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Contents

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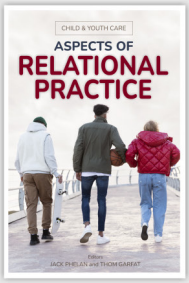

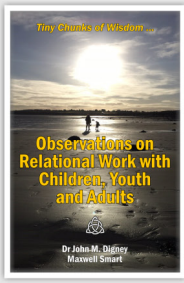

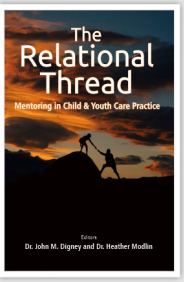

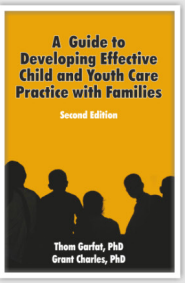

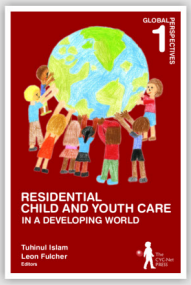

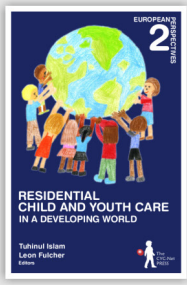

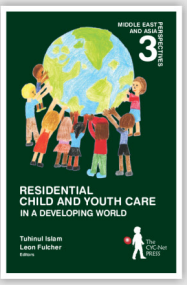

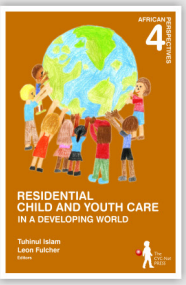

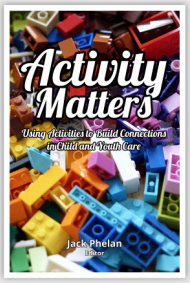

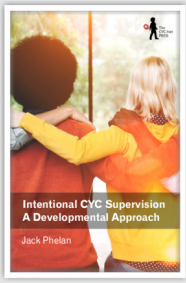

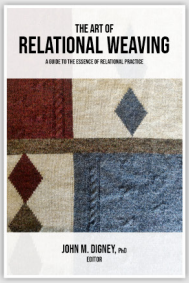

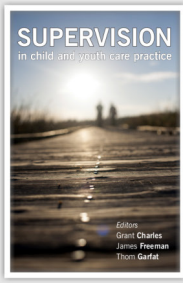

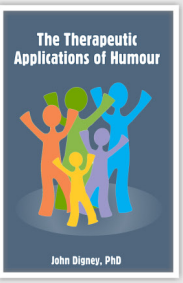

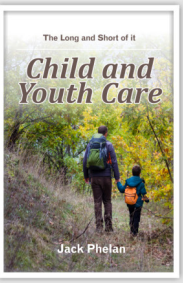

Editorial Comment

Navigating Marriage and Family Formation: Insights from India's First Study on Married Care-Experienced Youth

Kiran Modi and Gurneet Kaur Kalra

At Udayan Care, our three-decade long journey in child and youth welfare has consistently reminded us that transitions into adulthood are never defined by education and employment alone. They are equally shaped by the invisible threads of relationships, belonging, and identity. Yet, when it comes to care-experienced youth, these threads are often frayed or absent, leaving them to navigate adulthood without the safety net of family.

In India, where marriage and family formation remain deeply embedded in cultural and social life, the experiences of care leavers in these domains

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have been overlooked for far too long. Udayan Care is honoured to present India's first systematic inquiry into the marital and family lives of youth with care experience. While global research on care leavers has traditionally emphasized education, employment, housing, and mental health, relational wellbeing, particularly marriage and parenting, remains strikingly underexplored. Without the safety net of families, these youths confront unique vulnerabilities in navigating adulthood. Marriage, a culturally significant milestone, often becomes a pathway to housing, social acceptance, and identity formation, yet it is fraught with challenges of trust, communication, stigma, and economic dependence.

Using a mixed-method design, we engaged 55 married care leavers through participatory tools co-developed with youth themselves. Quantitative analysis explored relationship between adverse childhood experiences (ACEs), marital outcomes, and parenting stress, while qualitative narratives highlighted lived realities of stigma, partner choice, and relational coping. Ethical safeguards including informed consent and counselling referrals were integral to the process.

Findings revealed a complex interplay of resilience and vulnerability. Demographically, most participants were in their mid-adulthood and employment was reported by 71%, though gender disparities persisted, with women facing higher unemployment. Partner selection reflected both agency and constraint where 73% youth married non-care leavers, with women more likely to do so, suggesting need and desire for social acceptance and stability. Love marriages were notably more common among women (51%) than men (13%), underscoring gendered dynamics in autonomy and emotional connection.

Accommodation patterns highlighted that most of the youth with care experience don't have stable homes of their own, which makes their living situation fragile: only 22% lived in owned housing, while the majority resided in rented or extended family homes, reinforcing the link between marriage and housing security. ACE scores revealed that nearly one in four care leavers had endured seven or more adversities before age 18, with parental loss, violence, and neglect most prevalent. These early traumas echoed into adulthood, shaping trust deficits, emotional regulation difficulties, and heightened parenting stress. Theoretical mapping enriched these insights, where attachment theory depicted how disrupted early bonds hinder intimacy and marital stability. Social exchange theory contextualized the heightened costs of relationships amid financial insecurity and the marriage market theory explained constrained partner choices due to stigma and limited social

capital. Together, these frameworks underscored how structural disadvantages intersect with personal histories to shape marital trajectories.

Despite challenges, marriage was often described as a turning point, a chance to rewrite narratives, build emotional bonds, and create nurturing environments for children. The findings clearly suggest that sustaining these aspirations require systemic support. Current legal frameworks, emphasize education and employability but somewhere don't focus much on relational scaffolding. Our findings call for integrating trauma-informed counselling, marital preparation, parenting workshops, and housing support into aftercare policies.

This editorial underscores that care leavers' journeys into marriage and family life are not peripheral but central to their transition into adulthood. By amplifying their voices and bridging research with practice, we advocate for a holistic aftercare system, one that recognizes relational wellbeing as foundational to dignity, stability, and empowerment.

DR. KIRAN MODI, Ph.D., founded Udayan Care in 1994 and has led major initiatives in family strengthening and care reform. She launched the niceh international academic journal, *Institutionalised Children Explorations and Beyond*, international conferences, pioneered India's first care leavers' study and network, and has published widely in national and international journals.

DR. GURNEET KAUR KALRA, Ph.D., is a trained social worker and Manager of Research and Advocacy at Udayan Care. She leads international research collaborations and administers the journal *Institutionalised Children Explorations and Beyond* (with SAGE). She has authored several papers and book chapters and presented at national and international forums.

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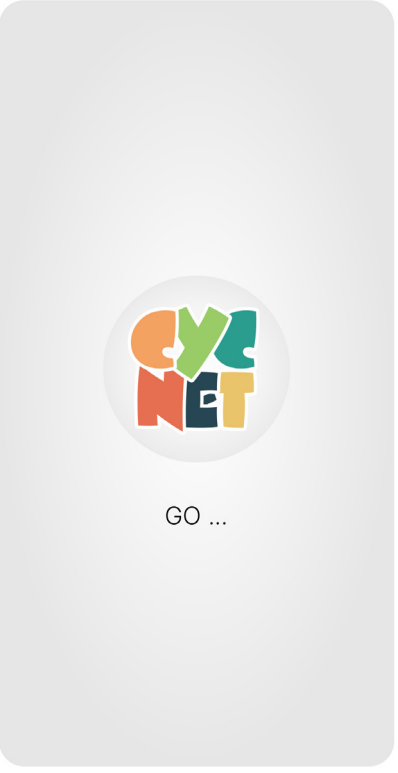

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Sleep, Eat, Play, Learn, Be You, Community (Part 1)

Kiaras Gharabaghi

There is quite a lively global conversation going on about quality standards in the context of residential care. Conferences are being convened to discuss such standards, new research and/or editorials in the literature on this topic abound, and policymakers across many jurisdictions are busy trying to articulate such standards. One specific challenge is how one might measure performance against those standards, which is further complicated by the prevailing view that residential care ought to be steeped in relational practices, and these have always been difficult to concretely define and meaningfully measure. One emerging outcome at least in some jurisdictions is a hard turn to the past. By this, I mean a return to hard categories of pathological assessment and labeling, such that the breadth and depth of clinical interventions become the flag bearer for quality in residential care. People are talking about categorizing young people according to their diagnoses, their assessed functional capacities, and their deficits. In fact, entire systems are being built to match services to such clinical profiles, where quality care is equated with the way the complexity of a young person's psychological circumstance corresponds to the availability of high-end clinical resources, such as psychiatry, psychology, a battery of assessments and fidelity to evidence-based practices.

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This might be a good time to remind ourselves that child and youth care practice, and by extension relational practices as a theoretical foundation for child and youth care practice, emerged specifically *in resistance* to this medical model of treatment. In North America, the treatment movement, driven by medical systems and ideologies that defined any behaviours of young people that were challenging to the norms of society as disease and illness to be cured, was very good at 'hospitalizing' children and youth, separated from their families and communities, and accultured into institutional ways of being. They were not so good at care. In fact, treatment involved little more than coercive interventions that imposed medications, control, surveillance, and conformity for as long as children and youth were within the system and then allowed for complete abandonment once they were discharged. Several generations of survivors from this cruel approach are still working through their trauma, and many are failing at that as evidenced by the relatively high rates of homelessness, addictions, and suicide amongst system survivors.

The current movement toward defining quality standards in residential care is probably not stoppable, and at any rate, it may not be a bad thing to focus on quality standards in relation to care. The question is where to start and what to focus on, and here I want to (once again) weigh in with my suggestions. I will do these over the course of my next three contributions to *CYC-Online*, this being the first one. Each month, I will speak to two standards from the six quality standards as described in the title of this essay: Sleep, Eat, Play, Learn, Be You, and Community. In my view, if one could raise the quality of these across all residential services, we would have a transformational impact on how such services are experienced by children, youth, their families and their communities. This month, I will describe the first two of these standards: Sleep and Eat.

Sleep

Sleep constitutes not only the physiological base for health, but it also represents one third of every person's life. Therefore, focusing on sleep and ensuring that the benefits of sleep are maximized is a critically important measure of quality of care. To this end, the following standard is measured routinely.

Quality Standard

Every young person in residential care must have a bedroom (shared or single, depending on preference and availability) that features a quality bed with a high quality mattrass and pillow, and bedding that is chosen by the young person and reflects the young person's needs and preferences in terms of weight of the bedding (eg: weighted blankets) and the aesthetics of the bedding (eg: something important to the young person). Furthermore, the lighting of the bedroom reflects the young person's needs from a trauma and desire perspective and is adjustable based on mood and the current moment. All bedrooms (or sleeping spaces if shared) are personalized to reflect things that are important to the young person (family pictures, transitional objects, etc.). White noise is available to young people who want that. The bedroom is the young person's private space, of the highest aesthetic quality available, and a sanctuary from the burdens of the day past and the day coming. Beyond the bedroom walls, the residence pays attention to the sensory factors that impact on sleep, including noise, smells, and temperature and humidity regulation.

Service providers must track the quality of sleep experienced by young people in three different ways. First, all young people are invited to rate the quality of their sleep each morning. Second, all overnight staff maintain a

separate tracking of each child or young person's sleep from their perspective, noting sleep interruptions and the causes for these wherever possible. And third, all periodic reviews of a young person's experience in the residential setting (eg: Plan of Care meetings) include a discussion of sleep, including dreams, and such discussions are documented.

All Plans of care must include a section that speaks to current and ongoing work to improve the sleep experience of every young person in the home.

Eat

Food and Nutrition are known and evidence-based factors in health, learning, behaviour, cultural connections, identity, and the development of personal autonomy through expressions of ideological preference (eg: veganism). What we eat and how food is handled in a residence reflects multiple dimensions of the care environment. To this end, the following standard is measured routinely.

Quality Standard

Food is always available to all children and young people in the home. Food is not locked up and children and young people must be able to access food without having to ask for it from staff. The types of food available in abundance must reflect the cultural and identity factors of the current group of young people living in the residence. Children and youth have leadership roles in determining the methods of procuring food, the menu planning process, the preparation of food for meals and snacks, and the allocation of resources pursuant to food in relation to the allocation of resources pertaining to other items in the home. While staff maintain teaching and guidance roles in discussing health-related matters pertaining to food (eg: limits on junk food; menus correspond to national food guides), all food-related matters in the home are subject to collaboration between young people and staff and neither group can veto the desires or preferences of the other.

All individual children and youth have food and nutrition plans documented in their case files. Such plans must take account of nutrition-based substitutes or enrichments for pharmacological interventions. Such plans must also take account of the connection of food to identity formation, cultural and religious needs and preferences, and the

development of personal autonomy on the part of individual children and youth with respect to ideological preferences (meat-less diets, organic foods, halal or kosher foods, etc.).

Food regimes in homes must be reflective of building a sense of belonging and care, and therefore food (withholding of food or offering reduced quantities or quality of food) can never be used as a punishment or a behaviour management measure. Furthermore, the food in the home is the only food for all people in the home at any given time. Staff cannot bring their own food (except for medical reasons) to the home, order food for themselves, or eat separately from the group. All food-related activity is activity reflecting the whole home environment, not the environment for children and youth separate from the environment for staff or other adults.

All residential care providers must have a dietician on staff or procure consulting services through a registered dietician, who reviews individual food plans for each child or youth as well as the overall food system in the home and makes recommendations to optimize the impact of food in the home. Documentation must be in place of all such recommendations and the home's response to these. Furthermore, all residential care providers must have a defined articulation of the food system in the home and its interfaces with child health, learning, and cultural and identity promotion.

Finally, all residential care providers must provide an annual report on their expenses on food, and all such expense reports must demonstrate at minimum year over year increases in line with inflation.

Next month, I will describe the next two quality standards: *Play* and *Learn*. These are more complex than Sleep and Eat but equally important and certainly interface with Sleep and Eat as well. Once again, while these quality standards may appear as simplistic, once I have described them all, I will synthesize how these standards give rise to a relational care environment that is sustainable and can be measured.

DR KIARAS GHARABAGHI is Dean of the Faculty of Community Services at Toronto Metropolitan University, Canada and a regular contributor to *CYC-Online*. He can be reached at k.gharabaghi@torontomu.ca

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The Importance of Storytelling

Alixandria Sims

Storytelling is essential for better engagement with young people. It affirms their dignity, validates their emotions, and fosters trusting and relational bonds. This story is not simply about a single incident of punishment, but about the lasting impact of power, silence, and emotional invalidation within a caregiving relationship.

+++

"AVERY JO[1]! ALEXIA EVANGELINE[1]! TARRA-BREE[1]!"

