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Family engagement and compassion fatigue in Alternative Provision

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ABSTRACT

In a sector largely ignored in policy and the public imagination, Alternative Provision works to care for and educate children for whom mainstream schooling does not work. Central to their mission is the engagement of families, often seen as both the cause of their child's difficulties and the solution to their successful educational re-engagement. Practitioners within Alternative Provision work within sophisticated strategies of family engagement, from regular communication to the more intensive interventions of home visits, supporting families with everything from filling in forms to cleaning, from managing outbursts to sourcing furniture. With the majority of families living within contexts of deprivation, many have life histories containing trauma, trauma that Alternative Provision Practitioners listen to, confront and, often, internalise, risking 'compassion fatigue'. This article focuses on the potential for compassion fatigue within family engagement in Alternative Provision, beginning with the impact on practitioners. It then discusses the role of leadership in building an assemblage of organisation interventions to both mitigate compassion fatigue and maximise 'compassion satisfaction', the fulfilment that comes from empathic work. Finally, it examines how compassion satisfaction could mitigate the deleterious impact of vicarious trauma.

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Introduction

As neglected as it is organisationally diverse, Alternative Provision (AP) educates those children for whom mainstream schooling does not work. Embracing children who have been excluded as well as children with social, emotional and mental health needs, the sector works to offer a different educational experience, one of smaller classes and flexible curricula, increased pastoral and therapeutic approaches. And key to the success of these children is engagement with families, an engagement that moves far beyond the strategies of mainstream schools and emphasises targeted and individualised support and home visits. Yet many of the families of the children within AP have difficult life histories and live within contexts of deprivation. The work of family engagement,

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then, often necessitates engaging with the trauma experienced by families, of active listening and empathy in order to plan the most effective interventions of support. Here, the trauma is vicarious, practitioners can internalise the stories they hear, they can lie awake at night thinking about the families they work with, they can struggle to be fully present for their own families and they can become exhausted. This vicarious trauma – compassion fatigue – is a constant risk within empathic work and has been researched within a range of settings such as social work, nursing and therapy. Based on a study in five AP settings in the UK, this research focuses on the risk of compassion fatigue within AP and the role of leadership in mitigating against it. However, while compassion fatigue is a major concern within the empathic work of family engagement, so too is *compassion satisfaction*, the sense of fulfilment and accomplishment achieved from successes within this type of work. As such, this article discusses how senior leaders can provide an assemblage of support for family engagement practitioners that minimises compassion fatigue while maximising compassion satisfaction, from instrumental interventions to the creation of a culture of authentic openness and support.

Family engagement in Alternative Provision

Of all sectors in education, AP is arguably the least understood and certainly the least attended to. It is a sector 'wide-ranging and disparate'(Trotman, Enow, and Tucker 2019), a sector that resists boundedness and easy international comparisons, adopting a number of organisational forms from the local council-run setting to the private school, from the Pupil Referral Unit for excluded children to the independent special school, from further education-linked to work-based learning units. Gutherson, Davies, and Daszkiewicz (2011) provide a definition that attempts to embrace this heterogeneity: 'schools or programmes that are set up by local authorities, schools, community and voluntary organisations, or other entities, to serve young people whose needs are not being met and who, for a variety of reasons, are not succeeding in a traditional learning environment' (11).

But where AP resists easy categorisation by form, it provides some level of unity in terms of function: in the best APs, there is a sense of belonging and connectedness beyond that found in the mainstream (Jalali and Morgan 2018); the emphasis on relationships between children and staff and a flexibility of structure (Malcolm 2018); there is a tailored curriculum according to the interests and needs of the children (Mills and McGregor 2016); care is prioritised to create a safe space (O'Gorman, Salmon, and Murphy 2016). There is also some level of international uniformity for the sector found within the characteristics of the children that it serves with an over-representation of children from poorer backgrounds (Malcolm 2018; Skiba and Knesting 2002), children from black, Latino and mixed race backgrounds (Christle, Nelson, and Jolivette 2004; Smith 2009; Malcolm 2015) and children with special educational needs and disabilities (Trotman, Enow, and Tucker 2019; Brown 2007). Finally, there is the nature of the home contexts of children in AP: trauma, domestic and sexual abuse, teenage parenthood, neglect, family conflict, criminality, all featuring consistently in the international literature.

