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DIRECT CARE PRACTITIONERS: AS PROMOTERS OF CHILD DEVELOPMENT

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ABSTRACT: This paper is an edited version of an address given at the Annual Seminar of the Residential Child Care Committee at Parkerville Children's Home, Perth, Western Australia in July 1983. The focus of the paper is on the importance of direct care practitioners as the promoters of child development. It also offers a formulation for thinking about the skills areas of direct practice.

The first question, which has to be addressed when considering direct care, is about how development takes place, how children grow and develop. It has to be remembered, in fact, that development takes place around everyday life events. Everyday life events are the simple things that we can very easily ignore or forget about or not place enough emphasis on (e.g., bedtimes, mealtimes). They are the ordinary, everyday routines that should not be seen as routine because they are of immense importance. In Maslow's (1954) hierarchy of human needs, the baseline of that hierarchy is written in terms of food, warmth, clothing and, until all of these things have been satisfied, developmental progression or change is unlikely to begin. What Maslow does is to nicely emphasize the importance of the work that direct care practitioners do in regard to these items.

It is through the provision of these very important items that direct care practitioners actually provide children with nurturing experience. What converts a piece of physical care (e.g., tucking a child into bed when he/she is not feeling very well) into nurturing care is the involvement of another person in that act (Maier, 1979). These physical care duties should never be seen as simply routine events. They are the very essence of what has to be done in work with children. These tasks provide practitioners with powerful ways of actually conveying care and concern to children. Children need to experience this care and concern because that is what will actually help them to grow, and to get over some of the difficulties that they may have encountered. Often junior practitioners fail to realize, for example, that when a child comes to them and says "I need a clean pair of socks," they have to do something about that. It is so much easier for them to say "Oh, I haven't got time at the moment," or "Go see so and so," and thus fail to recognize that the child is asking them to do something important for him/her and that they have to do it!

These are the real things that impact children in their drive towards healthy development, and most chlidren do have a drive towards healthy development. That drive is, moreover, reinforced and reconfirmed through the very minutiae of ordinary life experiences. It is the minute details that need attention; it is the minute interactions that take place with children, around the provision of everyday life necessities, that really gets through to them. What is done, as well as what is said, is important — especially the doing. An illustration of this can be given from some consultancy work that was undertaken with a hostel for adolescents. When young people were introduced to that hostel, they would be welcomed very warmly at the front door. A lot of things would be said to them about "how glad we are to see you" and "we hope your stay will be good."

Then, what used to happen was that they would be shown to their room and their room would not have been prepared: the bed was unmade or the place was untidy. So the verbal message was countered by a very powerful nonverbal message, and it was the nonverbal message that was absorbed. This emphasizes the importance of basic care giving as a core requirement for practitioners (Maier, 1981). Its provision is essential for children and young people wherever they are, whether they are at home or away in residential or daycare programs. It is the cornerstone of practice aimed at developmental progression or change.

For direct care workers, all of the above is especially important, because they are the people who are responsible for these things all the time. They are the people who have the most power to influence what happens to children. It is, in fact, strange that direct care workers often feel the reverse about this and express powerlessness. It is even stranger that programs should sometimes disregard their importance and their powerfulness. It is something of a paradox.

But, let me now reference another set of ideas that is useful in thinking about the way in which children learn, grow and develop. It is the notion of learning dyads. Bronfenbrenner (1979) talks about three types of learning dyads. They are all learning dyads in which direct care practitioners are involved. The first of these is an observational dyad; this refers to learning that takes place when a child observes an adult doing something. It is the kind of classic thing that happens in any situation where a child watches an adult, possibly preparing a meal or washing up; just ordinary, everyday life events. The child learns through the process of observation. This is important, but it is not as powerful as the next type of learning dyad.

The next type of learning is learning which is based in a joint activity dyad — learning that takes place through shared experiences when practitioners are working with a child and actually doing something together. A child may learn by watching an adult prepare a meal, or may learn by watching an adult wash up. Even more is learned if the child actually helps the adult prepare the meal, and helps the adult to wash up. This is because the process of active participation in these events speeds up the learning process.