The yell could be heard across the street in the park where my younger sister played. Both names: they were angrier than usual. *It wasn't me. It wasn't me. It wasn't me. It wasn't me.* I emerged quietly from my bedroom, book in hand, index finger holding my place. My eyes shifted around the room, trying to sort out what had gone awry this time. My mind ran with questions. *It couldn't be something in my room, or we wouldn't all have been called, plus I knew my room was up to scratch because it had been looked over after school. The kitchen seemed fine; I walked through it on my way to the living room. It wasn't a question of hygiene because Avery was too young to leave a period mess in the bathroom, and mine wasn't due yet.*

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"Sit. Down." Their voices rumbled with fury; their eyes were hot with anger as they pointed at the couch. I had to walk past them to sit. I kept my book in my right hand and moved toward the love seat as my older sister walked in. The book was snatched from my hand and snapped shut. Great. *Now my page was lost, and I was in trouble for who knows what. It wasn't me. It wasn't me. It wasn't me. It wasn't me.* Avery ran in, breathless and red in the face and squeezed in with us. She didn't know to worry yet. She was only seven. Our mum and Avery's dad stood over us with crossed arms, glaring daggers and eyes glazed from the marijuana they smoked in "secret". *Had they already been drinking, too?* [1]

"Who did it? If you come clean now, no one will get into any trouble." *That was a lie*. It was always a lie. *Someone would get in trouble. It wasn't me. It wasn't me. It wasn't me. It wasn't me.* I still didn't know what was going on.

"Did what?" Tarra asked. *Very brave.* I couldn't have done that. It never mattered how calm and nonconfrontational we tried to sound; we were always "talking back." *It wasn't me. It wasn't me. It wasn't me. It wasn't me.*

"You know every well 'what' and don't talk back like that. Goddamnit! You're always so disrespectful. Why are teenagers today so rude?"

"I have no idea what you're talking about?"

"DON'T talk back! The spray painted eff word in your new bathroom! We worked hard on that. It isn't finished and one of you three has RUINED it with a swear word painted in blue across the wall!" *It wasn't me. It wasn't me. It wasn't me. It wasn't me.*

We were traipsed down the steep, rickety stairs, and into Tarra's private bathroom. I hated those stairs; they didn't have a handrail. The bathroom had a toilet, a sink with a small cabinet, and a stand-up shower. My parents

[1] Names have been changed to protect the identities of the children involved in this situation.

wrenched open the accordion door and there was the offending word. All capitals, about two inches wide, and in bright blue paint. *It wasn't me. It wasn't me. It wasn't me. It wasn't me.*

FUCK

I was fascinated, horrified, and terrified at the same time. *It wasn't me. It wasn't me. It wasn't me. It wasn't me. Why would either of the other two? Did a parent do it and forget? Why?* While my mind raced, the parents yelled at us for what felt like 15 minutes or more. I knew my face looked like I wasn't listening and maybe I wasn't. I was too busy trying to solve it. I got yelled at for not caring, too. I was just trying to be helpful as I stood there, tears streaming down my face. *I did too care!* I couldn't very well say that out loud. I knew it would cause more trouble and be seen as back talk.

"That's not all." Cold voice. Angry faces. We were marched out to the garage. On the garage floor behind the motorcycle were flathead thumbtacks, points up. *Would those pop the tire if no one noticed before the motorcycle backed up?* I chanced a glance at my sisters. Avery looked cherubic, as always, a smile on her face, eyes wide in innocence. Tarra was fuming. If this were a cartoon she would have smoke coming out of her ears. We were taken out of the garage and across the road to the park. *It wasn't me. It wasn't me. It wasn't me. It wasn't me. What was happening?*

AVERY

Pressed into the tree and spelled out in the same thumbtacks as on the floor in the garage. The silver heads glinted in the sunlight against the wrinkled bark. *It wasn't me. It wasn't me. It wasn't me. It wasn't me.*

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"Get. Back. On. The. Couch." Quiet but furious. Whispered through clenched teeth. Not making a public scene but making sure we knew not to cause a fuss and get our butts in the house and get ready to be railed at. *It wasn't me. It wasn't me. It wasn't me. It wasn't me.*

Tears continued to well up in my eyes; I could barely see through the fog on my glasses and the wall of tears that struggled to fall to my cheeks. *It wasn't me. It wasn't me. It wasn't me. It wasn't me. Stop crying. STOP crying!* This would forever be to my detriment. Crying was a sign of guilt in my family.

They were still yelling at us and making promises that if we just gave ourselves up, then no one would be in trouble. It was decided that the three of us would be left alone to decide the guilty party and then come find them when we were through. I guess it was a peer court. In the end, nothing was decided by us. None of us knew who did it. *It wasn't me. It wasn't me. It wasn't me. It wasn't me.* We only knew, each in our hearts, that it wasn't us.

When our parents returned, they informed us they had made an executive decision. My tears were still coming, and my breath kept catching. *It wasn't me. It wasn't me. It wasn't me. It wasn't me.* I couldn't see anyway, so I put my glasses in my lap and waited.

"We know none of you will rat out the others, and if you don't stop crying, we'll really give you something to cry about! We've thought about it *(probably while they were drinking or smoking)* and made a decision. Avery is too young to even know what those words mean, and WHY would she put her own name in a tree?! And since she wouldn't put her name, WHY would she put thumbtacks behind the motorcycle tire?! Tarra was away last night, and it wasn't there yesterday." *It wasn't me. It wasn't me. It wasn't me. It wasn't me.*

They were screaming at me. They never seemed to need breath. It all came out at once. How-dare-you-and-the-disrespect-and-stop-crying-or-I'll-give-you-something-to-cry-about-and- vandalism-and-why-is-it-

always-you? *It wasn't me. It wasn't me. It wasn't me. It wasn't me.* It was never me, but I could never say it out loud. It's disrespectful to talk back. My sisters were sent out of the room. Tarra stomped back down to her room, slamming doors on her way, and Avery, smiling ear to ear, ran across the road and back to play at the park.

I was grounded for two weeks. *It wasn't me.* No TV. *It wasn't me.* No friends. *It wasn't me.* No phone. *It wasn't me.* No books. *It wasn't me.* The last one was torture. I lived for books. I didn't really have friends; books were my escape from my life. *It wasn't me.*

+++

"Hey do you remember the blue fuck? And the thumbtacks?" Avery, in her 20s, asked at a family dinner. We still call it the blue fuck. *It wasn't me. It wasn't me. It wasn't me. It wasn't me.* Everyone else chuckled. I just felt my face flush, and I got angry. A scowl spread across my face.

"It was me." Laughter. They had figured it out years ago. They knew all along and never told me. No apologies, no guilt at punishing the wrong kid, no contrition from my sister. Just laughter and "oops." My anger was considered an overreaction.

It wasn't me. It wasn't me. It wasn't me. It wasn't me.

+++

I am intensely aware of how damaging silencing and blaming children without listening to them can be. I hope that sharing this experience allows practitioners to better understand how a past can inform empathy for young people who feel misunderstood, disbelieved, or unable to safely express

themselves. Adults are not omniscient authorities; we need to be relational partners who model accountability and respect.

Reflective Questions

1. What messages about safety, trust, and voice might the child internalize from this experience? How might unresolved injustice manifest in adulthood?
2. If this youth were on your caseload, how would you build relational safety with a youth who fears being disbelieved?
3. This story takes place in a lower-middle-class blended family with some substance use. How might caregiver substance use influence escalation and perception, and how might a practitioner assess substance-related risk without making assumptions?

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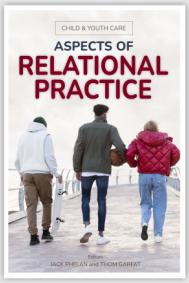

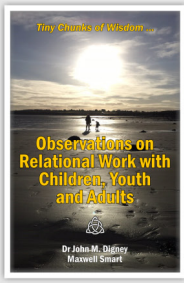

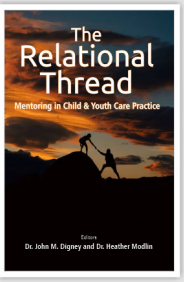

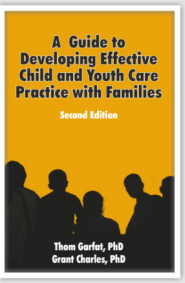

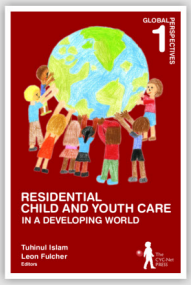

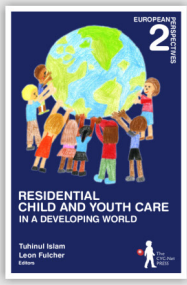

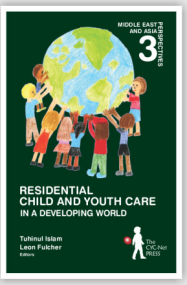

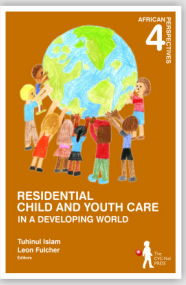

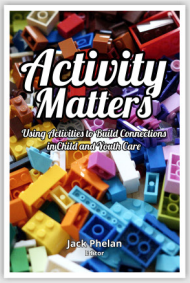

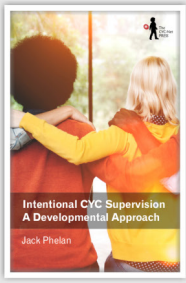

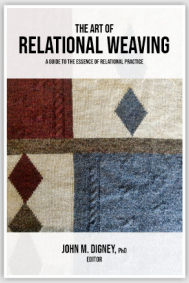

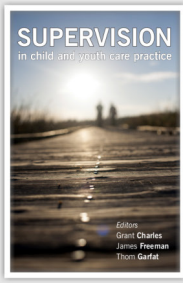

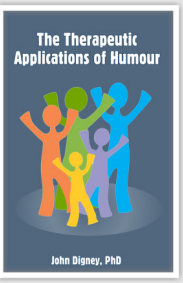

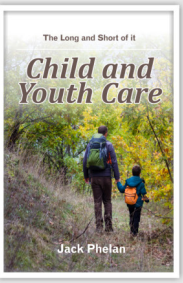

Kids Today: Thoughts From Research, Practice, and the Classroom

Young people can be unfairly and negatively judged by older generations

David A. Jobes

Across time and generations, elders have often bemoaned with exasperation, “Kids today!” As a quintessential Baby Boomer, I often hear same-aged peers complain about youth (e.g., those born between the late 1990s and early 2000s). While developmental psychologists eschew using broad labels to describe large generational cohorts (i.e., the Silent Generation, Baby Boomers, Gen X, Millennials, Gen Z, and Gen Alpha), these labels tend to stick and become integrated into our cultural narrative, evoking common associations and perceptions. To this end, I would like to reflect a bit on young people who make up Gen Z and Gen Alpha—presently in their teens and 20s—from three distinct perspectives: clinical trial research, psychotherapy practice, and the college classroom.

For 20-plus years, I have been immersed in randomized controlled trials (RCTs) of a suicide-focused treatment called the "Collaborative Assessment and Management of Suicidality" (CAMS—Jobes, 2023). While various RCTs

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of CAMS are underway in the U.S. and abroad, I am presently focusing on three NIMH-funded studies with young adults, college students, and teens who are suicidal. The "Suicide Status Form" (SSF) is central to CAMS. It is a multipurpose tool for assessing, treating, tracking, and documenting clinical outcomes. In the first session of CAMS, patients rate SSF constructs (i.e., psychological pain, stress, agitation, hopelessness, self-hate, and overall risk of suicide) and respond to qualitative prompts writing out descriptions of these variables. Moreover, patients are prompted to write out reasons for living and dying, respectively, and describe the "one thing" that would make them no longer suicidal.

Thirty-five years of studying SSF responses has provided a valuable window into the thinking of people who are suicidal. In terms of contemporary youth, we are currently seeing some noteworthy SSF responses that are unusually existential and focused on social determinants. For example, when asked about shame, one 12-year-old said, "Yes, I am ashamed of my existence!" An 11-year-old boy noted "the brain-rot of my peers." In a college-student RCT, we saw comments such as: "I will always be in debt" and "I'll never own a house." Others noted "the earth is dying" and "our political divisions." One female college student described her self-defined "drivers" of suicide as "racial and gender oppression" and "there is no point in living." Finally, an eighth-grader grimly summed up his reasons for dying, writing, "The boomers have messed up the world for us!" This particular response struck me.

As a university professor, I am used to working with young people; as a clinician, I have seen countless teens, college students, and young adults over four decades. When I reflect on young people, what is common across generations is generally more striking than what is different. However, unlimited access to internet information, the explosion of social media, the Covid-19 pandemic, and artificial intelligence have been impactful on us

all. One could argue that contemporary young people have encountered *species-level* changes without parallel in history. While this may be debatable, it is nevertheless fair to say that a lot has happened over the last 20 to 30 years that may uniquely and profoundly impact young people today.

I am currently teaching an undergraduate class ostentatiously titled “The Psychology of Living,” and it has been a joy. When I think about my students, I reflect on media-based complaints, critiques, and criticisms of young people today: that they are notoriously stuck on their phones, obsessed with their social media, and frantically seeking ever more likes. One research piece noted that an overreliance on technology and Covid-related social isolation has led to today's youth literally talking less than previous cohorts. However, my Psych of Living students do not conform to this finding; they are engaged and active in our class. They are initially riveted by an exploration of lessons learned from suicide research and continue to come alive as we pivot to life as a journey, existential philosophy, the psychology of awe, the unconscious, living intentionally, mental health, post-traumatic growth, possible lives, love/relationships, mindsets, grit, spirituality, values, and how to create a life worth living with purpose and meaning. In turn, my students actually have a lot to say about all these topics. But for this to happen, I must ensure that our class is a “safe space." I tend to use silences to help draw them out, and I sometimes ask all of them to comment on a topic. While this approach creates some discomfort, it also helps students who might not otherwise speak up find their voice. And when they do speak up, they discover validation and support from their classmates and me. Last week, for example, I led a class exercise wherein students spent time reflecting on their purpose in life. As each student shared, it became abundantly clear through their emotions, laughter, and connection with each other that they relished the

chance to talk, revealing vulnerable versions of themselves not typically shown outside of class. Having mulled over what my students shared, I have concluded that today's young people are too often unfairly judged and criticized by their elders. In turn, I believe that we elders must endeavor to create more and better opportunities for young voices to be expressed and heard.

Years ago, I visited a prestigious private boys' school in Washington, D.C., after some troubling mental health-related incidents. My consultation involved meeting with parents on a Thursday evening, followed by a Friday morning meeting with all the upper-school students (300-plus teens), with a final faculty meeting in the afternoon. My plan was to present a well-disguised case of a teenager from my clinical practice. My patient, who had high-achieving parents, was emotionally distraught as he struggled with academics, peers, parents, and too many extracurricular activities and sports. I presented the case in each meeting before shifting to Q&A. On Thursday night, I saw parents squirm uncomfortably as I presented my case. On Friday morning, many nodding heads showed that the students readily identified with the case, and later, the faculty also gave knowing looks. My takeaway from the consultation? Parents complained that their sons *refused to talk to them!* The students bitterly complained that their parents *refused to listen to them!* And in exasperation, the faculty queried: *What should we do with all the crazy parents*?