The involvement of families in AP features throughout the literature but not generally in detail, despite its importance (Michael and Frederickson 2013; Menzies and Baars

2015; Ruzzi and Kraemer 2006). Where it is discussed, the family is seen as a paradox, 'problems or partners' (Smith 2009), with poor parenting being a prime cause of children being excluded from the mainstream but also a prime resource for children's re-engagement with education. Families within the literature are characterised as often challenging (Macleod et al. 2013), resistant and non-compliant, living within complex and difficult contexts. But they were also often angry at their treatment through the process of exclusion and changing schools, feeling themselves excluded from the bureaucracy and decision-making that so deeply affected them (McDonald and Thomas 2003). Once children were in AP, families appreciated the frequent communications and updates from the settings, communication that emphasised the progress their children were making. Central to family engagement was the creation and maintenance of a trusting relationship (Mowat 2009) and the centrality of the triadic connection between the family, the referring school and the AP setting (Äärelä, Määttä, and Uusiautti 2016).

In the first study to focus exclusively on family engagement in AP, (author anonymised) found that AP settings shared a number of family engagement strategies with mainstream schools yet in modified forms to reflect the often transitory nature of the children in their care that precluded the potential for long-term relationship building. As such, within a limited window, settings moved beyond family engagement to family support, support that other agencies couldn't or wouldn't do. Practitioners escorted parents who were too anxious to leave their homes to medical appointments; they cleaned kitchens; they sourced furniture for bare rooms and bought curtains to allow the children to sleep more soundly; they completed forms, they fostered family learning, they provided a listening ear and calmed volatile confrontations. Part planned, part improvisational, this micro-work, often during home visits, was enacted through six domains: *behavioural*, challenging inappropriate interactions and modelling behaviour management; *emotional*, supporting the affective within the home and supporting children and parents; *safeguarding* to establish risks to children; *functional* in terms of supporting with finances, hygiene and practicalities; *pedagogic*, fostering family learning and sharing educational progress; *capacity building*, helping parents to understand the complexities of the educational system and advocating on their behalf.

While family engagement in AP is a largely neglected area of concern, so too is the impact of the work on practitioners. Families had complex life histories that often contained traumatic incidents that were foregrounded during family engagement that created a challenging work experience. With the literature is mostly silent on the effect of this work on the wellbeing of AP staff, I instead turn to the wider literature concerning similarly caring and empathic work that focuses extensively on nurses, therapists and social workers.

Burnout, compassion fatigue and compassion satisfaction

There is a risk at the heart of empathic work in trauma contexts: to be effective, practitioners must maintain empathy, they must listen with openness and share the experiences of those they work with imaginatively or phenomenologically (Wilson and Lindy 1999), demonstrating authenticity and positive regard. They must be exposed to the trauma within life histories, they must listen to narratives of abuse, violence, addiction and tragedy in order that they can most effectively support their clients or patients.

However, the more empathic practitioners are towards their clients – the greater the absorption level (Wertz 2000) – the more likely they are to internalise that trauma (Conrad and Kellar-Guenther 2006) with empathic engagement acting as the 'primary conduit for the transmission of traumatic stress (Craig and Sprang 2010). One of the impacts is vicarious traumatisation (McCann and Pearlman 1990) or 'compassion fatigue', the 'natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced or suffered by a person' (Figley 1995, 7). As a condition, compassion fatigue is characterised by 'episodes of sadness and depression, sleeplessness, general anxiety, a loss of objectivity and intrusive thoughts that mirror the experiences of their clients (Cerney 1995) as well as 'relational disturbances' (Hoffman, Palladino, and Barnett 2007), the 'process of distancing and detaching from family, friends and colleagues'. Symptomatically, compassion fatigue is similar to burnout but there are important differences: burnout is a 'syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment' (Maslach 1982) that arises from prolonged periods of excessive workloads and occupational stress (Cherniss 1980); compassion fatigue, on the other hand, can occur from a single exposure to a traumatic incident (Conrad and Kellar-Guenther 2006).