The third type of dyad that Bronfenbrenner talks about is a primary dyad and this incorporates learning from observational and joint activity dyads. It also emphasizes the key element of adult influence as an additional characteristic. The importance of a primary dyad is that it continues to influence a child's behavior even when, as a physical reality, it no longer exists. This is exactly what adults try to do with children. They work with children and get them to incorporate behaviors and values that will have an influence on children even when they are no longer with that adult. In working with children who have difficult behavior patterns, practitioners are, in fact, trying to get children to adopt certain new approaches to situations so that when they are no longer together, the children will still be able to manage their own behavior in a way that is more productive for them.

These three simple ways of thinking about the learning process in terms of child development are, in my view, helpful. This is because the notions are easy to remember, and reflect what direct care practitioners are actually going all the time with children. Moreover, the sort of learning outlined is infinitely more powerful than the kind of learning that may go on in some kind of special counselling situation in private office space. In that respect, it is worth repeating that real learning takes place in and around ordinary, everyday life events. Other kinds of learning that stem from formal counselling sessions are of a different type. It is at another level in the hierarchy of human need that Maslow constructed.

Finally, in this section, it is worth saying something about attachment and attachment behavior (Maier, 1981). So far, the focus has been on ways in which direct care

practitioners build links with children, establish working relationships with them, and become powerful influencers, and how they actually help the child to become attached to them so that these processes can be used beneficially. How this is done is important, because what children learn in the process of becoming attached to an adult is a way of relating that they will use later in other situations. What practitioners are actually doing is modelling for them a way of behaving and relating that they will use in the future. That places considerable responsibility on practitioners. It means that they have to be careful about what kind of relationships are modelled and what form of attachments are created. It is important, for example, for a child to have some freedom in a relationship. Practitioners would not, for example, want to model relationships that are punitive, or inappropriate in other ways. Indeed, practitioners have to model mature adult relationships and this, again, emphasizes the importance of the work direct care practitioners undertake.

Part of the problem with the attachment issue is that troubled children often indulge in difficult, disruptive, troublesome behavior. They certainly do that in the initial stages when they are trying to get to know a new range of practitioners. It is, at that time, very easy to misconstrue the nature of this behavior, because it is so troublesome, demanding, awkward to handle, and irritating. It is also easy to try to control or stop this behavior, whereas, in fact, much of this behavior is what is best described as attachment behavior. It is the way these children have of making contact with practitioners. It is searching behavior. They are searching for ways of getting attached to practitioners and that is exactly what has to happen. However, if practitioners miscontrue the nature of the behavior, they may intrude into it in an inappropriate way and simply act in a controlling way as opposed to listening to what the behavior is about — finding out, in fact, about the demand that is being made. What actually has to be considered is the appropriate way of responding so that the child can feel reassured and cared for, and therefore reach a point at which he/she is able to relinquish the difficult behavior. Practitioners have to hear the music behind the words and find a way to pursue the analogy further, strike the right note. Now this is not to say that there are not some situations in which limit setting is highly appropriate. How those limits get set is, however, important, because these can be set in a way that responds to the underlying need, as opposed to simply imposing controls in a rather heavy-handed way. Moreover, because attachment behavior is essentially behavior that children engage in, in their struggle to make links with adults, it actually gives practitioners an opportunity to get close to them. If practitioners are going to have an impact on a child and actually assist with personal development, then the child and practitioner have to get close to each other. Many children who enter residential and daycare programs have had a hard time; they are stuck at a particular point in their development and they need caring adults who are not afraid of their awkward behavior or of being near them. This close involvement between child and practitioner is, in fact, a necessary part of the work practitioners have to do. Effective work with children cannot be done from a distance.

