enhanced CRB disclosure and obtaining informed consent from staff and parents (see below pp.75ff), took nearly 8 months to complete.

One of the early discussions concerned the sample of the resident population that I would study. There were a number of options. I could have spent short periods in each of the residential units (seven in total), or in each of the classrooms, or in one classroom, or one residential unit. The decision to adopt the last option was taken because it allowed me to observe a wide range of young people, working with the same residential child care staff, but attending a different range of classrooms and activities and this was likely to

¹⁸ For information about the National Association of Independent Schools and Non – Maintained Special Schools go to www.nassschools.org.uk

offer the best opportunity to explore the key issues necessary to answer the research questions. The particular unit was chosen because of the range of ages and impairments represented by the resident pupil group. The research site, its structure, organisation and shift system is described in detail in Chapter 5.

Field Role

The core methodology of an ethnographic study is an extended period of participant observation. O'Reilly (2009 pp. 157 - 162) argues that the term *participant observation* is an oxymoron (the more you participate, the less you observe and vice versa) and so this statement in itself is not very helpful. The question that needs to be addressed is the nature of the role adopted, how that affected the data collected and the impact that that may have had on the research itself. In much of the literature, these questions have been framed as those of the 'role' undertaken in the field by the researcher and the starting point for exploring participant observation has been Gold's article 'Roles in Sociological Field Observations' (Gold, 1958) in which he distinguishes four different ideal typical fieldwork roles:

- complete participant
- participant as observer
- observer as participant
- complete observer

In Hill House Farm School, the option of *complete participation* was not available because of the extreme vulnerability of the young people concerned. Complete participation would have required applying for a post (either voluntary or paid), undertaking full Criminal Record Bureau checks, and participating in preliminary training that would have extended the research period (which was not funded) beyond what was manageable.

Additionally, the research site was nearly 100 miles away from my home to reduce the possibility of my being known to any of the staff or managers and this alone would have precluded full participation in the regular shift system, without moving temporarily to the area. Even had it been available, it is doubtful how useful it would have been. Whilst Gold upholds *complete participation* as a key ethnographic strategy (1958 pp.219 - 220), albeit based on the adoption of a covert approach to research, others are not so sure. O'Reilly, for example says that a *complete participant*, is a participant, not a researcher, and if a participant begins to research, then they become a participant observer, not a complete participant (O'Reilly, 2012 p.110).

If complete participation was not an option, neither was complete observation. Because the research was overt, rather than covert (Gobo, 2008 pp. 107 - 109), staff knew that I had prior experience in the field and talked freely to me about their joys and difficulties, hopes and fears, and whilst I never emphasised my prior managerial role, it was clearly stated in my information sheet, and so I was to some extent a 'knowledgeable other' to whom one could speak, at whom one could moan, off whom one could bounce ideas, with whom one could discuss concerns. I was, perforce, a participant, not an observer. Again, even if the role had been technically available to me, virtually all commentators agree that an ethnographic approach requires some degree of participation. Pure observation is not ethnography.

Participate I did, and although I strove to maintain a position of neutrality, it would be naive to assume that my presence made no difference to how staff undertook their roles, although I have no direct evidence of specific changes arising from my presence either. On at least one occasion, I was approached by a member of staff outside the unit who seemed to me to have a particular view of how the school should be managed and was seeking my endorsement and I took conscious steps to avoid meeting that person again in order to maintain neutrality.

To the resident young people, I was not simply an observer either. As I demonstrate later in this chapter, although it took a long time for many of the young people to really notice me at all, some did. To those who did, I was an object of curiosity, to be poked, touched, stroked and held on to. My watch and glasses were explored, my hands were held on to, I was spoken to and I was given mugs to put in the kitchen. In effect, I was another helpful adult of whom there were many in the lives of the young residents, and it is not clear to me that the residents distinguished between me and any other adult in the unit.

So if I was not a complete observer, or a complete participant, what was I? Gold makes a distinction between 'the participant as observer' (1958 p.220) and the 'observer as participant' (1958 p. 221). On the face of it, I was not a 'participant as observer' since the extent of my participation was very limited. This fact was emphasised, I think, by the requirement that I wore a 'Visitor' identity badge whenever I was on the school premises. Nobody could be under any real illusions as to whether I was a colleague or not whilst I wore that badge. Sufficient immersion in practice to meet Gold's definition would, no doubt, have been very productive as examples of 'participant as observer' research, such as Emond's studies of residential child care, have shown (Emond, 2002, 2003a, 2003b, 2004, 2005). But it wasn't available and that also meant that any role I adopted would fall short of what Adler and Adler (1987) call 'membership', even of the most peripheral nature.

That leaves us with Gold's concept of the 'observer as participant' (1958 p.221). He defines this role in negative terms, arguing that it involves such limited engagement with the field as to lead inevitably to mutual misunderstanding between researcher and informants. Other writers take different views. Bryman writes:

It is likely that certain situations are unlikely to be amenable to the immersion that is a key ingredient of the [ethnographic] method [and] to dismiss it totally as an approach to ethnography is rather restrictive (2004 p.302)

Perhaps more significantly, others like Hammersley and Atkinson (2007 p. 85) (who consider whether the difference between 'participant as observer' and 'observer as participant' has any value to be a 'moot point') disagree. O'Reilly (2009, 2012) argues that roles adopted in the field are a great deal more fluid than formal definitions allow for, . Certainly, the latter would be my experience. When I was sitting in a classroom, with all the staff engaged in restraining a couple of agitated young people, and the resident I was sitting with clung on to me for security, his arms entwined with mine, looking intently at me for reassurance, I was for that period wholly a participant. When I retired to the staff office to write up that encounter, I was a 'participant as observer'; when I returned to the lounge to watch staff at work and ask my naive questions, I was an 'observer as participant'. The roles shifted, the roles changed, sometimes I was consciously aware of those changes, sometimes they registered in my unconscious and I became aware of them later (Hunt, 1989); always, as a researcher, I sought to use those shifting roles in the collection of data, and on reflection on its significance.

Data Collection

The research was conducted over an intensive eight – week period during which I was present at least one day a week, and I ensured that by the end of the period I had been on the premises on each of the different days of the week. My approach was to arrive in the residential unit around 12 noon and remain until young people were getting ready for bath & bed around 6.30, return again at 8.00 in the morning and leave at noon and to do so until I had covered every day, and included both school days and holidays. I also stayed for one long weekend from noon on Friday to noon on Monday, and one day when I stayed until 10.00 at night to observe night staff at work and talk to them. Altogether, this amounted to 75 hours of non-participant observation. This included periods in the house, or accompanying young people into the classroom, going out on short trips, sitting in on staff meetings and shift handovers.

Within the house I would usually position myself where I had good all round vision, and where I would be passed by residents and staff regularly, usually in the hallway, lounge or dining room, or in staff meetings, in a corner of the room. In addition to observing, I also asked 'naive' questions.

This approach was suggested by Delamont and Atkinson's (1995 pp. 8 - 10) recommended strategy for challenging familiarity in the research to 'adopt the ethnomethodological manifesto'. Delamont and Atkinson suggest that this strategy involves two important principles:

The researcher must recognise that every social scientist inevitably uses his or her member's knowledge when studying schools and classrooms. If he or she did not use her (*sic.*) member's knowledge, he or she could not categorize them as schools, classrooms, or recognise lessons, discipline, laughter or finger painting. The researcher must pose the member's knowledge as problematic, and then he or she must explicate the resources shared with participants throughout the research process. A continuing process of making problematic and explicating the resources must occur throughout the research. Such procedures do, by their very nature, make the all too familiar classroom strange.' (p.10)

As an experienced practitioner and manager in childhood disability, I went into the setting with some well established understanding of what practices took place and why. The adoption of a 'naive' questioning strategy 'What were you doing then?' 'Why were you doing that?' 'What will you do next?', allowed me to 'bracket' my prior knowledge and allow my informants to teach me their way of looking at residents, at the task, at the workplace, without imposing my own prior knowledge on it.

Observations, explanations and responses to questions were written down at the earliest possible moment. I had access to the staff office, and so could disappear at regular intervals to write summary notes of what I had seen and heard, which were then written up more formally at the end of each research session. Although I had a small digital tape recorder with me, I swiftly abandoned any attempt to use it, partly because of the practicalities of recording in a busy corridor, lounge or dining room, but also because, if I had used it to record my own observations whilst in the staff room, it would have disturbed other staff working.

The pattern of the research involved staying at a local hotel overnight during each visit and so the balance of time was used to turn initial notes into more formal recordings using a laptop computer. Three different types of recording were kept:

a. Field Notes

A field note was a direct recording of an observed incident, a short interview, an activity or the response to a question. Each note recorded where the observation was made, when (date and time), and the key informant(s). As far as possible, participants' responses were recorded verbatim, although sometimes when a participant's English was difficult to follow, the conversation was summarised rather than reproduced.

b. Theoretical Notes

A theoretical note was an aide-memoire, where a theoretical idea was suggested by an incident, or where an observation seemed to link to ideas from the literature review. Theoretical notes were used later to support ideas emerging from the primary data analysis

c. Research Journal

A simple computer record was kept of what had been done, when it had been done, and which field notes and theoretical notes had been generated during the day, to prevent confusion over data handling at a later date.

In addition to the direct observations and recordings of interviews and question responses, I had access to a wide range of documents in the staff office, including school policy documents, message books, diaries and the files of all the residents. For data protection reasons, none of this material was kept, but notes were taken and included in the field notes, and used for triangulation purposes.

I also had two long, recorded interviews with the Head Teacher, and the Head of Care, towards the end of the research period, and both of them kindly supplied me with a range of school policy documents. Although I used the latter, I did not use the former because, as the analysis proceeded, it was clear that the clash of perspective between the school's senior managers and staff on the ground was very marked, and I chose to prioritise trying to characterise the perspective of staff on the ground without pursuing the reasons for the very different views, although that would make a fascinating agenda for future research.

Data Analysis

Gobo (2008, see also Brewer, 2000, Fetterman, 2010, Hammersley and Atkinson, 2007) suggests that data analysis in ethnographic research is a three-step process. The researcher begins with 'deconstruction', taking apart the data collected and breaking it into smaller units in an attempt to understand the rules and conventions governing a specific interaction. From there, the researcher moves to 'construction', as the beginnings of a story about the data and the interactions that it represents emerge, and finally, there is a process of 'confirmation', when the initial story is tested against other data to ensure that any emerging hypotheses are supported across the whole of the collected data.

In this study, analysis began with the systematic reading and re-reading of all the field notes collected over the observation period. From this reading initial themes began to emerge. These tended to cluster around three areas:

- the principal events of the day: getting up, eating meals, going to school, coming back, getting ready for bed,
- relationships between staff and residents
- relationships between written plans and actual practice

and led to the development of a series of open codes listing these major elements, utilising all the data, observational, interview based and documentary.

At this point the intention had been to use a computer-based data management tool to code and sort all of the data, and two were looked at in detail – the commercially available NVivo¹⁹ and the open-source Weft-QDA²⁰, but both seemed too sophisticated for the task needed and instead the ‘find & replace’ and ‘cut and paste’ functions of Microsoft Word were used to carry out a detailed thematic analysis of all the field notes under the major themes identified. Thus, for example, when the initial coding indicated how important a part was played by mealtimes, Word was used to look for all references to ‘food’, ‘meals’, ‘kitchen’, ‘dining room’, ‘eating’, ‘snacks’, and so on, until there was a set of field notes that exhaustively reproduced all the data relating to food practices, and the surrounding context of those practices.

In Gobo’s ‘construction’ phase, the data was searched for incidents and observations that appeared to illustrate a critical point, and suggest a working hypothesis. At the final stage examples of triangulating data were looked for - either to confirm, or disconfirm, the apparent point. Thus, for example, an early hypothesis concerned the very different ways in which mealtimes were used educationally in the residential unit as opposed to the classroom. From the data in the field notes, it was possible to identify the differences in staff: student ratios in the two different settings, and the differing lengths of time allocated to eating in the two settings and this led naturally to confirmation as to the sources of strain in the residential setting which confirmed the original hypotheses.

The confirmed and triangulated data, along with theoretical material suggested by the developing analysis, was then shaped into a connected

¹⁹ NVivo is published by QSR International and is copyright. Information from <http://www.qsrinternational.com>

²⁰ Information from <http://www.pressure.to/qda/>

story that attempted to explore what was happening in the residential unit. This included what the staff were doing, the context in which they were doing it, the relationship between the task they were doing and the 'official' formal goals of the school, and the relationship with what increasingly seemed to be some of the underlying, perhaps even unconscious contexts of the child care task. These generated the major thematic chapters which are, each of them, an attempt at 'thick description' (Geertz, 2000 pp. 6 - 7) of an aspect of child care practice in a residential special school.

How reliable is the data and the conclusions drawn from it?

The conventional criteria for assessing the strength of any social science research is twofold: is it reliable and is it valid?(Bryman, 2004 p.273) From these two broad questions, one can then derive four subsidiary questions:

Is it externally reliable? This criterion asks if the research is replicable, and the short answer is that this study is not replicable in any conventional sense. An account like this is of a specific place and a specific group of people at a specific time. This particular study was undertaken in the autumn of 2010 in a single residential unit of a single school, and there is no realistic way of generalising, either to other units in the school, to other periods of time in the school's history or to other schools. One might infer from an understanding of the data whether a particular finding might be more widely relevant but only further research would confirm whether it were so, or not.

Is it internally reliable? This criterion is derived from research where there are multiple researchers working on a single project and seeks confirmation that all researchers read the data the same way. However, this criterion cannot apply to a single – researcher project like the current one, and indeed, in so far as I have been successful in addressing questions of familiarity, one would expect at least some of the research subjects not to immediately recognise the findings either.

Is it internally valid? This criterion requires a good match between the theoretical models emerging from the research and the researcher's observations. This criterion is well met, as there is generally a good fit between the data and the emerging theoretical framework, and that theoretical framework is consistent with those developed in studies of equivalent institutions elsewhere.

Is it externally valid? This again requires generalisability, and again this highly specific study cannot easily be generalised, although the fact that other related studies produce not dissimilar results suggest that the outcomes here may be suggestive of wider social structures but only additional research could demonstrate that.

On these criteria, then, one would have to answer the questions 'is it reliable?' and 'is it valid?' with the answer 'to a limited degree'. But in saying this, one is only identifying a problem common to qualitative research and there are other ways of assessing reliability and validity that are more appropriate to a study with an ethnographic approach.

Lincoln and Guba (1985, cited in Bryman, 2004 pp. 273 - 4) suggest that in the place of 'reliability' and 'validity' should be substituted 'trustworthiness' and 'authenticity'. 'Trustworthiness' they break down into four sub-categories:

Are the findings credible? These findings are credible because they are soundly based on a wide range of data from across all of the staff on duty over a two month period in the residential unit studied. Wherever there have been differences of view, these have been faithfully recorded in the research. When shown to school managers, their reaction was to accept that the findings were credible, although they were shocked by them (as the author was at times) and thus the criteria of defamiliarisation was also satisfied²¹.

²¹ In a personal e-mail from the Head Teacher 30th April 2012

Are the findings transferable? Whilst the results are neither generalisable nor replicable in the strict sense, the findings here may well be of value in guiding future research both in residential special schools and other institutions.

Is the research process dependable? This criterion requires a careful auditing of the research process, showing how a particular judgement has been arrived at. The description earlier in this chapter confirms that this criterion is met since every judgement is ultimately based on a field observation, interview or response to a question for which a full audit trail is available.

Is the research process confirmable? This criterion requires that the researcher has not allowed their own preconceptions, personal values or theoretical orientation to sway their judgement. The present author thinks not, but there is a discussion of reflexivity further on in this chapter, and the reader can make up his or her own mind!

In addition to trustworthiness, Lincoln and Guba suggest the additional criterion of 'authenticity'. Of their five headings, four relate to action research, or user – led research of which this is not an example, but the other sub-heading asks: is the research fair? The answer to this is 'yes' in that all viewpoints have been represented. Indeed, part of the emerging hypothesis is that there are differing perspectives within the unit studied, and I have made some attempt at explaining how this has come about.

In summary, then, with all the limitations that apply to any study that makes use of ethnographic approaches, it is reasonable to conclude that this research is both trustworthy and authentic.

Reflexivity and Familiarity

Of course, an emphasis on getting under the skin of an institution and of seeking to 'defamiliarise' begs the question of how would one would know if

one had been successful, to which the most obvious answer is if the research findings take the researcher by surprise. That is, essentially what happened to me in the course of this study, as I intimated in setting the context in Chapter 1 (pp. 3 - 4). In order to establish the degree to which these research findings took me by surprise, it is necessary to say something about my professional background and the assumptions that I brought to the research.

When I first explored the idea of a study of a residential special school over six years ago, I brought a number of key assumptions to the topic which were drawn from my long experience as a social worker, manager and teacher in the childhood disability field including nearly four years as Head of Care in a similar (but smaller) residential special school between 2001 – 2004. Those assumptions, of course, had been shaped by my own personality, training and experience. I am of that generation of social workers who were trained psychodynamically, but whose practice was shaped by the move away from relationship-based practice towards a more outcome focussed approach in the 1980s.

When the Children Act 1989 was introduced I was running a community support service for children with learning difficulties largely influenced by normalisation and social role valorisation approaches. As the manager of a large staff team, I was asked by my employer, (the Children's Society) to train as a Children Act trainer and was intensively exposed to the (then new) Children Act's emphasis on assessment, planning, review and the identification of outcomes. Whilst I did not abandon my commitment to psychodynamic practice (Pike, 1999), much of our work in our project took on emphases on assessment and outcomes even though they were not, at the time, legally required, and when I moved to teach at what is now the University of Winchester, the model of assessment, planning, review and an outcomes focussed approach was what I taught as good practice in child care practice, and in childhood disability practice in particular.

Moving to a failing residential special school in 2001 as Head of Care meant

a fresh opportunity to introduce a planned, outcome focused approach to child care practice. In order to do so I brought in academically well trained practitioners (graduates in psychology and learning disability) including recruiting trained social pedagogues from Holland and Germany. I oversaw the registration of the school as a Children's Home, introduced the National Minimum Standards (DoH, 2002), overhauled the whole of the admissions process, introducing a specialised assessment framework that was built on and consistent with the *Framework for the Assessment of Children in Need and their Families* (DoH, 2000), trained staff in behavioural planning with children, and introduced a new review system. When I went back to teaching it was this model that I taught, with my commitment strengthened by the opportunity to participate in a European social work network where European models of social pedagogy in residential child care predominated (Petrie, 2001, 2003, Petrie et al., 2006). This coincided with a major Government emphasis on social pedagogic approaches that underlay the Green Paper: Care Matters (DfES, 2006) and the White Paper: Care Matters: Time for Change (DfES, 2007).

How did this influence my approach to the research proposal? In this way: I assumed that the kind of interests that I had had, and the kind of battles that I had fought would be the same ones in any residential special school, and that what I expected to discover in any such school were managers and staff who were working towards the same goals that I had worked towards, and which is reflected in much of the research literature and in formal Government policy documents.

This is the discourse that in Chapter 7, I call 'professional child care practice' (see pp.106 ff. below). It is the discourse represented in the literature review in the research conducted by Eric Emerson and his colleagues at Beech Tree House (Emerson et al., 1996, Robertson et al., 1996) and in that produced by Alaszewski and his colleagues (Alaszewski and Nio Ong, 1990). These are clear examples of what I would have called 'professional child care practice' and which I would have been expecting to observe in some detail in The Hawthorns.

As Chapter 3 demonstrates, my review of the literature had gradually begun to suggest that these assumptions not as sound as I had thought at the commencement of the research project, and the research questions that I formulated before going into the field were appropriately exploratory, but it takes more than a literature review to shake a lifetime's professionalization, and I entered the field with some of my assumptions still intact. In fact these assumptions can still be seen in Chapter 7, where I spend a considerable amount of time exploring the available planning documents and the usage made of them (or not) by child care staff.