Radey and Figley (2007) suggest four major factors that contribute to compassion fatigue: firstly there is poor self-care covering a wide range of elements including exercise, relaxation and diet; secondly is previously unresolved trauma within practitioners' own life histories that finds a connection within the narratives they hear; thirdly, an inability or refusal to control work stressors; finally, a lack of satisfaction from the work. Once manifested, the literature details a number of strategies to manage compassion fatigue, advocating a menu of interventions to allow individualisation (Aycock and Boyle 2009). However, compassion fatigue is not an inevitable result of empathic work and vicarious trauma; practitioners can also derive an enormous sense of wellbeing from work experienced as deeply fulfilling. This alternative is *compassion satisfaction*, the 'positive benefits that individuals – caregivers, teachers, social workers, clergy – derive from working with traumatised or suffering persons' (Conrad and Kellar-Guenther 2006).

But it is essential to note that compassion satisfaction is not an alternative to compassion fatigue and both can exist simultaneously (Stamm 2002). From the perspective of viewing them as potentially concurrent, compassion satisfaction, an internalised belief that empathic work is a calling and contains a fundamental meaningfulness despite the challenges and risks it presents (Friedman 2002), may function as a means of mitigating compassion fatigue and ameliorating its harmful effects (Ray et al. 2013). Here, distress is 'modulated' through individuals being conscious of the trauma being experienced and the transference of that energy into satisfaction through a range of interventions: self-care practices should be integrated into daily lives (Henry and Henry 2004); organisational support and adequate staffing should be in place (Barnard, Street, and Love 2006); training that presents strategies for creating emotional distance and self-regulation (Badger, Royse, and Craig 2008) as well as the symptoms of compassion fatigue allowing practitioners to self-monitor more effectively (Braunschneider 2013); specialist training in managing trauma (Sprang, Clark, and Whitt-Woosley 2007); personal therapy and supervision (Linley and Joseph 2007); support in creating and maintaining an emotional boundary from clients/patients (Hayward and Tuckey 2011);

meaningful recognition of achievement and effectiveness within the workplace (Kelly, Runge, and Spencer 2015); the use of evidence-based practice exemplars to provide frameworks for managing traumatic cases (Craig and Sprang 2010); peer support and action learning where practitioners share examples of vicarious trauma to create shared approaches; an increase in the number and variety of practitioners' support systems to allow separation from the empathic role (Figley 2002). However, here again is the dilemma at the heart of empathic work: full engagement in contexts of trauma results in higher levels of job and compassion satisfaction but, at the same time, risks compassion fatigue.

For leadership within AP, the aim is to create contexts that foster and maximise compassion satisfaction while simultaneously providing strategies to minimise compassion fatigue. While not straightforward, the literature from contexts including nursing and social work provide a number of evidence-based strategies, many of which can be translated into the focus of this article and will be considered in the discussion section following analysis of the data.

Methodology

The research design aimed to achieve an emic perspective, an insider's view from a particular group or community (Savage 2006), in this case, practitioners within the Alternative Provision sector who engaged regularly with families. However, as detailed above, AP is incredibly diverse and so a purposive sampling strategy was used to create a representative sample as possible. At the organisational level, this involved selecting five different settings in the north of England spanning primary and secondary age phases, Local Authority and independent Academies and special education, all here given pseudonyms: Ash Grove Academy, a relatively new school that taught primary and secondary and belonged to an urban Multi Academy Trust; Oakview, a secondary Academy that was part of a large regional Multi Academy Trust; Templeton, a specialist school for children with social, emotional and mental health needs that contained both primary and secondary children; Broadtown, a small primary setting specialising in supporting children who had been excluded temporarily; Southfield, a secondary AP over two sites within a medium-sized city that had just become independent from the Local Authority.

