

Abstract

When children are placed in care, a significant challenge for those who support them is helping the children have an understanding of the reasons they are in care (Selwyn, Magnus & Stuijzand, 2018). The Narrative Model (Coman, Dickson, McGill & Rainey, 2016) is a model for supporting Social Workers to structure conversations with children in care about entry their entry to care and other complex issues. In this article we briefly summarise the Narrative Model and how it supports placement stability. We clarify how the model differs from Life story work and how we include birth parents in the process. We then describe how the child's response to the experience of having a narrative shared with them can aid social workers in making decisions about what the child may need next.

An explanation for being in care

In this day and age it is inconceivable to think that an adolescent would be admitted to hospital without some age appropriate explanation that they are ill, the type of illness they have, the treatment planned and what that treatment involved.

Indeed, how can they consent to the treatment and be a collaborative partner in their recovery journey without such an explanation? Good practice is that younger children also receive enough information with explanations being given in a developmentally sensitive way.

One might apply the same logic to children in care. They need to know why they are not living with their parent(s). Indeed, if they don't have such an understanding how can they:

- understand the actions of the social worker in taking them from their parents
- be open to an ongoing relationship with the social worker
- be a collaborative partner with processes in social services that are designed to include their views and opinions (ie engage with and contribute to LAC reviews, share their views about potential decisions) while they live away from their parent (s)

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- have open and honest conversations with their parent(s) that can help them better understand their pre-care experiences and/or engage meaningfully during contact
- accept the care being offered by the caregiver
- develop a coherent personal narrative
- be clear and appropriate in what they share with friends, other children in care and at school and other adults involved in their lives.

Coram Voice argue convincingly that “coming to an understanding about this life-changing event is the ‘right’ of every child or young person and fundamental to their development, identity and emotional well-being” (Bright Spots Insight, 2019, p.1).

Yet a significant number of children do not have an adequate understanding of why they are in care.

As part of a wider online survey of Looked After Children’s views on their wellbeing, Our Lives Our Care, Coram Voice asked children and young people if they had received enough information about their entry to care. 3314 Looked After Children aged 4-18 years in 23 English and Welsh Local Authorities responded to the survey. 48% of children aged 4-7; 33% of 8-10 years and 20% of children aged 11-18 years reported not having enough information (Brinheim-Crookall, Baker & Selwyn, 2018).

In a similar study of care leavers aged 18-25, nearly one quarter reported they had not received a full explanation about why they were in care. (Baker, Briheim-Crookall, Magnus & Selwyn, 2019).

Staines & Selwyn (2020) note that placement type, duration of care experience and whether or not the child had contact with parents had no influence on the results.

Staines and Selwyn (2020) further note that lacking a full explanation is associated with feeling unsettled in placement and low social wellbeing for some children.

Given the importance of children having an explanation about why they are in care, a question arises as to why so many feel they don’t have an adequate understanding.

We, the authors, were members of a Therapeutic Team for Looked After and Adopted Children. We encountered this issue frequently in our consultative and

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therapeutic work when the team was first established in 2011 and continue to encounter it presently.

We formed a view that children ought to be given age appropriate information on entry to care routinely, upstream from our service, by the social worker. We thought this would reduce the confusion for many children and, in turn, reduce challenging behaviour and the need of some children for our service.

An obvious starting point was to introduce leaflets describing the care journey. While leaflets are helpful for giving corporate information, they are impersonal and do not address the key issue we believed the children were struggling most to understand: why am **I** (as distinct from anyone else) in care? What is wrong with me or my family?

We also found there are various reasons why children might feel they don't have an adequate explanation. In some cases, children may have been given no explanation by adults. In others, children are given an explanation - but it is a partial account or a sanitised version of events that doesn't stand up to probing questions.

In some cases, children receive conflicting messages from the adults involved in their caregiving, reflecting the conflicting views among the adults. In these cases the child didn't know who to believe and which explanation is truthful and so remain confused. In other cases, children were given an adequate age appropriate explanation but they just couldn't accept it - it was too emotionally painful for them.