Part of the problem, however, for direct care workers in all situations — because of some of the difficult behavior they encounter — is that it is easy to slip into being custodians, and that certainly is not what practitioners should be doing. A lot of the negative history of residential and daycare programs stems from practitioners adopting that irrelevant position. It is also easy for practitioners to simply be passive caretakers rather than being active promoters of development. And it is also very easy for practitioners to slip into being social policemen. In my view, none of these role models are relevant. They are, in fact, negative role models. What, therefore, needs underlining is the importance of direct care workers acting in a very real and significant way as child develop-

ment specialists. That is their job! The job is about how you help children, who are having difficulty with normal developmental progressions, to move beyond the stage at which they may be temporarily held. In my view, the sooner direct care practitioners begin to see themselves as child development specialists and value themselves accordingly, the better.

Direct Care Practice

As a consequence of the above, it can be seen that there is an enormous need and urgency for direct care practitioners to update their theoretical knowledge, to articulate their skills and to demonstrate their importance. These things have been done less than adequately, in my view. It has not been done well by people who understand direct care practice, and the tendency has been for direct care practitioners themselves not to be assertive enough or as articulate about their practice skills as they ought to be. The consequence of this is that their position has been downgraded and they have not received the rewards and status that they deserve. It is time to get into the business of rectifying this, and responsibility for doing this resides with us all. Direct care practitioners themselves clearly carry some of this responsibility.

What is also clear is that the focus of work that is undertaken in residential and daycare programs must reflect understanding of developmental issues and respond to developmental needs. It means that practitioners themselves have to acquire a great deal of special knowledge. An assumption that practitioners will acquire this knowledge, as a consequence of working with children, or derive it from their own childhood, is not valid. In the main, sophisticated knowledge about child development is knowledge acquired first through study and is only secondly tempered by direct experience. We all have to work hard at acquiring this knowledge and this is particularly true for direct care practitioners. Another aspect of the problems, of course, is that it is very easy for practitioners to respond to institutional or program requirements rather than what I would describe as developmental or primary life requirements. The primary life requirement is that central core of care that I referred to earlier. In addition, all too often residential and daycare programs have an organizational format that emphasizes a hierarchical structure, with the direct care workers at the base of this. And, regrettably, the positions at the peak of these hierarchies often seem to be rather more valued than those at the base. The need to turn that organizational and value hierarchy around is now acute. This is a big demand and it places an enormous responsibility on the people who are in senior positions in programs. However, this need exists because the focus in programs needs to be on what goes on between the direct care worker and the child. The rest of the organization has to promote that and protect it. We have, in fact, yet to learn how to do this. In my view, if we do not make this shift, we will not be responding to the needs of the children and many residential and daycare programs will continue to be ineffective. What is likely to happen, then, is that other ways, other kinds of programs for responding to these needs, will be found.

There are, however, further problems for residential and daycare practice — frankly, an area that has too few frameworks that actually enable practitioners to think about the kind of work that they are involved in. Some of these difficulties stem from the historical heritage of this field of practice. This is because many residential and daycare programs were started by people who were incredibly well-motivated, but who can be described as being part of a broader child-saving movement. These people were immensely concerned, and rightly so, about two things. One was to take children out of family contexts that were unhelpful for them in terms of growth and development, and secondly, to take them out of poor social cir-

cumstances produced by a rather broader set of environmental factors. Many of the earlier programs for children, started by individuals with powerful social and religious convictions, illustrate this. These programs were, of course, important child care service developments. However, one of the difficulties with that approach is that, having removed a child from poor surroundings, the tendency was to think that the mission had been achieved when, in fact, it had just begun. Yet, there has been a great tendency for the residential and daycare field to want to justify itself by means of that one act of charity or intervention.

Increasingly, what we now talk about in evaluating the effectiveness of residential and daycare programs for children is not this point of entry issue, but two different sets of criteria. One is process criteria and the other is outcome criteria. We are, in fact, beginning to evaluate residential and daycare programs against what happens while the child is in the program and afterwards. The "process" is the way in which the program encourages development in children, while "outcome" criteria highlight what happens to the child once he/she leaves the program.