The purposive sampling strategy also extended to practitioners within each of the settings – 23 in total – who ranged from Executive Principal to Teaching Assistant and from classroom teachers to pastoral, therapy and attendance teams. To gain the emic perspective, an interpretevist approach was used, with semi-structured interviews adopted to explore the daily experience of family engagement. Data saturation (Guest, Bunce, and Johnson 2006) occurred at a relatively early stage, despite the variety of settings and roles and so additional settings and participants were not recruited. All interviews were recorded and transcribed in full before open coding (Corbin and Strauss 1998) to establish initial categories and themes before beginning selective coding (Moghaddam 2006).

One significant caveat concerns the nature of the families described. In a sector already containing an over-representation of children in poverty, the families that received the most attention from the practitioners were those most in need. While the participants did discuss working with relatively affluent families, they were very much in the minority

among case-loads. Instead, those families most affected by structural inequalities tended to form the bulk of the family engagement work within settings. All the practitioners described the impacts of austerity and slashed public sector finances and the impact that this had had on the families most in need of support. Family engagement, and home visits in particular, were a matter of resource: in contexts with budgets and staffing stretched to their maximum, family engagement was prioritised for families with the greatest need within the greatest contexts of deprivation. Given the nature of AP and the nature of family engagement within the sector, this partiality is inevitable but needs to be highlighted within the reading of the data.

Findings

The impact of family engagement

While the settings varied in the extent and depth of their engagement with families depending on their size and associated resource, one thing was common in all of the settings: it was a difficult work that took a toll on practitioners. The majority of families lived within significant deprivation and their lives were complex: there were histories of abuse, addiction, violence and criminality, traumas that became everyday narratives with which practitioners would engage. The potential for vicarious trauma was even more acute for those colleagues who conducted homes visits, the most effective strategy of family engagement within AP (author, anonymised). Here, often within stark poverty, children slept on dirty mattresses, floors were covered in pet faeces, kitchens were devoid of food, families were cramped within small, damp rooms. And here, within homes, families would recount the trauma they had experienced, grateful for a listening ear. Practitioners found it exhausting:

> Beth, Broadtown: It is challenging. It's a challenging environment. You have to be mentally and physically fit to be able to withstand a full half term, a full week some weeks depending on how it is. Some days, just a full afternoon might be enough to make you feel extremely exhausted because it can be like that.

> Helena, Ash Grove: It's not just physically exhausting, but it can be mentally exhausting and you need to be well emotionally and physically to be able to do this job.

Sleep was disturbed; their own families were not always given the attention the practitioners felt they deserved; lethargy was common. But this was not just exhaustion resulting from the actual contact within operating hours; it was about the impact the work had on practitioners outside of working hours. Here, many spoke of their difficulty in switching off, in their ability to separate themselves from their empathic roles. Once practitioners had gained the trust of families, they were often incredibly open and would give practitioners great detail about their life histories and current issues. Often during the exclusion process of the children, parents were similarly excluded, suddenly without parental networks that had been built in their child's original school. Some even had to leave their jobs as a result of exclusion. As a result, parental loneliness was reportedly common and so contact with practitioners within settings was prised. What the openness of this connection brought was sometimes traumatic:

> Keith, Templeton: God there's so many incidents, you've got domestic violence in the house, you've got sexual exploitation, you've got emotional, physical neglect. Some students that we

deal with, families have completely given up … it's surprising how some of them actually come in and they get straight on and work and when you start reading about their backgrounds, you think 'oh my god, how is that child even functioning, how have they even managed to get out of bed?' Some of them don't even have a bed to sleep in.

Once absorbed, the recounted trauma acted as a channel between work and home:

Bethany, Ash Grove: I think I care about all of my families and there's certain times when I lie in bed at night and think, "What's happening now?" Because I've got that family in my head.

Michelle, Southfield: I do, I do take it home but I think that just means I really care about it, so although I'm very tired a lot of the time [laughter] I do really care about all of the students that I teach, so it's exhausting but in a nice way [laughter].