But my assumptions of what I considered to be 'good child care practice' were not what I found and whilst my review of the literature should have prepared me for what I found, I still experienced a considerable shock when I realised that, in practice, little of what I had spent a professional lifetime thinking of as 'good practice' was taking place in the research site despite the young people being well cared for, nurtured and encouraged to develop. This developing awareness drove me to re-engage, in an iterative process, a wider range of literature, some of it previously known, some freshly encountered, some drawn from other institutional studies as I tried to make sense of the data that I was gathering.

Instead of seeing what I had called 'good child care practice' I saw kind, caring and humane practice that seemed to be based on a very different set of assumptions from those that I brought. I was not alone in this. When I sent the Head Teacher a copy of the findings, his response was one of some shock:

I appreciate your integrity as a researcher and the validity/ accuracy as a reporter of facts stated by some employees. I do find it difficult to believe some of the more damning statements from some employees, showing a considerable lack of knowledge; for instance your focus on items such as the SoP²² and how it is incorporated into practice on a day-to-day basis etc. There are other examples as you are aware. (Personal communication)

²² Statement of Purpose

This sense of surprise shared by myself as a researcher and the Head Teacher goes a long way to suggesting both the trustworthiness and the authenticity of the findings.

Of course, as well as being trustworthy and authentic, social scientific research needs also to be conducted ethically, and the rest of this chapter explores the ethical issues raised by the research and the steps taken to address them.

Ethical issues, consent and assent

The study was an exploration of child care practice in a residential special school for children with complex learning difficulties and challenging behaviour. Given the paucity of knowledge about the experiences of such young people, it could be argued that a better focus for the research would have been the lives of the residents themselves, and that rather than seeking to understand how a particular institution or part of an institution works, I should have been focussing on the social processes that led to young people being in the residential setting at all. However, as the studies of Abbott and his colleagues (2001), and the ESRC 'Life as a Disabled Child' (Watson et al., 2000) project illustrate only too well, the scope and scale of such an exercise would have been well beyond the resources of a single unfunded researcher.

Should, however, the research have been conducted on a more participatory, or emancipatory basis than it was (Walmsley, 2001)? There is an extensive literature now on research where people with learning difficulties either participate as co-researchers or more actively direct the focus and progress of a research project (Walmsley and Johnson, 2003, Beresford, 1997, Gilbert, 2004). However, there is little in the literature to guide researchers in enabling young people with profound impairments to play an active role in the research and what there is points to some of the

real challenges that are posed for researchers (Morris, 1998a, Stalker, 1998).

Of the seven young people (two girls and five boys, age range 14 – 17) in the unit, all were diagnosed with global developmental delay, none had more than a few words, often used well out of context and with multiple meanings: most had only the most basic of Makaton signs, and all were subject of intensive communication programmes, mostly based on the Picture Exchange Communication System (PECS)(Bondy and Frost, 2002). The severity of impairments of the young people, and the challenge of communication meant that at an early stage, the idea that the research might be conducted on a participatory basis was abandoned.

However, as the research involved intensive interaction with vulnerable individuals, a number of strategies were adopted to minimise any potential harm, and full ethical approval was obtained from the School of Social Sciences Research Ethics Committee. These strategies began with a series of explanatory letters sent to the research site for distribution to school managers, to residential staff and to the parents of resident young people. For reasons that are discussed in full below, a simplified explanation was also provided for young residents with a version prepared in Makaton symbols.

Consent from staff and school

Following the explanation, written consent was sought from the Head Teacher, to my presence on the premises, and to allowing staff to participate in semi-structured interviews, to the use of anonymised data from the school in writing up the research and to access relevant school policy documents. As part of this process, I signed an undertaking not to use material gathered in the school until it had been read and approved by the Head Teacher. This commitment was fulfilled in April 2012, when, after some mild adjustments to Chapter 5 to further anonymise the research site, written approval for the use of the material was provided.

Written consent was also obtained from frontline staff to the researcher's presence observing direct practice, to participation in semi-structured interviews, and to the use of anonymised data in writing up the research. Preliminary visits were made to the research site to meet with the unit manager and other staff and to explain the research before consent forms were signed.

Parental consent

Whilst obtaining informed consent from the school and from frontline staff was unproblematic, obtaining consent from parents was much more complex. The starting point was that full consent to observation of the work undertaken with their child and to the use of anonymised data in writing up the research would be requested from each parent, and that was the basis on which approval was given by the School Research Ethics Committee.

The problems in obtaining this were two – fold. Firstly, being a 52 – week school, many of parents had quite limited contact with their child, the school or the school staff, so identifying a way of contacting parents was not straightforward. Secondly, data protection requirements meant that I could not be given the names and addresses or telephone numbers of parents and relied on school staff to contact parents on my behalf. An information sheet and consent form was sent on my behalf. The response to this was signed consent forms from just one parent. After a discussion with the unit manager, a second letter was sent which produced a second response. Helpfully, the unit manager followed up this low response, contacting parents by 'phone and e-mail, and encouraging key workers to do the same, but with no response.²³

²³ The e-mail trail from this period of the research reminds me that during June and July 2010, when parental consent was being pursued by school staff, I was being made redundant and was unable to give as much time to overseeing/supporting the attempts as I might otherwise have done.

The strategy that I adopted thereafter was twofold: firstly, I decided that I would introduce myself to visiting parents and obtain consent face – to – face whilst they were on the premises. Secondly, I would focus my attention on work done with the two young people for whom I held parental consent and try to avoid using material from the other residents. Neither of these strategies worked, and with hindsight, neither of them ever could. It was always going to be unreasonable to intrude on what were often quite stressful parental visits to talk about research, and I never did it. Equally, it was impossible to answer the research questions by focussing only on two residents – as so much material would have been missed.

The solution that I eventually adopted after amended approval from the School Research Ethics Committee in April 2012, was to write a third letter to the remaining parents. This contained a more detailed information sheet including the steps taken to anonymise children, an example of an anonymised field note so that parents could have a flavour of how the research was being written up, and a slip on which parents were asked to ‘opt – out’ of the research if they wished me not to use data involving their child. No such requests were received.

With hindsight, this was less than ideal. Were I undertaking the research again, I would first want to ask whether full parental consent was necessary, given that residents were living in a 52 week environment. If the answer was ‘no’ – then consent on an ‘opt – out’ basis would have been sufficient. Assuming the answer, though, is ‘yes’ then the research should not have gone ahead without a complete set of consent forms. There were a couple of steps that could have been taken but weren’t. One step would have been to have included stamped addressed envelopes with the information sheets and consent forms, which makes completing and returning a form much easier. The other would have been to have sat down with a member of staff, and with their assistance, contacted every parent by telephone or e-mail (or both) to obtain at least verbal consent if not written.

Assent from residents

So far, we have considered the informed consent sought from school managers, school staff and parents. What about the young people themselves? Even though I had abandoned the idea of enabling the young people to be active participants in the research, it remains an axiom of childhood research that children are active agents in the construction of their social worlds and that any attempt at understanding any aspect of a child's social world requires personal engagement with the child in his or her social context (Corsaro, 1997). However the engagement of strangers in the lives of children is both intrusive and potentially harmful to a child.

Established ways of resolving this dilemma by reference to parental or professional consent (such as those outlined above) to a child's participation immediately undermine the concept of the child as an active agent in their own world (Cocks, 2006). If children can only participate as a result of parental or professional consent then they are, at least in part, being viewed as passive participants in an adult world.

For most researchers this dilemma is resolved by reference to the concept of informed consent (Hill, 2005). Can a child be shown to have understood the reasons for the researcher's presence and the nature of the researcher's engagement with them? Has the child given consent to participating in the research? If that is then supported by professional and parental consent, and robust measures for protecting children, then to some extent the intrusive and potentially harmful nature of the research is mitigated.

But what does it mean for a child to give informed consent? Practice in the UK is dominated by the Gillick judgement of 1985 which replaced an emphasis on age with an emphasis on understanding and competence (Cocks, 2006). Consequently, researchers seeking informed consent need to ensure that material about a research project is presented in an age-appropriate manner, to assess a child's competence to understand the material and to confirm a child's competence to consent. Most discussions

about such informed consent have concerned mainstream, normally developing, children.

Far fewer discussions have taken place concerning gaining consent from disabled children, and where they have, they have tended to focus on children with physical or communication impairments, rather than children with intellectual or cognitive impairments (Ward, 1997, Morris, 1998a, Mitchell, 2010). Where such discussions have taken place, they have often emphasised the difficulty of obtaining consent or the need to rely on parental and professional consent (Davis et al., 2000).

Cocks (2006), in a discussion founded on work by Lee (1998), suggests that this is putting the issue the wrong way around. Immaturity, incompetence, and limited understanding, she argues, is of the essence of childhood, and if we construct an approach to consent that relies on adult notions of intelligence, competence and understanding, we are necessarily going to exclude large numbers of children from participation in research.

Cocks argues that we should start from a minimum expectation of 'assent'. 'Assent' means that the researcher is continuously seeking evidence that his or her presence is welcomed and valued by the child, and is causing no distress to the child. She describes the concept as follows:

Assent is represented within the relationship between the researched and the researcher, by the trust within that relationship and acceptance of the researcher's presence. It removes the reliance on the child demonstrating adult-centric attributes such as maturity, competence and completeness; rather it accepts the child's state of being.

Seeking assent requires the researcher to remain constantly vigilant to the responses of the child at all times. It is not something gained at the beginning of the research, then put aside. It requires time and constant effort on the part of researchers, who need to attune themselves to the child's unique communication in order to know when to remove themselves. (pp.257 – 258)

'Assent', then, requires constant openness to the child's communication, and adapting your response accordingly. If the child is indicating happiness at

your presence, you can remain, observed and engaged, if the child indicates that your presence is intrusive or distressing, then you are obliged to respond by removing yourself.

Cock's approach was developed in her doctoral thesis '*We Were All Rather Out of Breath*' (2003) which explored the development of peer groups amongst children with moderate and severe learning difficulties in two respite care establishments. But could such an approach be adopted in research with young people with much greater levels of communication impairment? Or indeed with young people for whom communication was the core problem – young people with classical autism. Severe autism impairs the ability to understand and make meaningful social relationships and to interpret and respond to communicative behaviour. This was the challenge addressed at the beginning of this research

Preliminary discussions with school staff before beginning the research confirmed that informed consent would be virtually impossible, but alongside the consent forms for staff and parents, I also produced very short information sheets for residents and a version in Makaton symbols, along with a photograph so that my face would be familiar when I arrived. Whilst these materials were useful in establishing my own values regarding the importance of children's participation, there was no evidence that they made any contribution to the young people understanding of who I was, or what I was doing there.

So, we are back to assent. For the purposes of this research, assent had been defined as 'a child's active acceptance of the researcher's presence', drawing on Cock's definition. This proved to be wildly over-optimistic. Given that I was prominently located in the corridor, in the dining room, in the lounge, what did the young people make of me? Well, for three of the young people, there was no discernible indication that they had any awareness of my presence at all. And this was typical behaviour. Whilst each of them had staff that they related to, other staff were largely ignored, or treated as if they were part of the furniture.

For the other four young people, recognition of my presence was a very slow process, with the first young person showing signs of recognition after about three visits. The incidents were recorded in field notes as follows:

As far as the young people are concerned, it is not clear to me that any of them are really aware of my presence. Three (Sandy, Amarjeet & Ryan) have come up close to me, and two (Sandy and Amarjeet) have briefly touched me, but there was no sense of any attempt to communicate with me. I got a couple of good hard slaps from Amadi during a period of disturbed behaviour, but I had no sensation that this was targeted and personal; I was merely an object in the way. (Field Note 22nd September)

Amadi spent a lot of time 'exploring' me this morning. He was generally in a very good mood (no more suggestions of an ear infection) and wandered happily up and down the bottom half of the corridor, loudly humming to himself, spinning, turning and moving close in to me and Pete (relief RSW) and then spinning away again.

Frequently, he would look carefully at my face (but without making proper eye contact). On a number of occasions, he picked up my right hand and held it to his nose, sniffing gently. Sometimes he would stroke my hand and others press one of my fingers between his thumb and forefinger. I responded by gently stroking his head, rubbing his hand and patting his shoulder. At one point, he came and stood with his head against my armpit before moving away.

My overall impression was that Amadi had noticed me and was indicating that he was comfortable in my presence. I have yet to note any similar response from any other young person. (Field Note 28th September)

'Singing with Graham' was chaotic with lads running forward to make their choices from the whiteboard, knocking over chairs, falling over other people and having to be restrained. At one point, three members of staff were engaged holding one young man back from getting at the screen and I found myself on my own with Bryn. He reached for my left hand and intertwined his hands around mine, as I had seen him do with other staff. After a while, he removed his hand and began to explore my watch (which I removed), my glasses (ditto) and my 'visitor' badge. Whilst it would be hard to say that he was making any kind of a relationship with me, I felt that he had noticed me and was happy to be sitting with me. (Field Note 28th September)

Sandy had never seriously acknowledged me on any previous visit, but at 4.00, she came across the lounge to me and gently pushed me out of the door. (Field Note 22nd October)

For the second time in 24 hours, Sandy noticed my existence – firstly to hand me her now redundant cup to get rid of, and then to push me out of the room. A balanced approach.

I'm doing well this morning. Not only has Sandy noticed my existence, but Colin came up to me, kissed my shoulder, gently touched me in an exploratory way and then told me 'don't be rude'. I promised I wouldn't. (Field Note 23rd October)

These observations not only indicate how difficult any form of assent, let alone consent, is to obtain from young people with complex learning disabilities, but that if assent is to become a baseline for research with disabled young people, as it should be, if we are to take severely impaired young people seriously as research participants it will need broadening beyond 'active acceptance of the researcher's presence' to include 'no evidence of distress at the researcher's presence' and even 'complete lack of interest whether the researcher is present or not'! As has already been indicated earlier in this chapter, this was not the first, and would not be the last occasion when the particular combination of impairment and setting meant that tried and tested theories and methods from other residential settings did not really apply to the residential school environment

Anonymisation and protection of students and staff

All data has been anonymised, and the thesis has been written to ensure that no individual or the research site could be identifiable in the thesis or any publications arising from the thesis. The research site was further anonymised at a draft stage because the Head Teacher was concerned that in professional circles, it might be recognised, and he now agrees that it cannot be anonymised any further.

All data has been maintained securely in compliance with the Data Protection Act 1998. I have securely retained field notes and theoretical reflections for future work, but all other data will be securely destroyed at the end of the project.

As indicated earlier, because of the vulnerability of the young people, I adopted a participant observer role and did not intervene in the day-to-day care of any child or young person, although I would have done so where a child or young person would be put at risk of serious harm by non-intervention.

Additionally, after discussion with the Head Teacher, I made it clear to staff that the research was non-evaluative or inspectorial, but that I would have taken steps to report practice that was likely to be prejudicial to a child's health or welfare. No such action was necessary.

Having described and discussed the methodological approach of the study and explored the ethical challenges posed by it, Chapter 5 begins the recording of the research findings with a detailed description of the research site.

CHAPTER 5 THE RESEARCH SITE

The research was conducted on site at a residential special school identified here as Hill House Farm School. The research took place between September and November 2010²⁴. In this chapter which introduces the findings from the study, I describe the school, its physical layout, management structure, staffing, the day to day organisation of the residential unit, and the young people resident in the unit in September and October 2010. All names have been changed and geographical references are deliberately generalised to protect identity. Hill House Farm School itself is located in an isolated rural area. It is on an unclassified road about two miles outside the nearest market town, with a couple of small hamlets nearby.

Layout of the school

A narrow single-track driveway with passing places and a 10 mph speed limit leads upwards through overhanging coniferous trees that mark the entrance to the school. At the top of the lane, a right turn opens into the main car park, where the large number of parked vehicles suggests the school's reliance on staff commuting.

The school consists of a mixture of buildings of different dates and styles. At the centre is Hill House Farm itself, a rather grand and well maintained farmhouse of a distinctly 'manorial' appearance. Surrounding the principal building are a mixture of converted outbuildings in the same stone as the farm house (worn limestone in colour) with much of the conversion done in green wood, with dark wood doors and windows.

Further out are residential units, grouped together, all built of a dark red brick and red tiles which contrast sharply with the older buildings. To the left of the

²⁴ The description of the school, its practices and activities are thus those of autumn 2010 and there is no attempt in this thesis to represent any changes that may have been made since November 2010, or to suggest that the findings here are necessarily replicated in other parts of the school. The description is drawn from direct observation and extended interviews with the Deputy Home Manager, Head Teacher and Head of Care.

car park is a large modern building made of yellow concrete, steel and glass with a modernistic sign proclaiming it to be a leisure centre. Connecting the buildings are gravelled paths running between grassed areas, and behind the residential units and to the right are some fenced activity/ play areas.

The farm house and its immediately adjoining buildings contain the main classrooms and additional teaching rooms. The school is split into upper and lower schools. Lower school caters for pupils at Key Stage 3 & 4 (11 – 16) and upper school for the 16 – 19 age group. In 2010 there were 9 classes (5 in lower school, and four in upper) and class size averaged 5 (with one class of three). Lower school is in a modern purpose-built unit to the left of the main entrance. Upper school is in the old house, on both floors. Most classes had an attached break out room if a young person needed to get out of the group, and each group of classrooms had attached art rooms, computer suites and toilets. There was a white room (a sensory suite), and a pottery. The central buildings also housed management and administrative offices, a kitchen and a staff dining room.

There are seven residential units at Hill House Farm School; one of these is a 'preparation for independence' unit called 'The Flat' which houses just two residents, two are newer units for 6 – 7 residents at the bottom of the site, and four are older units at the top of the site, of which The Hawthorns (where the research was undertaken) is one.

The four units are located around a rectangular courtyard which includes a grassed area, some seating and some basic play equipment. The long sides of the rectangle are punctuated by gates giving access to the courtyards and the entrances to the units lie to the left and right of the gates. This means that each residential unit is 'L' shaped. The short arm of the 'L' houses staff toilets and offices and the long arm of the 'L' houses young people's bedrooms, the lounge, the dining area, the kitchen, one bathroom, two shower rooms and several storage areas. The outside of the building and some of the corridors are constructed of a deep red brick, with red tiled roofs. Windows and door frames are of dark wood, although the gates are green.

The corridors are constructed so that there is a convex bulge in the wall half way along, which has the effect of making the corridors narrow, and, combined with the dark red brick, the whole looks dark and narrow. Rooms in the unit are not plastered but constructed of painted breezeblock²⁵.

Management structure and staffing of the school

The management structure of the school was as follows: the school was managed by the **Head Teacher** to whom both the **Head of Education** and the **Head of Care** reported. The **Head Teacher** was supported by an administration and maintenance team dealing with Human Resources, finance, administration and maintenance matters.

The **Head of Education** led the team of class teachers and classroom support workers. Each classroom team consisted of a teacher and classroom support worker. RSWs made up the rest of the team which was always a minimum of 1:1+1. The School only employed experienced SEN teachers as it had only limited capacity to support NQTs and did not run its own Graduate Teaching scheme.

The **Head of Care** led a team of **Home Managers**, a team that was restructured during the research period. On arrival, each of the units had its own Home Manager, but during October 2010, this changed to an arrangement where units were paired with the two senior staff working together, one designated as Home Manager, and the other Deputy Home Manager.

Fully staffed, the staff establishment for The Hawthorns in Autumn 2010 was:

- 1 Deputy Home Manager
- 21 full time Residential Social Workers
- 2 part –time Residential Social Workers

²⁵ A detailed description of the internal design and furnishing of The Hawthorns, with particular attention paid to residents' bedrooms can be found in Chapter 9.

2 Night Support Workers

However, the Home was not in September 2010, and rarely before, fully staffed. At the time of the research, the Home was short of 7 full time Residential Social Workers and the deficit was made up from staff overtime, a bank of relief workers maintained by the school, and if that was not sufficient, agency staff supplied by a staffing agency who were the preferred provider for the whole of the group of schools and residential establishments in the company of which the research site was part.

Approximately 40% of the RSWs were not British Citizens, with the majority being of Eastern European origin, predominantly Polish. A major recruitment campaign a few years previously to bring in Polish workers had been fairly successful. Recruitment was identified by the school as a continual challenge although less because staff turnover was too high, more because it was difficult to fill the vacancies in the first place. The school did not offer accommodation to staff, but incoming staff found little difficulty in securing a place to live in the nearby market town, although staff did need access to a car to get to and from the school.