We quickly discovered that supporting a child to have a good-enough understanding of why they are in care is a much more complex task than it first seems. Coman, Dickson, McGill & Rainey (2016) detail elsewhere significant challenges that can arise for the child, the parent(s), the social worker and indeed all involved in corporate parenting in communicating about entry to care and other care related issues. As the mantra goes: "Its not rocket science; it's way more complicated than that".

The task involves first gaining an understanding from the child about what they know already. Then one needs to identify whether the child wishes for further information. Often the information sought is highly complex and this needs to be translated into language that is understandable for the child. The information then needs to be

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communicated to the child in a way that they can receive it and not be overwhelmed by it.

All this needs to be done in a timely manner and within a challenging systemic context: corporate parenting where caregiving responsibilities are shared among a number of people in addition to parent(s) and is in the arena of court proceedings.

Acknowledging this complexity, we came to the view it would be helpful for social workers to have a model to navigate their way through the various dilemmas that can arise and therefore better communicate with children.

An initial informal literature review revealed no models of best practice for this area. A systematic literature search of CINAHL Plus, PsycINFO and Social Care Online, the Cochrane Library and Campbell Collaboration has since been undertaken by one of the authors (McGill, 2017) as part of MA dissertation and this confirmed our initial findings¹.

While no best practice models were identified, we did come across many useful models and excellent tools for communicating with children about a range of issues. These include and are not confined to the following:

- Fictional Stories
- Autobiographical stories
- Social Stories (Gray, 2015)
- Workbooks that a social worker can complete with a child
- Therapeutic Stories - especially the work of Golding (2014), Sunderland (2001), and more recently, Treiseman (2019)
- The Words and Pictures Storyboard (Hiles, Essex, Fox & Luger, 2008)
- Helping Children understand their parent's mental illness (Reupert, Cuff, Maybery, 2015)

¹ It did identify models of communicating with children about....mental health (ref), substance abuse (ref) and cancer care (ref).

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- Lifestory work (Rose, 2017)

We found these to be helpful aides in our therapeutic work with Looked After Children. We were seeking something, however, that could be used upstream from our service - an early intervention, as distinct from something that is completed as part of a Therapeutic Intervention. We wanted it to be something that Social Workers could integrate to their work and so we needed to be mindful of their role and function and their particular skill set. We wanted the Social Workers to experience Psychological safety so they, in turn, could help the children experience psychological safety. The model, therefore, needed to be something to help them in the complex social context of corporate parenting.

We also wanted the experience to be personal for the child, not impersonal. We wanted it to be experienced by the child as therapeutic - even though it occurred outside a Therapy setting. We wanted it to be a process for starting dialogue, not an end in itself. Finally, we wanted it to be completed in a timely manner (for more on this see section below: Multiple Narratives) but not be a tick-box exercise.

We came to a view that we needed to build a bespoke model for this task.

The Narrative Model

The Narrative Model was developed in Northern Health and Social Care Trust by workers from a Therapeutic Team for Looked After and Adopted Children (Coman, Dickson, McGill, & Rainey, 2016) to support adults to collaborate together and communicate with children about difficult issues.

Our theory of change: if we intervene with the adults involved in caregiving for a particular child to bring about greater congruence about the messages they communicate with a child, and supported them to do this in a developmentally sensitive way, this would, in turn, increase the likelihood of the child 'hearing' any explanations given to them and indeed, their understanding of such explanations.

We believed the reduction in fragmentation among the caregivers would increase the child's sense of psychological safety, reduce safety-seeking behaviour and promote greater acceptance of their immediate care circumstances.