For my part, I am working hard to neither judge nor look down my nose at “kids today,” and I will continue to endeavor to create opportunities for young voices to be expressed, heard, and validated—the very thing I craved when I was young.

Key points

- Every generation struggles with the challenges of their youth.
- Today's youth are often criticized for their use of cellphones and social media.
- Perspectives from clinical research, practice, and the classroom reveal the valuable insights of youth.
- There is virtue in not judging kids today who simply need forums to make their voices heard.

Reference

Jobes, D. A. (2023). *Managing Suicidal Risk: A Collaborative Approach,* 3rd edition. Guilford Press.

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Self-Harm and Suicide in Residential Care

Ellie O'Donnell

Abstract

Self-harm and suicide behaviours in residential childcare require effective interventions, practices, and policies that ensure the safety and wellbeing of young people. This literature review examines current research on prevalence, risk factors and interventions, identifying inconsistencies in definitions and risk management. Trauma-informed care, dialectical behaviour therapy, staff training, supporting relationships, and adaptive coping strategies are highlighted as key approaches. The review highlights the need for developmentally appropriate and individualised care and safety planning, particularly for younger children and autistic children. Research gaps are noted, and policy recommendations include improved risk assessment, safety and care planning, and enhanced staff support.

Keywords

Residential childcare, self-harm, suicide, risk assessments, Scotland.

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Introduction

Understanding self-harm and suicide behaviours in residential childcare is essential to developing appropriate interventions, practices and policies to ensure young people are safely cared for (Evans, 2018). This ensures those working within residential organisations have consistent training, understanding, and responses to self-harm and suicide behaviours (Paul & Hill, 2013). Research places importance on factors such as increased feelings of hope for the future and positive outcomes, and on reduced engagement in self-harm and suicide behaviours (Burnand & Johnson, 2022; Ngune et al., 2021). Therefore, this literature review aims to explore existing research on self-harm and suicide behaviours in residential childcare, including current interventions and supports. The review makes recommendations for policy, including risk assessment and management, safety and care planning, and staff training and support.

Language and definitions

The language used to describe topics such as suicide and self-harm, and looked-after young people's experiences, are complex. To ensure a consistent understanding of topics, the following section will provide an overview of 'residential childcare', 'suicide', and 'self-harm' within the context of this review.

Residential childcare

In Scotland, residential childcare encompasses various settings, such as children's homes, residential schools, and secure care (Scottish Government, n.d.). Children may reside in residential care for a number of reasons, such as behavioural and emotional difficulties, exposure to violence in the family home, abuse or neglect (Pinheiro et al., 2024). As a

result, children may be placed under a Compulsory Supervision Order through the Children's Hearing (Scotland) Act 2011, Section 25 of the Children (Scotland) Act 1995, or through permanence orders under Section 80 of the Adoption and Children Act 2007 (Scottish Government, n.d.).

Suicide

Although suicide has never been an offence in Scotland, until 1961 it was regarded as a crime in England and Wales (Suicide Act 1962; UK Government, n.d.). The act of suicide is often referred to as 'committing suicide', implying an offence has occurred, with phrases such as 'completed suicide' or 'died by suicide' being more compassionate (Padmanathan, 2019).

Self-harm

The definition of self-harm is often inconsistent due to differing understandings of the behaviour and motivations behind it (National Collaborating Centre for Mental Health, 2011). Descriptions such as 'parasuicidal behaviour', 'non-suicidal self-injury' and 'self-mutilation' have all been used to describe self-harm (Furnivall, 2023). For the purpose of this review, self-harm will be defined in line with the NICE guidelines (published in 2022): 'Self-harm is defined as intentional self-poisoning or injury, irrespective of the apparent purpose'. Common behaviours include cutting, burning, biting, scratching skin, and poisoning (Cipriano et al., 2017) However, '[t]he guideline does not cover repetitive, stereotypical self-injurious behaviour (such as head banging)'. Headbanging has been viewed as the most frequent form of self-injury among those with autism spectrum disorder (ASD)or those in a secure setting, due to it being a more 'accessible means of harm' (Mournet et al., 2024; Steenfeldt-Kristensen et

al., 2020; Summers et al., 2017;). Research has uncovered that most individuals who engage in self-harm behaviours use more than one method, for example, cutting and ligature use (Cipriano et al., 2017). Frequent engagement is associated with mental health difficulties and increased risk of suicide attempts (Castellvi et al., 2017).

Method

To explore self-harm and suicide in residential childcare, a narrative literature review methodology was adopted. A systematic search was conducted across peer-reviewed databases for articles between 2008 and 2025, with inclusion criteria focusing on self-harm and suicide in residential childcare. Studies from similar systems, for example, youth justice, kinship, foster care, and inpatient mental health, were also included where relevant to draw transferable insights. Analysis involved thematic synthesis of risk factors, intervention models, and policy frameworks. This review is not an exhaustive exploration of self-harm and suicide behaviours in residential childcare.

Key findings

Measuring and recording risk of self-harm and suicide

Behaviour is described as having a temporal component, meaning it unfolds and develops over time. Therefore, tools have been developed to focus on risk factors, such as mental health and adverse childhood experiences (Stewart et al., 2020). An exploration of the Child and Youth Mental Health Screener (ChYMH-S; Stewart et al., 2017) found that the tool assesses varying factors, including mental state indicators, substance use, behaviours of concern, harm to self and others, communication,

development, stress, trauma, relationships, and education. Stewart et al. (2017) found the ChYMH to be a strong predictor of self-harm and suicide behaviours within mental health organisations.

Additional tools, such as the Strengths and Difficulties Questionnaire (SDQ; Hall et al., 2019), the Revised Children's Anxiety and Depression Scale (RCADS; Baron et al., 2021), the Massachusetts Youth Screening Instrument – version 2 (MAYSI-2; Grisso & Barnum, 2006), and the Children Revised Impact of Event Scale (CRIES; Ossa et al., 2019), have also been validated for the assessment of mental health concerns. Such measures and tools should be repeated at regular intervals to continue to assess the risk and effectiveness of intervention (where appropriate) (Law, 2012). Qualitative designs, such as the 'ABC' model, propose that activating events or triggers, resulting in self-harm and suicide behaviour, which creates an emotional or behavioural response are also effective in monitoring risk (Fowler et al., 2021).

Self-harm and suicide behaviours require various measures to further understand them (Bateson & Martin, 2021; Madge et al., 2011). Residential organisations adopt their own data entry system for how self-harm and suicide incidents are monitored and assessed (Wadman, 2017). UK guidelines for young people who present with self-harm and suicide behaviours recommend comprehensive psychological assessments should be completed (National Collaborating Centre for Mental Health, 2011). Various scales, tools and measures are a key part of this assessment for predicting future risk. Available tools include: the Suicide Risk Monitoring Tool (SMT), Ask Suicide Screening Questions (ASQ), Self Harm Questionnaire (SHQ), Suicide Ideation Questionnaire (SIQ), Beck Hopelessness Scale (BHS) and Children's Depression Rating Scale-Revised (CDRS-R) (Erbacher & Singer, 2017; Harris et al., 2019).

Safety planning

NICE guidelines state that young people who have engaged in self-harming behaviours should be supported through a 'safety plan'. This includes key coping strategies and sources of support for the young person during crisis, whilst highlighting warning signs for professionals to monitor (NICE, 2022). The guidelines further encourage a 'designated lead', to support staff and young people in implementing safety plans and ensuring these are adhered to.

Research has placed further emphasis on the importance of safety plans using a Multi-Disciplinary Team (MDT) approach (Abbott-Smith et al., 2023).

The Centre for Suicide Prevention (2021) describes a safety plan as 'a written document that supports and guides an adult with suicidal ideation or behaviour to help them avoid a state of intense suicidal crisis'. Research has further described safety planning as a structured primary intervention between young people and professionals (Stanley & Brown, 2012). Safety plans are often developed in line with key aspects of the Cognitive Behavioural Therapy (CBT) model and have been found to lessen the risk of self-harm and suicide (Stanley & Brown, 2012; Mann et al., 2021). Research has identified that safety plans should include warning signs, coping strategies, social support, professional contacts, and environmental support (Bryan & Rudd, 2018; Mann et al., 2021).

Various approaches have been identified for creating safety plans with young people. The Stanley and Brown model (2009) utilises a CBT-informed safety plan. This approach was found to be positive in reducing suicide ideation, however, motivation to engage in the plan was low (Stanley et al., 2009).

Therefore, motivational interviewing informed safety plans were developed (Czyz et al., 2019). Such studies found increased coping and engagement in safety planning but did identify a need for plans to be developmentally appropriate to young people (Abbott-Smith et al., 2023). OverCome (Muela et al., 2021) is a new intervention that focuses on self-harm and suicide behaviours. This intervention places foregrounds the development and implementation of safety plans that the young person can utilise during periods of crisis. Muela et al. (2021) also suggest professionals and care staff working with young people should have safety plans to reduce the stigma around self-harm and suicide and to normalise the need for support.

Further approaches, such as the SAFETY Programme (Asarnow et al., 2017), Family-Based Crisis Intervention (FBCI; Ginnis et al., 2015), the

COPES model (Wolff et al., 2018), and the Adolescent Safety and Coping Plan (ASCP; McManama O'Brien et al., 2020), have been developed to explore family involvement for young people who continue to reside in the family home and for those who are transitioning out of highly-supervised environments.

Gaps within the literature have identified a need to develop safety plans suitable for autistic children, due to social barriers and differences in communication styles (Camm-Crosbie et al., 2019; Crane et al., 2019). As a result, Rodgers et al. (2023) developed a safety plan to support autistic individuals, the 'Autism Adapted Safety Plan'. This encompasses key elements required for a safety plan, however, with attention paid to communication styles. Strategies to support autistic young people in completing safety plans include visual aids, clear instructions, and recognition of sensory needs (Schwartzman et al., 2021).

Prevalence and risk factors of self-harm and suicide in residential childcare

Young people who reside in residential care have an increased likelihood of experiencing childhood adversity and trauma in comparison to those living in the family home (National Audit Office, 2015; Rosa, 2019; Rouski et al., 2021).

Such experiences increase the prevalence of psychological difficulties and engagement in risk-taking behaviours, such as self-harm (Calvo et al., 2024; Cleare et al., 2018; Martin et al., 2016; Yates, 2009). Mental health difficulties, such as depression, anxiety, and post-traumatic stress disorder, are correlated with self-harm behaviours, particularly for those residing in residential childcare (Varley et al., 2022). Carter et al. (2025) reported the use of self-harm to cope with distress and negative emotions related to the

young person's life experiences. Young people living in care can also experience social isolation, loneliness and victimisation due to the stigma of residential care, further perpetuating the risk of self-harm (Emmerich et al., 2024).

Research has identified that 35 to 40% of young people living in residential care engage in self-harm, in comparison to 15% of those living with family (Geoffroy et al., 2022). This is further evidenced by Hawton et al. (2022), who identified that those living in residential childcare are at greater risk of self-harm, thus emphasising the need for tailored prevention and intervention. Young people may be exposed to the distress of other's behaviours, contributing to what is often described as a 'contagion effect' (Chandler, 2016; Hawton et al., 2020; Papadima, 2019). For staff, frequent incidents can contribute to emotional fatigue, reduced tolerance, and reactive care practices, which in turn affect how well trauma-informed principles are applied (Brown et al., 2019; Clark et al., 2022; Friis et al., 2024; Grybush, 2020).

Research has highlighted the significance of adverse childhood experiences (ACEs) and mental health difficulties with respect to the prevalence of suicide (Stinson et al., 2021). An American study found experience of childhood trauma to be a predictor of suicide ideation and self-harm (Stinson et al., 2021). Further research identified each additional ACE increases an individual's risk of suicide by 123% (Dudeck et al., 2014). Muela et al. (2024) found that, of 185 young people in residential care in Spain, 26.5% had previously attempted suicide and 36.2% had ongoing suicidal thoughts. Only one-third of young people who had thoughts of suicide had sought professional support. Limited care staff knowledge and training impacted young people's confidence in seeking support from them (Muela et al., 2024). Burnand and Johnson (2022) identified the importance of relationships, talking interventions, practical support, and professional

support for young people who engage in self-harm and suicide behaviours in residential care.

Deaths of care experienced children in Scotland

The Care Inspectorate (2020) conducted an overview of the deaths of care experienced children in Scotland between 2012 and 2018. They found that of the 42 children and young people who died, 14 died as a result of substance use, self-harm, and suicide. Half of these young people previously resided in secure care or settings with high levels of supervision. The review recommended the need for earlier identification of distress, effective multi-disciplinary team working, and available interventions.

Additional risk factors

It should be noted that trauma and adversity are not exclusive factors for engaging in self-harm and suicide behaviours, however, these are the most significant factors for young people residing in residential childcare (Calvo et al., 2024). Additional risk factors include interpersonal difficulties, grief and bereavement, financial difficulties, mental health difficulties, and sensory needs (Blanchard et al., 2021; Darol & Mishara, 2021; Elbogen et al., 2021; Ford, et al., 2021; Rasmussen et al., 2016; Reichl & Kaess, 2021). Research further states that young people with a learning disability (LD) or neurodevelopmental diagnosis (NDD) are at greater risk of engaging in self-harm and suicide behaviours (Blanchard et al., 2021). Such diagnoses can impact the individual's understanding, management, regulation, and communication of their emotions (Cibralic et al., 2019; Reyes et al., 2019; Sari et al., 2024).

There is limited research on the relationship between those who identify as transgender or gender diverse (TGD), or lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI), living in residential childcare and their engagement in self-harm and suicide (Cawley et al., 2019). Findings from the Life in Scotland report (LGBT Youth Scotland, 2022) indicated that 69% of LGBTQI young people had experienced suicide ideation and 43% engaged in self-harming behaviours. Those living in residential care, or who had unstable living environments, reported high levels of distress. Research has explored TGD individuals and their engagement with Child and Adolescent Mental Health Services (CAMHS), finding that those who identify as TGD had increased vulnerabilities to experiencing mental health concerns and engagement in self-harm and suicide behaviours (Whittle et al., 2024).

Criminal justice context: Young offenders

It is important to recognise that young people involved in the criminal justice system may be young prisoners. Since 2011, ten young people have died by suicide in HMPYOI Polmont (Judiciary of Scotland, 2025). Following the deaths of two young people, Katie Allan and William Lindsay, in custody, a Fatal Accident Inquiry (FAI) was conducted. The inquiry identified multiple systemic failings, including limitations in multi-disciplinary communication; inadequate mental health and suicide risk assessments; lack of trauma-informed practice; and misattunement to signs of distress and risk (FAI, 2025). Recommendations included in the FAI focused on the need for proactive risk assessments and management, including ligature prevention and suicide prevention technology, as well as the appropriate recording and communication of information (FAI, 2025; Judiciary of Scotland, 2025).