How well equipped, for example, is the child to manage in the adult world? Increasingly, thinking about residential and daycare programs is focusing on their use as arenas in which mastery and competence can be taught. It is, in that respect, very compatible with these evaluation criteria. Mastery and competence can, of course, operate at a number of levels. It can be at an educational level in terms of schooling, or it can refer to self-care abilities, as well as relationship skills. In fact, both process and outcome measures tend to focus on all of these areas of competence. Everyone knows that most adults survive in the world because they achieved mastery in some of those areas: in the educational area, in regards to work, self-care and relationship abilities. It is, therefore, not surprising that we are beginning to look at residential and daycare programs in this way as well.

In this respect, residential and daycare programs have now entered an era of accountability; it is professional accountability as well as cost accountability, and this is to be welcomed. It is a development that is long overdue and one which we should not avoid facing. Of course there is a problem, in that much of the evidence, in terms of process and outcome in relation to residential and daycare programs, is poorly collected. There is also a great deal of material which indicates that children leaving residential and daycare programs do not manage very well outside. That is, of course, where much of the criticism of these programs comes from, and rightly so. All practitioners must, therefore, be in the business of learning how to redesign their programs, and how to structure them so that they actually respond to developmental need and give children the mastery and competencies in the areas which have been identified.

Skills In Direct Care Practice

Until there is more clarity about the skills that direct care workers need to have, in order to help children grow and develop in the way described, it really is going to be very difficult to up-grade the level of practice and to respond to some of the issues referenced above. Clarity, in regard to this issue, would be an important step forward, in my view. This is because it would allow for a much more disciplined and systematic approach to practice. It is only if this is achieved that the professional recognition that is deserved by direct care practitioners is likely to be forthcoming. Let me say, however, what is meant by professional. From my point of view, being a professional is about using acquired knowledge and experiential wisdom in a disciplined manner in the service of others. It is important to see professionalization in this way. Many practitioners want to be more professional, but the problem is that it is easy to come across

negative examples of so-called professionals. This makes for a great deal of misunderstanding of current trends towards professionalization and the changes that this implies in the work that has to be undertaken on behalf of children. These objections are, however, clarified if the careful definition that is cited of what being a professional means, is used. In trying to think, therefore, about the skills that practitioners need, it is useful to envision an analysis of different types of activity that are to be found in residential and daycare programs. In doing this, it is possible to use two relatively crude, but nevertheless useful, distinctions. One is direct care and the other is indirect care. Direct care refers to the work that has to be done directly with children. Indirect care is the work that is done for and on behalf of children, but not necessarily in their presence. Recognition is, of course, given to the fact that these two types of activities are constantly interacting. Nevertheless, in my view, this simple distinction is helpful in beginning to think more clearly about the work undertaken in programs by practitioners. The problem is that when you enter a residential and daycare program, masses of events all seem to be happening at once. It is easy to be overwhelmed by all these events and to think that there is no way that these can be analyzed. Such a view is not, however, very helpful. The range of activities present have to be analyzed out, in my view, for purposes of understanding. What can then be done is to put them all back together again and, in the process of putting them back together again, we can understand the program activities and practice skills more fully. This issue can be thought about by drawing an analogy between a program and an onion. Each has many layers. And a program can, as an onion, be peeled. You can remove one layer and then you can remove another layer. But, of course, the point about that analogy is that one layer of activity or skills area does not an onion, program or practitioner make! In using this idea, it is then possible to put together a model (C.C.E.T.S.W. 1983) that contains eight layers or areas of activity or skill that direct care practitioners need to have. There is, of course, a problem in terms of which activity or skills area comes first. In one sense, though, it is not important because it is possible to start from either the center or from the outer layer. What is more critical is that the activity or skills area are identified correctly. What follows is such an attempt.