Within these narratives is the risk of empathic work reported throughout the literature, across contexts: to do the job well, practitioners need to demonstrate empathy, they need to listen to histories of trauma, they need to feel the impact upon the lives of families. Only by understanding the full context that children and their families lived within could practitioners implement plans and interventions that were most likely to succeed. All of the settings conducted home visits depending on their capacity and it was here that families were at their most open, generally more relaxed than within a formalised school environment. However, home visits were often challenging (author, anonymised): there were homes that were almost impenetrable, parents who hadn't left the house for months due to anxiety; there were homes that were permeable with neighbours and strangers walking through; there were dogs barking, fierce arguments, difficult conversations, suspicions, all factors that added risk to home visits and led practitioners to consider their own safety. In contexts that were already stressful for practitioners, it was here that families really opened up, where they shared their life histories and where the risk of vicarious trauma was at its most heightened. But while empathy was essential, while it was necessary to support families effectively, being empathic is to risk opening the self to vicarious trauma, the risk of compassion fatigue, especially when it was the intensity of caring – the absorption level (Wertz 2000) – that allowed the work/life boundary to become eroded.

Individuals coping

What was significant in the accounts of the transfer of empathic work into lives outside of work was that this was not a passive experience – practitioners did not allow the experience of vicarious trauma to be unchallenged. Instead, they actively self-coached. For some participants, this involved actively creating emotional distance:

Dorothy, Southfield: But you've got to have some amount of empathy and some amount of attachment. It's just knowing when to not be too attached and cutting off.

Interviewer: So, how do you cut off?

Dorothy: I talk myself out of it.

For others, self-coaching was a direct response to emotional distress arising from vicarious trauma and acted as reassurance that they had done everything possible to support the families they worked with:

> Rachel, Broadtown: I might go home and I might have a little cry … but then you bring yourself back round again and you think, you know what, I just need to get on with it and do what I can do, for that child. As long as I've done my part and done as much as I can, then that's all I can do.

Finally, self-coaching was a matter of literally reflecting upon their own practice and determining if they had been successful:

> Susan, Templeton: Do I switch off? No. And I'm awake at one o' clock in the morning and thinking, "Could I have done that differently," and, "Should I have done that?"

Self-coaching was a dialectic, an out-of-work tension between a focus on the work and a focus on the self, an interrogation of the interplay between effectiveness and wellbeing. But it also functioned as a means of distancing, of analysing the day objectively with the self removed. For others distancing was a matter of actively enjoying a long commute with favourite music playing, spatial and emotional distance commingling. There was also boundary setting in terms of working hours with emails turned off, work phones turned off, weekends and evenings demarcated as time dedicated to their own families.

> Pete, Oakview: I have a – from here – it's a half an hour drive. I try my best to leave everything in that half an hour drive, and when I go in, [my] family is everything to me, that's what's important

But there was also an effort, beyond self-coaching, to consciously switch off – and this was the most difficult strategy. Here, practitioners discussed forcing themselves to shut off from difficult cases, they created mental boundaries intended to repel the emotional pull of their work:

> Greg, Oakview: You've just got to sort of like do what you can to put it to the back of your mind and forget about it.

> Kim, Southfield: You've got to be able to cut off that emotion and if you can't put off that emotion, you would literally drive yourself insane with these families.

Organisational support

The senior leaders who participated in this research were well aware of the demands of the role – and experienced it themselves – and within all of the settings there were a number of strategies to mitigate against the risk of compassion fatigue. Supervision, where practitioners are supported to reflect on cases by an independent and usually external specialist, was the top priority but its availability depended on the level of resources available in each of the settings. In the largest, this was formalised and allowed practitioners to analyse cases and their practice in more depth.

> Bethany, Ash Grove: Having regular supervision, a proper supervision rather than case management, being able to unpick situations but also how has that made me feel as a professional, as a person. … We need to be able to have those opportunities to just reflect on things with support sometimes so that we're not keeping it all in and we're not being consumed all hours of all day, every day with worry of that family or that child.

While supervision was undoubtedly effective, more common was support from line managers – their most immediate manager responsible for their performance and support – who tried to make themselves as available as possible to offer instant support:

> Colin, Southfield: That's how I try and work as a manager where, you know, I am trying to be always available. Say like as soon as you had a meeting, if you need to just ring me and reflect on what's happened, and what was said, I am there to talk about that and what could happen, or what else could have been added.