RSWs were appointed on an incremental scale with the entry salary being approximately £13500 and the top of the scale £17500. Promotion followed annual appraisal and was linked to both experience and the taking on of named responsibilities including shift leading, key working and acting as a 'Meds officer' –that is: overseeing safe administration of medication. Staff training was varied. On appointment, a new member of staff did a week's classroom based induction with a basic introductory curriculum²⁶. They then shadowed an experienced worker for two weeks (longer if they needed it) before joining the rota. A rolling programme of internal and external training was also available and all staff were encouraged to enrol on NVQ 3.

²⁶ Although this was not explicitly stated by my informants, I assume that this was the Skills for Care Common Induction Standards

In addition to the teaching and care staff team, there was also a team of therapists available to all classes and units and this included two nurses, a clinical psychologist, an assistant psychologist, a speech and language therapist and two speech and language therapy assistants. The services of a consultant psychiatrist were available and the team included a reviews coordinator, a transition coordinator and a MAPPA (behaviour management) coordinator.

The school was registered as a Children's Home under the Children's Homes Regulations 2001, was required to meet the National Minimum Standards for Children's Homes issued under the Care Standards Act 2000, and was subject to announced and unannounced inspections by OFSTED, one of which took place whilst the research was being undertaken.

Shift system in The Hawthorns and a typical day for staff and residents

The shift system is on a three shift basis: the early shift is from 7.30 – 15.30; the late shift is from 14.30 – 21.30 and the night staff work from 21.30 – 7.30. There was only a formal shift handover between early and late shifts, but a planned revision to the shift system to come into effect in November 2010 would allow for handover time between night and day staff. Day staff are organised into three teams (nominally of seven staff each) each of which is led by a shift leader: 'Team 'A'', 'Team 'B'', and Team 'C' and the rota pattern for each team is '7 early shifts, 7 late shifts and 7 days off'. Into this pattern are fitted a regular training commitment, usually on Mondays (training took place in a nearby village hall) and 30 days annual leave (14 of these days were rostered i.e. staff had no choice when to take it, and 16 were flexible). Planned changes to the rota would allow all staff to take 30 flexible days in future.

Early shift staff supported young people in the classroom, whilst late shift staff prepared the unit for the young people's evenings. A typical day in The Hawthorns looked like this:

7.30	Day staff arrive. Some young people will already be up and may have had breakfast. Night staff do not help young people wash and dress unless they have soiled themselves.
7.30	Young people assisted with bathing, helped to dress and eat breakfast
8.30	Young people are escorted to school
9.00	Young people take part in one of two assemblies (one for Key Stage 3 & 4, one for post – 16's)
9.30	Work in classrooms
12.30	Young people return to the home for lunch, accompanied by classroom support workers; early shift RSWs take half – hour lunch break
13.00	RSWs return and classroom support workers take a half hour break
13.30	Young people return to school and work until 15.30
15.30	Young people return from school and early shift RSWs go off duty. Individual leisure activities take place in the unit.
17.00	Tea time
18.00	Individual leisure activities in the unit.
20.00	Young people get ready for bed
21.30	Night staff arrive and late shift RSWs go off duty

Residents in the school and The Hawthorns

At the time of the research 43 young people were resident in the School, aged between 11 and 19 with severe learning difficulties and challenging behaviour. The range of placements available included day placements (none at the time of the research), 38 week (term time only), 52 week (full residential) and options between 39 and 51 weeks residential care. The school took pupils from a very wide geographical area covering much of the United Kingdom. Referrals were handled by the senior team (Head Teacher, Head of Education & Head of Care) who would visit any potential new entrant and assess their suitability for the school, and the school's suitability for them. In reaching that decision, the Senior Team might call on advice

from the School's psychologist and/or speech therapist. Once a decision to admit had been taken, a preliminary view as to which unit to place a child in was formed, and the Home Manager consulted as to the suitability of the child for fitting in to the resident group.

At the time of the research, there were seven young people resident in The Hawthorns, as follows:

- **Amarjeet** (female, ethnic origin Indian) aged 14 – parental home in the East Midlands
- **Ryan** (male, ethnic origin White British) aged 16 – parental home in the Home Counties
- **Colin** (male, ethnic origin White British) aged 14 – parental home in the East Midlands
- **Sandy** (female, ethnic origin White British) aged 15 – parental home in South West England
- **Amadi** (male, ethnic origin Black African) aged 14 – parental home in London
- **Bryn** (male, ethnic origin White British) aged 16 – parental home in Wales
- **Callum** (male, ethnic origin White British) aged 15 – parental home in Wales

All the young people had a primary diagnosis of either autism or pervasive developmental delay (PDD), with additional severe learning difficulties, challenging behaviour, communication delay and ADHD. All the young people were mobile.

Having now described the research site, the next chapter begins the analysis of the research findings and asks the question of how residential staff go about the task of understanding the needs and wishes of the young people that they are working with.

CHAPTER 6 THE CHALLENGE OF UNDERSTANDING

Having described Hill House Farm School and The Hawthorns as they were in the autumn of 2010, the next four chapters go on to outline and discuss the data gathered during the research period. In the present chapter, the challenge of understanding young people with complex learning disabilities, challenging behaviour and autism, and the strategies adopted by child care staff to do so, are reviewed. Chapter 7 explores the way in which the child care task was construed in the Hawthorns, in relation to the overall aims of the school and the formal structures of child care planning. Chapters 8 and 9 then consider two very specific and complex areas of the child care task in the Hawthorns – meals and mealtimes (Chapter 8) and the challenges posed by the decoration, furnishing and usage of residents' bedrooms (Chapter 9).

As discussed in Chapters 4 and 5, all the residents in The Hawthorns during the research period had a primary diagnosis of either autism or pervasive developmental delay (PDD), with additional severe learning difficulties, challenging behaviour, communication delay and ADHD. This particular combination of impairments severely limits the ability of a young person to understand and make meaningful social relationships and to interpret and respond to communicative behaviour (Baron - Cohen, 2008, Frith, 2008, Hewett and Nind, 2006).

Of the seven young people in the unit, all had severe global developmental delay, none had more than a few words, often used well out of context and with multiple meanings, most had only the most basic of Makaton signs, and all were the subject of intensive communication programmes, mostly based on the Picture Exchange Communication System (PECS)(Bondy and Frost, 2002).

The complexity of communication

In order to address the needs of the young residents, staff needed to develop strategies for understanding the personalities and needs of each young person. The complexity of this task is well illustrated by the following entries from field notes

‘At lunchtime I observed Sarah (a teacher) asking Sandy if she wanted seconds of her main course. She held out her PECS symbol and the food was put on her plate. However, whilst waiting she removed her plastic apron. Sarah said to the server ‘I think that means ‘no” but passed Sandy the plate anyway, and Sandy ate the food.

Later, before tea, I was talking about communication with Alenka (a support worker) who said that ‘you can usually work out what residents are trying to communicate’. I told the story of my lunchtime observation and Alenka was quite dismissive. She said ‘if the teacher had known Sandy well, then she would have known that Sandy never turns down food!’ ‘However, she said, ‘she finds waiting very stressful and when stressed fiddles with and removes her apron’. Her view was that Sandy was saying yes to food and please hurry up’. (Field Notes 21st September)

Here we have examples of two members of staff, both experienced workers, both with prior knowledge of the resident, albeit in different circumstances, reaching opposite conclusions from the same behaviour as to what a resident is trying to communicate.

The complexity of understanding the young people was highlighted by Halina who said that that she didn’t think that anybody really knew for certain what the young people were trying to communicate.

‘How do you try and work out what they are saying? I asked’ ‘Well, she said – there are three ways: we can go through the paperwork as a team, and see if there are any patterns; or we can look – does he have a temperature, is he eating, is he losing weight? Or we can guess what the meaning is, try something and see if it works’. (Field Notes 21st September)

Looking for patterns as a team, observation and guesswork. These three strategies are well illustrated by an incident when it was unclear whether a resident had an infection or not. In this situation staff observed that a resident

who was not usually agitated had returned from school in a more fractious mood than usual and was repeatedly poking one ear (Field Notes 26th September). Could this be an indication of an ear infection that was causing pain? If so, should an appointment be made with a GP to have the resident's ear examined? In the end, the conclusion was that there was insufficient evidence of an infection, a painkiller was administered as a precaution, and staff decided to 'wait and see'. The following morning the resident was in a very sunny mood and all questions of an ear infection were dropped (Field Notes 27th September). Observation and guesswork. Two other examples illustrate the complexity of the task:

Alenka told me that Sandy had smeared faeces all over her room last night. She wondered why: 'she doesn't usually do that – and she is putting her shoes in the clothes basket, perhaps there is something we are missing' (Field Notes 24th October).

There was no clear answer to Alenka's question – was Sandy unwell? Was she aware of her parents visiting in the morning and expressing distress? There was no answer to any of these questions and the only way to proceed was to wait and see. Rather more difficult was the challenge posed by Bryn on the same day. After refusing to get dressed and lying naked on his bed all morning

Casimir made one more attempt to get Bryn out of bed, and Bryn had a tantrum during which he exhibited extreme distress, banging his head on the corridor floor and with his hands, rolling about and shouting and crying. Casimir got down on the floor beside him, asked someone to fetch some painkiller (served in yoghurt) and gently held Bryn until he calmed. He gave him the painkiller in the yoghurt and after a while, Bryn returned to bed, much calmer. I (wrongly) assumed that the medication was a PRN anti-psychotic and asked what it was. Casimir said that he strongly disapproved of using medication to deal with young people's distress but that as he was unsure whether Bryn was in pain or not, he thought a painkiller a sensible precaution. (Field Notes 24th October)

Note again that it was not possible to come to a clear conclusion as to what was troubling Bryn, and the strategy here involved direct intervention to calm Bryn, combined with the administration of a pain killer and 'waiting to see' what happened next.

Making sense of complex communication

Strategies and responses like this are essentially intuitive and not notably different from the kinds of responses that parents make to newborn infants in the early days of adaptation and adjustment to the newborn (Hewett and Nind, 2006 pp. 16 - 27) and which is described in the literature of EBD schools as being part of a 'containing environment' (Woodhead, 1999) . Entirely missing from these responses was any theoretically driven analysis of the troubling behaviour displayed or the adoption of any form of formal intervention strategies such as intensive interaction (Hewett and Nind, 2006, Hewett and Nind, 1998, Kellett and Nind, 2003, Nind and Hewett, 2003, Hewett, 1998) or applied behavioural analysis (Emerson, 2001). Instead the responses were 'lay' 'common sense' responses drawn from staff member's own life experience. Indeed one member of staff made a point of stressing the importance of not having a detailed knowledge of the particular developmental challenges faced by residents, or of therapeutic interventions to address them:

I asked Pete what training the staff had in autism. 'We get a brief introduction – then have a look at Makaton, MAPA etc'; 'just enough to let us know how their brains work'; 'you wouldn't want to go too far into it or you'd get bogged down. Our role is support so we don't need to get bogged down'. (Field Notes 15th October)

For Pete, therapeutic work with residents is something that takes place in the school environment, not in the residential unit (an issue that will be returned to in Chapter 7 below). For another member of staff, her lack of specialist training was a positive strength:

I asked Beata 'and did you do NVQ3?' She replied 'yes, but I think you learn most on the job. Some people come from Poland (not so many now as used to) and they have lots of theory about what the job is, but they come here and they say to me 'the theory doesn't work here and I have no power' (I think she meant competence) – me, I am lucky because I did not go to University, but started as an au pair and learnt on the ground' (Field Notes 22nd September)

Whilst for Pete and Beata the absence of a theoretically oriented approach to understanding and intervention was a strength, it was not so for everyone:

Alenka and Elaine told me that the school did not use the knowledge and skills that care staff brought. 'That's why Iona is leaving'. 'Is she leaving?' 'Yes, she handed in her notice today – she thought she would be able to use her psychology degree here, but no one was interested – but when she went for interview to her new job, they were very interested in her degree.' (Field Notes 28th October)

These two staff members were not only concerned about the lack of opportunity to use their own and colleagues professional skills and knowledge, but went on to express concern about the general lack of professional support for residential child care staff:

We were all by the window in the corridor leading to the lounge; Bryn was leaning against the radiator and Alenka was massaging his shoulders. 'It's that we don't have one of those, what do you call them, people who help straighten muscles' she said. 'A physiotherapist?' I asked 'Yes, a physiotherapist', she replied 'because, the way he stands, his shoulders are narrowing, and later that will cause his spine to bend and affect his breathing'. 'Is there no school physiotherapist?' I asked. 'No' they replied and commented on the lack of support from professional staff for care staff. Elaine was particularly scathing about psychology support 'she gets paid a fortune, only comes in one day a week, and the intervention plans are based on our observations which we have to take to her. She never comes to observe a child'. 'What about a full psychological assessment – is that ever done on a child?' I asked. 'Not that I am aware of', she replied. 'What about speech and language therapy support?' 'That's better, but they only seem to come at lunch time, when you can't really talk to them'. (Field Notes 28th October)

Whether or not care staff assessment of the role of professional staff is accurate, it seems clear the predominant resource used by residential workers to understand young people's behaviour and think about appropriate interventions is their own lay, commonsense knowledge. Whilst some staff were unhappy about that, this was not a view held by the majority who saw their role as supportive, rather than therapeutic.

In a recent study by Huws and Jones (2010) of lay understanding of autism, the authors found that one of the commonest ways of thinking about autism was to compare autistic behaviour with that of normally developing children and young people. This comparison would highlight behaviour that would then be viewed as different, unusual or 'transgressive' and therefore indicative of autism (pp. 336 – 8). Huws and Jones' respondents were

deliberately chosen from people who had no prior knowledge of any individual with autism.

In the Hawthorns, where staff were continuously in contact with young people with complex learning difficulties and challenging behaviour, comparisons worked the other way around: the behaviour of normally developing children and young people was invoked to provide explanations of behaviour that would otherwise be hard to explain.

During the day, I noted several attempts to give formal explanations for resident's behaviour. These included 'she likes to get attention' 'she doesn't like it when others get attention' 'she gets frustrated' 'Callum and Bryn don't like each other and try to wind each other up'. (Field Notes 27th September)

As I have suggested, such explanations were drawn from 'common sense' everyday life experience rather than any explicit understanding of either complex learning disability or autism.

In an earlier unpublished study of family life with children with tuberous sclerosis (Pike, 2000), I found that many parents drew on a lay psychology to understand the experience of living with a cognitively impaired child and that these lay narratives demonstrated a 'making sense' of the experience that located it in relation to family values and family history. Families expressed particular concerns over understanding and managing complex and challenging behaviour and moved between three different modes of explanation. The first was a popular version of a biomedical explanation, where complex and challenging behaviour was explained as the result of unmediated impact of particular tubers or cysts on critical areas of the brain surface. There was, therefore, no element of meaning or purpose in the child's behaviour, which was essentially random.

The second explanation was a language frustration hypothesis: that the child's behaviour was the result of an inability to communicate their inner anxieties, worries, or needs and that the child's behaviour was essentially communicative in nature. The final explanation was that the child's

behaviour was both purposeful and destructive – (i.e. wilful, naughty, inappropriate) and is consistent with any child's behaviour (reference being made to “tantrums” “the terrible twos” etc.)

Each prospective explanation generated a potential strategy. The first required tolerance, explanation to third parties, and behavioural strategies for control. The second required some attempt at understanding and acknowledgement, combined with teaching of more appropriate communicative strategies. The third required control and management.

In private, parents moved between explanations and remedies and as a consequence expressed great uncertainty as to how to interpret and respond to the child's behaviour. However, such uncertainty did not generate a usable framework for action in public. As a consequence, family members had to pick an explanation that worked for them. In every family in the study, despite the complexity of their views in private, in public they adopted the biomedical explanation, and developed control strategies based on it, utilising clear boundaries; structured rewards and punishments, time out etc.

There seemed to be several reasons for adopting this strategy: firstly, it absolved the child from responsibility for his behaviour; secondly, it absolved the parents from responsibility for his behaviour; thirdly, it allowed for a dialogue with medical and psychological staff utilising biomedical and behavioural frameworks and finally it offered an easy explanation to passers by noting a child's difficult behaviour.

This process was described by one participant as "once I understood, then I could cope". Understanding, in this case meant adopting a workable explanatory framework that generated a usable set of actions (Pike, 2000 pp. 9 - 11).

The same broad usage of these three approaches to lay psychology: 'biomedical', 'language frustration' and 'naughtiness' could be found amongst staff in the Hawthorns, but whereas amongst parents of children with

tuberous sclerosis, the public explanation was always biomedical, in the Hawthorns there was somewhat of a preference for the 'naughtiness' explanation and at times this could lead staff into assumptions about resident behaviour that seemed hard to warrant.

Fiona came through the dining room door just as Amadi was facing it. He broke into a broad smile (the first one I've seen). My immediate impression was that it was a smile of pure pleasure in the presence of a familiar face. Fiona interpreted it quite differently. 'I don't like the look of that smile, young man', she said, 'I think you have just thought of something naughty to do.' (Field Notes 28th September)

Whilst this may have been a simple misreading of an individual incident, there were other more significant examples of ways in which some residents acquired reputations that were perhaps not wholly justified:

I arrived at 8.15 and young people were still getting up. Bryn was being generally uncooperative, refusing to get dressed or eat breakfast. Pete (relief RSW), Lucja (RSW) and I fell into a discussion about Bryn's mood swings. Pete was inclined to the view that Bryn's behaviour was manipulative. 'It all depends what frame of mind he's in'; 'he's a bit of a drama queen, likes to push things to the limit, shouting, screaming and crying'. Lucja was more inclined to think about his sleep patterns 'if he has slept well and is rested, he can be lovely'; 'if he's been up in the night, he's tired, and then we won't let him sleep during the day, so he gets grumpy, like we all do'. (Field Notes 15th October)

Here we have two different accounts of the same young person's behaviour, one of which is of the 'naughtiness' type which attributes the behaviour to the resident's character - 'manipulative' 'drama queen', 'likes to push it to the limit', and thus, in the member of staff's perception, holds the resident accountable for his actions; the other biomedical account links behaviour to whether the resident is over-tired or not, and consequently to any underlying sleep disorder. In each case, the member of staff is constructing an account to make sense of behaviour that is not immediately understandable: an account which may later influence judgements about how to treat that young person and their behaviour.

And this is particularly important when aggression breaks out:

By about 7.30, things were getting a bit noisy. Callum was in his bedroom, bouncing up and down to a DVD as usual, but the noises suggested a degree of frustration and anger. Bryn was wandering in the corridor supported by Bogdan and shouting loudly. Suddenly, as Bryn passed Callum's room, he let out a loud shout, and Callum came hurtling out of his room, stark naked and tried to grab Bryn. Three staff intervened, pulled Callum back and pushed him into his bedroom, closing the door and holding it shut. Callum shouted and banged on the door and walls and bounced up and down on his floor, and staff decided not enter the room for a few minutes as it might be too dangerous (Field Notes 6th October)

What was especially interesting about this incident was that in the discussion afterwards, Bryn's shouting in the corridor was considered to have been a deliberate provocation to Callum, as he was said to 'like trying to wind Callum up' (Field Notes 28th October).

Working at understanding

Whilst the recourse to predominantly lay, common-sense explanations of residents' communication and behaviour limited the options available to staff in terms of both understanding and intervention, this does not mean that support workers did not take great care in their efforts in trying to make sense of residents' communication and respond appropriately to their needs as the conversation between Pete (a relief RSW) and Colin illustrates:

Pete was trying to help Colin make sense of the time until he was due to leave on a parental visit and gave me a running commentary on how he went about imposing a structure:

Colin: 'At half-past ten'

Pete: 'Yes, at half-past ten we'll go to the leisure barn; after that we'll get ready and go in the car at half-past eleven'

[to me: 'he gets obsessed with precise times and it's important to give him a clear sense of structure, but not give him too much choice, as he cannot cope with it']

Colin: 'to see Mummy and Daddy?'

Pete: 'yes, to see Mummy and Daddy'

[to me: 'it's usually enough to give him a sense of the next two events in sequence']

Colin: 'at ten o'clock?'

Pete: 'No, we're going to the leisure barn at half-past ten. What time is it now (showing watch)?'

