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CHILD AND YOUTH CARE IN A CHANGING WORLD

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ABSTRACT: This paper offers a comparative overview of changing patterns of care in a changing world, focusing particularly on Europe, North America, and the South Pacific. Twelve comparative variables are used to focus attention on structural features of group care practice with children and young people in different parts of the world. Some wider points are made in relation to each variable on how to improve the quality of child and youth care services, by ensuring the appropriate use of group care services and by improving the quality of care offered by such services.

Introduction

Reflections are offered on residential child and youth care as practiced in both the Old and New Worlds during the past quarter-century. After qualifying education in America, more than a decade of group care practice, teaching, and research in Scotland and Northern Ireland (as a "come-from-away" Yank) highlighted the way that residential child and youth care services came to feature prominently in the provision of human services across Europe from as early as the Middle Ages, or even earlier (Fulcher and Ainsworth, 1985). A decade in New Zealand has presented alternative challenges and taught new lessons, arguably the most important being on themes of monetarist economic reform and the voices of indigenous peoples asserting self-determination over the care of their children (Rangihau, 1986).

Child and youth care in the so-called "New World" has grappled with a colonial history which saw the imposition and uncritical importation of institutional structures that were alien to the cultural traditions of indigenous peoples living there (Seed, 1973). The colonial structures of European residential care were used unsuccessfully to assimilate children from indigenous communities into European life in Southern Hemisphere colonies from the early nineteenth century. As de-institutionalization and de-colonization gained momentum, so residential child and youth care has changed. In what follows, an attempt is made to describe the general situation and make some wider points on how to improve the quality of group care services for children and youths, by ensuring the appropriate use of these services and by improving the quality of care they offer. The comparative model identified in *Group Care far Children: Concept and Issues* (Ainsworth and Fulcher, 1981), is used to highlight twelve structural features of changing care in a changing world. These include:

1. Social Policy Mandate
2. Siting and Physical Design of the Center
3. Personnel Complement and Deployment
4. Patterns in the Use of Time and Activity
5. Admission and Discharge Practices
6. Social Customs and Sanctions
7. Social Climate of the Center
8. Links with Family, School, and Community
9. Criteria Used for Reviewing and Evaluating Performance
10. Theoretical or Ideological Determinants
11. Cost Factors in the Delivery of Care Services, and
12. Organizational Turbulence External to the Center.

Each variable is used to highlight ways in which residential child and youth care services can be found operating internationally, and its potential influence on quality service outcomes (Casson and George, 1994; 1995).

Comparative Variable 1: ***Social Policy Mandate***

In the past two decades, major legislative and policy changes have altered the mandate of residential care and the way these services feature in national child welfare strategies. Contemporary policy has been shaped by: ***normalization, de-institutionalization, mainstreaming, use of the least restrictive learning environment, minimal intervention, and diversion*** (Fulcher and Ainsworth, 1994). In both Old and New Worlds, children still in receipt of residential care have more specialized needs. Many who used to be placed in residential care are now placed more appropriately with extended family networks, foster families or in semi-independent living arrangements in the community. The need for specialist residential services still persists in both worlds however, to provide for the needs of very troubled and troublesome children.

The social policy mandate and focus of care is today very different from what it was. It is interesting to note how colonial structures such as the English Boarding School and Approved Schools were exported to all parts of the Commonwealth where they have operated for more than a century as imported forms of residential child and youth care service. The English Approved School system, established to address problems of poor school performance, maladjustment, incorrigibility and delinquency, is now substantially different and largely dismantled. However, the English boarding school still has its Commonwealth variation in most parts of the New World, and these schools continue to educate the ruling elite of each new generation.

It may come as a surprise to learn that the 1950s Curtis Committee vision of family homes for Post-War English children was exported too. To this day, "family homes" confuse the development of quality foster care in New Zealand, since the two forms of child care were considered to

be, until very recently, one and the same! In a country which prided itself in establishing a "God's Own" vision of European utopia, New Zealand imported each new phase of social policy reform from post-War Britain, and refined that vision until 1984, by which time it had established one of the most elaborate Welfare States found anywhere in the world.

Changes in the social policy mandate for child care reflect transformation in political and professional attitudes towards children, and ideological assumptions about family responsibility for the care of children (Fox-Harding, 1991). Social, political, and economic changes over the past decade have been in the New World perhaps even more radical than Old World revolutions since the turn of the century. New World revolutions have not always been so protracted but the effects of social transformation have been no less significant. In the former Old World colonies of the South Pacific, **"community responsiveness"** and **"quality of services"** have became the rhetoric for public sector reform, cuts in public expenditure, and nonintervention in the lives of children (Fulcher and Ainsworth, 1994).

Comparative Variable 2: ***Siting and Physical Design of the Center***

In a changing world, there have been changes in the types of facilities used for residential care and treatment. One generalization is to say that facilities are no longer located in isolated areas. Centers are sited nearer to population centers where transport costs can be reduced and services made more readily accessible to a wider range of families, professional groups, and services. Another generalization is that residential services are smaller than they once were. The residential care village can still be found operating, whether in the Nineteenth Century "Samardo's Village" example just outside London, or the "Quarriers Homes" example at Bridge of Weir in Scotland, Twentieth Century examples of therapeutic community villages in Scandinavia, or SOS Children's Villages scattered throughout the developing world. All over the world, there are "purpose-built" residential facilities with the wrong purpose built into them! Facilities built in one decade have been difficult to adapt as concepts about child and family services changed. The idea that children in care should live in circumstances that do not distinguish them from other children is now common, and the doors in residential centers have fewer locks!