Although these deaths occurred in a custodial context, they highlight wider concerns about the safety and care of vulnerable young people across Scotland's systems, including residential and secure care. These concerns formed part of the broader policy and public discourse that contributed to legislative reform, including the Children (Care and Justice) (Scotland) Act 2024 (Scottish Government, 2024). While this is not a direct result of the FAI or the Children's Hearing System review, the Act introduces significant changes, including raising the age of referral to the Children's Hearing System to 18 years and ending the use of Young Offender's Institutions (YOIs) for children (Scottish Government, 2024; Scottish Prison Service, 2025). As a result, children are no longer placed in YOIs, and those requiring a custodial sentence are now accommodated in secure settings up to the age of 18, after which they may transition to HMPYOI Polmont if required.

Approaches to intervention and support

There are various interventions and supports which have been developed to support young people who engage in self-harm and suicide behaviours in residential childcare. These focus on trauma-informed care, relational factors, and evidence-based therapies. A key approach to supporting young people in residential care is the adoption of trauma-informed care (TIC) (Goddard, 2021). TIC promotes safety, connection, and trust within a caregiving environment, assisting young people to manage their emotions and behaviours safely (Bath, 2008). Research identifies that staff training in TIC improves emotion regulation in young people and reduces self-harm behaviours (Hodgdon, 2023; Nikopaschos et al., 2023). Burnand and Johnson's (2022) research found that giving young people the opportunity to discuss their engagement in self-harm and suicide behaviours is beneficial in the management of such behaviours. This discussion can take place with professionals or care staff.

Research emphasises the importance of stable and supportive relationships between care staff and young people in reducing self-harm and suicide behaviours (Burnand & Johnson, 2022; Epstein & Ougrin, 2020). Holland et al. (2020) found that young people in residential care were more likely to seek support from CAMHS, peers, and pets, rather than care staff. Research has identified positive outcomes for those who access online peer support groups related to engaging in self-harm (Joens et al., 2011; Rowe et al., 2014). This was reported to be due to the informal aspect of online forums, however, mitigations for potential risks were required, for example, professional facilitators, trigger warnings, and training (Abou et al., 2022). Peer-led support groups were also found to reduce self-harming behaviours by empowering individuals and providing them with access to information and support (Abou et al., 2022). Although there is limited research as to the

effectiveness of family interventions in reducing self-harm behaviours, there is evidence of a positive impact on therapy attendance (Witt et al., 2021).

Therapeutic interventions, such as Dialectical Behaviour Therapy (DBT), have been shown to support a reduction in self-harm behaviours and suicide ideation (Asarnow et al., 2021; Kothgassner et al., 2021). DBT is a variant of cognitive behaviour therapy that can consist of individual psychotherapy sessions, group skills training, telephone consultation, and a therapist consultation team (Linehan, 2014). Research on the implementation of DBT within residential settings is limited, however, studies have found that where used young people have engaged in fewer incidents of self-harm and suicide behaviour (McIntyre, 2020). Witt et al. (2021) completed a study to assess the effectiveness of psychosocial interventions on incidents of self-harm behaviours. Interventions such as DBT, Cognitive Behavioural Therapy (CBT), Mentalisation-based Therapy (MBT), and family interventions were explored. This study found that DBT was most effective in reducing self-harm incidents post-incident in comparison with CBT, MDT, and alternate psychotherapies (Witt et al., 2021).

CBT allows young people to evaluate their thoughts, feelings and behaviours whilst supporting them to develop coping skills (NICE, 2024). Knowles et al. (2022) found that young people favoured developing coping skills supported by staff, and safe and accepting environments, over therapy as a way of reducing self-harm. They felt this risk would reduce once the young person had appropriate coping strategies and felt safe within their environment (Knowles et al., 2022).

Organisational considerations

Research has identified key factors to further reduce the risk of harm for those working with self-harm and suicide behaviours. These include the environment, training, observations, and technology (Care Quality Commission, n.d.; Slaatto et al., 2022). Healthcare Improvement Scotland (2019) developed guidance for those working within the National Health Service (NHS), especially when working with individuals who present with complex mental health difficulties. The guidance, 'Observation to Intervention', focuses on factors such as patient history, safe environment, safety and care planning, trauma-informed approaches, risk assessment and management, observations, and tailored training and supervision. Although this is not focused on residential childcare, the guidance provides key elements that can be adapted and implemented into residential organisation practice and policy.

Further consideration should be given to individuals' observations and how these are implemented. The National Confidential Inquiry into Suicide and Safety (2021) published data reporting that 40% of patients in hospital settings who died by suicide were subject to enhanced observation levels. As such, research has highlighted the importance of observations being carried out using therapeutic conversations (Barnicot et al., 2017; Insua-Summerhays et al., 2018). The 'Observation to Intervention' document (Healthcare Improvement Scotland, 2019) highlights the importance of using communication during observations. This has been found to reduce social isolation and immediate risk of harm. It is deemed a key factor for the individual's recovery as it provides an opportunity to communicate thoughts and feelings that may be related to their risk (Insua-Summerhays et al., 2018). Technology/artificial intelligence has been developed to monitor patients' physical wellbeing without the requirement for visual observations

(Barrera et al., 2020). The technology monitors movement and heat changes, allowing for staff to observe any alterations in the patient's breathing that may indicate distress (Barrera et al., 2020). This is mostly used within hospital settings and is yet to be explored within residential childcare homes.

Additional factors related to risk include access to items. Research has highlighted that individuals who present at greater risk of harm to self often require certain belongings/items within their living space to be removed to create a safe environment (Bailey et al., 2024; Healthcare Improvement Scotland, 2019). However, research has highlighted the need for such risk management strategies to be proactive, due to the often-impulsive nature of self-harm and suicide behaviours (Asarnow & Mehlum, 2019; Wadman et al., 2019).

Staff training is a crucial component in understanding and supporting young people who engage in self-harm and suicide behaviours (Ervine, 2022a). Applied Suicide Intervention Skills Training (ASIST), SafeTALK, and Assessing Suicide in Kids (ASK) have been adopted by many residential childcare organisations (Shannonhouse et al., 2017). ASIST provides training to staff on how to connect, understand, and assist a person who is at risk of suicide (Rodgers, 2010). Although there is limited research on the effectiveness of ASIST in residential childcare, according to data from the National Suicide Prevention Lifeline, callers were significantly less likely to feel depressed, suicidal, and overwhelmed when an ASIST interview was completed (Gould et al., 2013). Due to training often focussing on adolescents, the 'ASK' workshop has been developed to support young people and children under the age of 14 (Mental Health Learning, n.d). This ensures developmentally appropriate resources and support are available for younger children.

Definitions of self-harm and risk are often subjective due to being based on staff experiences and perceptions (Ervine, 2022a). Ervine (2022a) found that staff were more likely to support young people who did not voice suicide ideation over those who did, as this was perceived as 'care seeking' (Klineberg et al., 2013).

Burnout and secondary traumatic stress additionally impacted staff's ability to understand and manage self-harm and suicide (Pintar Babic et al., 2020). To support staff with this, research has identified the need for appropriate guidance and policy (Burnand & Johson, 2022). This works to increase awareness and knowledge of how to safely manage and record incidents of self-harm and suicide, thereby limiting feelings of uncertainty and fear (Brown et al., 2019; Burnand & Johson, 2022).

As discussed previously, safety plans have been developed to suit individuals with LD and NDD (Camm-Crosbie et al., 2019; Rodgers et al., 2023), however, these focus on NDD-specific facilities, rather than generic children's homes or secure care (Bagshawe, 2023; Heady et al., 2022). Further consideration and research are required to assess the population of young people with LD and NDD who engage in self-harm and suicide behaviours in residential childcare.

There is limited research on preadolescents (under 12 years of age) who engage in self-harm and suicide behaviours (Bolger et al., 1989; Peyre et al., 2017).

However, pre-adolescent suicide has increased in recent years, resulting in it being the fifth-highest cause of death for this age group (Peyre et al., 2017). A systemic review completed in 2022 found that approximately 17% of preadolescents who experience thoughts of suicide proceed to attempt suicide (Liu et al., 2022). Factors such as childhood trauma, limited parental support (Hostinar et al., 2015), mental health issues (May & Klonsky, 2016), and diagnoses including attention deficit

hyperactivity disorder (Beh-Yehuda et al., 2012), showed a higher risk of suicide behaviours.

Policy implications

This review emphasises the complexity of self-harm and suicide behaviours of young people in residential childcare and highlights several key areas for policy development and organisational practice. In summary, there is a need for clear and concise guidance and policy when working with young people who engage in self-harm and suicide behaviours. Not only is this to protect the wellbeing and psychological safety of the young people, but also that of the staff caring for them. From areas identified within this review, self-harm and suicide policy should include the aspects outlined below.

Risk Management and Assessment

Accurate assessment and ongoing monitoring of self-harm and suicide risk is critical (FAI, 2025). Organisations should implement validated screening and assessment tools, as reported in this review; these should be repeated at regular intervals to monitor risk trajectories and evaluate interventions (Harris et al., 2019). Documents for recording self-harm and suicide behaviours should be accessible and clear to avoid missed information and assessment; this will likely reduce staff fears of wrong practice (Brown et al., 2019).

Policies should recognise the impulsivity of self-harm and suicide behaviours, whilst appropriately assessing and monitoring risk (Asarnow & Mehlum, 2019; Wadman et al., 2019). Consideration should be given to appropriate risk management, such as observation levels, safe environment, technology-assisted support, and safety and care planning (Bailey et al., 2024; Barrera et al., 2020; Healthcare Improvement Scotland, 2019).

Safety planning

Individualised safety planning should be central to organisational policy and practice, with it being recognised as a primary intervention to reduce incidents of self-harm and suicide behaviours (Mann et al., 2021). NICE (2022) guidance emphasises the co-development of these with young people, multidisciplinary teams, and families where appropriate (Abbott-Smith et al., 2023). Safety plans should be appropriately adapted to the young person's needs, including learning disabilities or neurodiversity (ND and LDD). Staff training could incorporate motivational interviewing and collaborative safety planning approaches to enhance engagement (Czyz et al., 2019).

Research has evidenced the need for trauma-informed and developmentally appropriate adaptations of safety and risk management for

those with learning disabilities, neurodevelopmental disorders, and pre-adolescents. For example, communication aids, visual supports, and support with sensory needs (Peyre et al., 2017; Rodgers et al., 2023).

Psychological therapies

Policies should promote trauma-informed care, therapeutic relationships, and access to evidence-based psychological treatments such as DBT and CBT (Asarnow et al., 2021; Hodgdon, 2023; Witt et al., 2021).

Staff Training

Tailored training, such as trauma-informed care, allows staff to understand how to safely assess and manage incidents of self-harm (Bath, 2008; Ervine, 2022b). Staff should complete specialist training in suicide prevention models such as ASIST, SafeTALK, and ASK (Rodgers 2010; Shannonhouse et al., 2017). To ensure appropriateness within residential childcare, continued use of such models should be coupled with evaluations and developmental adaptations.

Consideration should be given to involving young people in the development of staff training due to their lived experienced. However, this must be approached ethically, safely, and through co-development, to avoid triggering distress (Knowles et al., 2022). Young people's involvement may include the development of key messages, staff responses, and support strategies. Those involved should be offered appropriate debriefing and support.

Staff Wellbeing

Organisations should acknowledge the emotional demands on staff with respect to supporting young people with complex needs. Staff should have access to supervision, reflective practice, and psychological support (Brown

et al., 2019; Burnand & Johnson, 2022; Ervine, 2022b; Pintar Babic et al., 2020). Staff should attend frequent supervision to complement training, thereby ensuring they meet the competencies required to work with such complex behaviours (Health Improvement Scotland, 2019).

Definitions

The subjective nature of self-harm and suicide definitions, and staff perceptions, may affect the consistency and accuracy of reporting incidents. Therefore, the definitions and language used should be that of guidelines, such as NICE, to ensure a universal understanding of the terms (NICE, 2022).

Addressing the gaps

Organisations should consider and address the gaps in current literature and guidance, particularly in relation to those who identify as TGD and LGBTQI, pre-adolescents, and young people with LD and NDD (Whittle et al., 2024).

Conclusion

This literature review examined self-harm and suicide among young people in residential childcare, exploring key definitions, prevalence, risk factors, and interventions. It highlights the challenges of inconsistent language and definitions, noting the influence of staff perceptions on the management of self-harm and suicide risk. Studies highlight the need for tailored interventions, such as trauma-informed care, therapeutic interventions like Dialectical Behaviour Therapy, and staff training in suicide prevention techniques. Additionally, it emphasises the importance of building supportive relationships and offering coping strategies to reduce

self-harm. While safety planning and risk assessment tools are crucial for managing risks, there is a need for developmentally appropriate and individualised approaches, especially for younger children and autistic children. The review notes gaps in the literature, particularly regarding the need for more research on younger children in care and less intrusive monitoring of young people in crisis. It also explores the implications of organisational policy on supporting and managing self-harm and suicide behaviours in young people.

References

Abbott-Smith, S., Ring, N., Dougall, N., & Davey, J. (2023). Suicide prevention: What does the evidence show for the effectiveness of safety planning for children and young people? A systematic scoping review. *Journal of Psychiatric and Mental Health Nursing*, *30*(5), 899-910. https://doi.org/10.1111/jpm.12928

Abou Seif, N., John-Baptiste Bastien, R., Wang, B., Davies, J., Isaken, M., Ball, E., Pitman, A., & Rowe, S. (2022). Effectiveness, acceptability and potential harms of peer support for self-harm in non-clinical settings: systematic review. *BJPsych Open*, *8*(1), e28. https://doi.org/10.1192/bjo.2021.1081

Asarnow, J. R., & Mehlum, L. (2019). Practitioner review: Treatment of suicidal and nonsuicidal self-injurious behavior in adolescents. *Journal of Child Psychology and Psychiatry, 60*(10), 1046–1054. https://doi.org/10.1111/jcpp.13166

Asarnow, J. R., Berk, M. S., Bedics, J., Adrian, M., Gallop, R., Cohen, J., & McCauley, E. (2021). Dialectical behavior therapy for suicidal self-harming youth: Emotion regulation, mechanisms, and mediators. *Journal of the American Academy of Child & Adolescent Psychiatry*, *60*(9), 1105-1115. https://doi.org/10.1016/j.jaac.2021.01.016

Asarnow, J. R., Berk, M., Hughes, J. L., & Anderson, N. L. (2015). The SAFETY program: A treatment-development trial of a cognitive-behavioral family treatment for adolescent suicide attempters. *Journal of Clinical Child & Adolescent Psychology*, *44*(1), 194–203. https://doi.org/10.1080/15374416.2014.940624

Asarnow, J. R., Hughes, J. L., Babeva, K. N., & Sugar, C. A. (2017). Cognitive-behavioral family treatment for suicide attempt prevention: A randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, *56*(6), 506–514. https://doi.org/10.1016/j.jaac.2017.03.015

Bagshawe, M. J. (2023). *Comparing suicidal thoughts and behaviours of youth with fetal alcohol spectrum disorder and autistic youth: Caregivers-reported suicidality, access to services and barriers in seeking support.* University of Calgary. https://ucalgary.scholaris.ca/server/api/core/bitstreams/7252edd5-afdf-4c71-8d93-fa9fcaf7b566/content

Bailey, E., Bellairs-Walsh, I., Reavley, N., Gooding, P., Hetrick, S., Rice, S., & Robinson, J. (2024). Best practice for integrating digital interventions into clinical care for young people at risk of suicide: a Delphi study. *BMC Psychiatry, 24*(1), 71. https://doi.org/10.1186/s12888-023-05448-7

Barnicot, K., Insua-Summerhayes, B., Plummer, E., Hart, A., Barker, C., & Priebe, S. (2017). Staff and patient experiences of decision-making about continuous observation in psychiatric hospitals. *Social psychiatry and psychiatric epidemiology*, *52*(4), 473–483. https://doi.org/10.1007/s00127-017-1338-4

Baron, I., Hurn, R., Adlington, R., Maguire, E., & Shapiro, L. (2021). Revised Children's Anxiety and Depression Scale (RCADS): Psychometric properties in a clinical sample in the United Kingdom. *Clinical Pediatrics: Open Access*. https://uhra.herts.ac.uk/id/eprint/10044/1/revised_childrens_anxiety_and_depression_scale_rcads_psychometric_properties_in_a_clinical_sample_in_the_united_kingdom.pdf

Barrera, A., Gee, C., Wood, A., Gibson, O., Bayley, D., & Geddes, J. (2020). Introducing artificial intelligence in acute psychiatric inpatient care: qualitative study of its use to conduct nursing observations. *Evidence-based mental health*, *23*(1), 34–38. https://doi.org/10.1136/ebmental-2019-300136

Bateson, M., & Martin, P. (2021). *Measuring behaviour: An introductory guide*. Cambridge: Cambridge University Press.

Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth, 17*(3), 17–21. https://www.researchgate.net/publication/234706984_The_Three_Pillars_of_Trauma-Informed_Care

Bennett, D. (2015). Understanding suicide in children and adolescents. *Clinical Child Psychology and Psychiatry, 20*(2), 135–148. https://doi.org/10.15190/d.2024.2

Ben-Yehuda, A., Aviram, S., Govezensky, J., Nitzan, U., Levkovitz, Y., & Bloch, Y. (2012). Suicidal behavior in minors–diagnostic differences between children and adolescents. *Journal of Developmental & Behavioral Pediatrics*, *33*(7), 542-547. https://doi.org/10.1097/01.DBP.0000415830.85996.e6

Blanchard, A., Chihuri, S., DiGuiseppi, C. G., & Li, G. (2021). Risk of self-harm in children and adults with autism spectrum disorder: A systematic review and meta-analysis. *JAMA network open*, *4*(10), e2130272-e2130272. https://doi.org/10.1001/jamanetworkopen.2021.30272

Brown, A., Raymond, C., Caygill, L., & Powell, J. (2019). One moment you are covered in blood and next it's what's for tea? An interpretive phenomenological analysis of residential care staff's experiences of managing self-harm with looked after children. *Scottish Journal of Residential Child Care*, *18*(3), 1-28. https://doi.org/10.17868/strath.00084481

Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention*. New York, N.Y.: Guilford Publications.

Burnand, L., & Johnson, D. (2022). Self-Harm in Residential Care: A consideration of the evidence and the implications for practice. *Scottish Journal of Residential Child Care*, *21*(2). https://doi.org/10.17868/strath.00084162

Burton, M. (2019). Suicide and self-harm: Vulnerable children and young people. *Practice Nursing*, *30*(5), 218-223. https://doi.org/10.12968/pnur.2019.30.5.218

Calvo, N., Lugo-Marín, J., Oriol, M., Pérez-Galbarro, C., Restoy, D., Ramos-Quiroga, J. A., & Ferrer, M. (2024). Childhood maltreatment and non-suicidal self-injury in adolescent population: A systematic review and meta-analysis. *Child Abuse & Neglect*, *157*. https://doi.org/10.1016/j.chiabu.2024.107048

Camm-Crosbie, L., Bradley, L., Shaw, R., Baron-Cohen, S., & Cassidy, S. (2019). 'People like me don't get support': Autistic adults' experiences of support and treatment for mental health difficulties, self-injury and suicidality. *Autism*, *23*(6), 1431-1441. https://doi.org/10.1177/1362361318816053

Care Inspectorate. (2020). *Deaths of Looked After Children in Scotland 2012–2018: A thematic review.* https://hub.careinspectorate.com/media/3948/report-on-the-deaths-of-looked-after-children-in-scotland-2012-18.pdf

Carter, B., Shelton, K. H., Holmes, L. J., Sprecher, E. A., Javed, M., Macleod, J., & Hiller, R. M. (2025). The mental health and wellbeing of care-experienced young people during early and later adolescence. *Clinical Child Psychology and Psychiatry*. https://doi.org/10.1177/13591045251333028

Centre for Mental Health and Safety (2021). *Annual Report: England, Northern Ireland, Scotland and Wales.* National Confidential Inquiry into Suicide and Safety in Mental Health. www.hqip.org.uk/wp-content/uploads/2021/05/NCISH-Annual-Report-2021.pdf

Castellví, P., Lucas-Romero, E., Miranda-Mendizábal, A., Parés-Badell, O., Almenara, J., Alonso, I. Alonso, J. (2017). Longitudinal association between self-injurious thoughts and behaviors and suicidal behavior in adolescents and young adults: A systematic review with meta-analysis. *Journal of Affective Disorders*, *215*, 37–48. https://doi.org/10.1016/j.jad.2017.03.035

Cawley, R., Pontin, E., Touhey, J., Sheehy, K., James Taylor, P. (2019) What is the relationship between rejection and self-harm or suicidality in adulthood? *Journal of Affective Disorders*, 242, 123-134. https://doi.org/10.1016/j.jad.2018.08.082

Centre for Suicide Prevention. (2021). *Safety plans to prevent suicide – Centre for Suicide Prevention.* https://www.suicideinfo.ca/resource/safety-plans/

Chandler, A. (2016). *Self-injury, medicine and society: Authentic bodies*. London: Palgrave Macmillan.

Children (Care and Justice) (Scotland) Act 2024. https://www.legislation.gov.uk/asp/2024/5/enacted

Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology*, *8*, 1946. https://doi.org/10.3389/fpsyg.2017.01946

Clark, P., Holden, C., Russell, M., & Downs, H. (2022). The impostor phenomenon in mental health professionals: Relationships among compassion fatigue, burnout, and compassion satisfaction. *Contemporary family therapy*, *44*(2), 185-197. https://doi.org/10.1007/s10591-021-09580-y.

Cleare S, Wetherall K, Clark A, Ryan C, Kirtley O. Adverse childhood experiences and hospital-treated self-harm. *Int J Environmental Res Public Health*. 2018;15(6):1235. https://doi.org/10.3390/ijerph15061235

Crane, L., Adams, F., Harper, G., Welch, J., & Pellicano, E. (2019). 'Something needs to change': Mental health experiences of young autistic adults in England. *Autism*, *23*(2), 477-493. https://doi.org/10.1177/1362361318757048

Czyz, E. K., King, C. A., Prouty, D., Micol, V. J., Walton, M., & Nahum-Shani, I. (2021). Adaptive intervention for prevention of adolescent suicidal behavior after hospitalization: A pilot sequential multiple assignment randomized trial. *Journal of child psychology and psychiatry, and allied disciplines*, *62*(8), 1019–1031. https://doi.org/10.1111/jcpp.13383

DeVille, D. C., Whalen, D., Breslin, F. J., Morris, A. S., Khalsa, S. S., Paulus, M. P., & Barch, D. M. (2020). Prevalence and family-related factors associated with suicidal ideation, suicide attempts, and self-injury in children aged 9 to 10 years. *JAMA network open*, *3*(2). https://doi.org/10.1001/jamanetworkopen.2019.20956

Dorol, O., & Mishara, B. L. (2021). Systematic review of risk and protective factors for suicidal and self-harm behaviors among children and adolescents involved with cyberbullying. *Preventive medicine*, *152*. https://doi.org/10.1016/j.ypmed.2021.106684

Dudeck, M., Sosic-Vasic, Z., Otte, S., Rasche, K., Leichauer, K., Tippelt, S., & Streb, J. (2016). The association of adverse childhood experiences and appetitive aggression with suicide attempts and violent crimes in male forensic psychiatry inpatients. *Psychiatry Research*, *240*, 352-357. https://doi.org/10.1016/j.psychres.2016.04.073

Elbogen, E. B., Lanier, M., Blakey, S. M., Wagner, H. R., & Tsai, J. (2021). Suicidal ideation and thoughts of self-harm during the COVID-19 pandemic: The role of COVID-19-related stress, social isolation, and financial strain. *Depression and anxiety*, *38*(7), 739-748. https://doi.org/10.1002/da.23162

Emmerich, O. L. M., Wagner, B., Heinrichs, N., & van Noort, B. M. (2024). Lifetime victimization experiences, depressiveness, suicidality, and feelings of loneliness in youth in care. *Child Abuse & Neglect*, *154*, 106870. https://doi.org/10.1016/j.chiabu.2024.106870

Erbacher, T. A., & Singer, J. B. (2018). Suicide risk monitoring: The missing piece in suicide risk assessment. *Contemporary School Psychology*, *22*, 186-194. https://doi.org/10.1007/s40688-017-0164-8

Ervine, K. (2022a). Investigating the understanding and management of self-harm in a children's residential therapeutic community. *Scottish Journal of Residential Child Care*, *21*(2). https://doi.org/10.17868/strath.00084158

Ervine, K. (2022b). Trauma-informed care in youth residential services. *Residential Treatment for Children & Youth, 39*(3), 233–248. https://doi.org/10.1007/978-3-031-77215-3_24

Evans, R. E. (2018). Survival, signalling, and security: Foster carers' and residential carers' accounts of self-harming practices among children and young people in care. *Qualitative health research*, *28*(6), 939-949. https://doi.org/10.1177/1049732318759935

Falkirk Sheriff Court. (2025). *FAI into the death of Katie Allan and William Brown, Case Number (FAL-B118-23).* Scottish Courts. www.scotcourts.gov.uk/media/1olg15np/2025fai006-fai-katie-allan-william-brown.pdf

Ford, T., John, A., & Gunnell, D. (2021). Mental health of children and young people during pandemic. *Bmj*, *372*. https://doi.org/10.1136/bmj.n614

Fowler, J. C., Orme, W. H., & Hart, J. M. (2021). Cognitive-Behavioral Therapy. In A.E. Skodol, & J.M. Oldham (Eds.), *The American Psychiatric Association Publishing Textbook of Personality Disorders* (3rd ed, Chapter 14). Washington D.C.: American Psychiatric Association Publishing. https://doi.org/10.1176/appi.books.9781615379699.lg14

Friis, C. B., Henriksen, A. K. E., & Liebst, L. S. (2024). Staff victimization at residential youth care institutions: An incident-based study. *Nordic Journal of Criminology*, *26*(1), 1-19. https://doi.org/10.18261/njc.26.1.2.

Furnivall, J. (2023). Exploring the meaning and impact of the studies of young residential care-leavers, from the perspectives of those who worked and lived alongside them in residential child care. http://hdl.handle.net/1893/36031

Geoffroy, M. C., Bouchard, S., Per, M., Khoury, B., Chartrand, E., Renaud, J., & Orri, M. (2022). Prevalence of suicidal ideation and self-harm behaviours in children aged 12 years and younger: a systematic review and meta-analysis. *The Lancet Psychiatry*, *9*(9), 703-714. https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(22)00193-6/abstract

Ginnis, K., White, E., Ross, A., & Wharff, E. (2015). Family-based crisis intervention in the emergency department: A new model of care. *Journal of Child and Family Studies*, *24*(1), 172–179. https://doi.org/10.1007/s10826-013-9823-1

Gould, M. S., Cross, W., Pisani, A. R., Munfakh, J. L., & Kleinman, M. (2013). Impact of applied suicide intervention skills training on the national suicide prevention lifeline. *Suicide and Life-Threatening Behavior*, *43*(6), 676-691. https://doi.org/10.1111/sltb.12049

Grisso, T. & Barnum, R. (2006). *Massachusetts Youth Screening Instrument-Version 2: User's Manual and Technical Report*. Sarasota, FL: Professional Resource Press.

Groves, S., Lascelles, K., & Hawton, K. (2024). Experiences of clinical staff who work with patients who self-harm by ligature: An exploratory survey of inpatient mental health service staff. *Journal of Psychiatric and Mental Health Nursing*, *31*(3), 376-390. https://doi.org/10.1111/jpm.12995

Grybush, A. L. (2020). *Exploring attitudes related to Trauma-Informed Care among teachers in rural Title I elementary schools: Implications for counsellors and counsellor educators.* [Doctoral dissertation, The University of North Carolina at Charlotte].

Grybush, T. (2020). Understanding contagion in adolescent self-harm within care settings. *Journal of Adolescent Health, 67*(5), 789–796. https://doi.org/10.1097/00004583-199802000-00014

Hall, C. L., Guo, B., Valentine, A. Z., Groom, M. J., Daley, D., Sayal, K., & Hollis, C. (2019). The validity of the Strengths and Difficulties Questionnaire (SDQ) for children with ADHD symptoms. *PloS one*, *14*(6) https://doi.org/10.1371/journal.pone.0218518

Harris, I. M., Beese, S., & Moore, D. (2019). Predicting future self-harm or suicide in adolescents: a systematic review of risk assessment scales/tools. *BMJ open*, *9*(9), e029311. https://doi.org/10.1136/bmjopen-2019-029311

Hawton, K., Hill, N. T., Gould, M., John, A., Lascelles, K., & Robinson, J. (2020). Clustering of suicides in children and adolescents. *The Lancet Child & Adolescent Health*, *4*(1), 58-67. https://doi.org/10.1016/s2352-4642(19)30335-9

Heady, N., Watkins, A., John, A., & Hutchings, H. (2022). Prevalence of neurodevelopmental disorders and their impact on the health and social well-being among looked after children (LAC): A systematic review protocol. *Systematic Reviews*, *11*(1), 49. https://doi.org/10.1186/s13643-022-01923-6

Healthcare Improvement Scotland. (2019). *Suicide prevention action plan: Every life matters*. HIS. https://www.gov.scot/publications/scotlands-suicide-prevention-action-plan-life-matters/

Hodgdon, H. B., Lord, K. A., Suvak, M. K., Martin, L., Briggs, E. C., & Beserra, K. (2023). Predictors of symptom severity and change among youth in trauma-informed residential care. *Child Abuse & Neglect*, *137*. https://doi.org/10.1016/j.chiabu.2023.106056

Holland, J., Sayal, K., Berry, A., Sawyer, C., Majumder, P., Vostanis, P., Armstrong, M., Harroe, C., ke, D., & Townsend, E. (2020). What do young people who self-harm find helpful? A comparative study of young people with and without experience of being looked after in care. *Child and Adolescent Mental Health, 25(3),* 157–164. https://doi.org/10.1111/camh.12384

Hostinar, C. E., Johnson, A. E., & Gunnar, M. R. (2015). Parent support is less effective in buffering cortisol stress reactivity for adolescents compared to children. *Developmental Science*, *18*(2), 281-297. https://doi.org/10.1111/desc.12195