Colin: 'A quarter past ten, a quarter to eleven'

Pete: 'No (demonstrating by drawing a clock face with his finger on the wall). It's ten o'clock, and we're going to the leisure barn at half-past ten'.

[to me: 'but if you give him the choice of, say, would you like to do this, or that, or the other, he simply becomes overloaded']

Colin: 'At half-past ten?'

Pete: 'Yes, at half-past ten'

Colin: 'At ten o'clock?'

There was more in this vein, and the conversation ended with a much earlier trip to the Leisure Barn than intended! (Field Notes 23rd October)

Here we see a slow, careful, thoughtful and patient attempt to help a resident make sense of a puzzling time sequence (albeit with only limited success). The exchange between Pete and Colin was unusual for the level of verbal communication involved. More commonly, staff needed to explore young people's needs in a much more observational, experimental way:

When the late shift came on duty, it included Bryn's keyworker, Elaine, who very quickly persuaded Bryn to put on a pair of shorts and get up. He came into the lounge, settled in a chair, with his arms tucked tightly under his back, and his legs stretched out in front of him. Slowly, she set about enticing him into a more active frame of mind.

She began by encouraging him to eat a few snacks, starting by feeding him, then insisting he sat up to feed himself. She then gave him a drink, again insisting he sit up to drink. When he lay back down, she began to play a game with him, dangling a string of small beads over his head; starting by swinging them while he tracked them with his eyes, then gently touching his forehead, nose and mouth, and then on to his chest, stomach and side. This was repeated several times until he slowly started to giggle, and tried to catch the beads in his mouth.

Once he was giggling, Elaine told him she was going to take him for a walk, and that he would have to get dressed. With Lucja's assistance, clothes and shoes were fetched, and Bryn was asked to stand and required to help get himself dressed.

Once dressed, he got anxious about doors that were or weren't closed and Elaine checked with Bryn as to which doors were troubling him and encouraged him to check them. They then went into the courtyard and Bryn began to leap and jump – something I hadn't seen all day. (Field Notes 24th October).

The complexity of caring

This was one of a number of examples of caring, thoughtful interaction between residents and staff that built on a careful observation of the resident's attempts at communicating their needs. Each such interaction was highly individual and this degree of individualised interaction marks out the Hawthorns as being very different from many other forms of group care.

One of the key features of the group care setting is that the resident group itself becomes both a source of supportive interaction and a context for therapeutic intervention (Ward, 2006c pp. 13 - 77, Ward and McMahon, 1998, Smith, 2009 pp.88 - 90). The group is both 'cared-for' and caring.

Such an understanding of care also lies at the heart of the (feminist) ethic of care whose advocates have stressed the importance of seeing care as interdependence with care-receivers being caregivers as well (Orme, 2002, Sevenhuijsen, 1998, Meagher and Parton, 2004, Shakespeare, 2000). In a study of looked after children living in foster care and residential units, Holland has emphasised the way in which children living away from home can actively shape the care that they receive (Holland, 2010). Emond in an extended ethnographic study of residential child care in Scotland has shown how relationships within the cared-for group help to frame relationships between resident children and staff (Emond, 2002, 2003b, 2004). Similar findings, sometimes drawing on Turner's concept of 'communitas' in liminal settings, (Turner, 1995) have been noted in ethnographic studies of hospices for the dying (Froggatt, 1997) and older persons homes (Hornum, 1995, Spencer et al., 2001).

Such features are not restricted to settings where residents are relatively cognitively unimpaired as Cocks has shown in two unpublished studies (1999, 2003) where extensive mutual peer support within the resident group was found to characterise respite care establishments for children and young people with severe learning difficulties.

Not surprisingly, nothing of this nature was observed in the Hawthorns. As Hollway points out:

Babies are not born with a capacity to care, but they do need care. They have a capacity to communicate their internal states, and by extension their needs, to someone, usually an adult, on whom they depend absolutely for physical survival, psychological security and viability (Hollway, 2006 p.42)

Given the severity of the global developmental delay of residents in the Hawthorns, they were largely at the stage of communicating their own internal needs, not at the stage of reciprocal caring and, despite the staff interpretations referred to above, seemed generally unaware of each other, interacting predominantly with staff members, in a largely indiscriminate way, although occasionally there were signs that some residents enjoyed the company of identified staff members.

Amarjeet greeted the arrival of Brenda (an RSW) with great excitement, running to her, with a big smile on her face and throwing her arms around her. (Field Notes 14th October)

Such incidents stood out because of their relative rarity. In general terms, the highly individualised challenges posed by residents' behaviour, communication and needs resulted in highly individualised responses from and relationships with staff members. Such relationships could be stressful:

Bryn was very insecure, wouldn't leave the lounge, but was sat in a chair, with Alenka sat on the arm of the chair, her hands interlaced with his. She tried to encourage him to go for a walk, but he insisted on coming back after 10 minutes and then stood in the hallway, hands interlaced with hers, head sometimes on her shoulder, sometimes shouting, sometimes freeing his hands to hit his head, sometimes moving towards the wall to bang his head. He refused point blank to cross into the dining room and showed no interest in food. He remained in this position for nearly an hour. (Alenka said to me that 'sometimes being with the young people is so tiring that we swap staff over – someone is with one child until 6.30 and someone else after that') (Field Notes 21st September)

Staff sometimes managed that stress by noting and laughing at the idiosyncrasies of the behaviour that regularly confronted them. A particular favourite for amusement was Callum's predilection for eating wood,

especially from the unit's door and window frames. This habit had some unexpected consequences:

Callum was out of his room, in the corridor, trying to bite a bit of wood on one of the bedroom door architraves. Pete showed me other places where whole chunks of wood had been eaten. I asked 'does he swallow the wood?' 'Oh, yes, although I don't know how he does it. If you or I were to try and do it, we'd get splinters, or stomach ache, or throw up. It doesn't affect him, although it does affect his faeces. Have you ever seen what he produces?' (I said that was carrying observation one step too far). 'The first time I had to clear up after him, I was amazed. It was this round (describing circle about one and half inches in diameter) and this long (describing 11 – 12 inches with his hands) and when I touched it, it was rock solid. I'll never look at a Christmas log in the same way'. (Field Notes 6th October)

Huws and Jones (2010) found that one of the ways lay members of the community recognise and describe autism is by identifying behaviour that is socially dysfunctional. Here that recognition is being used to comic effect, a not uncommon strategy in stressful working environments where interaction with disturbed and disturbing people is involved (Jeffery, 1979), but, as with Jeffery's study, the implications can be considerable, since the effect is to highlight the differences, the oddities, the bizarre nature of residents' behaviour, to see them, in effect as 'other' than us (Marks, 1999 pp. 126 - 131, Shakespeare, 1994).

'Othering' and liminality

By seeing others as different from 'us', characterised by their odd and challenging behaviour, staff can to some extent distance themselves from the residents, and protect themselves from the anxiety that can be provoked by seeing another in pain and distress or behaving bizarrely (Menzies Lyth, 1988b, Cohn, 1994, Mawson, 1994). It becomes, effectively, an unconscious defence mechanism. The desire to keep oneself separate is well illustrated by this comment from a teacher, helping with lunch in The Hawthorns:

'when I first began working here, I thought I would like to get inside the young people's minds, to try and see the world as they see it, but now I've been here a few years, I'm glad I can't because I think their world is a scary one...sometimes

you can see it in their eyes – just how frightened they are.’ (Field Notes 28th September)

Although this is a casual comment and language is not being used with any great precision, it is worth noting that for this member of staff, residents seem to exist in a completely different world from the rest of us, a world that is fundamentally more frightening than our own.

Once it becomes possible to think of residents as fundamentally different from ourselves, with inexplicable behaviour that contravenes social norms, with behaviour that is out of place (Douglas, 2002 pp. 36-50, Hubert, 2000), it opens up a question that hangs over all forms of institutional care where it is unlikely, or unintended, that the resident will return to a valued social role in the community, that is: what wider societal purpose is played by this institution?

Such questions lead us back to Miller and Gwynne (1972) whose controversial study (Hunt, 1981, Barnes et al., 1999 pp.213 - 214) described the consequences of admission to institutional care: ‘social death’:

[W]hen people cross the boundary into such an institution, they are displaying that they have failed to occupy or retain any role which, according to the norms of society, confer social status on the individual.

To lack any actual or potential role that confers a positive social status in the wider society is tantamount to being socially dead. To be admitted to one of these institutions is to enter a kind of limbo in which one has been written off as a member of society but is not yet physically dead (p.80)

They argued that one of the core functions of long term residential institutions was to manage the transition between ‘social death’ and physical death (pp. 72 – 90). Few writers would use such stark and offensive language today, but a number of studies of long-term institutions have drawn instead on Van Gennep’s and Turner’s concept of ‘liminality’ (Van Gennep, 1960, Turner, 1967, 1995, Deegan, 1989 pp.8 - 12, Szokolczai, 2009, Thomassen, 2009).

Turner wrote that people in a liminal condition are without clear status, for their old position has been expunged, and they have not yet been given a new one. They are 'betwixt and between', neither fish nor fowl, they are suspended in social space without firm identity or role definition. Liminality, he maintained, is an 'interstructural situation' (p.93) [*reference original*]. Contrary to all structural principles, liminal people have been declassified, but are not yet reclassified, they have died in their old status and are not reborn in a new one. In a very real sense, they are nonpersons, making all interaction with them unpredictable and problematic. How does one treat an individual who is in certain sociological respects dead? Due to this nonstatus [*sic*] and its redolence of death, the liminal are socially dangerous people and the solution is to sequester them, interacting with them only within the protective armor [*sic*] provided by ritual formalism (Murphy et al., 1988 p. 237 citing Turner 1967)

The concept of 'liminality' used in this way goes somewhat beyond Turner's original usage and draws on the extended definitions developed by Deegan (1975, 1989) Murphy (1987, 1988) and others. So defined, it clearly overlaps with the Miller and Gwynne concept of 'social death' and has been used extensively in two ways relevant to our understanding of the child care task in the residential special school.

The first of these is its application to the stigma experienced in our society by disabled people, an application made by, amongst others, Deegan (1975, Willett and Deegan, 2001), Murphy (Murphy et al., 1988), Shakespeare (1994) and Harrison and Kahn (2004). Shakespeare, for example, argued that:

the presence of disabled people in the community is a constant reminder of human frailty, vulnerability, and mortality, and as such poses a threat to the social order.(Pike, 1999 p.11)

Secondly, the concept has been widely applied to the provision of care to vulnerable groups including older persons in care homes (Hornum, 1995, Spencer et al., 2001), patients in hospices for the dying (Froggatt, 1997), and caring for older persons with Alzheimer's (Galvin et al., 2005).

The identification of liminality as a core aspect of the experience of disabled, marginalised and dying individuals in our society would suggest that, as

anticipated in the literature review, alongside and underneath the expressed purpose of a residential special school there may be other, wider, societal purposes and that these shape, perhaps not consciously, the way in which child care workers understand the young people that they work with, and the task upon which they are engaged.

In summary, in this chapter I have reviewed the way in which residential care staff in The Hawthorns seek to make sense of the communication, behaviour and needs of the residents they work with. I have suggested that, notwithstanding the undoubted commitment and care that staff manifest towards their residents, they draw predominantly on lay 'common sense' explanations of behaviour and intervention strategies rather than on a coherent theoretically driven knowledge base.

Additionally, I have suggested that some of the ways that staff construct their understanding of their residents is defensive in orientation, to protect themselves from stress and anxiety, and that some of that anxiety may be generated by the social ambiguity of the task of the residential special school which I have suggested may include a wider social role of containing people who, because of the severity of their impairments, are cast into a position of permanent liminality (Murphy et al., 1988 p.238)

If this is an accurate assessment of how residential care staff make sense of the residents that they work with on a day to day basis, how does that effect the way in which they understand their core tasks in relation to those same pupils. What do they think the task is, and how do they reach their understanding? This will be the task of the next chapter to explore.

CHAPTER 7 THE CHALLENGE OF THE CHILD CARE TASK

In the preceding chapter, I suggested that in developing their understanding of the residents that they worked with, residential care staff drew predominantly on lay, 'common sense' understandings of complex learning disability and challenging behaviour. Some of these understandings, I argued, arose from trying to respond to the unique challenges posed by the residents that staff were working with. Others, more defensive in nature, arose from some ambiguity between the expressed educational goals of the school, and a wider social purpose based on the containment of pupils who could be considered to be in a state of permanent liminality or 'social death'.

If this is the case, then it may well be that, from the perspective of staff members, the fundamental purpose of the school itself and the residential staff task within it may be more difficult to make sense of than might at first appear. In this chapter, I continue the process of reporting and discussing the ethnographic data collected during the period of non-participant observation described in Chapter 4.

This chapter explores the fundamental question of the child care staff's understanding of the purpose of the school and how that understanding is turned into every day practice. It has five main sections. The first part explores different discourses of care and education represented in the comments and activities of teaching and care staff working in The Hawthorns. In the rest of the chapter, I explore three sources of knowledge potentially available to staff to shape their understanding of the care task: statutory care planning documents; local care planning documents and staff meetings. In the final section, I draw together some observations of some of the factors that appear to be the most important in shaping care staff understanding of their task.

Competing discourses of care and education

On the face of it, the purpose of Hill House Farm School is very straightforward. Its prospectus describes the school's purpose as being an educational environment where:

learning opportunities extend beyond the classroom to encompass every opportunity for students to develop to their full person potential²⁷.

This is the model of residential special education advocated by Aird (2001), and supported by Jackson (2004). The residential school is said to offer an holistic solution to the education and care needs of very vulnerable young people, with an educational experience that spans the whole of a young person's life offering consistency and continuity. This is what Saunders calls 'the 24-hour curriculum' (Saunders, 1994). The school's prospectus is very much in line with this approach.

But is this how things are actually experienced on the ground, and particularly in the Hawthorns? Two informants suggest otherwise. The first of these is Damian, an experienced care worker, originally from Poland, who suggested to me:

'I think they think that going to school is a strange idea. Sit down. Why? Cut something out with scissors. Why? Stick something on card. Why? There are so many more interesting things to do: places to wander, clouds to look at, wood to be eaten and yet, it is really important that they learn some basic things because they are going to need care as adults and if they cannot sit down at a table, eat with a fork and a spoon and use the toilet, they will end up in much worse accommodation than they should' (Field Notes 28th September)

The second informant was an experienced teacher who had been in the school since 1993. She said:

'The school has changed. When I came here 17 years ago, it was much smaller (just 24 children) and although the children had challenging behaviour, they only had moderate learning difficulties. Then we operated as a combined whole,

²⁷ Taken from school prospectus available in Autumn 2010

education and care staff, working together under the direction of teachers within an overall educational philosophy.

It's not like that anymore and the classification of the residential unit as a children's home has made it worse. We're now inclined to see residential care as 'down time', relaxation time for young people; there is a developing gap between care and education and no overall planning, and recent legislation has made it all worse.

Planning is now based separately on the child's Statement and on the LAC plan, but they only come together in the review process and there is no real underpinning philosophy. Too much attention is paid to legislation and not enough to basic love and care'. (Field Notes 14th October)

Taking these two comments together, we have a number of competing ideas about the purpose of the school and the residential care task within it. The first comment highlights a central dilemma of special education, especially for young people with complex learning difficulties – what is it for? Here there is an acknowledgement that the formal educational programmes in which residents are enrolled are not ones that the young people themselves might have chosen or valued. They are not geared to enabling young people to develop new skills, new knowledge, but rather they are preventative – to prevent young people ending up in more restricted environments in the future. There is no expectation here of a future life in the community, or a valued social role, but rather a choice between less restricted and more restricted environments in the future.

The objectives identified by the informants are those commonly known as the 'hidden curriculum' which is described by Tomlinson as:

those unofficial, informal, activities which count as learning, but which would not appear on a timetable – for example, the learning of implicit standards of appropriate behaviour (Tomlinson, 1982 p.137).

The hidden curriculum is of course common to all schools (Meighan and Harber, 2007, Eggleston, 1977) but what is hidden, or implicit in mainstream education is often made explicit in special education. Tomlinson again:

what goes on in special school might bear little resemblance to the passing over of knowledge, and is often defined more in terms of social skills and the modification of behaviour. In much of special education, the hidden curriculum of normal schools becomes the curriculum of special schools (Tomlinson, 1982 p.137)

The importance of this 'hidden curriculum' approach to education in the school was stressed by Alenka who said of one resident:

She has changed a lot; she was like an animal, eating food off the floor, throwing plates, cutlery and cups and smearing faeces up to 14 times a day. She is not like that now'. (Field Notes 23rd October)

Alenka's observation is, in a way, the reverse of Damian's. Here the very basic level of the social skills being encouraged in the resident is not seen as an imposition on the freedom of the young person, for their own protection, but as an achievement by and for the child. The learning is not to ward off longer term challenges, but to make life better now.

But, as the comment from the teacher noted above makes clear, these are not the only perspectives in play in the school and influencing staff at the Hawthorns. The teacher is drawing on two competing professional discourses, the professional discourse of education, and the professional discourse of care. Here, there is a perceived clash between two competing perspectives, and the replacement of one dominant discourse, that of education, with the division of the school into competing elements characterised by differing discourses.

Trying to disentangle the differing perspectives and discourses, we can see that there are three suggested ways in which the residential care task might be viewed. Firstly, it could be viewed as an *informal care task*, where residents do not have educational goals imposed upon them, and they are allowed or encouraged to pursue their own interests and activities in a caring environment. This is the approach described but rejected by Damian and Alenka, but, intriguingly, in the teacher's observation, described as '*basic love and care*' it is seen as the desirable core function of the residential care staff.

Secondly, it could be viewed as an essentially *educational task* where, in line with the school prospectus, every aspect of the life of the resident is seen in terms of their learning and development. This is the position adopted by Damian and Alenka (reluctantly in Damian's case) and championed by the teacher informant, although in her case, she thought that this was not the predominant approach adopted in the Hawthorns.

Finally, the task could be viewed as a *professional care task*, which is the approach that the teacher informant thinks is adopted in the Hawthorns, to its detriment, but which is not mentioned by either Damian or Alenka.

To look at these perspectives in more detail, we need to start by contrasting informal care and education with professional care and education. In an ethnographic study of the changing role of childminders, O'Connell (2011) distinguishes between the *informal care* given and valued by childminders which is characterised by spontaneity, amateurism, responsiveness and 'tacit knowledge' (p.781) and *professional care* which is characterised by structure, planning, training, certification and the 'technology of quality' (p.782). Holland, drawing on the feminist ethic of care literature, likewise distinguishes between *care relationships* and the *care system* (Holland, 2010). This is reminiscent of the approach adopted by some informants in the previous chapter where lay, commonsense understandings of autism were preferred to theory driven interpretation and understanding.

O'Connell argues that much of the work of childminders is informal in nature, and draws heavily on the experience of childminders as mothers, and there is evidence from the Hawthorns of the same kind of spontaneous, responsive caring that draws on the fundamentals of parental care:

Beata arrived. She opened up the French doors in the lounge, and encouraged Sandy to go out into the courtyard. She then began a chasing game with Ryan which left him in fits of laughter – and led to him initiating a game of 'tag' going up

to Brenda (relief RSW), tapping her on the hand and running away laughing. (Field Notes 23rd October)

Lucja and Iona were playing chase and tag games with Ryan - at which he was laughing hilariously. (Field Notes 24th October)

I was watching Ryan in the courtyard as the afternoon shift were arriving. He was playing 'high fives' with Pete (RSW) and clapping his hands, laughing as he did so. Elaine said 'you should have seen him when he came here. He was very withdrawn, with very intense routines to his behaviour – whereas now he will play with familiar staff. It's a big change.' (Field Notes 28th October)

For Elaine, the spontaneous interactive caring between residential staff and resident is a key element in enabling residents to grow and develop in much the same way that O'Connell's childminders argued that 'mother care' was a more appropriate strategy for working with young children than formalised, professional educational approaches being advocated by government, regulatory bodies and training programmes (2011 pp. 793 - 4) and the respondents in Holland's study were more concerned about the informal relationships they had with carers than with the formal aspects of the care system (Holland, 2010 p. 1676)

In the Hawthorns, as the previous chapter argued, the majority of staff were committed to this model of informal care based on commonsense understandings of the task, although a minority of staff regretted that this was the case. We have already seen that Iona, a young psychology graduate, handed in her notice because she didn't think her degree was being put to use (p.93 above) and that both Alenka and Elaine had lamented the lack of professional support in planning for the care of residents.