Line managers – while not usually leading supervision – would often adopt the pattern of interrogation of incidents and encourage practitioners to reflect and this was highly valued. But rather than just being a function of line management, it was evident settings had worked hard to create a culture of openness, a culture that encouraged all staff to discuss the difficulties of their work, to normalise the impact that empathic work could have.

> Pete, Oakview: You have to talk and we have to create a culture in here where staff are really happy to talk to each other and when we're struggling, we need to express that because it can be challenging, and I think as a school I think we have that culture where we do help each other, yes.

Here, narratives focussed on the informal as much as the formal peer meetings: chats over coffee in the staffroom following a difficult encounter where practitioners felt secure enough to vent or phone calls to a colleague in the evening after a particularly bad day to talk through issues or to receive a kind word. What was apparent in all of the settings was the culture of care that ran through the data, a culture that allowed – and actively encouraged – the expression of vulnerability that normalised the pressures of empathic work and the potential for vicarious trauma. It was also a culture that highlighted the importance of self-care, that included exercise and healthy eating but also time away from the pressure of the settings that was explicitly not about the work:

> Emma, Broadtown: It's Staff and Emotional Wellbeing Week where we invite staff out to play golf rather than sitting through another info session, at the end of term, that wasn't going to get them anywhere. It's like, 'actually, we just need to do something fun'. We try to do a few staff nights out and things like that. Gym, wine, holidays. Yes, you feel like you're putting something back but sometimes it does get to the point where it's like, "Oh, my god!"

Discussion

With the impact of vicarious trauma a major concern for leaders within AP settings, the leadership focus needs to be on minimising compassion fatigue and maximising compassion satisfaction. While there was evidence of a culture of openness and support and, to a lesser extent, supervision, the role of leadership in family engagement should focus on building an assemblage of support measures, an assemblage that allows 'intervention individualisation', a personalisation of support for each practitioner (Aycock and Boyle 2009). The family engagement practitioners in this research came from a wide range of backgrounds: some were from the police or armed forces, some came from clinical backgrounds, others were teachers from mainstream schools and some were direct from university. Given such a breadth of backgrounds, the assemblage needs to begin with initial training and the importance of this is foregrounded within the literature from other fields.

First and foremost, initial training needs to be explicit that emotional distress is highly likely within family engagement work for two primary reasons: firstly, this normalises

discussions of vicarious trauma and the risk of compassion fatigue to ensure it becomes part of the everyday discourse within settings and encourages the peer support participants found so essential; secondly, it provides new practitioners with an understanding of the signs and symptoms of compassion fatigue so that they can exercise intrapersonal vigilance and self-assessment to identify the warning signs. But beyond the understanding of compassion fatigue is the importance of specialist trauma training (Sprang, Clark, and Whitt-Woosley 2007), especially the use of evidence-based practice that presents models and even scripts for managing trauma work, as evidenced in Addis et al's (1999) study of training interventions with therapists that found that this type of training resulted in lower levels compassion fatigue. However, there is a caveat: as Craig and Sprang (2010) argue, evidence-based practice that relies on scripts may decrease job satisfaction by limiting creativity and spontaneity, both of which are essential in effective family engagement (author, anonymised). As such, trauma specific training in AP should use models of managing trauma without becoming too prescriptive – there should be a framework but not a script, a scenario of actual experiences with families with discussion and interrogation, not a planned encounter that would stifle the improvisation necessary to meet the needs of individual families.

Part of the effectiveness of evidence-based trauma training is that frameworks provide a means of creating and maintaining emotional distance, an issue that many of the participants struggled with. Applying schema to experienced traumatic may act as a guard against excessive absorption, a means of analysing situations without internalisation. Yet distance can also be achieved by an emphasis on self-care that should be integrated not only into training but into the daily lives of those engaged in empathic work (Aycock and Boyle 2009) and leadership here is key. Self-care should become a constant within line management processes, a standing item in meetings, discussion of which strategies work for individuals and modelling by all levels of leadership throughout settings. Furthermore, leaders should create space within work to fulfil the dual aims of self-care and emotional distance by providing spaces away from children and families within buildings and, where resources are available, to plan activities for staff that have absolutely nothing to do with work. Just as family engagement practitioners follow strict safety protocols when conducting home visits (sharing times and addresses, facing the car the quickest way out etc.), so too should self-care protocols be planned as standard.