Insua-Summerhays, B., Hart, A., Plummer, E., Priebe, S., & Barnicot, K. (2018). Staff and patient perspectives on therapeutic engagement during one-to-one observation. *Journal of Psychiatric and Mental Health Nursing*, *25*(9-10), 546–557. https://doi.org/10.1111/jpm.12497

Judiciary of Scotland. (2025). *FAI determination summaries: Katie Allan and William Brown.* https://judiciary.scot/home/sentences-judgments/fai-determination-summaries/2025/01/17/katie-allan-and-william-brown

Klineberg, E., Kelly, M., Stansfeld, S., & Bhui, K. (2013). How do adolescents talk about self-harm? A qualitative study of disclosure in an ethnically diverse urban population in England. *BMC Public Health, 13,* 572. https://doi.org/10.1186/1471-2458-13-572

Knowles, S., Sharma, V., Fortune, S., Wadman, R., Churchill, R., & Hetrick, S. (2022). Adapting a codesign process with young people to prioritize outcomes for a systematic review of interventions to prevent self-harm and suicide. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *25*(4), 1393–1404. https://doi.org/10.1111/hex.13479

Kothgassner, O. D., Goreis, A., Robinson, K., Huscsava, M. M., Schmahl, C., & Plener, P. L. (2021). Efficacy of dialectical behavior therapy for adolescent self-harm and suicidal ideation: A systematic review and meta-analysis. *Psychological Medicine*, *51*(7), 1057-1067. https://doi.org/10.1017/s0033291721001355

Law, D. (2012). *A practical guide to using service user feedback & outcome tools to inform clinical practice in child & adolescent mental health some initial guidance from the children and young people's improving access to psychological therapies outcomes-oriented practice.* https://www.researchgate.net/publication/272824486_A_Practical_Guide_to_Using_Service_User_Feedback_Outcome_Tools_to_Inform_Clinical_Practice_in_Child_Adolescent_Mental_Health_Some_initial_guidance_from_the_Children_and_Young_Peoples'_Improving_Access

LGBT Youth Scotland. (2022). *Life in Scotland for LGBT Young People: Education Report 2022*. https://lgbtyouth.org.uk/wp-content/uploads/2023/12/life-in-scotland-for-lgbt-young-people-2022-e-use.pdf

Linehan, M. (2014). *DBT Skills training manual.* New York, N.Y.: Guilford Press.

Madge N., Hawton K., McMahon E.M., et al. (2011). Psychological characteristics, stressful life events and deliberate self-harm: Findings from the Child & Adolescent Self-harm in Europe (CASE) Study. *European Child Adolescent Psychiatry 20,* 499–508. https://doi.org/10.1007/s00787-011-0210-4

Mann, J. J., Michel, C. A., & Auerbach, R. P. (2021). Improving suicide prevention through evidence-based strategies: a systematic review. *American Journal of Psychiatry*, *178*(7), 611-624. https://doi.org/10.1176/appi.ajp.2020.20060864

Martin J., Bureau J.-F., Yurkowski K., Fournier T. R., Lafontaine M.-F., Cloutier P. (2016). Family-based risk factors for non-suicidal self-injury: Considering influences of maltreatment, adverse family-life experiences, and parent–child relational risk. *Journal of Adolescence, 49*, 170-180. https://doi.org/10.1016/j.adolescence.2016.03.015

May. A.M., & Klonksky, E.D. (2016). What distinguishes suicide attempters from suicide ideators? A meta-analysis of potential factors. *Clinical Psychology Science and Practice*. https://doi.org/10.1111/cpsp.12136

McIntyre, K. (2020). Evaluation of a DBT group within Adolescent Residential Care. *Scottish Journal of Residential Child Care*, *19*(1). https://doi.org/10.17868/strath.00084232

McManama O'Brien, K. H., Almeida, J., View, L., Schofield, M., Hall, W., Aguinaldo, L., Ryan, C. A., & Maneta, E. (2020). A safety and coping planning intervention for suicidal adolescents in acute psychiatric care. *Cognitive and Behavioral Practice*, 28, 22–39. https://doi.org/10.1016/j.cbpra.2019.08.003

Moseley, R. L., Gregory, N. J., Smith, P., Allison, C., & Baron-Cohen, S. (2020). Links between self-injury and suicidality in autism. *Molecular Autism*, *11*, 1-15. https://doi.org/10.1186/s13229-020-0319-8

Mournet, A. M., Millner, A. J., & Kleiman, E. M. (2024). Characteristics of self-harm on an adolescent psychiatric inpatient unit based on neurodevelopmental diagnoses. *Journal of Affective Disorders Reports*, *17*, 100796. https://doi.org/10.1016/j.jadr.2024.100796

Muela, A., Balluerka, N., Sansinenea, E., Machimbarrena, J. M., García-Ormaza, J., Ibarretxe, N., & Baigorri, P. (2021). A social-emotional learning program for suicide prevention through animal-assisted intervention. *Animals*, *11*(12), 3375. https://doi.org/10.3390/ani11123375

Muela, A., García-Ormaza, J., & Sansinenea, E. (2024). Suicidal behavior and deliberate self-harm: A major challenge for youth residential care in Spain. *Children and Youth Services Review*, *158*, 107465. https://doi.org/10.3390/ani11123375

National Audit Office. (2015). *Children in care*. UK Government. www.nao.org.uk/wp-content/uploads/2015/07/The-NAOs-work-on-children-in-care-leaving-care.pdf

National Collaborating Centre for Mental Health. (2011). *Self-harm: Longer-term management*. British Psychological Society. https://pubmed.ncbi.nlm.nih.gov/23534084/

National Institute for Health and Care Excellence. (2022). Self-harm: Assessment, management and preventing recurrence. NICE Guideline NG225. *https://www.nice.org.uk/guidance/ng225*

Ngune, I., Hasking, P., McGough, S., Wynaden, D., Janerka, C., & Rees, C. (2021). Perceptions of knowledge, attitude and skills about non-suicidal self-injury: A survey of emergency and mental health nurses. *International Journal of Mental Health Nursing*, *30*(3), 635-642. https://doi.org/10.1111/inm.12825

Nikopaschos, F., Burrell, G., Clark, J., & Salgueiro, A. (2023). Trauma-Informed Care on mental health wards: The impact of Power Threat Meaning Framework Team Formulation and Psychological Stabilisation on self-harm and restrictive interventions. *Frontiers in Psychology*, *14*, 1145100. https://www.frontiersin.org/journals/psychology/articles/10.3389/fpsyg.2023.1145100/full

Ossa, F. C., Pietrowsky, R., Bering, R., & Kaess, M. (2019). Symptoms of posttraumatic stress disorder among targets of school bullying. *Child and Adolescent Psychiatry and Mental Health*, *13*, 1-11. https://doi.org/10.1186/s13034-019-0304-1

Padmanathan P, Biddle L, Hall K. et al. (2019) Language use and suicide: An online cross-sectional survey. *PLOS One 2019 14*(6) https://doi.org/10.1371/journal.pone.0217473

Papadima, M. (2019). Rethinking self-harm: a psychoanalytic consideration of hysteria and social contagion. *Journal of Child Psychotherapy*, *45*(3), 291–307. https://doi.org/10.1080/0075417X.2019.1700297

Paul, S., & Hill, M. (2013). Responding to self-harm: A documentary analysis of agency policy and procedure. *Children & society*, *27*(3), 184-196. https://doi.org/10.1111/j.1099-0860.2011.00399.x

Peyre, H., Hoertel, N., Stordeur, C., Lebeau, G., Blanco, C., McMahon, K., & Delorme, R. (2017). Contributing factors and mental health outcomes of first suicide attempt during childhood and adolescence: Results from a nationally representative study. *The Journal of clinical psychiatry*, *78*(6), 20396. https://doi.org/10.4088/jcp.16m10876

Pinheiro, M., Magalhães, E., Calheiros, M. M., & Macdonald, D. (2024). Quality of relationships between residential staff and youth: A systematic review. *Child and Adolescent Social Work Journal*, *41*(4), 561-576. https://doi.org/10.1007/s10560-022-00909-6

Pintar Babič, M., Bregar, B., & Drobnič Radobuljac, M. (2020). The attitudes and feelings of mental health nurses towards adolescents and young adults with nonsuicidal self-injuring behaviors. *Child and Adolescent Psychiatry and Mental Health*, *14*, 1-10. https://doi.org/10.1186/s13034-020-00343-5

Preston, L. (2023). Residential Childcare Workers' Experiences of Behaviours that Challenge. https://uhra.herts.ac.uk/id/eprint/15927/

Rasmussen, S., Hawton, K., Philpott-Morgan, S., & O'Connor, R. C. (2016). Why do adolescents self-harm?. *Crisis*. https://doi.org/10.1027/0227-5910/a000369

Reichl, C., & Kaess, M. (2021). Self-harm in the context of borderline personality disorder. *Current Opinion in Psychology*, *37*, 139-144. https://doi.org/10.1016/j.copsyc.2020.12.007

Rodgers, J., Goodwin, J., Nielsen, E., Bhattarai, N., Heslop, P., Kharatikoopaei, E., & Cassidy, S. (2023). Adapted suicide safety plans to address self-harm, suicidal ideation, and suicide behaviours in autistic adults: protocol for a pilot randomised controlled trial. *Pilot and Feasibility Studies*, *9*(1), 31. https://doi.org/10.1186/s40814-023-01264-8

Rodgers, P. (2010). Review of the applied suicide intervention skills training program (ASIST). *Living Works Education*. https://livingworks.net/wp-content/uploads/2023/09/Review-of-ASIST.pdf

Rouski C, Knowles SF, Sellwood W, Hodge S. (2021). The quest for genuine care: A qualitative study of the experiences of young people who self-harm in residential care. *Clinical Child Psychology and Psychiatry*, 418-429. https://doi.org/10.1177/1359104520980037

Rowe SL, French RS, Henderson C, Ougrin D, Slade M, Moran P. (2014). Help-seeking behaviour and adolescent self-harm: A systematic review. *N Z J Psychiatry, 48*(12): 1083–95. https://doi.org/10.1177/0004867414555718

Schwartzman, J. M., Smith, J. R., & Bettis, A. H. (2021). Safety planning for suicidality in autism: Obstacles, potential solutions, and future directions. *Pediatrics*, *148*(6). https://doi.org/10.1542/peds.2021-052958

Scottish Government. (2024). Children (Care and Justice) Bill passed. https://www.gov.scot/news/children-care-and-justice-bill-passed/

Scottish Government. (n.d.). Looked after children: *Residential care*. https://www.gov.scot/policies/looked-after-children/residential-care/

Scottish Prison Service. (2025). *SPS response to FAI recommendations.* https://www.gov.scot/news/children-care-and-justice-bill-passed/

Shannonhouse, L., Lin, Y. W. D., Shaw, K., & Porter, M. (2017). Suicide intervention training for K–12 schools: A quasi-experimental study on ASIST. *Journal of Counseling & Development*, *95*(1), 3-13. https://doi.org/10.1002/jcad.12112

Slaatto, A., Mellblom, A. V., Kleppe, L. C., & Baugerud, G. A. (2022). Safety in residential youth facilities: Staff perceptions of safety and experiences of the 'basic training program in safety and security'. *Residential Treatment for Children & Youth*, *39*(2), 212-237. https://doi.org/10.1080/0886571X.2021.1978035

Sparks, R. (2024). *Examining factors which impact the emotional and behavioural outcomes of care experienced children and young people* [Doctoral dissertation, University of Glasgow]. https://theses.gla.ac.uk/84604/

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, *19*(2), 256–264. https://doi.org/10.1016/j.cbpra.2011.01.001

Stanley, B., Brown, G., Brent, D. A., Wells, K., Poling, K., Curry, J., Kennard, B. D., Wagner, A., Cwik, M. F., Klomek, A. B., Goldstein, T., Vitiello, B., Barnett, S., Daniel, S., & Hughes, J. (2009). Cognitive-behavioral therapy for suicide prevention (CBT-SP): Treatment model, feasibility, and acceptability. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(10), 1005–1013. https://doi.org/10.1097/CHI.0b013e3181b5dbfe

Stewart, S. L., & Babcock, S. E. (2020). interRAI child and youth mental health-screener (ChYMH-S): A psychometric evaluation and validation study. *Child Psychiatry & Human Development*, *51*, 769-780. https://doi.org/10.1007/s10578-020-01003-7

Stinson, J. D., Gretak, A. P., Carpenter, R. K., & Quinn, M. A. (2021). Adverse childhood experiences and suicidality and self-harm in persons in secure forensic care. *The Journal of the American Academy of Psychiatry and the Law*, *49*(4), 553-564. https://doi.org/10.29158/jaapl.210007-21

Summers, J., Shahrami, A., Cali, S., D'Mello, C., Kako, M., Palikucin-Reljin, A., & Lunsky, Y. (2017). Self-injury in autism spectrum disorder and intellectual disability: Exploring the role of reactivity to pain and sensory input. *Brain Sciences*, *7*(11), 140. https://doi.org/10.3390/brainsci7110140

UK Government. (n.d.). *Suicide Act 1961*. https://www.legislation.gov.uk/ukpga/Eliz2/9-10/60

Varley, D., Fenton, C., Gargan, G., Taylor, O., Taylor, A., Kirby, N., … & Wright, B. (2022). A systematic review of systematic reviews exploring the factors related to child and adolescent self-harm. *Adolescent Psychiatry*, *12*(2), 79-114. https://psycnet.apa.org/doi/10.2174/2210676612666220721101210

Wadman, R., Williams, A. J., Brown, K., & Nielsen, E. (2019). Supported and valued? A survey of early career researchers' experiences and perceptions of youth and adult involvement in mental health, self-harm and suicide research. *Research Involvement and Engagement*, *5*(1), 16. https://doi.org/10.1186/s40900-019-0149-z

Whittle, K., Moore, E., & Stallard, P. (2024). Self-harm, suicidal ideation, depression and peer relationships in transgender and gender diverse adolescents accessing

specialist mental health services. *Child and Adolescent Mental Health*, *29*(4), 363-370. https://doi.org/10.1111/camh.12738

Witt, K. G., Hetrick, S. E., Rajaram, G., Hazell, P., Salisbury, T. L. T., Townsend, E., & Hawton, K. (2021). Interventions for self-harm in children and adolescents. *Cochrane Database of Systematic Reviews*, (3). https://doi.org/10.1002/14651858.cd013667.pub2

Wolff, J. C., Frazier, E. A., Weatherall, S. L., Thompson, A. D., Liu, R. T., & Hunt, J. I. (2018). Piloting of COPES: An empirically informed psychosocial intervention on an adolescent psychiatric inpatient unit. *Journal of Child and Adolescent Psychopharmacology, 28*(6), 409–414. https://doi.org/10.1089/cap.2017.0135

Yates T. M. (2009). Developmental pathways from child maltreatment to non-suicidal self-injury. In M. K. Nock (Ed.), *Understanding non-suicidal self-injury: Origins, assessment, and treatment*. (pp. 117–137). American Psychological Association. https://psycnet.apa.org/doi/10.1037/11875-007

Zetterqvist, M. (2025). The DSM-5 diagnosis of non-suicidal self-injury disorder: a review of the empirical literature. *Child Adolescent Psychiatry Ment Health 9,* 31. https://doi.org/10.1186/s13034-015-0062-7

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Remembering Jesse Jackson: A Leadership Lesson

James Freeman

On February 17, 2026, American civil rights leader Jesse Jackson passed away at 84 years old. For more than six decades, he committed his life to human rights and the ongoing struggle for dignity and opportunity. His work spanned social justice efforts, international diplomacy, and a lifetime of public advocacy.