In brief, the model comprises seven components and these include the following:

1. **Caregiver Network** – This refers to those who have a significant role in caring for the child including the Social Worker, Foster Carers or Residential Workers and, where possible, the birth parent(s). The Caregiver Network work together to identify the priority Narrative a child needs at this time, to develop an agreed form of words and develop a plan for sharing with them.
2. **Use of Narratives** – the adults do the work of translating complex information rather than leaving it to the child to decipher – they translate the invariably complex context into words the child will easily understand; a written copy is available for the child and others.
3. **Delivery of the Narrative to the child** – the Caregiver Network attend not only to the content of the Narrative, but to the process for communicating this to the child. The Caregiver Network work together to plan the delivery of the narrative attending to the roles of each person in supporting the delivery and the practicalities of delivery. Attention is also given to the child's sensory strategies and what might aid them so they are not overwhelmed.
4. **Responding to the child's emotions** – those involved in delivering the Narrative are attentive to the child's emotions prompted by the narrative, are accepting of them and communicate empathy to the child.
5. **Responding to the child's questions** – those involved are attentive to the child's questions – validating those questions and promoting the child's curiosity about their experiences and using those questions to continue the conversation in ongoing meetings with the child.

6. **Broadcasting the narrative to significant others** – identifying those key people the child might wish to share the Narrative with and helping them to do so is considered an antidote to the secrecy and fragmentation that often accompanies child maltreatment.

7. **Building on the Narrative** – reflecting on the child's responses to the Narrative can signpost other ways to support the child to adjust psychologically.

We have described elsewhere in detail the rationale for the model and the components of the model (Coman et al, 2016). The components of the model are not new; indeed, they are principles evident in many models of good practice (Leamy, Bird, Le Boutillier, Williams & Slade, 2011; McGill, 2017). Where we have been creative is in bringing these principles together, making them explicit and applying them for a specific task- communicating with children about complex issues.

For various reasons those using the model may be tempted to focus on one component of the model and exclude others. In our experience, however, this weakens the intervention. For example, one social worker decided to exclude the caregiver network component in order to reduce the time cost. The narrative they shared with the child was an accurate account of the circumstances that resulted in the child's admission to care. But they had not been inclusive of the birth parent's views and this was understood by the birth parent as an effort by the social worker to align the child 'against' the birth parent. The resulting conflict among the caregiver network functioned to undermine the very sense of psychological safety the social worker wished to create for the child and resulted in the child not accepting the Narrative.

Accordingly, we believe each and every one of the components of the model are necessary in helping the child adjust psychologically to challenging circumstances and to promote a child's engagement while in care.

Narratives

We have used the word 'narrative' quite deliberately in order to describe what it is we deliver to a child. Indeed, we have named the process for creating the narrative, delivering it to the child and responding to them: the Narrative Model (McGill et al, 2018). We are conscious that the term 'narrative' is used in many contexts and can evoke different meanings. Accordingly, we thought it useful to clarify our use of the term in this paper.

We use the term as defined by the Oxford Dictionary (2019):

“A spoken or written account of connected events; a story”

We think it important also to distinguish between the personal narrative of the child and 'our' narrative (the narrative that the caregiver network creates and offers to the child). The latter is based on some information the caregiver network holds at a particular moment in time; it is not the child's "story"². The child is the author of their own story and the Narrative Model is not meant to replace the child as author. Rather, it is a tool for prompting communication with the child about aspects of their story and as an aide for reflection and meaning making. It serves as a temporary scaffold within which the child is supported to construct or edit their personal narrative.

Accordingly, the narrative that the caregiver network creates, the caregiver narrative, ought to be held lightly and offered tentatively to the child. It is offered to the child as a 'best guess' by the caregiver network about what happened to the child. The spirit of the approach is one of collaborative enquiry and curiosity about the child's experience.

Evidence to support the Narrative Model

We have anecdotal evidence of the usefulness of this model. The following are some quotes, selected from many positive comments people have made, about the model:

² We have observed some workers title a narrative that they are offering to a child: "Your Story".

“For anyone using the model for the first time it is scary, but I say embrace it. I see a confidence in my social workers at LAC reviews and I am able to endorse the plans”
SWSM

“It helps professionals all come together with foster carers and parents; it allows children to have the same consistent information from the adults around them. The focus remains on the child and focuses the adults on what we need to share” GAL

“I definitely wanted my view given; we worked hard to make it an agreement between us all. It was really helpful” Birth mother

“Amazed at how simple it can be and how effective it can be” Supervising Social Worker

“If I was on my own, I don’t think I would have been able to be as honest to the kids”
Birth mother.