The first and outer layer of this model can be identified as the ORGANIZATION OF THE ENVIRONMENT. An illustration of this was given earlier when reference was made to the adolescent hostel, where young people were welcomed at the door warmly, but then taken into a rather poorly tidied room. That was a good illustration of the way in which the direct care practitioner had failed to organize the environment and, in so doing, had communicated very negative things. Direct care practitioners have to have a substantial understanding and skill in the utilization of the environment. All too often an environment is itself depriving. It may show in the clothes the children are asked to wear, or in badly equipped living space where they are expected to live and, as before, if insufficient attention is given to these factors, the messages are negative. In short, it does not matter what is said; if what is offered is an uncared for environment, it is that uncaring message that will get across and limit the usefulness of the work practitioners may want to do with the children involved. Quite clearly, this area of practice also has major implications for senior personnel who carry responsibility for purchasing and maintaining equipment. The focus here is, however, on the impact of these factors as they affect happenings between direct care practitioners and children.

The next skills area that I want to talk about is TEAM FUNCTIONING. One of the interesting things about residential and daycare practice is the extent to which it is team practice. More than in almost any other area of work, practice is about being a member of a team. The reasons for this are quite clear. A

direct care worker may work an eight-hour shift or possibly a five-day week, but then another practitioner covers his/her work for other parts of the day or week. Practitioners are, therefore, members of a team that hands over responsibility for work that they are doing to each other. In this instance, the analogy for me is that of the athletics relay team, where there are a number of members who, having completed their specific task, hand over responsibility for further progress to the next team member. The other thing about that is, of course, that unlike many other areas of practice, when direct care workers are on duty, what they are doing is observed not only by fellow practitioners, but children as well. So it is very much a fishbowl-type situation. Unless practitioners are comfortable with the other people in that situation, and they are in turn comfortable with the practitioner in question, it is going to severely influence the service that is delivered. The whole team approach is, therefore, of immense importance. There is also a third issue. This issue is about what a practitioner can claim responsibility for. In many areas of professional practice (e.g., for community based social workers), the worker may be the only person who ever sees a particular client. If you are a social worker in such a position, practice may involve journeys from an office to see a client, with that being the only contact between that person and the agency. Discussion with colleagues about the work that is undertaken as well as with a supervisor may also take place, but those colleagues and that supervisor may never actually see the work that is undertaken with the client. So, if some changes take place with the client, it is reasonably safe for the social worker to assume some measure of responsibility for them. That worker can give himself/herself some self-praise for what has taken place if the changes are positive. The position is somewhat different in residential and daycare situations because practitioners are members of a team, handing over work to other colleagues. So it is never really possible to claim that what happened with a particular child — that the development that took place — was because of individual work. All that can be said is *we* (the team) did that rather more than I (the practioner) did that. That makes a very substantial difference. Team practice can, however, be taught and can be learned, although as yet it rarely seems to receive much attention.

The third layer of the model is concerned with ACTIVITY PROGRAMMING. This is about education, recreational and leisure time activities. In any residential or daycare program there are always many types of activity of this kind taking place, and rightly so, because they provide good socialization opportunities for children. Children need good socialization opportunities, as well as nurturing care, if they are going to grow and develop. They need a variety of experiences. However, there is some evidence that recreational and leisure time pursuits, in the context of residential and daycare programs, have been used in rather an undisciplined way. They have been used as time fillers, to fill those empty hours on a Sunday evening, for example. It is, however, important to think through more systematically the ways in which we can use those events to enable children to have the kind of experiences that are relevant to their stage of development. Again, this is an area that requires thinking about, and warrants training input so that these things are done in a skilled way. It is no longer possible to allow activity programs just to happen. It is necessary to use them in a professional and disciplined manner.

The fourth area that warrants attention is WORKING WITH GROUPS. This phrasing is deliberate and is used in preference to Group Work, because as soon as you walk into a residential unit, you are faced with a group of children and staff. Similarly, as soon as you walk into a daycare program you are faced with a group. Now this is not to say that residential and daycare practitioners do not do work with individuals. Of course they do, but they are much more likely in the first instance to be faced with a group. It is, how-

ever, going to be the natural living group rather than some kind of specially constructed clinical enterprise. Part of the problem with much of the literature on group work, and certainly in the way it has been taught, is that it has tended to have a therapeutic or clinical focus. That is not the kind of group work which is of most use to child care workers. There is a place for some specialist inputs of this kind in residential and daycare programs, but that is not the major need. The major need is for understanding about group processes and knowing how to work with natural living groups in a constructive and positive manner so that they actually are comfortable places for children to be in, and a place in which children can learn, grow and develop.