However, even within the model of informal care there were differences of emphasis. For example:

Bryn had been lying on his bed, naked, all morning, refusing all attempts to get him up and dressed and getting progressively more distressed as the morning went on. Marco, a relief RSW, expressed the view that Bryn's behaviour was his own choice 'this is his room, and he is not at school so he doesn't need to do something he doesn't want to'. (Field Notes 24th October)

In other words, in Marco's view, the day, week or year can be divided into 'school' and 'non-school' periods with the former characterised by reduced choice and an expectation that a resident will participate in educational activities. Some staff, echoing Damian's view at the start of this chapter, had real difficulties with the idea of imposing any activities on the residents. Beata, one of the shift leaders, put it like this:

Sometimes, I say to them 'it is time for school' and they say 'this child is having a nice quiet time in his room – it's his choice'. So they teach them about choice in the classroom, but I say there is no choice. Do you not know it is the law – they have to go to school and we have to take them? They do not have choice'. (Field Notes 21st October)

School, then, in these accounts has ceased to be a 24-hour holistic experience, but had become one part of a young person's life alongside other parts.

There was universal agreement within the staff team that between the hours of 9.00 to 12.00 and 1.30 to 3.30, Monday to Friday, in term time, pupils should be 'at school', and needed to comply with school routines and requirements. What was not so clear was what was expected to happen outside those limited hours which is at the core of the residential child care task

Staff opinion was divided between those who shared Marco's view as given above, and those who took the view that the whole of the student's day should be a structured learning experience. For example, as we saw, Bryn was allowed to spend all of a Sunday morning and early afternoon lying naked in bed as a result of the application of Marco's approach, but on the change of shift at 3.30, his choices became sharply restricted, as the sequence of events described in the field notes on p.99 above, resulted in him getting up, getting dressed, eating and drinking, and going out for a walk. It was the same sequence of events that led to Sandy being encouraged into

the courtyard and Ryan playing chase with a couple of staff members compared with the situation immediately before the shift change:

Ryan was outside in the courtyard, sitting on the large four-wheeled trike, not moving, shaking his head from side to side and clapping; Amarjeet was in her bedroom listening to music; Sandy was in the lounge watching Tobermory and Tots TV on an endless loop (that's what it felt like; what actually happened was that as each video ended, she would take a member of staff's arm, lead them to the video cabinet and choose the next video. Unfortunately, these were the only two she ever chose) (Field Notes 24th October)

It would be possible to describe these two different approaches to informal care as being '*self-determination*' and '*interventionist*'. Neither of them drew on any formal planned interventions or theory driven approaches to care, but they appeared to be based on different understandings of how the young people should be viewed: in the former case *comparatively* as adolescents whose behaviour was compared with 'normal teenagers', and in the latter case, *developmentally*, as young people who were much less well developed emotionally and cognitively than normally developing young people of the same age. Such different approaches are not uncommon in learning disability or SEN service (Hewett and Nind, 2006 pp.158 - 63, Samuel and Maggs, 1998) and are often linked to misunderstandings of the core framework of normalisation/SRV (Race, 1999, Wolfensberger, 1972, Thomas and Wolfensberger, 1999)²⁸.

So far, we have identified five different potential approaches to the care task in the Hawthorns which are set out in the Table 1 below for clarity

²⁸ Very crudely speaking, the misunderstanding centred around a tendency in practice to interpret 'normalisation' as a requirement to impose age – appropriate culturally 'normal' behaviour on individuals regardless of their specialised needs rather than treating service users as valued individuals encouraged to develop to their maximum capacity.

Table 1 Models of Care and Education in the Hawthorns

	Education	Care	
Formal	'professional'	'professional'	
Informal	'informal'	'informal'	self – determining
			Interventionist

The division between the two models of informal care, 'self-determining' and 'interventionist' is reminiscent of Miller and Gwynne's (1972) study of residential care for mobility impaired adults; they identified two competing approaches which they called 'warehousing' and 'horticultural' (pp. 87 – 90). Whilst again it would be hard to justify the offensive language, and the examples that they give of the two models are now very dated, the basic thrust of their argument still holds water. A 'warehousing' approach focuses on ensuring that the physical and emotional needs of residents are appropriately met without any great aspiration to see residents grow and develop their potential. By contrast a 'horticultural' model emphasises opportunities for development but without regard for the wishes of the resident themselves (Goble, 1999).

Miller and Gwynne's argument is that both models are inadequate ways of addressing the care and development of severely impaired individuals because they fail to recognise the liminal circumstances of disabled residents ('social death' as they called it), and that the care models in use were largely defensive in nature, as they were built upon a refusal to acknowledge the underlying social reality of the residential institution which acts as a place of permanent liminality. Miller and Gwynne argued that care staff needed first to understand and accept the underpinning social purpose of the institutions in which they worked, and then build appropriate care strategies around them.

Examples from the research already cited suggest that for some staff (like Damian) something of the ambiguity of the circumstances in which they find themselves has caused them to ask the fundamental question: what are we really here for? We have also seen that is not the only response that care staff have made. Some like Alenka and Iona have seen the answer as lying in a more professional approach to the care task, which the teacher informant thought was already in play, despite it being rarely acknowledged by Hawthorns staff.

This professional care model is rehabilitative in nature and outcomes orientated. It is the model advocated by Cole (1986) and Alaszewski (Alaszewski and Nio Ong, 1990), is consistent with social pedagogy models from Europe (Petrie, 2003, Petrie et al., 2006, Cameron and Moss, 2011) and is what I described as 'good child care practice' in Chapters 1 and 4. A very good example emerges from the extensive research undertaken by Emerson and his colleagues into Beech Tree House School in the 1990's (Emerson et al., 1996, Robertson et al., 1996). Beech Tree House (Jones, 1983) was designed explicitly on an Applied Behavioural Analysis (ABA) theoretical basis (Emerson, 2001), focussed specifically on the reduction of challenging behaviour, took young people for only two years, taught and trained parents as well as residents and then returned young people to their local community. This is a very different role from the one played by Hill House Farm School and requires a great deal of careful planning and evaluating of interventions with educational and care staff working together.

Planning tools and discourses of care

Residential special schools do have a number of tools, formal and informal, to ensure that there is consistency in the way the residential task is understood and delivered, and taken together these can be seen to be part of a professional discourse of care (the 'technology of audit' in O'Connell's usage (O'Connell, 2011) and the 'care system' in Holland's (2010)).

Not only are the formal elements of care planning a statutory requirement, but a significant body of research suggests that such systems are closely linked to positive outcomes for young people in specialist settings.

Alaszewski and his colleagues, for example, in their study of the Barnardos project in Liverpool in the 1980s, concluded that such units need a robust child care planning system based around six-month reviews setting medium - and long - term objectives, combined with a goal plan setting short - term (day - to - day) objectives. Such a planning system needs to offer: a structure for care; a basis for monitoring progress; a method of coordinating care; objectives that are regularly reviewed and reassessed and effective records. Whilst such systems do not replace high-quality personal relationships between staff and residents, they are critical to success (Alaszewski and Nio Ong 1990). By contrast Beail (1989), in a small evaluative study of a similar service, noted that it was possible for services to slip quickly into institutional practices, and one of the factors that assisted such a slip was the lack of a systematic process of child care planning.

The importance of child care planning was also underlined by Brown and her colleagues in a study aimed at identifying good outcomes in residential child care (Brown et al. 1998). In a study that followed 15 young people from a variety of care settings, she concluded:

The five children who did best were all in centres which produced coherent child care plans. All 10 who did worst lacked such a plan. (p.114)

Most of the remainder of this chapter reviews the various elements of the formal care planning system in Hill House Farm School and explores how the elements are used to shape the residential care task. The first part begins with a review of the statutory child care and SEN planning process.

Statutory planning tools

Any registered children's home (including residential special schools providing more than 295 days care a year) must have a **Statement of Purpose** which is a legal document required under Section 4 (1) of the Children's Homes Regulations 2001²⁹, the content of which is specified in Schedule 1 to the Regulations, and which should be available on request to any member of staff. A summary of the aims and objectives of the residential care provision is the first item to be included in the Statement. The National Minimum Standards 2002³⁰ required that:

all those working in the home are aware of the contents of the Statement of Purpose, and a copy is easily accessible (Standard 1.2).

The role of staff members in relation to the Statement of Purpose was to be a core theme of regular monthly supervision (Standard 28.4). The purpose of this standard was to ensure that all staff worked to the same aims and objectives.

During the research, there did not appear to be an accessible copy of the Statement of Purpose in the Hawthorns, and whilst no informant ever discussed the content of their individual supervision, none ever referred to the Statement of Purpose in explaining their role or intervention, and there was no reference to the Statement of Purpose in any handover or staff meeting attended by the researcher.

Alongside the Statement of Purpose, child care staff should have access to a range of planning documents setting out the aims and objectives of the placement for each young person, and the methods of achieving those objectives.

²⁹ Now replaced by the Children's Homes Regulations 2011

³⁰ Now replaced by the National Minimum Standards for Children's Homes 2011

Formal educational planning documents include: the **Statement of Special Educational Needs**, a legal document prepared under Section 324 (1) of the Education Act 1996, which sets out, in six parts, the results of a multi-professional assessment of a child's special educational and non-educational needs, including confirmation of what those needs are, the proposed learning objectives for the young person, the methods of achieving those objectives and any specific resources to be provided (including a residential school placement). This document is required to be reviewed and updated at least annually. This is supplemented by the **Individual Education Plan** a document setting out short and medium term educational goals for a child or young person

The **Integrated Children's System** (ICS) is used for care planning for children provided with accommodation by Local Authorities under Section 20 of the Children Act 1989 ('looked after children') (although not those whose accommodation is provided under Section 17 of the Children Act 1989 ('children in need')). The ICS documentation contains the following elements: the **Care Plan**; the **Personal Education Plan**; the **Health Action Plan**; the **Placement Plan** (which includes the detail of day to day care arrangements) incorporating a behaviour management plan; the **Assessment and Progress Record** and records of six-monthly reviews.

All of the residents of The Hawthorns had special educational needs within the meaning of the 1996 Education Act, and will have had Statements of Special Educational Needs, Annual Statement Reviews and IEPs. The legal status of pupils was much harder to reconstruct from resident's files, but it appeared that two residents were accommodated under Section 17 of the 1989 Children Act, three under Section 20; one was described as 'accommodated' without being specific as to which section of the Act applied, and one resident had no readily available information about her care status.

Despite some of the ambiguities over legal status, the range of documentation potentially available to child care staff should have given very

clear indications of the aims and objectives of each resident's placement and the approaches to be adopted in caring for them. In practice, this was not really the case as I discovered when I reviewed the two files that I first gained access to at the beginning of the research period.

The detail on the documents varied: that for Ryan was fairly detailed with well written reviews by the key worker and adequate, if not full, reviews and ICS documents compiled by Ryan's social worker. Bryn's ICS documentation was very poor, with the Placement Plan II: Day to Day Arrangements simply stating that these would be decided by the school.

Missing from both files were any of the major documents upon which child care planning in a residential special school should be based. These include the Statement of Special Educational Needs, and the ICS Child Care Plan. Also not included was any assessment of the child done prior to admission which would have set out clear objectives for the placement from the school's point of view.

Perhaps not surprisingly, then, there was little sense in the files of any longer term objectives towards which staff could be working. There were guidelines for managing the 'here and now' but no longer-term objectives that I could see. (Field Notes 14th September)

These were not the only two files which lacked major documentation or where such documentation was poorly completed:

I reviewed the files of all seven residents to try and establish their legal status, the basis of their placement at Hill House Farm and the aims/objectives of their placements as identified by the placing authorities. It was a very frustrating task. There were no copies of Statements of Special Educational Needs on any files, so the educational objectives of all but one young person could only be reconstructed by reference to review documents which in some cases linked IEP targets back to Statement objectives.

The legal status of the seven residents was not always clear and seemed rather idiosyncratic with some young people on 52 week placements with very little parental contact being accommodated under Section 17, contrary to Circular LAC 2003 (13), whilst others with much higher parental contact were accommodated under Section 20. (Field Notes 23rd October)

Whatever their legal status, none of the files contained a full set of documents required either under the old LAC system or the ICS and such documents as there were contained little in the way of formal objectives/outcomes for the placement.

No file contained an ICS Care Plan; 3 residents had all or part of the LAC Placement Plan, with only one of them having both parts I & II. The most common document was the Placement Plan Part II: Day to Day arrangements, of which one was a fairly full document, despite leaving quite a lot to Hill House Farm School to decide, but one was incomplete and in very poor English, and one had targets that were completely inappropriate to the young person's developmental level in which Ryan (a young man with severe learning difficulties and autism) was described as going through an adolescent identity crisis.

No resident had a PEP or an ICS Health Plan (although there was a very full Hill House Farm School Health Plan for each young person) and no Assessment and Progress Record was on file. (Field Notes 23rd October)

The single fullest document on file was an SEN commissioning report for Sandy which set out clear aims and objectives for the placement, under the headings of the Every Child Matters outcomes. However, given the severity of her developmental delay, I wondered how realistic and achievable some of those objectives were, for example:

For Sandy to be provided with sex education; to demonstrate that she has made at least one friend amongst her peers and one friend amongst the staff; to demonstrate that she has taken part in at least one activity in the community; to demonstrate that she can care for herself independently. (Field Notes 23rd October)

The contrast between the placement objectives and the description of Sandy on admission is stark:

she was like an animal, eating food off the floor, throwing plates, cutlery and cups and smearing faeces up to 14 times a day. (Field Notes 23rd October)

It is worth comparing this situation with O'Connell's discussion of childminding (O'Connell, 2011). She describes the formal planning requirements of the Early Years Foundation Stage, and the registration and inspection regime of OFSTED in Foucauldian terms as a 'technology of governance'. She writes of a 'technology of quality' and a 'technology of audit' and suggests that childminders treat the requirements for planning and accounting for the quality of their work as a 'language game' in which childminders adopt the professional language and complete the required

paperwork, but it does not impinge on what childminders actually do, or say that they do, in private.

On the face of it, it seems that a similar situation exists in the Hawthorns – all of the registration and planning documentation referred to above will have existed, but there is little evidence of it being used to develop and guide care interventions on the ground, because it has either not been used to establish clear individual goals and outcomes for residents, or because the materials are not available to staff to shape their daily work.

Local planning tools

If the formal education and care planning documentation in practice offers little guidance to child care staff, may it not be that the school's own documentation might play a constructive part in orienting staff towards an understanding of their task? Hill House Farm School certainly has a range of relevant documentation, and more of it is readily available to child care staff than is the case for statutory documentation:

The files, together, contained a summary of likes and dislikes written as if by the child and illustrated with pictures and symbols; some SEN review documents with an IEP and targets for the term ahead (some of which in Ryan's file included goals for the residential staff), a colourfully illustrated communication strategy, a behaviour management strategy and notes on restraint approaches (the school uses MAPPA as a restraint framework), risk assessments and detailed health records (trips to GP, dentist, eye tests etc.) and some notes of visits and communication with parents etc. There were also specific guidelines for mealtimes and bedtimes, old medication charts and some blank forms for various eventualities.

The detail on the documents varied. That for Ryan was fairly detailed with well written reviews by the key worker. Bryn's keyworker was clearly someone for whom English was a second language, and all the documents were completed minimally, and riddled with language and spelling errors, and conveyed very little sense of Bryn, his needs and objectives. (Field Notes 14th September)

But these documents were not without problems:

there was little sense in the files of any longer term objectives towards which staff could be working. There were guidelines for managing the 'here and now' (mealtimes, bedtimes, medicines, challenging behaviour), and generic guidelines on communication – and, even, in Ryan's case, some short-term targets for the months and weeks ahead – but no longer-term objectives that I could see. (Field Notes 14th September)

Many of the local plans had been written by professional staff working centrally in the school, and as was discussed in the previous chapter, some residential staff expressed concern at a lack of support in interpreting and applying the plans that existed. A particularly good example of this comes from the attempt to implement communication plans prepared by the school's speech therapists at mealtimes in The Hawthorns. This communication plan is included in each child's file, and part of it is reproduced as a laminated card that serves as a table mat for each young person.

Crucially, though, the learning opportunity is predicated on there being a 1:1 staff: resident ratio during lunch, which means, given that one member of staff (often the shift leader) is in the kitchen serving the food, if every resident is in the dining room, at the same time, there needs to be eight staff on duty. Even when that staff ratio is maintained, it is a struggle to maintain the meal as a learning opportunity. What happens when that staff: resident ratio is not available?

As usual, RSWs were replaced by teaching staff for the first half an hour, and initially just two teachers were supporting seven young people, with Fiona, the shift leader, serving meals from the kitchen. Indeed, so stretched were they, that one teacher radioed for additional assistance. However, a ratio of 3:7 still left staff very stretched. This is illustrated firstly by the abandonment of the formal meal structure 'sit, wait, bring up your PECS symbol, take your food, sit and eat with fork or spoon' that underpins social learning in the unit. Today, some meals were served directly to students at the table, others were allowed to eat with their fingers or hang around the kitchen hatch until served. The second illustration came when one teacher, Sarah, was talking briefly to me and took her eyes off Bryn. In a flash, he stood up, picked up his plate and threw it out of the window (the window is about five feet off the ground). Sarah and Bryn then had to go out of the building to fetch the plate, leaving a staff ratio of 2:6 to cover all other eventualities. (Field Notes 27 September)

What happens, of course, is that the use of a mealtime as a learning opportunity has to be abandoned.

Staff meetings

Important though a written care planning process is, it is not the only tool that is available to care staff. Ward (2007 pp. 154 - 6) emphasises the importance of staff meetings and identifies eight different types of meeting. I was not present for any formal staff meeting, and no informant ever referred to one in their discussions of the work. However, shift handover meetings were held once a day. Ward says of handover meetings:

[they] should play an important part in helping individual workers to 'process' the day's work, and the proper use of a system of handover meetings will enable the team as a whole to bring the work of the shift to a satisfactory conclusion, just as we have already seen that it provides the means of bringing people together at the start of the shift to share their planning and preparation (Ward 2007 pp. 139 – 40)

Ward's pattern was barely recognisable in the handover meetings observed:

The handover was carried on against the background of the Home Manager working at her desk, and taking and receiving telephone calls and a couple of people popping their heads around the office door with queries for the Manager. I found it distracting, but none of the participants seemed to.

Conversation was entirely restricted to the three female participants who seemed lively and engaged. The three men did not participate. For reasons that were not clear to me, the handover did not just cover the period that had elapsed since the last shift handover but covered the whole of the weekend.

The focus of the handover was firmly on the young people: indeed I did not notice any reference to anything done by a member of staff, left outstanding to be done, or any specific tasks for the rest of the day. The handover was anecdotal, dealt sequentially with each young person in turn, and highlighted the things that the young person had done, the challenges that they had posed (if they had) and specific issues around the issuing of medication and toileting problems. As with the files, there was no sense of there being longer-term objectives in relation to the young people, but very much a sense of tackling and resolving 'here and now' challenges.

A key phrase that repeated itself in respect of several young people was 'he was happy' 'she was very happy' 'he was very, very happy' and as far as I could

determine this was the only reference to a successful outcome of any activity that was referred to. (Field Notes 14th September)

What emerges from these meetings is that they are not used as planning meetings either for individual children, or for the activity of a whole shift, and there is no exchange between shift teams of approaches to planning for individuals or the whole group. They vary from 'letting off steam' after a stressful shift through to 'managing the here and now' in relation to immediate problem solving. During the meetings observed, there was never any reference to the longer-term goals for any or all of the residents, or to the purpose of the school as a whole.