We have written elsewhere about a survey of social workers who had used the Narrative Model (McGill, Coman, McWhirter, & O’Sullivan, 2018). 18 Social Workers responded to the survey and completed information about 48 children. Importantly no respondents within the survey indicated any detrimental impact on the children from using the narrative model nor did they highlight any reduced placement stability. Indeed, the Social Workers reported finding the Narrative Model to be a helpful tool to aid communication with children about the ‘tough stuff’; all stated that the model had benefited the children they had used it with. They also reported it had had a positive impact on the child’s placement.

We have delivered training on the model to over 300 Social Workers in a number of different teams (Family Support and Intervention Social Work teams, LAC Social Work Teams, Therapeutic Teams/CAMHS, Fostering, Post Adoption, Independent Review Chairs) across a number of different agencies (n=8) on the model. The

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feedback about the training, and in particular the usefulness of the model, has been overwhelmingly positive as measured by standard training evaluation feedback forms using likert scales.

Further research is needed to ascertain the views of birth parents and foster parents on how helpful they believe the Narrative Model has been. Research is also needed to evidence if those young people with whom the Social Workers have used the model, demonstrate greater satisfaction with their understanding of why are in care.

The Narrative Model and Life-story work

In training events a key question that arises is the relationship between this Narrative Model and Lifestory work. Indeed, some view the Narrative Model as a method for short-cutting life-story work. Such an approach is in contrast to what the Narrative model promotes and is a disservice to both the Narrative Model and Life-story work.

In a previous publication (McGill et al,2018) we have described the relationship between the Narrative Model and Life Story work as akin to the relationship between a 'frame' and an entire movie. The life story is composed of many, many narratives; the Narrative Model has a much narrower focus than lifestory work.

Indeed, the first task for the caregiver network is to identify what, of all the information that needs to be communicated to the child, would be most helpful to focus on at this particular moment in time in order to help this child adjust to a particular challenge. It is highly specific.

Furthermore, the Narrative Model is a tool for having a structured conversation with the child. When people deviate from this purpose this can result in delays in the construction and delivery of the narrative and most importantly, can result in the child being distracted or overwhelmed by information.

Multiple Narratives

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A related challenge is where workers try to deliver multiple Narratives in one conversation.

A case example may help illustrate. A child of 6 years is about to be placed for adoption and the social worker wishes to prepare the child in advance of the move using a Narrative.

In an ideal situation one would like the child to have experience of at least four Narratives about their care journey prior to moving to the new placement – each one targeting a particular psychological challenge they need help adjusting to.

The first narrative, completed shortly after entry to care, is to help the child adjust to entry to care. It communicates to the child there are multiple viewpoints about why they are not currently living with their birth parents, that there are judicial proceedings underway which will decide their future care, that they will live with these particular “short term” foster carers until the proceedings conclude, and this is what to expect from the “short term” carers while living with them. It also includes the level of contact with family members.

A second Narrative follows the conclusion of proceedings (for example when a Care Order is granted) and the principle focus is to acknowledge the child is not returning to the care of their parents and to support the child adjust psychologically to this.

A third Narrative (which usually follows the second one quite quickly) is to prepare the child in advance for moving from their current home – it acknowledges the process for finding a family for the child and endorses the importance of finding, not just any family, but a family that is a good fit for them. It also acknowledges the feelings the child may have about moving from their current placement and the feelings of uncertainty they experience while awaiting being matched to a placement. In our experience caregivers often value the Narrative model at this stage as it not only gives them words, but role clarity and a framework for supporting the child with their emotions.

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A fourth Narrative includes a summary of the previous narratives and introduces that a new family have been identified, describes why we (the Caregiver Network) think this is a good fit and outlines what we think might support the child and family in making the transition.

A fifth and sixth narrative may follow the child being placed if the child is freed for adoption and an adoption order is subsequently granted.

In the best case scenario, the narratives are completed in a timely way and in sequence, supporting the child adjust psychologically to 'news'. Each narrative also lays the foundations for the next narrative.