I was 14 when he delivered his address to the Democratic National Convention in San Francisco. It was the year the Macintosh computer was released. I had my first Bruce Springsteen CD. Prince released Purple Rain and top movies were Ghostbusters and Karate Kid. The Night Stalker dominated the news and the Summer Olympics were in Los Angeles.

As a teen I was more tuned into movies, music, and delivering newspapers on my bike in the afternoon. But even then, I was aware of Jesse Jackson as an influential Black leader. I remember he seemed like someone who carried conviction and a sense of purpose that reached far beyond a person or position.

On July 18 of that year, near the end of his convention address, Jackson began naming the lessons he had learned through the hard-fought campaign. One line in particular stands out:

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> Leaders must be tough enough to fight, tender enough to cry, human enough to make mistakes, humble enough to admit them, strong enough to absorb the pain, and resilient enough to bounce back and keep on moving.

There's a deep connection between what he described as leadership and what our world still needs today in our own organizations and communities. I'm not suggesting this was his original meaning, only that his words speak to the kind of leadership our work still calls for.

"Tough enough to fight"

Leadership requires the courage to advocate for what's right, even when it's uncomfortable or unpopular. It's about protecting people and interrupting harmful patterns before they take root. It's the willingness to speak up and take responsibility for the wellbeing of the team and the community you serve.

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“Tender enough to cry”

Tenderness is a part of what makes us human. Leaders who can feel, express emotion, and stay connected to their own humanity create space for others to do the same. This is the heart of trauma-informed practice: Permission to feel without shame and the understanding that vulnerability can strengthen trust rather than weaken it.

“Human enough to make mistakes, humble enough to admit them”

Every leader makes mistakes. What matters is how we respond to them. Humility allows us to acknowledge ruptures in relationships and repair them when needed.

“Strong enough to absorb the pain”

Leadership often means holding the emotional overflow of a team, whether that’s frustration, fear, grief, or uncertainty. We don’t have to carry it, but we do have to stay grounded enough not to pass it back to others. It requires support structures, reflective practice, and the ability to respond to pressure in ways that keep the environment safe and steady.

“Resilient enough to bounce back and keep on moving”

Resilience in leadership is the capacity to return to presence after a rupture or a hard moment. It’s the ability to re-center and regain clarity after a challenging moment. To have a presence without becoming reactive or withdrawn, holding energy for our teams.

Jackson’s reflection was lived experience distilled into a singular thought. Decades later, his words read like a blueprint for leading and caring with a relational approach. If we can embody even a fraction of that in our daily work, we will strengthen the spaces we lead and the

communities we care about and perhaps carry forward a piece of the legacy Jesse Jackson spent his life building.

Reference

Jackson, J. (1984). *Address to the Democratic National Convention.* Democratic National Convention, San Francisco, CA. Retrieved from https://www.americanrhetoric.com/speeches/jessejackson1984dnc.htm

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Navigating Grief in Child and Youth Care

Harrison Dax Nash

Introduction

Within child and youth care practice we are often working with children who have experienced profound loss. The news of a loved one's death has an immediate, complex and deeply personal impact on the children we work with. It is something that I have had to approach frequently over the years, and this has helped my own understanding of how practitioners can respond sensitively and with the right level of compassion.

From the environment we create, to the emotional readiness we bring, all these factors influence a child's processing of loss. At the same time, no two situations are ever the same, but certain themes emerge both in practice and throughout the literature. In this article, I will endeavour to draw on practice examples whilst also exploring theoretical perspectives and practical guidelines to help highlight the essential role practitioners have and providing direct support to help children navigate the cyclical nature of mourning.

Breaking the News

Over the years I have, unfortunately, been involved in breaking the news to numerous children of loved one's passing away. In more recent years our older youth may be more likely to hear the news themselves – e.g. through a

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phone or even social media - and need us to console them afterwards, but as practitioners we always need to be emotionally prepared to inform children of such sad news knowing the detrimental impact it can have on their life (Thompson, 2019). My own personal tips around this is to not build up the conversation too long before getting to telling them what has happened – often children's anxiety can rise rapidly if they feel that they are about to receive negative information and therefore we need to try and get to informing them promptly whilst being ready to deal with the emotional aftermath and response (Daly & Woods, 2012).

Further, consider the environment in which you take the child to inform them of what has taken place. I have never done this in an office but tried to walk with the child to a quiet place – ideally in nature or a garden space – where there are limited distractions or disruptions. This sometimes needs planning, because the child's own reaction can be unpredictable, and we need to ensure the environment is at least as calming as one can manage in the moment. Again however, if we are unnaturally taking the child to a location far away from where they stay, it can also present feelings of uncertainty, so we need to factor that in our plans too (Rutland County Council, 2019). We also do not want one specific place to be continually associated as somewhere that 'sad news' is given.

I have decided to share some of the cases that I have remembered over the years because all of them illustrate the multitude of different scenarios that we can encounter in relation to children and grief:

- One girl aged 6 had been placed at our youth centre for only a couple weeks. Her mother had substance misuse issues and had abandoned her child at the shelter in which she was staying. The mother had then overdosed and unfortunately passed away. As this girl was most comfortable in speaking Xhosa, I told the news to her

along with one of our child and youth care workers, sitting on a bench in a garden. At first, this girl was totally shocked, and appeared confused, before calling out 'mama' and being inconsolable. We had to inform the other girls who she stayed in a house with and fortunately in this regard they were all collectively supportive. With the counselling and assistance, she was then given, including a very nurturing pre-school environment where she also excelled at dancing, she was able to do very well and was ultimately reunified with her Grandparents which made for a positive outcome for this young lady.

- Two teenagers aged 13 and 15. The younger female sibling was generally seen as more expressive and had a penchant for drama, whereas the older brother was milder mannered and studious. Unfortunately, their mother had passed away some years earlier before they arrived at the youth centre, and it had taken a considerable amount of time to trace their paternal family. As such they had not had as long to re-formulate a relationship with their father, who himself had challenges with alcohol and on-going health issues. Having said that, the news of his passing did seem to be very sudden. It was also not lost on me that this would be the loss of their second parent. The three of us went on a walk to our nearby field area, and whilst the sister was very upset, the brother was most deeply affected even remarking that he should just go and 'kill himself' and 'throw his life away' just like his father had. I had to re-visit this with him later because of course as practitioners we always need to attend to any ideations of suicide, although ultimately, he reframed this himself as being determined not to repeat the same mistakes that his father had made in his life. Of course, in residential care we know there are always added

complexities with grief, because there is always a reason for why the child is unable to stay with their parent However, both siblings ultimately completed high school successfully and went on to carve higher education and work pathways for themselves, with them both finding extensive involvement in extra-curricular activity to be a positive outlet for themselves.

- The final one that stands out is three siblings, at the time age 9, 12 and 14. The two younger siblings were girls – although one more introverted and one more extroverted, whereas the older brother had a perceived harder exterior. In this instance it was an aunt and uncle who had passed away, but in a violent shooting. As such, it was a completely unexpected situation. There was a secluded area under trees where we could sit together, but the news was especially shocking to them and I had to enlist the support of our child and youth care workers because ultimately these children stayed in different houses at our centre – as the living spaces were divided by gender – but clearly all the children were needing a collective level of emotional support. It was particularly striking to me that the boy – who would be the least expected to have an expressive reaction – was outwardly most devastated, collapsing to the ground in a profound display of grief and tears. Counselling was of course needed as a priority in this regard. Whilst the siblings may have shown a level of resilience following this, as practitioners we should be aware that such situations always need on-going monitoring because PTSD can also be triggered from a traumatic loss (Thompson, 2019).

While this article will explore grief from a more theoretical perspective, I always find that reflections from our own practice examples are some of the most powerful sources of learning we can have. It is also worth noting that

all of us need to be aware of the idea of 'vicarious trauma' and ensure we take proactive steps to aide our own mental health and wellbeing (Daly & Woods, 2012).

Before I look further at theory, I also wanted to share one further reflection which is around the impact of Covid-19. Within residential care, as I am sure many of those reading this will relate to, we were seen as essential workers and ultimately had to make many adjustments aligned with the guidelines and recommendations around 'social distance'. One thing that was experienced as very difficult during this time was when children experienced a loss of loved ones, and we had to also navigate attendance of such events as funerals whilst then having an appropriate level of isolation on return from this. Whilst the adaptations that were needed to be made at a child and youth care centre during the pandemic is a whole other journal article in itself, I genuinely also want to commend the child and youth care sector at large for their own commitment, resilience and creativity, as this experience made very clear (Sebastian & Sathyamurthi, 2025). Here, we also saw how significant the unique form of care provided by child and youth care workers in the life space is, as children also had to contend with enormous feelings of hurt and uncertainty (Swanzen and Jonker, 2021).

Theoretical Context to Grief in Children

Often, we associate grief mainly with the loss of loved ones. However, it is important to see grief as an intense emotional reaction to a loss. This is not exclusive to death – feelings of grief can also occur when there is:

- Loss in the environment.
- Loss related to skills and abilities.
- Loss of external objects.
- Loss of relationships.
- Loss of self.

This broader understanding of grief is consistent with contemporary bereavement theory, which recognises that grief can arise from many forms of loss, not only death (Daly & Woods, 2012). Whilst the focus of this article may draw on examples specifically around bereavement, this broader acknowledgement is also important. As I have often spoken of with our child and youth care workers, even children being taken away from their home environment – however the conditions may have been – has grief attached to it.

Common responses to grief can show themselves in ways that can be physical, behavioural, emotional, academic, social and spiritual. There is also not a 'one size fits all' approach to dealing with grief – a child can be as likely to display behaviours that are aggressive as much as they can display behaviours that are regressive. Such signs are covered extensively in available literature on the topic (Sebastian & Sathyamurthi, 2025).

If we now look at cognitive responses in relate to death, at times children may seem preoccupied with the person who is deceased – even looking to have conversations with them or appearing to look for them. This can cross into hallucinations, such as believing they see or hear the

deceased. Concentration can be affected which can include a lack of orientation of time and place, with short-term memory lapses also occurring. These cognitive reactions are well-documented in child bereavement research (Thompson, 2019).

As practitioners we also need to know that, whilst all matters need to be handled sensitively, children should also not be protected from grief, funerals or issues of death and dying in general. Adults cannot shield children from sorrow caused by death but can guide and comfort them through their mourning (McEntire, 2004). Children need to be educated in terms they can understand. This links to the developmental stages of children which impacts on their comprehension of grief as follows (NASP, 2015):

Age	Understanding of Grief	Common Behaviors
0-2	Cannot understand death/loss. All he/she knows is that someone who cared for him/her is no longer present.	Needing to be held, sleep problems, stomach problems, separation anxiety, crying.
3-5	"Magical thinking" leads them to believe that they somehow caused the loss or somehow can bring the person back. They will repeatedly ask questions about the loss.	Regression in behavior, confusion, concerns about their own safety.
6-10	If loss is due to a death, they begin to suspect that they might die. Develop interest in causes of the loss. Loss is viewed as final and inevitable. Start asking for reasons and connect the fact that what is happening to others may happen to them.	Anger, difficulty in paying attention and concentrating, not completing schoolwork, withdrawal.

11-14	Comprehend loss as final and unavoidable. May start to show concern for future and impact it can have on others.	Anger, risk-taking, lack of concentration, unpredictable ups and downs or moodiness.
15-18	Essentially adult views of loss.	Withdrawal from parents, pushing limits or rules, inability to focus, increased risk-taking, wanting to spend lots of time with friends.

There are also other important points to consider when it comes to grief. Whilst children feel the pain of loss, they do not yet possess the coping skills that adults have developed. As such, feelings of grief are more often expressed through behaviour. Children may also hide sadness or deny the reality. It is also important to see grief as cyclical – reoccurring again over time. This aligns with the "continuing bonds" perspective, which recognises that grief re-emerges at different developmental stages (Klass et al, 1996).

In residential care settings there is an essential need to ensure grief is sufficiently worked through. Perhaps a child is placed in a home soon after the death of a parent for example, and the usual steps that take place on a new admission of a child end up taking priority over the immediate need for counselling and therapeutic support. It is easy for this to inadvertently take place! Then the observation feedback shows that this child is very well adjusted and has quickly made new friends. But then, when we see complex behaviours from this child a couple years later? Or conduct that is considered 'explosive' in nature? It can be easy to gloss over the impact of the initial loss, and the cyclical nature of what we see further down the line. We must also note the importance of a comprehensive child-friendly social work assessment (Ziyambi, 2020) as this helps to guide a lot of the intervention planning for the child. In South Africa, the initial assessment needs to be done within 48 hours of the child being placed at the centre (Children's Act 2005) but does not mean the assessment process cannot be expanded upon.

In my own work providing therapy, I remember using Gestalt play therapy with art and seeing one teenager's projections being the word 'Mom' on the clouds in the sky. The pain had not been dealt with, but this 'unfinished business' had been manifesting itself as anger in terms of behaviour. We can also see how play therapy can allow traumatised children to overcome anxiety and express themselves in a nonverbal and non-threatening way (Burgh, 2016). There is also evidence to suggest males may be more silent in their grief, but more likely to exhibit addictive behaviours (Stroebe & Schut, 1995) and as such creative approaches to therapeutic intervention should be utilised as a preventative measure. If insufficient attention is paid to supporting the grieving child, disturbances can continue into adulthood (Berg, 2006).

In general, there are four tasks grieving children must complete for recovery from grief. Social workers and child and youth care workers should be aware of the intrinsic role they have in providing support for such children during this process. The tasks are:

- Acknowledging the reality of the loss.
- Experiencing the feelings of grief and confronting the pain of the loss.
- Adjusting to a way of life without the person who died, the lost object or the change in the family.
- Re-entering life – becoming involved with others.

These tasks align with Worden's widely recognised "Tasks of Mourning" (2009).

Words and Actions to Avoid

Another important point to cover is 'What should I NOT do?'

I am acutely aware that most literature will guide us on what we should be doing to help children process grief, but on an innately human level it is also helpful for us to be told what we should not be doing, or what might not be conducive to helping children to cope with their loss.

For those working with families, the following points can also be helpful in relation to teaching parents as well:

- DO NOT suggest that the child has grieved long enough or indicate that the child should get over it
- DO NOT act as if nothing happened
- DO NOT tell a child things that she/he will later need to unlearn
- DO NOT force them to go to the funeral if they adamantly refuse to go or (importantly) deny them the opportunity to go to the funeral home for the visitation or funeral if they do want to
- DO NOT rely on a child for your own emotional support
- DO NOT burden your child with adult responsibilities
- DO NOT try to protect a child from your own sad feelings
- DO NOT say things like:
  "I know how you feel."
  "You'll be stronger because of this."
  "It could be worse you still have …".