My fifth layer is something that can be referred to as ON-THE-SPOT COUNSELLING. There is a massive literature aimed at enhancing counselling techniques, but so much of that has been built around a notion of one worker meeting with a client in some kind of private office situation. There may indeed be a place for that type of counselling in residential and daycare programs, but most of the counselling that is done with children in these situations is done in public, around ordinary events, in a very limited time period (possibly as little as five minutes). It is actually done, and most effectively done when, for example, a practitioner stands at a sink washing dishes with a child helping. Gradually, in these situations, practitioner and child relax and become involved in shared activity learning of the kind that was mentioned earlier. In the middle of this type of activity, children often start talking about issues that concern them, or alternatively practitioners feel comfortable enough to say to a child "What's happening about so and so" or "You said to me the other day something about . . . and it struck me that you were worried about it. What's going on." This is the kind of counselling that residential and daycare practitioners do all the time, although the importance of what they are doing is rarely given enough recognition. The other problem, of course, is that this type of counselling is almost always done as an adjunct to another event and within a limited time framework.

This type of counselling can be taught. It is possible to set up a video laboratory to teach practitioners how to do counselling of this kind. This needs to be done. It is this kind of on-the-spot counselling, when adults and children are relaxed, that takes place around a shared activity and daily life events, that is so full of importance. Good technique, time limited interventions with carefully planned goals, is the message here.

The next area of skill or layer of activity, and the sixth, is the USE OF EVERYDAY LIFE EVENTS. This does not need much elaboration as it refers to the kinds of things that Maslow noted in his hierarchy of human need. It is about the nurturing experience that stems from basic care activities and how you use these events to encourage growth and development. Getting up in the morning, having a shower, getting dressed, eating, and going to school are examples of these events — all of which have to be used very deliberately in order to convey nurturing care. This is because without nurturing care, children do not grow. It is just as simple and straightforward as that.

The final two layers of my model are DEVELOPMENTAL SCHEDULING and FORMULATION OF INDIVIDUAL CARE AND TREATMENT PLANS. There is some overlap between the two. Currently, there is a great deal of discussion in the area of residential and daycare service provisions about the need to individualize care and treatment plans for children. Fair enough. The issue is, however, how can this be done? No doubt many practitioners have, over the years, read many reports written about children in residential and daycare programs that are just unreal. They are frequently unreal because they fail to recognize that in meeting individual needs in these programs you have to do so in the context of the group. So you may get marvelous plans written by various other professionals that say what needs to be

done with a particular child, but which fail to take any account of the context in which this is going to have to be implemented. There is, therefore, a real need when formulating individual care and treatment plans to write these in realistic terms, bearing in mind that work with a particular child will not be happening in isolation from others. What we are talking about is practice that is shaped by a physical context and which involves a group of practitioners, working as a team with a group of children. If these facts are not addressed, then what is put forward is likely to be unrealistic. This all too often is the case. However, there is such a thing as DEVELOPMENTAL SCHEDULING. In my view, this is the way care can be individualized. Such scheduling refers to the detailed, step-by-step working out of plans for an individual child which a practitioner will systematically use, with the child's cooperation, to raise his/her level of social performance. This activity is at the heart of individualized care and treatment in residential and daycare centers. Because of the discipline required to achieve such purposeful use of time in a center, much commitment and knowledge of certain "out-of-place" behavior is required by practitioners. Illustrations of this type of scheduling might be teaching a pre-adolescent child how to collaborate with peers in team games or an age relevant older-adolescent skill, in regard to behavior in public in, say, a restaurant or cinema situation.

It is through these kinds of processes that developmental scheduling takes place. Workers undertaking these activities are indeed working as child development specialists. That, in the final analysis, is what residential and daycare practitioners who work with children have to be. The future now demands this of them.

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