In the worst case scenario, the worker is confronted with having to develop a narrative at a later point in the child's journey without any of the previous narratives having been completed or heard by the child. The child now has to adjust psychologically to: the news they are not returning to their birth parent, that they are not staying with their current carer with whom they have lived with for some time and that we have found a new family for them to whom they are moving imminently.

How will this prepare the child for the new placement? How is it fair to present caregivers or indeed the new caregivers? How is it fair to birth parents who have the capacity to be supportive of the adoption? What will the child think in future about social workers and Children's Services?

'Psychological constipation' is the term one of the authors uses to describe the reaction of children in such circumstances. There are so many significant psychological issues occurring simultaneously for the child that the issues bind to one another and become too big for the child to process them further. This can predispose them to intense emotions that are very challenging for the new carers to contain (given they don't have a historical relationship with the child) or indeed, in some cases, to reject the new carers entirely.

If these issues have not been addressed in sequence for the child before moving to the adoptive placement, they can also predispose adopters to become blocked in their ability

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to communicate with their children about their narratives. In our experiences to date, where this scaffolding has not been laid down in a timely responsive way before the point of adoption it tends not to be progressed in the child's future, thus culminating in significant future difficulties within the family.

Engaging the Network

Another area of discussion that arises during training on this model and we thought it might be helpful to comment on, is the caregiver network.

The African proverb 'It takes a village, a whole village, to raise a child' alludes to the fact that children flourish within a healthy community context. Dr Bruce Perry notes "what maltreated and traumatised children most need is a healthy community to buffer the pain, distress and loss caused by earlier trauma. What works to heal them is anything that increases the number and quality of a child's relationships". (Perry & Salavitz, 2006).

When a child is admitted to care, their 'community' extends and changes; they have a new village that includes, but is not confined to, their birth family. It is right and proper for the social worker to seek opportunities within this extended village to strengthen a child's relationships. The professional meeting can be an excellent opportunity for mining for such opportunities.

An error, however, that some social workers make when establishing a 'caregiver network' is that they understand the 'caregiver network' to be the same as a professional meeting. Accordingly, they invite many members of the new village: Guardians, teachers, police, past social workers, etc., This meeting can then lose focus and duplicate other meetings.

Rather, we conceptualise the caregiver network as functioning like the village elders for the particular task of planning and delivering a narrative. Before deciding on the membership of the group, it is helpful for the social worker to have a reasonably clear sense of what, out of all the possible narratives that this child might need, the caregiver network will focus on in the first instance. They may change it in time, but this sharp focus will make it easier to select the membership.

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Typically we include the caregiver, family placement social worker and the birth parent.

The 'health' of the caregiver network is critical to the successful implementation of this model. And the health of the caregiver network is evident in the degree to which members can be congruent in the best interests of the child. Elsewhere, Coman & Devaney (2011) have said: congruence is to care what hygiene is to surgery. Without due diligence to it the intervention will be undermined and possibly result in a worse outcome than if one never started.

In deciding membership of the caregiver network therefore, one must evaluate the degree to which members can work together.

Often the child's networks have become fractured somewhere along the way. Parents and professionals may disagree about the reasons or concerns that led the child to become looked after or why a child is presenting with particular behaviour. As adults try to navigate their way through positions that might conflict with one another, managing the conflict can become the adult's primary focus and the child's need for psychological safety can be eclipsed.

We have found that adopting the narrative model with the network can assist the child's 'village' to refocus on what the child needs, even when conflict exists. So we do not necessarily exclude a family member on the basis of conflict. Only if the conflict is unmanageable or the parent is unable or unwilling to engage. Even then, we seek to include their views- see next section.

On a very rare occasion we have decided that a foster carer should not be part of the caregiver network. This has been largely due to their having become involved in unmanageable conflict with social work or adopting a position of intractable hostility to a birth parent that social workers have assessed as being able, willing and ready to engage in the work. Alternatively, they may have been kin carers and were overly aligned with a hostile parent's position. In such cases we have tried to be creative in identifying who is best placed to support the child while the narrative is delivered.