Tacit knowledge and shift team culture

So, in the absence of a consistent approach to the understanding of the residential child care task or to a clear sense of planned outcomes for individual residents, how do child care workers make sense of the task? In the previous chapter, I argued that staff were continuously engaged in trying to make sense of the needs and wishes of the residents they were caring for, albeit often finding it very difficult to do so. What seems to be happening is that in the absence of a clear formalised understanding of the residential child care task, either globally, or in relation to specific young people, staff start to develop an informal understanding of the task, 'tacit knowledge' as Schon (1991) describes it.

As with other forms of meaning making, such activity will be done intrapsychically in relation to an individual's previous life experiences, both consciously and unconsciously recalled and in relation to the primary social group in which the individual is located (Stevens 1996). In the case of child care workers, that primary social group is a two-fold one. In the first place, much of the nature of care work replicates the everyday experience of family care, of caring for and being cared for in family groups in a very informal and intuitive way. The roots of the capacity to care lie in our childhood experiences of intersubjectivity, attachment and separation (Heard and Lake,

1997, McCluskey, 2005, Hollway, 2006) and therefore draw upon our experiences, good and bad, in an unconscious way (Menziés Lyth, 1988b, Obholzer and Roberts, 1994). But, in addition, many of the tasks of caring in an institutional setting are essentially private tasks replicated in a public environment (Willcocks et al., 1987, Ward, 2004): the tasks of helping children get up, use the toilet, get showered and dressed, prepare and eat breakfast, get ready for school etc. not to mention the more basic tasks of changing soiled incontinence pads, changing bed linen and washing clothes, or settling an unsettled young person to bed, are essentially domestic, family oriented tasks that draw upon experiences of our own childhood, or own experience as a parent. Indeed, O'Connell in her study of child minding (O'Connell, 2011) argues that informal, family-oriented care is not only what childminders draw on for their daily practice, but also what parents leaving children with them expect.

However, the internalised family may not be the only primary group to influence the care task in the Hawthorns. Brown and her colleagues (Brown et al. 1998) noted that in the children's homes in her study, there were often strong staff cultures. Culture, in this sense, is used to describe the unwritten norms and expectations of a staff group which governed the nature of child care practice. She noted some cultures that were consistent with the formal aims and objectives of the homes, whilst others actively undermined such objectives, and suggested that positive outcomes for residents were linked to the degree of conformity between formal structures of the homes and the staff culture. Where formal goals and staff culture coincided, outcomes were usually good; where they clashed, outcomes were less good.

Kate Fox, in her studies of race goers and pub regulars argues that participants in liminal spaces seek to reduce the anomalies of their situation by the creation of what she calls 'a social micro-climate' which she defines as a 'social environment' 'with behaviour patterns, norms and values that may be different from the cultural mainstream' (Fox, 2004 p.89, Fox, 2005). What Fox calls a 'social micro-climate' contains the same elements as Brown's 'culture' and her concept, in turn, is based upon Turner's concept of

'communitas'³¹ - the social anti-structure that develops between participants in liminal situations, where hierarchy breaks down, normal social conventions are put to one side and a strong sense of group identity develops. Given that in Chapter 6, I suggested that the residents of the Hawthorns were in a permanently liminal position, were 'socially dead' and that the staff themselves are also in a liminal position (an idea that O'Connell also uses for her childminders (O'Connell, 2011), is there evidence in the Hawthorns of the development of 'team culture' or a 'social micro-climate'?

The evidence is elusive. There was never any reference during the research period of loyalty to the school as an organisation or to The Hawthorns as a unit but there was a small amount of evidence both of loyalty to the shift team, and of the possibility that shift teams could contain differing assumptions about the nature of the care task. The primary loyalty of staff to the shift is suggested by the following two illustrations, both relating to the same shift team:

I was standing in the corridor and heard Bogdan, Tony & Pete talking about tomorrow's shift. They were commenting that Diane (the shift leader) was going to do another 14 hour double shift tomorrow and was likely to be short of staff. Pete said 'I told her that I'd come in and help, and so did Tony. Now I see we're down on cover sheets³² for tomorrow. But I'm only coming to work in this house for Diane, not for the school. She does a lot for us, and leads a good team, and we need to help out in any way we can'. (Field Notes 6th October)

and a few moments later, Diane herself commented:

'I'm very fortunate. We've got a good team here and they work together well. It hasn't always been like that. Sometimes in the past we've had a couple of people who don't really pull their weight'. 'Have you had to get rid of people in the past?' 'Oh, yes. It wasn't easy, but we had to do it. Fortunately, none of those problems now.' (Field Notes 6th October)

³¹ As before, the way in which the concept of 'communitas' is used here goes well beyond Turner's original usage and is used in the same way as Fox (2004, 2005) and Hornum (1995)(the latter in the context of residential care of the elderly)

³² 'being down on the cover sheet' meant that you were potentially available to work in any residential unit

May it be that the different shift teams also adopt different care cultures? Earlier I suggested that there were two different approaches to informal care in the Hawthorns which I called 'self-determination' and 'interventionist' and illustrated this with examples from a shift handover from one shift team to another at 3.30 on a Sunday afternoon. This may suggest that each shift has a slightly different informal philosophy of care which is strengthened by a strong sense of mutual loyalty within shift team.

Unlike Brown's study, cited earlier (Brown et al., 1998) it would be wrong to say that staff in Hawthorns undermined formal objectives, rather that their culture developed in the absence of a clear understanding of what those objectives were. Where the Hawthorns differs from Brown's findings may lie in the way that different shift teams, rather than different units incorporate different cultures, and this, presumably would be related to the relatively long periods that people work on a specific shift and the depth and quality of the personal relationships that develop. The evidence from this research is too limited to be certain, but would make a fruitful area for further research.

This chapter has suggested that far from having a clear understanding of the professional care task, drawing on a clear philosophy of care and well planned objectives and outcomes for children, residential carers in the Hawthorns draw largely on informal models of care that draws more on a forms of 'tacit knowledge' than formal planning frameworks. Additionally, there may be competing models of informal care associated with a sense of identification with particular shift teams.

It is argued that such position arises partly because of the usage of the formal planning process as a 'language' as opposed to a serious working tool, and partly because of the inherently ambiguous position of the residential special school and the liminal status of both resident and care staff.

In the next two chapters, the ambiguity of the residential child care task, and the ways in which staff adapt to address the challenges posed by residents

are explored in two very specific contexts: that of the provision of food at mealtimes, and the complexity of developing a common understanding of how residents' bedrooms are to be used.

CHAPTER 8 THE CHALLENGE OF MEALTIMES

Chapter 7 has argued that the nature of the residential care task in the Hawthorns depends less on such formal planning mechanisms as exist in the school than on the way in which the task is constructed from the tacit knowledge of the staff, and possibly in interaction within the shift teams. This is particularly well illustrated by the way in which staff interpret in practice the core elements of everyday life: getting up, getting washed and dressed, eating meals and going back to bed.

Chapters 8 & 9 explore the micro-construction of the residential care task at The Hawthorns in detail, as it is seen in one core task: delivering food to residents at mealtimes, and with regard to one core location, the resident's bedroom. In both chapters, there is an attempt to demonstrate how the anomalous nature of the setting, and the complex challenge of resident behaviour, require the adoption of new strategies that do not fit comfortably within any of the prevailing discourses of care and education identified in Chapter 7. It is in the adoption of these strategies that the team cultures or social micro-climates identified in the last chapter develop.

This chapter is about food and meals. Mealtimes feature in both of the professional discourses discussed in Chapter 7, the discourse of education and the discourse of care. In the former, mealtimes are seen as a key opportunity for the teaching of essential behavioural and social skills (Warner, 2006 pp.70 - 80). Cartwright and Wind – Cowie describe the approach in detail:

Mealtimes are occasions that should be developed collaboratively using advice from speech therapists, occupational therapists, physiotherapists and dieticians. Many schools now see mealtimes for pupils as part of the learning day and feeding programmes are seen as educational programmes included in the hours recorded as curriculum time. Attention should be given to choice-making, anticipation, likes and dislikes and signals used to demonstrate these responses. These times need to be carefully developed, planned, monitored and where appropriate recorded (2005 p.14)

In the latter discourse, eating together is one of a number of everyday requirements that are at the very core of the residential child care task, and are conceived as such by writers on residential child care practice. Such writing is predominantly in the therapeutic tradition (Ward, 2006c, Ward et al., 2003, Hardwick and Woodhead, 1999), and the emphasis is on what Ward (2006a) calls an 'ordinary life' approach. He writes:

this ordinary life approach to residential care is implemented through planning everyday routine events in such a way that they will perhaps feel more like 'family life' than 'institutional living' - and even the very notion of 'routine' events may be questioned. Thus, for example, mealtimes will be relaxed and informal, using home-cooked food, sitting in 'ordinary' sized rooms and in small groups rather than at large refectory – style tables: all of which is now standard practice in almost all residential child care settings (2006a p.338)

In other words, the emphasis is on recreating the idealised family meal at the expense of the reality that children are not at home, and that the people sharing food with them are not their parents.

Other writers emphasise the importance of quiet, reflective, shared meals as a key part of the therapeutic experience for the child; the building of relationships between young people and between residents and staff. The aim, in therapeutic terms is to rebuild the trusting relationship between adult and child that many residents will not have experienced:

At mealtimes, it may be possible to recreate something of the context of the earliest relationship with food that a child has. In order to do this, mealtimes need to become more structured and quiet, with the opportunity for individual conversation between carer and child, conducted in an unhurried manner, with space for attending to the emotional experience of the child (Pike, 1999 p.9).

Jackson, in his book Holistic Special Education (2006a), exploring residential special education in the Camphill/Steiner tradition, includes the following comment from the parent of a pupil that brings together both discourses in a single mealtime model:

Meals at Camphill provide a dual purpose – an opportunity for the whole house to get together and an opportunity to learn by example (p.248).

The formal approach adopted in relation to food at Hill House Farm School is the education model described above and follows the statement in the prospectus that the school offers:

learning opportunities [which] extend beyond the classroom to encompass every opportunity for students to develop to their full person potential (School Prospectus 2010).

The specific teaching approach is devised by the school's speech and language therapy department and is contained in a colourfully illustrated communication strategy included in each child's file, part of which is reproduced as a laminated card that serves as a table mat for each young person.

In reality mealtimes in the school were very different from either a professional educational model or a residential childcare model, let alone the dual model advocated by Jackson. The rest of this chapter explores those differences, beginning with a description of the structure of food practices during a typical day. After this comes a discussion of the 'learning opportunity' model of mealtimes, followed by a discussion of food practices as relationship building, before looking at what is actually taking place and drawing on some parallel studies of food practices in other residential child care settings.

The structure of food practices in The Hawthorns

Mealtimes are organised in this way: Resident young people take all meals in the residential unit, apart from snacks and drinks given as part of the teaching programme in the classroom.

Each residential unit has a separate kitchen and dining area. At the Hawthorns, the dining area had three pine tables, two of which were rectangular, each seating six people and one of which was circular, which could have seated up to four people. Apart from the tables and chairs, there

was no other furniture in the room, although there were a range of built in cupboards along one wall which stored art and craft materials. The dining area was accessed by a single doorway opening on to the main corridor, and a serving hatch leading to the kitchen. A further serving hatch on the other side of the kitchen opened into the lounge.

The kitchen has a range of storage cupboards for cutlery, crockery and food items predominantly for breakfast, and mid- afternoon and evening snacks. The school has a central kitchen which prepares main meals for lunch and tea, and this is fetched from and returned to the kitchen by child care staff using a large mobile heated trolley, which is plugged into a socket in the kitchen to keep warm, and meals are served individually to residents from the trolley, usually by the shift leader. When not in use, the kitchen is kept securely locked to prevent young people coming to harm. There is no capacity for youngsters to prepare their own meals, and, given the severity of cognitive impairment of residents, no real need to provide this opportunity.

In addition to the central kitchen, there is also a central school dining room where teaching and residential staff can take breakfast and lunch on weekdays, although staff can also take meals from the heated trolley or from stocks in the kitchen if they prefer.

Food is made available to residents and staff in the following pattern:

a. Breakfast

This is an informal meal, and particularly informal at the weekend. Whilst some residents who are up early may be given breakfast by the night staff, most take breakfast between 7.30 and 9.00 when the morning shift come on duty. Breakfast is made individually for residents drawing on staff knowledge of young people's likes and dislikes and offering basic choices (would you like 'this' or 'this'?). Young people can eat breakfast seated at a dining room table, but some take food back to their rooms and eat sitting on their bed, or on the floor. Whilst individuals are taking breakfast, others are bathing,

showering and getting dressed, so supervision of young people is very low key. Medication is often administered whilst young people are eating breakfast.

On a school day, school staff (teachers and SSAs on a rota basis) arrive to assist young people to finish off breakfast, get dressed and go over to school. Residential staff can then have a breakfast break, either in the unit, or in the staff dining room. At weekends and during school holidays, staff are not able to take a break and breakfast may go on much later, as young people sometimes remain in bed.

b. Mid – morning snacks

Around 10.15 in the morning, formal teaching and learning activities are suspended for mid-morning snacks, an activity that can take up to 45 minutes to complete. Practice varies between classrooms but young people may be offered a range of foods such as toast, biscuits, sweets, fruits and nuts along with a choice of hot or cold drinks. Staff also take either tea or coffee at this point. In some classrooms, pupils are expected to help prepare the snacks and clear away afterwards, and this can be recorded on a visual rota using PECS symbols affixed to the wall. Pupils are supported 1:1 in their activities by teaching staff, SSAs and classroom–attached RSWs.

c. Lunch

At 12.30, teaching staff (again on a rota basis) take pupils over to their residential units, link up with those residential staff who have not been in the classroom during the morning, and supervise the young people eating lunch. Residential staff who have been working in the classrooms take a half hour break in the staff dining room before returning to the residential unit at 1.00, to relieve teaching staff who can then take a short lunch break themselves.

Supported by staff, each pupil is expected to sit at the table, wearing a plastic apron if necessary, and, when their name is called, take the PECS

symbol from their symbol book for each course up to the hatch and exchange it for a plate of food and either a fork or spoon. They were then expected to return to their seat, eat their food quietly, with either the fork or spoon (not fingers!) and then repeat the process for the next course, and finally for a drink.

It has to be said that few meals actually followed this pattern:

When I entered the dining room, Callum had already arrived, and was supported by two members of staff, who were encouraging him to stop bouncing around the room, and to sit at the table. Once seated, he was supported to find the PECS symbol for dinner and take it to the serving hatch, when called. This was exchanged for a plate of food and a fork, and Callum returned to his place. This process 'sit, wait, listen for your name, take your picture up, collect your food and return' was repeated for seconds of the main course, dessert and a drink, and was much the same for each child.

The staff supporting Callum had to be continually watchful as, if their attention wandered, Callum would put his fork down and begin eating with both hands. It became clear as I watched that the core aims for the young people at lunch time were very basic – sit, wait, collect, and eat with an implement (fork or spoon).

Bryn arrived, stripped to the waist with a pair of jeans on, but no underwear, socks or shoes. He was supported by Veronique (a class teacher), who told me that he hated wearing clothes and took them off on arrival at the home. He sat at the end of the table with his hands interlaced with the teacher's and had to be accompanied to the hatch to fetch his food, and fed from a spoon.

Amanjeet, having finished her meal, stood up, removed her leggings, pants and pad and urinated on the floor. Staff immediately noticed that she was removing her clothing and whisked her off to her bedroom. It took them several minutes to realise that she had urinated on the floor (fortunately none of the barefoot youngsters stepped in the urine), and then they had to reorganise themselves to free someone from 1:1 support to fetch a mop and bucket to clear it up. (Field Notes 21st September)

Although the specific teaching approach devised by the school's speech and language therapy department is very clear and the part relating to mealtimes is reproduced as a laminated card that serves as a table mat for each young person, crucially, the learning opportunity is predicated on there being a 1:1 staff: resident ratio during lunch. This means, given that one member of staff (often the shift leader) is in the kitchen serving the food, if every resident is in

the dining room, at the same time, there need to be eight staff on duty. Even when that staff ratio is maintained, as the example above demonstrates, it is a struggle to maintain the meal as a learning opportunity. In Chapter 7, an example was given of how difficult that became when the required staff: student ratio was not available.

d. Mid – afternoon snacks

As with the mid- morning snacks, these took place about 2.30 in the afternoon, and preparing and distributing them and cleaning up afterwards took about 30 minutes. Much the same range of foods and drinks was available as in the morning and, again, classroom practice varied as to the extent to which pupils contributed to preparation, serving and clearing up.

e. After – school snacks

School finished about 3.30 and pupils were escorted back to the residential units by teaching staff and those residential staff who had been classroom– attached for the afternoon. Residents are met by the afternoon shift which comes on duty at 2.30, and the residents' arrival coincides with the morning shift's departure. Shortly after arrival, residents are offered a range of snacks and drinks. Like breakfast, these snacks are treated in a very informal way and whilst they can be eaten in the dining room, most young people either eat them in the lounge, or their own bedrooms. The range of foods includes sweets, nuts, fruit and sometimes toast. Hot or cold drinks are also provided.

f. Tea time

Tea, which is served around 5.30, follows the pattern of lunchtime, with a hot meal provided by the central kitchen and an expectation that students will take the meal seated at a table, following the same process of requesting and eating food as at lunchtime. However, at teatime, the residential staff team is not supplemented by classroom staff, and cannot have a break to eat their own meals. If staff choose to eat from the trolley, then they do so whilst

supervising young people, or when briefly relieved by a colleague. Staffing levels therefore never reach the 1:1 + 1 over needed to implement the residents' learning programmes. Even when the residents' behaviour is relatively well controlled, the results can be very challenging:

Teatime required seven young people and the relevant staff members to eat and the process was the same as at lunch time 'sit, wait to be called, bring up the symbol and collect the food, return, sit and eat'. However during teatime, the following happened:

Firstly, Bryn was very insecure, wouldn't leave the lounge, but was sat in a chair, with Alenka (RSW) sat on the arm of the chair, her hands interlaced with his. He refused point blank to cross into the dining room and showed no interest in food. He remained in this position for nearly an hour. Meanwhile, Callum went out to ride on a four wheeled cycle in the play area and showed no interest in food; one member of staff sat outside to watch him. She was relieved after three quarters of an hour by the shift leader trying to eat her own food at the same time, but at that point Callum ran off and had to be chased, cornered and returned to a supervised area.

Amadi began to become very distressed and aggressive, scratching and biting Alenka, slapping and kicking me, and attempting to hit others and had to be escorted to his bedroom to calm down. After eating his tea, Ryan became distressed and aggressive and had to be escorted to his room. Later, he went outside and rode on the cycle abandoned by the absconding Callum.

Sandy ate her tea and remained sitting in the dining room. She had to be watched all the time, as someone had spilt sweetcorn on the floor to which she is allergic. Every time someone's attention shifted, she scooped sweetcorn off the floor and put it in her mouth. It wasn't even safe to leave her long enough to get a broom.

Only Colin and Amanjeet ate tea in anything like an orderly way, and all the staff were eating standing up, whilst trying to remain engaged with individual young people. (Field Notes 21st September)

When behaviour deteriorates, as in the example below, the results can be very alarming:

Teatime was chaotic. Colin wouldn't come for tea and insisted on staying in his room to complete drawings; Callum wanted to watch a new Disney DVD and kept running off to his bedroom, or outside; Bryn decided he wanted to go for a walk, refused to cross the dining room threshold and had to be manhandled across. Sandy kept jumping off her chair on to the floor to eat dropped or spilled food. After dessert, Amanjeet threw her knife at Sandy, and then when told off, threw her fork

at Pete (RSW). On being asked to apologise, she then tried to overturn the table which she was sharing with Sandy and Ryan, refused to go to her bedroom and had to be manhandled up the corridor by three (male) staff. Whilst they were gone, Sandy got onto the floor and began eating food from underneath the table and had to be taken off to her bedroom. It was more like a battlefield than a mealtime, and when I left four young people were in their bedrooms as a consequence of their behaviour, and four members of staff were sitting on chairs outside closed doors to maintain order – while the remainder tried to snatch a quick meal. (Field Notes 27th September)

g. Bedtime snacks

After bathing and getting ready for bed, (roughly around 8.30 – 9.30) but before going to bed, residents may be offered a hot drink or a biscuit or a piece of fruit – which, as with the earlier snacks, is offered in an informal way, with a choice of dining room, lounge or bedroom as a place to eat and drink.