The above cautions reflect best-practice bereavement guidance (Thompson, 2019). For many of those reading this, the initial response may be 'but I would never say this'. However, I have often seen a bias that may creep in, for example, your colleague who has a depressive episode when it

comes to the anniversary of their father's death. Meanwhile, your own father died more recently, and you are judgemental in your outlook, believing they should have 'got over it'. Again, this speaks to the fact that all our experiences with grief are completely unique and naturally the same applies to the children we work with.

Remember, grief itself is open-ended and continually transformed as we go through life and experience further losses. But as practitioners, if we struggle with our own grief, it will be difficult to work in the presence of another person's grief. This is consistent with research on vicarious trauma in helping professionals (Daly & Woods, 2012).

Helpful Strategies

Ultimately, it is important for us all to upskill ourselves in relation to the most helpful strategies when it comes to working with grieving children. Specifically in residential care, there is a higher occurrence of loss in relation to loved ones. There can also be a multitude of complexities with this, as the exact nature of the child's relationship with that person may be unclear, and the grief must be navigated externally to the family home (Thompson, 2019).

While this is not a complete list, all of the points can be valuable in our approach to grieving children and young people (Daly & Woods, 2012):

- It is better for the child to learn about the loss from a family member (or refer to someone equipped to break the news to the child) – *in residential care it is important the practitioner breaking the news to a child has a pre-existing relationship with them and that matters such as home language is given consideration – the rest of the team should also be informed.*

- Answer questions with honesty and provide facts.
- Use accurate words, such as died (or, in another context, divorced).
- Provide developmentally appropriate definitions of words.
- Reassure that death is not “contagious”.
- Talk about and encourage discussion of the person (or pet) using names and memories.
- Where suitable, involve the child in decisions about attending the funeral or memorial service.
- Prepare the child for what will happen, what they will see and how people will behave at the funeral or memorial service.
- Model appropriate responses to loss.
- Offer physical contact (like hugs) and nurturing if the child responds to this, but respect personal boundaries and preferences.
- Encourage and allow fun and happy times.
- Ask and discuss “What do you need to comfort yourself?” - create with the child a list of comfort strategies.
- Listen much and say little.
- Acknowledge feelings with a word. “Oh … I see … mmmmm …” [active listening].
- Keep lines of communication open.
- Be aware of religious beliefs in explaining to the child.
- Reassure the child that all emotions (sadness, anger, relief, guilt) are normal responses to loss.
- If possible, teach the child about death (depending on age and developmental phase).
- Give the feeling a name e.g. “That sounds frustrating.” “You sound lonely.” “It sounds like you are worried.” – *in general feeling*

identification is very important in terms of engaging in any therapeutic process (Sebastian & Sathyamurthi, 2025).

- Be gentle and patient.
- Allow for expression of feelings but not in a way that hurts others, property or the child themselves e.g. “I can see how angry you are about … tell me with words (or draw me a picture), it is not okay to hit.”
- Plan an activity such as planting a tree, a memory book, or participate in the funeral in an appropriate way.
- Reassure the child of your love and support.
- Address the child’s unspoken feelings.
- Help the child to use their grief positively. For example, help others in similar situations – *in practice the commonality of children in residential care having endured similar grief experiences can be emotionally bonding.*
- Provide structure and routine with flexibility as needed.
- Reassure the child that he or she did not cause the death (or breakup, etc.)
- Include the child in the process of acceptance and healing.
- Encourage drawing, reading, playing, art, music, dance, acting and/or sports – *this is where it is always important to ‘know your child’ and understand what they like to do.*
- Allow for some regressive behavior and offer comfort.
- Expect and accept mood swings.
- Be proactive and inform children about changes in routine, expectations, etc. Consistency and predictability are important, whenever possible.
- Try to ensure plenty of sleep, proper nutrition, exercise and quiet time.

- Provide or replace items that provide security.
- Holidays and anniversaries can be especially painful – be aware of these where possible (such as Mother's Day and Father's Day)

Coping Mechanisms

I also feel that it is important that as practitioners we have a 'toolbox' of practical ideas that we can use to help children within the grieving process. I often mention to our team that within our 'Individual Development Plan' for children in our care the tasks to reach the goals should be explicitly mentioned along with the responsible team members. We all have a responsibility to help the child achieve in all areas with relation to the 'circle of courage' model we commonly utilise.

Coping strategies are not as predictable in children – noting that children respond differently to different techniques – but there are various bereavement rituals and activities that can be used to assist the child (Miller et al, 2020):

- Wearing/carrying a special object – a special object that reminds them of a loved one can be offered to be worn or carried or kept in a special place.
- Recalling dreams – children might have vivid dreams in which the loved one appears – expect feelings to arise and help the child express and release them – *there is also therapeutic work involving dreams that can be looked at, inclusive of utilizing a Gestalt approach.*
- Writing or drawing thoughts and feelings – many children express themselves through creative methods (this can trigger emotions but can be a release).

- Writing a letter to the person who died.
- Creating a memory box – the child can place special objects, photographs, messages, letters, thoughts and feelings in this.
- Doing something the deceased would enjoy – leading to an eventual acceptance of the loss.

By creating rituals, children are given an opportunity to reflect, express, share and release their emotions in significant times. A sense of purpose, integrity and empathy, as well as an understanding of the deeper meaning of life, is given space to blossom. On an even deeper level, through rituals, children realize they are not isolated or separate, whether in their joy or in their pain. Recognizing these significant events through ritual allows us to process our emotions in a healthy way (Daly & Woods, 2012).

Seeking Help

Should the intensity of the reaction to grief becomes uncontrolled and destructive, it may be that more advanced psychological and psychiatric support is needed. We should also be able to mitigate to ourselves that such assistance should be seen as part of a broader multi-agency collaborative approach to helping the child navigate a difficult period of their life (Daly & Wood, 2012).

The specific warning signs that could lead you to take such referral steps would be (Thompson, 2019):

- Extreme and sustained changes in behaviour after loss.
- Grieving process seems to interfere with the child's daily functioning for an extended period.

- If the expression of, or lack of, feelings seems too strong for what is happening or lasts too long and presents concern.
- Exhibiting self-destructive behavior.
- Getting into trouble with the law.
- Extreme belligerent (aggressive) acting-out, destructive or impulsive behavior that has a detrimental impact on those around the child.
- Expresses suicidal ideation.
- Prolonged appetite changes that cause severe weight gain or loss.
- Erratic sleep patterns that leave them unable to rest, or (adversely) sleep excessively at unusual times.
- Long term withdrawal from peers or family.
- Inability to experience pleasure.
- Feeling overwhelmed by anger, fear or hopelessness.
- Only feeling happy when using drugs and/or alcohol.
- Sharp drop in school performance or refusal to attend school.

Grieving is as natural
as crying when you hurt,
sleeping when you are tired,
eating when you are hungry,
or sneezing when
your nose itches.
It is nature's way of
healing a broken heart.

Doug Manning

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This reminder aligns with contemporary grief theory, which emphasises that grief is a natural, adaptive process rather than a pathology (Sebastian & Sathyamurthi, 2025).

Conclusion

Supporting children with grief is a profound responsibility of our practice, and there are a diverse range of responses and eventualities that can take place. While we can use information such as the developmental stage of the child to help us prepare, grief is not a linear process, and we must prioritise the child's own emotional safety. Ideally, supporting children with grief is a team approach and as practitioners we should also avoid minimising their personal experience.

By ensuring we have a full toolbox of strategies and coping mechanisms, we can complement our genuine care with practical support that helps blend human empathy with professional knowledge. Our own approach to grief can support healing whilst also strengthening foundations for resilience, connection and hope.

References

Berg, A. (2006). The bereaved family – the child's perspective. *CYC-Online, 87*, April 2006.

Burgh, N. V. (2016). *Effects of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood.* University of Pretoria, South Africa.

Daly, C., & Woods, F. (2012). Contemporary theories of grief and loss for children and families. *Oxford Textbook of Palliative Care for Children*.

Klass, D., Silverman., P.R., Nickman, S.L. (1996) *Continuing bonds: New understandings of grief.* Washington. Taylor & Francis

McEntire, N. (2004). Children and Grief. *CYC-Online, 60*, January 2004.

Millar, R., Quinn, N., Cameron, J., Colson, A. (2020). *An overview of evidence-based interventions for children and young people experiencing bereavement, loss and grief.* Glasgow. Mental Health Foundation.

National Association of School Psychologists. (2015). *Children's reactions to death: A guide for teachers and other school personnel.* NASP.

Rutland County Council. (2019). *Bereavement theories.*

Sebastian, A., & Sathyamurthi, K. (2025). Revisiting grief: Classical and contemporary theories on childhood parental loss. *International Journal of Indian Psychology*, *13*(3).

South African Children's Act 38 of 2005. Available at: https://www.justice.gov.za/legislation/acts/2005-038%20childrensact.pdf

Stroebe, M., & Schut, H. (1995). *Dual Process Model of Coping with Bereavement.*

Swanzen, R., Jonker, G. (2021). COVID-19 and Alternative Care in South Africa: Children's Responses to the Pandemic (2021). In *Institutionalised Children: Explorations and Beyond*, *8*(1).

Thompson, S. (2019). *Theories around loss & bereavement.*

Worden, J. W. (2009). *Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner.* 4e. Springer, NY.

Ziyambi, T. (2020). *An Explorative Study of the Experiences of Social Workers in Providing Therapeutic Services to Children in CYCCs*. University of KwaZulu-Natal.

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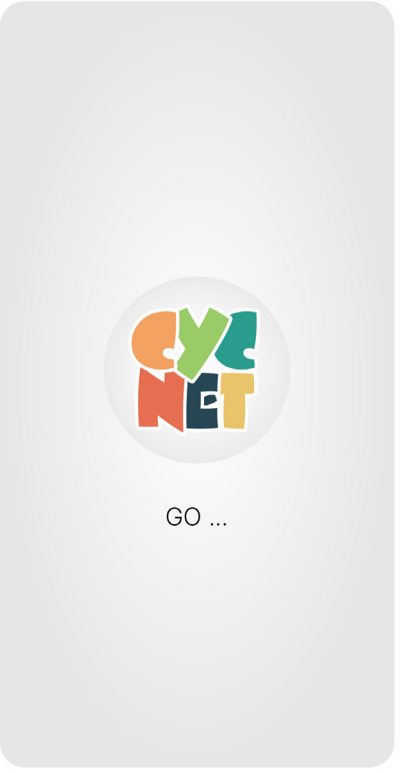

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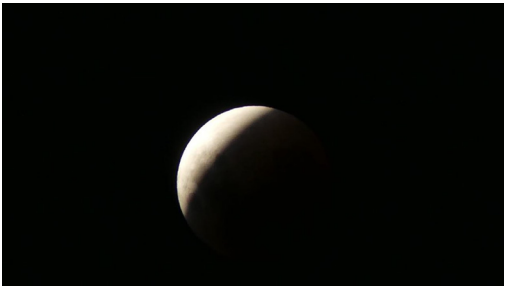
Postcard from Leon Fulcher

From New Zealand

Kia Ora Tatau Katoa and Warm Greetings to Child and Youth Care Workers and Supervisor wherever you are in our world! New Zealand has just recently experienced a full lunar eclipse that was visible from the Philippines and Southern Mexico from mid-evening onwards. This was said to be the last of its kind visible in the South Pacific for another two years, so we were keen to see and watch this eclipse unfold.



The lunar eclipse moved slowly, moving to cover from lower right to upper left

Watching a full lunar eclipse involves a lot of waiting around. While the sun and earth move in steady rotation, watching such movements from our Earthly location meant that the whole process took more than five hours. We watched time move slowly! At first the moon grew darker as the eclipse gained momentum. When the earth finally blocked the sun from shining on the moon, it changed into a full “red moon” over New Zealand.

Meanwhile, half the world away, prospects for World Peace took a setback after attacks on Iran by the US and Israel prompted immediate retaliation with missile and drone attacks on US military bases in the region. So-called Iran-backed proxies, Hezbollah and Huthie, have also been heavily bombed, in Beirut, southern Lebanon and Yemen. With control over the regional airspace, the US President says “4 weeks” although history tells a different story of short events ending soon.

The people living in Southern Lebanon have been told by the Israeli government that they should move away from the area if they wish to avoid the bombing episode that will shortly begin there. Basic infrastructure in Southern Lebanon is being destroyed, as has happened in the south side of the capital city, Beirut. Re-

The classic ‘Red Moon’ of a full lunar eclipse

Israeli tanks manoeuvre near the Israel-Lebanon border

Trying to stop a blaze at Israel bombed a solar farm and electricity generation plant

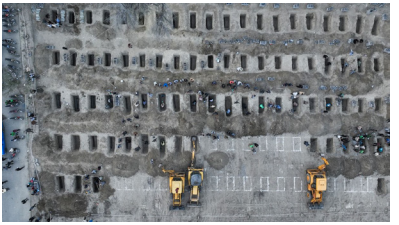
building in Lebanon will take years.

By targeting regional infrastructure, it means that electricity and gas supplies have been disrupted or destroyed. Regional warfare continues to spiral with significant victims of the violence.

Those who remained in Southern Lebanon have experience first-hand what bombing and warfare inflict on the population. The most vulnerable of that population are children and hundreds have been killed already. A school located 200 metres from an Iranian military base was demolished.

Graves were dug for at least 168 children killed when US-Israeli air strikes hit an elementary school located 200 metres from a US military base. This illustrates yet again how children are the real victims of war and the failures of adult peacemakers. May the Peace be upon us!

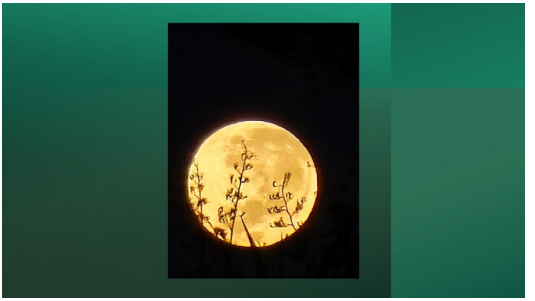
Israeli helicopter fires along the border between northern Israel and Lebanon



Mourners dig graves during a funeral for students were killed when US-Israeli airstrikes hit the Shajaba Tayyiba Girls' elementary school

The full moon rising on eclipse night

There are many cultural traditions associated with lunar eclipses. These tend to highlight beginnings and reminders of the powers that makes any eclipses of moon or sun worth standing in awe of such wonders. Lunar eclipses are historically viewed globally as celestial battles or mythical creatures consuming the moon, often inspiring traditions of making loud noises (pots, drums) to scare away evil forces. Cultural, spiritual, and protective rituals include reconciliation, staying indoors, and specific precautions for pregnant women.



Photographic art with the lunar eclipse

What folklore surrounds an eclipse of the moon where you live? If ever there is to be an eclipse near where you live, make sure you do everything possible to view one from start to finish. It is an amazing experience every time, but the first one is always memorable. Reach for the moon!

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