When Parents and professionals disagree

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Although every family is unique there are a number of key issues which have led to a child becoming Looked After including: child abuse, neglect, absence or death of a parent, the impact of alcohol or drugs, and domestic violence.

In most cases we have found that parents valued an offer of help to find words to communicate with the child about these difficult issues. Often the parent's views do not align neatly with professionals. This has not stopped us generating a narrative that is agreeable to all parties. Our purpose is not to get agreement about all aspects of everything. Rather, we try to develop a framework within which the multiple views can be held simultaneously: These are the facts (relevant for this child's narrative) we adults hold, this is what your parent(s) think about them and this is what the professionals think about them. We let the child know there is disagreement and that it is for this reason it is before the court and the Judge will decide after considering all positions. For most parent's, it is enough for them to know that their views are being included.

There are some cases, however, where this approach has not been sufficient in and of itself to arrive at an agreed narrative.

In some cases where parents are resistant to a Narrative being completed, we have found it is not the facts per se that are disputed but the meaning associated with them. For example; 'the child was hit by their father and injured'- may be perceived by the parent as adults calling them a child abuser. Or 'when your mum took alcohol or drugs she did not take good care of you', may be perceived by a parent as the adults saying to the child she was not a good mum. Such meanings can evoke intense feelings of shame for the parent, and may, in turn, manifest as resistance, conflict, and or anger.

In our experience investing time with parents and working collaboratively to find words and reduce shame has in itself reduced conflict and enabled parents to engage not only in the narrative intervention, but also to engage more positively with other professionals - even when court processes are on-going! Achieving this requires a child and family-centered approach (Boddy, 2013) within which

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compassion and an understanding of each other's perspectives is integral to successful narrative progression.

We have also found that parents resistance to a narrative often softened when they understood it is helpful not just for the child, but also for them and their on-going relationship with their child while the child is in care. The narrative can serve as a useful launch point in facilitated contact where the parent and child are supported to talk about what has not been ok in their family. This, in turn, can improve the quality of contact for children and their parents.

Furthermore, assisting parents and children to talk about experiences and repair relationships before they go back home, or gravitate back home when they are old enough to leave care, minimises the potential of unhealthy, or unhelpful conversations taking place at a later point, for example when under the influence of alcohol or drugs or when angry.

There have been some cases where parents have not participated because they have been unavailable or unable to due to their personal circumstances. In such cases we adopt the usual approach to the narrative outlining the threshold information and what professionals think about this. We include what we believe are the parent's views and own that this is our best guess. In exceptional cases we have had parents withdraw consent for a narrative to proceed. In those cases we look to legal services and the courts for legal permission before progressing as outlined in our last scenario.

A helpful concept we use within a narrative when dealing with disagreement is that of being puzzled. For example: "We have told your mum what needs to change so that you can be looked after safely and we have tried to help her to make those changes. Mum disagrees - she thinks she has made the changes. But this keeps happening and we are really puzzled why she doesn't make the changes. I'm guessing you are too."

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While the disagreement is central for adults, it is important to remember this is only a few sentences and the narrative is larger than this; it should not become such a big issue that it is insurmountable.

Narrative Model as a tool for informing further therapeutic work

The Narrative Model was designed to aide social workers communicate with children about difficult issues.

While the social worker needs some therapeutic skills (especially Playfulness, Acceptance, Empathy and Curiosity as described by Hughes, 2007) for this work to progress, they are not expected to be a therapist per se.

The delivery of the Narrative is not considered to be a 'one-off event' but a stimulus for social workers, carers and parents to relate to the child. Accordingly, it is never a completed task.

By attending to the child's response to the caregiver narrative the social worker can gain insight into what is important to the child and indeed, what they might be struggling with currently and need help with. This allows the Social Worker to adopt a more targeted approach to intervention, suggest interventions to the child that are more salient for them, which in turn, increases the chances of the child engaging with them.

The response of the child to the caregiver narrative, therefore, can serve as a signpost to the next intervention they require.