Food and learning

In terms of care practice, then, we can see that the ‘learning opportunity’ model based on a 1:1 staff: resident ratio with a carefully constructed teaching programme has to be radically modified and often abandoned because there are usually too few staff (or too many residents), which, combined with the need to manage complex and challenging behaviour, made the approach very difficult to implement. It is worth noting that even if 1:1 staffing were available, there is no guarantee that the model would work. The example of Callum from the field note above, which is partially reproduced below, shows that in order to ensure that he followed the set down programme, he needed a staff: resident ratio of 2:1:

Callum was supported by two members of staff, who were encouraging him to stop bouncing around the room, and to sit at the table. Once seated, he was supported to find the PECS symbol for dinner and take it to the serving hatch, when called. This was exchanged for a plate of food and a fork, and Callum returned to his place. The staff supporting Callum had to be continually watchful as, if their attention wandered, Callum would put his fork down and begin eating with both hands (Field Notes 21st September)

Even when numbers of residents were reduced because some had gone home for half – term, lunch was not unproblematic for the staff who were on duty:

Only three children for lunch today. Whilst Ryan has no problem sitting and waiting for his food, the two girls find waiting impossible – whether it is waiting for the meal in the first place, or waiting for dishes to be cleared at the end of the meal – both of them become very frustrated very quickly. (Field Notes 23rd October)

This contrasts sharply with what happened in the classroom, where an orderly approach to learning how to eat and drink socially was embedded in the twice – daily practice of ‘snacks’:

The main body of the morning was taken up with ‘snacks’. This was the preparation, serving and clearing away of snacks and drinks – the whole activity taking up nearly an hour of the morning. The activity was split into three:

a. preparation: each pupil had a task to do which was identified by a PECS symbol on a board on the wall. In turn, each pupil had to collect their symbol, take it to their support worker and then work with them to complete their task (with varying degrees of assistance). On completion of their task, they returned the symbol to the board.

b. eating and drinking: much as in the dining room at The Hawthorns, each pupil had to wait in their seat until called and prepare a PECS sentence strip with the symbol for ‘I want’ and the symbol for a food or drink item. They then took it up to the teacher. Those who had any speech at all were expected to ‘read’ their sentence – the rest handed them over. This continued until everyone had had at least two items of food and a drink.

c. clearing away: as before, each pupil had a task to do which was identified by a PECS symbol on a board on the wall. In turn, each pupil had to collect their symbol, take it to their support worker and then work with them to complete their task (with varying degrees of assistance). On completion of their task, they returned the symbol to the board. (Field Notes 22 September)

It is worth noting the differences in how this task was constructed. Firstly, the pupil group was usually smaller (5 – 6 on average); secondly, the staff: pupil ratio was consistently maintained at a minimum of 1:1 + 1; thirdly, the food and drink provided was of a much simpler nature than that provided in the Hawthorns, and finally, the process was much less rushed (45 – 60 minutes for snacks, as opposed to an average 30 - 45 minutes for lunch and tea).

In other words, under the constraints available in the Hawthorns, using the meal times as a learning opportunity was largely impractical. It was undermined by the persistent shortage of staff at mealtimes, and the need to balance the learning and nutritional needs of students, with the need for a break for staff. The solution adopted (bringing in teaching staff to assist) further undermined the learning potential of mealtimes for students by adding to the large and ever-changing number of people with whom any one resident will have to deal.

In the classroom, however, pupils have both 1:1 staffing, and a consistent core of staff to work with them, enhancing the likelihood of a consistent approach to teaching and learning, something that cannot be offered in the residential unit with its three shift rota supported by casual, agency and at meal times, teaching staff.

Surveillance, relationship building and food practices

At the same time, the standard child care model of staff and residents eating together in a relaxed way that replicated conceptions of 'normal family life' was not available either (the ten seats in the dining area would not have been sufficient for fourteen staff and residents, even if the shift was fully staffed). So what did staff actually do?

In practice, staff opted for a strategy of 'surveillance', which involved remaining standing in the dining room, able to intervene either singly or as a group to assist young people, intervene to respond to challenging behaviour or to follow a resident seeking to leave the dining room.

Punch and her colleagues in an extended ethnographic study of food practices in three children's homes in Scotland (Dorrer et al., 2011, McIntosh et al., 2010, Punch et al., 2009), all of which were very different from Hill House Farm School, also noted that adults exercising 'surveillance' over young people was a common feature of meal times and other food practices

and that this surveillance was seen by staff and residents as ambiguous: as both caring and controlling, facilitating and intrusive.

It would be difficult to conclude that in The Hawthorns, residents found staff surveillance intrusive or controlling, but how did it impact on the young people? Given the severity of the impairments of young people in the resident group, it is very hard to ascertain whether the particular way in which meals are organised is troubling to residents or not, but there is evidence of a high level of disruption at mealtimes, and some evidence of distress being exhibited:

Colin, who has some speech, sat at his table in some distress, shouting 'Stop' 'Stop' loudly and repeatedly, which I read as a protest at the noise level in the small room. (Field Notes 21st September)

With the change of staff, Bryn began to become more distressed, reluctant to move from his chair, refusing to go into the dining room, shouting and moaning. (Field Notes 28th October)

Additionally, there was resistance to the formal structure of mealtimes by some residents, but as Damian suggested (see Chapter 7 for full context), this might be for quite different reasons:

'There are so many more interesting things to do: places to wander, clouds to look at, wood to be eaten' (Field Notes 28th September)

However, whilst surveillance might be the predominant model in relating to residents at formal mealtimes, this did not mean that there were not moments when food was associated with the building of relationships, but these tended to be during the informal 'snack times' after school, in the evening or at the weekend. One example is the interaction between Bryn and Elaine reported in the previous chapter. This incident followed a long period of time during which Bryn had been both distressed and uncooperative, refusing to get dressed or leave his bedroom and involved an approach akin to that described as 'intensive interaction' which was developed from a series of important studies by Nind and Hewett based on work at Harperbury

Hospital in the 1990s (Hewett and Nind 1998; Kellett and Nind 2003; Nind and Hewett 2003; Nind and Hewett 2006; Firth and Barber 2010; Firth, Berry and Irvine 2010).

Intensive Interaction is a model of communication development and early learning for people with profound and complex learning difficulties explicitly based on research on early parent: child interaction, and has been adopted quite widely in the special education sector. No mention was made of training in this approach during the period of observation (although it would be no surprise if such training had been available) nor did any member of staff refer explicitly to this approach in describing any work, so it would be difficult to decide whether in this interaction (and many others like it during the period of observation), Elaine was drawing on prior training, or her own experience as a child, or as a parent to interact with Bryn.

Structure, rhythm and mealtimes

Punch and her colleagues (Dorrer et al., 2011, McIntosh et al., 2010, Punch et al., 2009), identified one of the key characteristics of food practices in residential care as being the provision of a rhythm or routine to life for residents and a structure for staff allowing a balance between professional tasks and relaxed personal time. They say that the rituals of mealtimes provide scaffolding around which time is organised and through which families and other social groups interact and to a large extent 'do' family' (James and Curtis, 2010, Finch, 2007, Morgan, 1996).

At Hill House Farm School, the structural role played by food in the lives of staff and residents is very pronounced, and brings with it a strong sense of predictability and security for residents. So much so that when the structure is subverted by (for example) the closure of the school for an afternoon, or attendance at a Harvest Festival service, or even the onset of school holidays, the disruption and upset for pupils can be significant.

Bryn was curled up in a chair, and Ryan had arrived in the kitchen an hour early for his 'snacks'. As it was half – term there had been no school in the afternoon, and the YPs' routine had been disrupted. 'Once their routine goes, they can get very frustrated' (Pete, agency RSW). (Field Notes 22nd October)

A number of the youngsters (Bryn and Sandy in particular) hung around the kitchen door and dining room hatch. Bryn kept up for the better part of an hour a single word request for 'Chocolate' (varied occasionally by 'Mini Rolls' and 'Jaffa Cakes') until distracted by the foot spa. Before that, Sandy's desire for food became so desperate that she spotted the dining room hatch was not completely closed, got the door open and launched herself through the hatch, over the work surface and headfirst onto the kitchen floor. Whilst the kitchen door was unlocked for staff to rescue Sandy, Bryn took the opportunity to drain the shift leader's coffee which had been put up on the window sill to allow her to open the door. (Field Notes 27th September)

However, unlike the study by Punch and her colleagues, the rhythm and structure of meals and snacks at Hill House Farm do not allow for the development of genuine interaction, except in 1:1 occasions, often away from the main dining areas and principal meal times of the day; they do not provide a period of relaxation for staff and resident alike, but offer rather a very stressful set of interactions which force staff to be constantly vigilant, resourceful and ready to intervene. Only at breakfast and lunch was it possible take a break for food, and then only because other staff provided relief.

'The theory doesn't work here'

In practice, expressed educational goals were more often abandoned than not; they were never really applied to breakfast or snack time which were very individual in character, and only really worked at main meals when student numbers fell at weekends or holiday times.

Despite, the positive statements about mealtimes as teaching and learning opportunities, it is clear that in practice, such approaches are largely undermined in the residential setting by the preference for more informal approaches to the provision of food at breakfast and during snack times,

informal approaches that are also generally (but not always) less stressful for residential staff.

In summary, the way meals and food practices have been developed in the Hawthorns tends to undermine the expressed purpose of providing teaching and learning opportunities for residents without, at the same time, generating opportunities for seeing meals more as 'family practice', or relationship – building exercises. Indeed, without reducing the size of the resident group or ensuring that 1:1 or better, more consistent staffing levels are available at mealtimes, it is difficult to see how such a change might be introduced. As a consequence, staff: resident relationship building is shifted towards the more informal food practices and formal mealtimes become something to be tolerated and got through as efficiently as possible, rather than being constructive and enjoyable.

The result is the sort of institutional practice that Sivendall (1999) describes in the very different setting of a hospital for older people:

'Meal procedures in the wards studied', she writes 'were neither adapted to disabled individual patient's personality and opinions, nor to their specific inabilities and needs' (p.326).

In the Hawthorns, main meals were neither well adapted to teaching and learning vital social skills, nor to providing the kind of relationship – building common to mainstream child care practice. The consequence for staff is well summed up by in a comment by one of the shift leaders that I have referred to more than once:

'the theory doesn't work here' (Field Notes 22nd September)

'The theory doesn't work here'. This is a very good way of describing the adaptive approach required of residential staff at The Hawthorns, which underlines the reliance on informal, tacit knowledge and the construction of shift team cultures or social micro-climates. And whilst it somewhat stretches Turner's original concept of 'communitas', it is consistent with similar

applications of the concept in other institutional settings (Hornum, 1995, Spencer et al., 2001).

So far, this study has suggested that the research site is an anomalous, liminal environment where there are conflicting understandings of and approaches to the child care task and a reliance on lay psychology and tacit knowledge rather than a well understood theoretical and philosophical approach to practice. This chapter has demonstrated that in respect of mealtimes and food practices the professional educational approach to the task is additionally undermined by the particular challenges of the resident group and the patterns of staffing, forcing staff to abandon the formal goals of the school, and develop their own local ways of addressing the needs of the resident group.

Whilst mealtimes and food practices are amongst the most visible examples of child care staff having to construct their task in a different way from that explicit goals of the school, or the expectations of placing authorities, it was by no means the only one, and this is illustrated by the complexity that surrounded the usage, furnishing and decoration of resident's bedrooms. The next chapter explores these issues in depth.

CHAPTER 9 THE CHALLENGE OF THE TEENAGE BEDROOM

Chapter 8 argued that in the specific case of food practices and mealtimes, the particular needs of residents and the way that staffing was organised made it impossible to deliver a care task in a way that met the requirements of either good teaching and learning strategies or of good residential child care practice. This chapter is concerned with the way in which the resident's bedroom is conceptualised, used, decorated and furnished, and the complexities that this throws up for both staff and residents.

Research in the sociology and social anthropology of family life has identified what Morgan(1996, 2011) calls 'family' practices , the everyday taken-for-granted ways in which family members live their lives and develop their relationships (Smart, 2007). Central to these ideas are the possession and display of what Miller (2008) simply calls 'things' .

In this chapter, I argue that Hill House Farm School's attempt to replicate one aspect of those family practices: those pertaining to the individually decorated and furnished teenage bedroom equipped with appropriate furniture, clothing and electronic media, becomes distorted by the complex purposes and meanings that surround the part played by the bedroom in a resident's life in a residential special school. In part, this argument reflects Weiss'(1994) view that the interaction of a young person with a complex impairment with a culturally normal home environment results in a reconceptualisation of what is meant by 'home' (pp. 167 – 193), although in this case, I am not suggesting that this is related to negative attitudes in the way that she reports in her research.

In respect of accommodation, Hill House Farm School adheres strongly to the 'ordinary living' approach to residential child care described in Chapter 8, as the 2010 prospectus makes clear:

Our students live in small group residential bungalows built around a central courtyard. We create homely environments that provide life skills training as well as having all the home comforts you would expect.

In the residential setting, of course, such 'ordinary living' is simulated, rather than replicated (Ward, 2006a). Even so, as Ward points out:

the apparently simple concept of the ordinary, in fact turns out to be potentially problematic... For example, children who have lived for any length of time in families or other settings in which other people's behaviour is persistently confused, violent, bizarre, neglectful, abusive or otherwise distorted have learned that **that** [emphasis original] is the norm with the result that what we might call 'ordinary' or 'common sense' may be experienced by them as confusing, bizarre or provocative. (2004 p.213)

And if this is true of families where children do not have significant cognitive and developmental impairments, it is even more likely to be true where they do.

Something of the complexity involved in the design, decoration and occupation of residents' bedrooms became clear on my first, introductory, tour of the building:

Generally, the internal decor was in a poor state of repair, with paint work peeling, grouting in the bathrooms discoloured and chunks of wood missing from door frames and window frames – Polly told me that one resident (Callum) liked to bite off chunks of wood. The blue carpet that ran through the corridors and into the lounge was very worn and gave off a faint smell of urine which there had obviously been vigorous efforts to clean up. The bathrooms and shower rooms were not adapted for disabled users. All fixtures and fittings (with the exception of chairs and tables) were fixed to the walls, usually boxed in with wood and covered with thick sheets of Perspex to prevent their destruction. Wardrobes and cupboards were kept locked, as were the kitchen and office areas.

Each resident's bedroom had been decorated and furnished to suit their individual needs and interests, although this was mitigated where furnishings had not been provided because of the child's tendency to use them to harm herself or others. All wardrobes were built in. Amarjeet's room had been painted pink and white, with representations of 'Rosie and Jim' on her wardrobe, pink and white bedding on the bed, and plenty of soft toys in the room. Colin's interests in 'space' and rockets had result in an imaginative painting of the solar system on a black background on one wall and a rocket shaped pyjama case on his bed.

Some bedrooms were much bleaker, though, with little on the walls and only a bed base and a mattress in the room. Some young people destroyed mattresses (one, Bryn, liked to open his up and climb inside it!) and The Hawthorns had recently invested in some specialised mattresses with a blue thick polythene exterior – these lasted for several months rather than the hours and days of conventional mattresses.

In the last room we went into, Polly asked me ‘tell me what you think of this’. This room had bare walls except for a large painting of Disney’s ‘Peter Pan’ on one wall, secured under Perspex and the room was empty except for a blue mattress on the floor. Polly told me that on admission, Callum’s mother had said that at home Callum slept on the floor in a completely bare room. Initially staff had tried putting a bed base and mattress in the room, but this had been destroyed and Callum had slept curled in a ball on the floor. Recently, they had succeeded in getting Callum to accept a mattress in the room, and he now slept (still curled up in a ball) on the mattress. The next step would be to introduce a bed base (although not of wood as he eats it) and see if he would tolerate that. The painting of Peter Pan was also an experiment as Callum liked Disney films but had not until recently accepted decoration on the wall. (Field Notes 14th September)

The basic philosophy is clear. Teenagers in their home environment would expect to have control over their bedrooms, to exercise a degree of choice over their decorations and furnishings, and for their rooms to be equipped with a range of personal electronic goods, and the school sought to replicate this. But this is a situation where replicating ordinary ‘family practices’ does not easily apply.

The first reason is that in the residential environment of Hill House Farm School, the bedroom serves more functions than the equivalent room in a family home. It is both a place of socialisation between child and key worker, and place of quiet self – occupation; it is place for assisted dressing and undressing, and an enforced time-out facility when residents become distressed or aggressive, where their behaviour is seriously anti social and as a last resort, it can become for the briefest periods, a place of detention³³.

³³ It should be noted that I am not suggesting that residents were locked into their rooms in breach of the 1989 Children Act, but rather that in extremes, and to prevent harm, residents were on occasions, forcefully removed to their rooms, the doors held closed for a minute or two, and afterwards residents were encouraged to remain in their rooms with a member of staff sitting on a chair by the bedroom door.

The following examples show the different range of meanings that can be attached to a bedroom in a residential unit. We start with the obvious. A bedroom is a place to sleep, rest and relax:

Very quiet on arrival – Bryn had been up for a bath, but had then gone back to bed; Amarjeet was in her bedroom; Ryan had been up for breakfast and had then gone back to bed. Sandy was still getting up. (Field Note 24th October)

Secondly, a bedroom is a place for getting dressed and undressed – although unlike conventional teenagers, the residents in the Hawthorns all needed significant assistance with dressing and undressing. Here's Bryn again, after lunch:

It was time to return to school. Casimir told Bryn that he was going on a trip. He took Bryn to his bedroom to get ready – which involved putting socks and shoes on and an old plastic anorak. These are Bryn's 'school clothes'. (Field Note 21st September)

A bedroom is also a place of retreat, a place to get away from other people; in fact in the Hawthorns, it was the only place to get away from others. On an initial tour of the building, Polly commented:

the space available to young people is very limited and if one young person wants to get away from another, the only option is to retire to their bedroom. (Field Note 14th September)

But as well as being a place of retreat, it is also a place to entertain and to build relationships. There were numerous examples of individual work between residents and key workers in the young people's bedrooms. One weekday, after school, the following was observed:

Iona was supporting Amerjeet in her bedroom and Nigel was drawing with Colin in his bedroom. Callum and Ryan were largely left to their own devices, watching Disney DVDs in their room, or ranging along the corridor, or wandering outside (watched from the windows).(Field Note 27th September)

These latter activities were not untypical for any teenager making use of their bedroom as a centre of their personal and social life, albeit, these tended to be based on relationships with staff rather than with peers.

However, this is not the whole story:

Amarjeet entered the dining room, removed her tights, pants and incontinence pad and began to masturbate. Two staff intervened telling her 'you do that in your room' and physically pushing her out of the dining room and along the corridor. She became very angry and began hitting and screaming, before the two staff managed to get hold of her upper arms and manhandle her along the corridor. (Field Note 28th September)

Here the bedroom is being used, against Amarjeet's own wishes, to enforce a view of what is socially appropriate behaviour, and the bedroom is therefore, at least temporarily, being used as form of behavioural control. This process is common in an establishment where there are no alternative facilities:

Whilst pupils and staff were milling around, Amadi became very agitated and he began scratching, pinching and biting. Four members of staff encircled him, so that couldn't run out of the lounge. Then two firmly held him by the upper arm, and escorted him away to his bedroom. No formal restraint method was used. (Field Note 22nd September)

After one particularly disruptive teatime, it was possible to see more than half the bedrooms being used to control behaviour, as I illustrated in an extract from my field notes for tea time on the 27th September (p.136 above)

On rarer occasions, bedrooms are used more forcefully to briefly detain an out of control resident and protect both staff and other residents.

Three staff intervened, pulled Callum back and pushed him into his bedroom, closing the door and holding it shut. Callum shouted and banged on the door and walls and bounced up and down on his floor, and staff decided not enter the room for a few minutes as it might be too dangerous. (Field Note 6th October)

What these examples show is that the concept of the resident's bedroom as being a private space, under the resident's control, subject to the resident's choice does not do justice to the complexity of the actual way in which bedrooms are used.