Physical space within settings away from children, as well as creating physical and emotional distance, is essential to foster peer support. In many empathic settings, there is a clear delineation between clients/patients and practitioners: social workers move from the empathic setting to the separate organisational space of the office, away from clients; therapists have private offices away from those they work with; practitioners within AP move from home visits to school settings where the children of families are cared for and so the potential for genuine separation is minimised. Staff rooms – in the traditional sense where children are not allowed – become an essential space of separation but also a space for peer support, so valued by the participants in this study. Staff-only spaces are places of humour, emotional release, tears, caring, a place to vent with others engaged in empathic work who understand the toll it can take. It is a place where the professional front can be lowered, where practitioners can be themselves and express their frustrations, their distress, but also, particularly important for the fostering of compassion satisfaction, the successes. And in this final element,

peer-spaces provide continuing professional development, an ongoing training environment of professional stories, organisational narratives of family engagement and 'representations of space' of neighbourhoods and homes (author, anonymised) that build maps of practice and schema that extends initial evidence-based training throughout careers.

Peer support, then, is one end of a continuum of interpersonal support, the informal. More formalised is effective line management that provides an immediacy of support in the more difficult cases, a semi-private dyad that allows practitioners to self-reflect on their practice, a scaffolded analysis of cases and their impact upon the individual. Here, line managers must not only remain vigilant to the signs of compassion fatigue, they should further normalise it, reminding practitioners that vicarious trauma is routine within empathic work, and also to foster the vigilance of practitioners in spotting the symptoms. At the furthest end of the support continuum is formal supervision, so essential in empathic work (Badger, Royse, and Craig 2008). Not only does this provide an opportunity to discuss difficult cases, it also – as with informal peer support – provides an opportunity to recognise successes. In this regard, supervision is at the heart of resolving the empathic work dilemma: in providing support to analyse challenging cases and vicarious trauma, it works to mitigate against compassion fatigue; in providing a similarly analytical approach to successes, it acts to enhance the fulfilment practitioners experience from their work and therefore maximises compassion satisfaction.

Of course, the issue of resource provides a constant spectre within the AP setting. While Ash Grove was well resourced and was able to implement a complex assemblage of practitioner support, others such as Broadtown were small and struggled to provide all the support measures they wished for. With funding a perennial issue, the extent to which measures such as external supervision could be implemented across the sector is limited. Even more so, the final means of supporting practitioners – providing adequate staffing (Barnard, Street, and Love 2006) – remains the most difficult. Excessive workloads are one of the primary underlying causes of compassion fatigue but finances may mitigate this is some settings. Instead, where case-loads of family engagement are of necessity high, line managers should try and allocate a caseload mix (Sprang, Clark, and Whitt-Woosley 2007), a variety of families from the high to the low need, which can help practitioners achieve additional successes in their work and increase compassion satisfaction (Radey and Figley 2007).

Conclusion

Family engagement in AP is essential in re-engaging children within education. It provides a cycle of learning and behaviour management between the home and the setting that can work to address poor previous educational experiences. However, like all empathic work, the need for depth of emotional engagement risks vicarious trauma that can exact a heavy toll on practitioners. For senior leaders, the aim therefore, is to create an assemblage of interventions that can reduce the potential of compassion fatigue while maximising the potential for compassion satisfaction. From initial training to physical spaces for physical separation, from supervision to activities away from work, leaders can provide mechanisms that underpin the entirety of the experience of family

engagement. But this is tricky work: vicarious trauma is not only experienced within office hours or within settings; it can appear in the lonely hours of the early morning, interrupting sleep and intruding into private lives. As such, interventions are of themselves not enough. What is needed is the creation of a culture that normalises compassion fatigue, a culture that recognises its symptoms and presents the need for support as routine. Here, leaders must model self-care, they must be open to talking about the difficulties and traumas of the work, in particular their own experiences, and they must be available for staff in distress. Only then, with practitioners who find satisfaction and fulfilment in their work can family engagement be truly effective and do what AP does best: transform the lives of children and families.

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