Some examples:

For some children, a narrative gives children permission to disclose abuse or elements of abuse they have not previously disclosed. During or after the delivery of the caregiver Narrative they may start to disclose new information about past abuse and it is now timely to commence joint protocol.

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The child may be curious about an aspect of their life that was omitted from the original caregiver narrative or was only mentioned in passing and now needs more detail. Examples include expanding on a parent's mental health issue, ongoing substance abuse, receiving a jail sentence or completing suicide. Or a narrative about a sibling being placed with birth family or siblings needing to be placed separately. One might support such narratives with helpful literature on families where there are similar challenges. Many children experience anxiety about what to say to friends and peers in school and one might help them to have a ready made narrative they are comfortable to share.

In the weeks following the delivery of the Narrative a child's communications may indicate they have gaps in their knowledge about the membership of their family or placements that were important to them indicating they might benefit from lifestory work. Or their communications indicate they are struggling to integrate the narrative or other important aspects of their personal story and they may benefit from Therapeutic Lifestory Work (Rose, 2017).

The child's questions or comments might indicate they feel they are the only one to have been maltreated in the world and they struggle with isolation and a sense of difference. Depending on the age and stage of the child, one might introduce books or stories that have themes that parallel their own personal journey. Or one might introduce biographies of others who have lived through difficult times and come out the other side or indeed, young people who can witness directly to them.

Therapeutic Stories might be helpful.

The child may present as highly anxious or aggressive prior to, during or after the caregiver narrative and if this is a typical response by them to anxiety it may indicate the need for sensory regulation skills training and/or specific anger/anxiety management or trauma focused interventions.

It may be that the child really struggles with being in a new family and the narrative, while a starting point, is not enough to help them accept the care and love offered to them in that new family. Accordingly they would benefit from work that can

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strengthen the relationship with their new caregiver and help them make sense of their maltreatment experiences (for example: Dyadic Developmental Psychotherapy (Hughes, 2007) or Theraplay (Booth & Jernberg, 2010)).

The Narrative can also be a starting point for supporting improvement in the relationship between a child and their birth parent(s). In some cases, children respond to the narrative with lots of questions about why their parents behaved in a particular way. In cases where the parents refuse to engage with the caregiving network we might encourage the children to write their questions for their parents and send them to them. When parents do engage with the caregiving network, we can support parents and children to dialogue further about important and difficult issues until they can manage these conversations without support. Understanding the needs and experiences of the birth parents therefore is central to the process; being able to support them within this process, but also highly relevant as their emotional wellbeing will continue to have bearing on the child's welfare within any continued contact arrangements (Memarnia, Nolte, Norris & Harbourne, 2015) and in their future relationships.

In our experience, when children and parents have been supported to dialogue about these challenging issues this has resulted in parents validating the children's experiences. For some children this has supported a pathway of continued conversations and an acceptance of the reality of where a parent is at and the issues that challenge their caregiving role; thereby enabling a greater settling within their placement or prospective adoptive home. For others, the experience has resulted in them making a decision to take a break from contact arrangements until they have processed their feelings further.

Using the narrative model does not guarantee that the child will 'hold' the caregiver narrative about their care circumstances over time. But the child usually has a written copy that they can refer back to if they once again become confused. And the experience of having a Social Worker who has initiated and promoted ongoing dialogue and a caregiver network who have been part of that dialogue, ought to make it easier for the child to turn to the adults when they have questions.

Conclusion

Since its development, feedback on the Narrative Model has highlighted its effectiveness in navigating the complexities of talking with children about their personal care circumstances. In particular we have found that the care giving network, by focusing on what information the child requires at this specific time, avoids an approach that overwhelms the child or causes psychological constipation. Investment of time in the child's caregiving network has been found to be integral to this process and through sensitive utilisation of the child's village, divergent views have been able to be mediated. Birth parents involvement within this process, whilst anxiety provoking for some social workers, has had some observable rewards; for the child in improving contact, reducing torn loyalties or influencing future orientated relationships with parents; and for parents themselves in reducing their levels of shame or conflict with the agency or carers.

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