The bedroom that would be a 'private' space in contemporary Western family homes, and increasingly so as a young person enters teenage years, is here a *public-private* space. Willcocks and her colleagues (1987), in a critical review of older persons homes pointed to the disorientation caused to residents by finding themselves carrying out essentially private life practices in the public space of the care home and argued for the development of residential care practices that made a clear distinction between public and private with a choice as to how much of the resident's private life was lived in public. The vulnerability and dependence of the resident group in the Hawthorns makes this challenge much greater, but it may be that recognising that residents' bedrooms are not genuinely private, or under the residents' control may open up opportunities for the redesign of the units so as to create more space for individuals to withdraw from the whole group without needing to resort to their bedrooms.

However, there is more to the complexity of bedroom utilisation than the question of bedroom usage, and this too reflects the gap between philosophy and reality when it comes to resident self-determination in their bedrooms. As we saw earlier in the chapter, in The Hawthorns, there was a genuine expectation that residents would exercise choice in the decoration and equipping of their bedrooms.

What happens, then, if a young person cannot or chooses not to exercise choice over their bedroom's design and equipment? Or, if a young person's choice is radically counter-cultural to the extent that their preference is for four bare walls and a bare floor? Which takes precedence, the culturally normal bedroom even if that causes distress, or respecting a young person's 'choice' even though the reasons for that choice may arise as a consequence of their particular cognitive impairment?

A very good example of this followed a decision of the school, in the wake of a disappointing OFSTED report, to comprehensively redecorate The Hawthorns. The manager told staff to draw up a list of what each resident would want in his or her bedroom:

Polly said she would like 'Team A' to take a lead in drawing up a list of what each resident would want in their bedroom – and in particular making sure that anything that needed to be kept was clearly identified, otherwise it would be disposed of by the builders. 'As far as possible', she said, 'I want you to involve the children in deciding what they would like in their rooms in terms of wall colours, furniture, equipment, storage etc. The catch is, I need to provide the Head with a complete list by Friday (today is Wednesday), although I'm sure we can stretch to Monday/Tuesday if we have to'

The team quickly discussed process and decided to make a start today, and for all to come in one hour earlier on Saturday to pool their thinking and finalise a list. Polly handed over two catalogues by a company called 'Tough Furniture' and sent Diane to Reception to collect other equipment catalogues [she came back empty handed].

Members then began to discuss in a very engaged way, their perception of the needs of individual residents, with a particular emphasis on enabling young people to exercise better control over their environment. An example was a discussion of Sandy, whose storage furniture, like everyone else's is currently locked. 'Would it be possible to have some storage units that were accessible to Sandy for her to take out and put away her soft toys, without needing staff present?'

There was also a discussion of the murals on many young people's bedroom walls. These are painted by the school handyman and would be lost when the walls are plastered. Dave suggested that they take photographs of existing murals and blow them up and frame them and put them on the wall until such time as the walls could be repainted. (Field Notes 6th October)

The principle of encouraging choice and control was clear; in practice it was much more difficult:

Two brief discussions after a lengthy period of time when individual workers had been with children in their rooms working on choosing furniture and fittings. Diane said 'Amarjeet was very clear – she wanted her room pink and you know how keen she is to follow Sikh tradition, well she has asked for the sort of headboard with curtains that are common in Sikh rooms.'

Tony described his attempt to engage Bryn more ruefully: 'I kept patting the wall and asking what colour, but all he kept replying was 'mini-roll' so I'm putting it down as brown and beige!' (Field Notes 6th October)

In practice, then, however committed to the principles of choice and control, given the severity of impairment of some young people, staff had to improvise and at times decide for themselves how rooms were to be

furnished and decorated. In doing so, they could easily find themselves in situations of conflict.

For example, as noted above, staff discussed the possibility of experimenting with unlocked drawers in Sandy's room, so that she could have access to more of her own things. Sandy's mother was very concerned about this proposal when she came to visit:

Sandy's mother spoke to Alenka (RSW) about the renovation of The Hawthorns. She was happy with the plans for redecorating Sandy's bedroom, but very concerned about the plan to leave Sandy's drawers unlocked and accessible. They had done this at home, and the result had been broken and flying furniture. She strongly recommended keeping all storage areas locked. (Field Notes 24th October)

Staff have to take note of parental opinion, which can be based on long experience of caring for the young person. It is notable that the decision to leave Callum's room unfurnished was based on parental advice. The complexity of following parental advice was, however, not always straightforward:

I arrived and went into the office, where Halina was working. She told me that Amarjeet & Callum were out on a trip for the morning with Casimir (shift leader) and Karol (RSW). Halina said that it was good to get Amarjeet out of the house as she had had a tantrum this morning and had thrown her television on to the floor and destroyed it. She talked of the dilemma of allowing Amarjeet access to her TV, even though she destroys it. I mentioned Sandy's' mother's views on Sandy's having access to unlocked drawers and Halina told me of Amarjeet's mothers request that Amarjeet have access to her computer – apparently, she has one at home that she has never attempted to destroy. 'Perhaps the thing is to allow access and let the items be destroyed. Sometimes that is done to get a reaction. Perhaps if we don't react, it will not be done – we might have 100 computers destroyed, but after 110 there will be no more destruction'. (Field Notes 28th October).

Here we have parental advice that runs in complete contradiction to that offered in respect of another resident; here choice and control is fundamental even if the outcome is distress and possible injury to the child, and

inconvenience for staff. But Hawthorns' staff didn't just have to deal with parental input. In respect of the same incident:

By now Halina was back from her crisis trip and was talking to Diane (Shift leader) in the office about Amarjeet's destruction of her TV. A new one had been delivered but had not yet been installed. Halina was saying that she understood that staff had been instructed (I wasn't clear by whom) to allow young people full access to their TV's, DVD players etc. on the understanding that all breakages would be swiftly replaced. Both Halina and Diane were sceptical about this approach. (Field Notes 28th October)

So we have here a complex set of conflicting ideas, principles and instructions from a variety of different sources. We have a starting point of trying to create a homely environment, broadly aimed at cultural normality for adolescents, which is now to be reinforced by instruction from within the school's management chain; this approach is perceived as alarming and distressing by some residents who react to it by destroying the fixtures and fittings that they do not want; it is perceived as impractical by staff, supported by some, but not all parents, and as a consequence, staff members will need to negotiate in respect of each child, each family and each bedroom a compromise solution acceptable to everyone.

In practice, then, however committed to the principles of ordinary living, of choice and control, given the severity of impairment of some young people, staff had to improvise and at times decide for themselves how rooms were to be furnished and decorated. In doing so, they could easily find themselves in situations of conflict.

As with Chapter 9, this chapter has suggested that with respect to professional discourses, in this case, the discourse of professional child care practice, upon which all the National Minimum Standards for Children's Homes are based, life in The Hawthorns was anomalous. Anomalous situations that contradict the expectations of the taken-for-granted world can be challenging and stressful requiring individuals and teams to develop their own original solutions to original challenges which may not easily reflect the expressed aims and goals of the institution.

Once again this underlines the creative, adaptive approach required of residential staff at The Hawthorns, and explains the reliance on informal, tacit knowledge and the construction of shift team cultures or social micro-climates.

The next chapter, Chapter 10, draws together the findings of the study, attempts to draw some conclusions and suggest some implications for the future of residential special schools.

CHAPTER 10 SUMMARY AND CONCLUSIONS

In this final chapter, I try to draw together the threads of the research, identify some conclusions and suggest some implications for policy and policy makers but I begin with a reminder of where I started. I came to the study as a former Head of Care in a similar, smaller residential special school and brought a number of key assumptions to the research. These assumptions were based on my experience of developing outcomes-led services that drew on the best of residential child care approaches to 'ordinary living' within the context of a systematic, planning framework focussed on measurable outcomes. I assumed that the kind of approach that I had taken, and the kind of battles that I had fought would be the same ones in any residential special school, and that the focus of the research should be on the strategies used by a school or schools to introduce what I then called 'good child care practice'.

As such, I accepted in principle the arguments of the proponents of residential special schools described in Chapter 2 (Saunders, 1994, Aird, 2001, Jackson, 2006a) and in reviewing the literature, I paid particular attention to studies that emphasised clear outcomes, consistent planning and 'ordinary living' approaches to child care practice (Alaszewski and Nio Ong, 1990, Emerson et al., 1996, Robertson et al., 1996, Ward, 2004, 2006a, 2006c, Smith, 2005b).

This is not what the research demonstrated. Instead what I saw was a humane, nurturing approach to care that was highly relational in nature. Whilst staff showed undoubted commitment and care towards their residents, they drew predominantly on lay 'common sense' explanations of behaviour and intervention strategies rather than on a coherent theoretically driven knowledge base as they sought to make sense of the communication, behaviour and needs of the residents they work with.

Additionally, I suggested in Chapter 6 that some staff had begun to see

residents as 'other' as radically different from themselves and that some of the ways in which staff constructed their understanding of the residents was defensive in orientation, to protect themselves from stress and anxiety.

But it wasn't just in understanding the puzzling and, at times, alarming, behaviour of the young residents, that staff drew predominantly on lay knowledge and tacit understanding. They also made very little use of formal planning mechanisms, partly because many of the documents were inaccessible to them, partly because many of the documents were poorly completed and did not always match well with the observable skills of the young people. Additionally, such plans as existed were predicated on a much higher staff: student ratio than was actually available, and the way shifts were organised made the carrying out of individual plans very difficult to achieve.

Far from having a clear understanding of the professional care task, drawing on a clear philosophy of care and well planned objectives and outcomes for children, residential carers in the Hawthorns draw largely on informal models of care and the nature of the child care task was constructed predominantly from the prevailing staff culture 'how we do things here'. There were also some indications that close working relationships in shift teams helped to shape individual shift cultures.

The way in which staff constructed the child care task was illustrated in Chapters 8 and 9 by a detailed examination of two micro-practices, providing meals and using bedrooms. In both cases, the research suggested that staff were working in a complex context of conflicting ideas, principles and instructions from a variety of competing sources, and that, however committed to the principles of ordinary living, of choice and control, or to learning from everyday life, given the severity of impairment of some young people, the complexity of the context and the shortage of staff, residential workers had to improvise and often decide for themselves how tasks were to be undertaken, without reference to such plans and programmes as were available.

So why was this happening? As the study unfolded, I came increasingly to the view that life in The Hawthorns was anomalous. In a sense, most residential child care is marginalised and seen as a service of last resort (McPheat et al., 2007) but this is particularly marked in the residential special school (McGill, 2008, Abbott, 2001, Abbott et al., 2002, Morris et al., 2002b, Abbott and Heslop, 2009). Here the issue is not only the difficulties faced by families under pressure in meeting the needs of unique individuals, but also the failure of local schools, social and health care services to meet the needs of the young person as well. Unlike residential child care in general, there is the added challenge when dealing with the needs of young people with the severity of needs presented in the Hawthorns: namely, that they are not going to return to the community after a period in a 'boarding school' but are going to need care for the rest of their lives. Whilst such a position is common in services for vulnerable older people (Hornum, 1995, Willcocks et al., 1987, Henderson and Vesperi, 1995, Farmer, 1996, Stafford, 2002), it is much less common in services for children.

How does an understanding of the residential special school as an anomalous setting help explain what was happening in The Hawthorns? In Chapter 3 I argued for a view of human beings as being engaged in the construction of identity and meaning throughout the life course and seeking actively to make sense of the circumstances they find themselves in, in relation to their own material circumstances; in relation to their previous life experiences (especially to earlier family relationships), and the network of social relationships in which they are embedded (Stevens, 1996). I called this 'sense-making'. There is much in the relevant literature to suggest that 'sense making' is itself a highly problematic, socially constructed activity (Berger and Luckmann, 1967) that both draws upon and actively maintains a social world i.e. a shared understanding of what 'normal' is. A sense of the "normal" is continually refined and redefined in the interaction with others in daily life: in the workplace; in dialogue with extended family members; in engagement with significant professionals.

In an anomalous situation, where there are fewer points of reference from 'normal' existence, individuals and groups have to work harder at making sense of the circumstances in which they find themselves. Stafford, an ethnographer of nursing homes and other facilities for vulnerable older people, using the allied concept of 'meaning-making', suggests that workers 'read' the environment and human interactions as a 'text':

As a cultural space, the medical institution of the nursing home establishes codes for understanding and behavior (sic). It is a crucible for the generation of meanings held and acted on by those who move through its hall. In the material sense, it concretizes assumptions about who lives there, works there, and visits there and what they are expected to do and to be. Members of the culture – patients, workers and visitors – see and interpret what's going on through an active process of 'reading' the environment and the human interactions within it. The cultural space does not fully determine meaning, however. No single reading is correct, although one may be more powerful than another. Rather the 'text' of the nursing home provides a backdrop for interpretation, always subject to revision and multiple readings (Stafford, 2002 pp. 8 - 9).

This, I suggest, is the significance of the competing discourses of education and care, described and discussed in Chapter 7, which are effectively different readings of the 'text' that is life and practice in The Hawthorns. The difference between Hill House Farm School and Beech Tree House (Jones, 1983), between Hill House Farm School and the Camphill schools championed by Jackson (2006a), or between what I called earlier 'good child care practice' from my own prior experience and what I found in the Hawthorns, is that there is no 'dominant reading' (i.e. Applied Behavioural Analysis, or the Camphill philosophy) that imposes itself on the text of everyday practice, and this generates the situation described in this study which requires staff to be constantly adaptive, creating new roles and approaches for themselves and making the best use that they can of lay understanding and tacit knowledge.

This lack of a dominant reading appears to result from a clear mismatch between the available professional discourses (professional child care or professional education) and the reality of providing care on the ground. As O'Connell found in her study of childminders (O'Connell, 2011), where there

is a mismatch between what practitioners do in reality and the dominant professional discourse for their practice, they tend to use the principal terms of the professional discourse as a language game for engaging with significant others, but without allowing it to shape their practice. In The Hawthorns, this mismatch was made up of the particular needs of the residents themselves, the persistent shortage of staff, the challenges posed by the shift system and the lack of appropriate and realistic planning for young people, all of which was summed up by Beata's response to those staff joining the team who brought with them their own understanding of what child care practice should look like:

I think you learn most on the job. Some people come from Poland (not so many now as used to) and they have lots of theory about what the job is, but they come here and they say to me 'the theory doesn't work here and I have no power' (I think she meant competence) – me, I am lucky because I did not go to University, but started as an au pair and learnt on the ground' (Field Notes 22nd September)

However well founded this is as an explanation, it begs the question as to why there should be a such a mismatch between what the school says it does, what placing authorities ask it to do, and what actually happens on the ground. In Chapters 3, 5 and 6, I drew on the controversial work of Miller and Gwynne (1972), and the somewhat less controversial work of Van Gennep (1960) and Turner (1967, 1995) - as extended by Deegan(1975, Willett and Deegan, 2001) and Murphy (1987, Murphy et al., 1988) amongst others - to suggest a deeper social purpose to the residential special school than that envisaged by the professional education and child care discourses.

Miller and Gwynne (1972) explored the nature of institutions where there is no intention that residents will return to the community as full, participating members. They described the consequences of admission to such institutional care as 'social death' and argued that one of the core functions of long term residential institutions was to manage the transition between 'social death' and physical death. And whilst Miller and Gwynne's language may be offensive, the fundamental concept is very similar to the way in which a number of studies of long-term institutions have drawn instead on the

concept of 'liminality' which has been used extensively both to help explain the stigma experienced in our society by disabled people and to analyse the provision of care to vulnerable groups in long term settings.

An understanding of the residential special school as a liminal space would certainly go some way to explaining the evidence for quite close relationships within shift teams, which show some evidence of being influential on the development of the practice culture. It is consistent with what Kate Fox found, in her studies of race goers and pub regulars, namely that participants in liminal spaces seek to reduce the anomalies of their situation by the creation of what she calls 'a social micro-climate' which she defines as a 'social environment' 'with behaviour patterns, norms and values that may be different from the cultural mainstream'(Fox, 2004 p.89, Fox, 2005). As we have seen, what Fox calls a 'social micro-climate' is based upon what Turner called 'communitas'³⁴ - the social anti-structure that develops between participants in liminal situations, where hierarchy breaks down, normal social conventions are put to one side and a strong sense of group identity develops.

If this interpretation of the liminal status of the school and its residents is correct, then we need to ask what the wider social purpose of the residential special school is. This is, in essence, Damian's observation from Chapter 6:

'I think they think that going to school is a strange idea. Sit down. Why? Cut something out with scissors. Why? Stick something on card. Why? There are so many more interesting things to do: places to wander, clouds to look at, wood to be eaten and yet, it is really important that they learn some basic things because they are going to need care as adults and if they cannot sit down at a table, eat with a fork and a spoon and use the toilet, they will end up in much worse accommodation than they should' (Field Notes 28th September)

Could it be that the primary purpose of the residential special school is not 'special education', nor 'good child care practice', but rather 'asylum' (using the word in its original meaning of a place of safety), a safe and nurturing

³⁴ As before, the way in which the concept of 'communitas' is used here goes well beyond Turner's original usage and is used in the same way as Fox (2004, 2005) and Hornum (1995)(the latter in the context of residential care of the elderly)

place for a young person whose family are exhausted and whose complex needs have not been and cannot be met by local services, and for whom this will be the beginning of a lifetime of sheltered accommodation?

If that is the case, is the reason for the mismatch between professional education and child care discourses that underpin placements at a school like Hill Farm House because they are themselves, in part at least, 'language games', ways of obscuring awkward truths? Could it be that the reason why placement plans are poorly completed, or are unrealistic, or there is limited professional contact from placing authorities, is because planned outcomes are not the primary purpose of any placement. Unlike mainstream boarding schools, schools for physically or sensorily impaired young people, EBD schools or residential child care generally, could it be that the purpose is not rehabilitation, but problem – solving and asylum?

So where does that leave us? Since residential special schools sit on the margins of SEN and child care policy, and are usually places of last resort, it is important that commissioners and policy makers are very clear what they expect a residential special school to do.

If such a school is predominantly to be an educational environment where pupils will learn and develop new skills that will reduce their need for institutional care in the future, or enable them to return to the community, then the planning framework needs to make this happen. The Beech Tree House model (Jones, 1983, Emerson et al., 1996, Robertson et al., 1996) offers a way of doing this, with time – limited placements, parental education, well planned and assessed learning programmes delivered by professionally trained and well supported staff, with built – in evaluation of a young person's progress. Such a model requires close integration between education and child care staff, careful assessment and planning, a clear understanding of the outcomes expected from a placement, and a staff: pupil ratio that makes it possible to carry out assessed plans in a safe and supportive environment.

As we have seen, such a model underpins practice in EBD residential schools (Wood and Cronin, 1999, Polat and Farrell, 2002, Farrell and Polat, 2003, Hardwick and Woodhead, 1999), and residential schools for young people with sensory impairments. It is also consistent with best residential child care practice in parts of the UK (Smith, 2005b, 2009), with European models of residential child care (Petrie, 2003, Petrie et al., 2006, Cameron, 2004, Cameron and Moss, 2011) and with the broad thrust of the previous Government's residential child care policy as expressed in Care Matters (DfES, 2006) and Care Matters: Time for Change (DfES, 2007) .

However, it could be that the correct role for the residential special school is more of an asylum where the emphasis on learning and development can be downplayed in favour of physical and emotional nurture and care. Such an approach would mean acknowledging that a small number of very young people are going to be dependent for the whole of their lives, as opposed to living independent or semi-independent lives integrated into their families and home communities. It would also mean revaluing care as a counter-balance to education in the lives of young people with complex impairments. Writers influenced by the 'ethics of care' debate have called for just such a re-examination of the place of nurture and care in our society (Sevenhuijsen, 1998, Barnes, 2012), a call that has extended to social work and social care (Orme, 2002, Meagher and Parton, 2004), and most recently, to looked – after children and residential child care (Holland, 2010, Steckley and Smith, 2011).

In reality, there is probably a place for both types of service amongst the options for young people with complex learning disabilities but in order for them not to slip back into the negative institutional patterns described by Tizard (Tizard, 1964), Morris (Morris, 1969) and Oswin (Oswin, 1971, 1978), they need to be brought in from the margins of educational and child care provision and become part of the mainstream. Any such step would reduce the need for staff to navigate their way through complex and competing demands as this research shows them to have done in The Hawthorns.

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