Other programs, notably Scouting, Outward Bound, and the New Zealand "Spirit of Adventure" sailing program, use bushcraft, life skills training and the development of group living to promote youth development. Programs known as **"te Kohanga Reo"** (literally translated as "language nests") combine child care and Maori language recovery, using child and family group life as the active medium for learning. Changing care in a changing world means that technology alone will not be successful, meaning that colonial knowledge and indigenous knowledge are both needed to promote effective child and family services.

Comparative Variable 3: ***Personnel Complement and Deployment***

The staff roster or work schedule is still one of the most important and least-used data sources relating to quality outcomes found in any residential child or youth care service. The most common arrangements are still either live-in houseparenting with relief workers, or team work where staff are rostered to share daytime, evening, and night-time duties in a weekly or monthly timetable. With smaller facilities, there are, generally speaking, fewer people to deploy and fewer live-in staff. In theory, at least, "community care" means that services in the community are accessible to people through targeted expenditure and purchase of service contracting with local providers.

The capacity of a team of carers to work together closely, with a shared vision and agreed practices, is vital if those carers are to deliver a service of consistent quality (Casson and George, 1994; 1995). Sadly, the most common approach to teamwork still involves re-creating the wheel. Length of service as a care worker is not always indicative of quality performance (Fulcher, 1983; Burford, 1990) in work with children in care, and in facilitating plans that will place them more appropriately elsewhere, hopefully within extended family networks. The ratio of male and female influences, and life experiences similar to those experienced by the children, are also important determinants of quality in residential services (Fulcher, 1991). Each time one hears, "Who's on duty tonight?" one gets confirmation of how this variable impacts on quality of care. Children make very discerning judgments about the carers in their lives, and about the care they receive from those carers.

Comparative Variable 4: ***Patterns in the Use of Time and Activity***

In residential care, the timing of activities is important if daily and weekly rhythms are to be established and maintained so as to facilitate opportunities for child development (Maier, 1979). Any young person who has lived in care knows how residents "almost always" know more about "what's going down" during the week than the staff do, except in the morning when nobody wants to get up for school! If purposeful use of time and activity is a core feature of quality care, then a starting point for evaluating these services must be the question: ***"What recurring patterns are there in the use of time and activity in this Center, and how do these support the mandated objectives of the service?"*** A Time and Activity Schedule can sometimes help.

TIME AND ACTIVITY SCHEDULE

Learning Objective: To identify and account for time and activity in the operation of one particular group care center. (Time refers to the maximum hours per week that clients and staff are engaged. Activity refers to both client and staff activities which relate to the center's operation.)

	MON	TUES	WED	THURS	FRI	SAT	SUN
0700							
0800							
0900							
1200							
1300							
1500							
1700							
1800							
1900							
2100							
2200							
2300							
2400							
0600							

Materials: Staff work schedule, graph paper, ruler, pencils, black pen, and Activity Schedule (if available).

Procedure:

1. Prepare a 7-day week calendar divided into 24-hour time blocks (see example above). In a day care center, block out all periods during which the center is closed.
2. Identify waking time and lights-out time for each day, or opening and closing times.
3. Identify meal times, school/activity/work periods, recreation periods and times for chores.
4. Identify all other "structured" activities in which residents are expected to participate each day.
5. Identify all free-time periods and time which could be used for other program activities.
6. Identify all time periods when residents are not available for program activities.
7. Identify when changes of shifts occur and what staff are on duty at any time the service operates.

One feature highlighted by the Time and Activity Schedule will be the extent to which ***the staffing roster shapes the program or the program is planned for particular children.*** Another pattern will be the extent to which ***transition periods are scheduled when predictable life crises for children and young people occur,*** such as at the start or end of school days, after meals, the start and end of weekends, or from one day to another, as in being home by midnight!

Child and youth care staff are encouraged at regular intervals ***to reconstruct a sequence of events in a center that may have developed into a crisis,*** such as when there has been an absconding, a theft, an assault, or a suicide attempt. Time and activity planning can also be used to ***introduce new energy into the life of a center*** when everyone complains of boredom (VanderVen, 1985). The Time and Activity Schedule also ***offers a valid and reliable research instrument*** that can be used to monitor program drift over time, or as baseline data for use in both formative and summative evaluations of service delivery with particular children or young people.

Comparative Variable 5: ***Admission and Discharge Practices***

In my view, the way that new members join into the life of group care, and rituals associated with how people leave are neglected aspects of practice in residential child care. Considerable teamwork and staff commitment is required to "connect" with a frightened or angry child entering a residential service. With staff turnover still high in most places, there are times when it is hard enough just "keeping the show on the road," let alone offer a personalized care and treatment program from the first "golden hour" of opportunity (Fulcher, 1994).

Rituals of initiation and induction to group life that take account of the developmental needs of each new resident are basic to the efficient and effective use of this costliest of all forms of human service (VanderVen, 1985). "Rites of passage," "graduation," "termination rituals," "rites of excommunication," "expulsion," and "last rites" are all important features of group life in any culture. It is in this sense that ***rituals of encounter*** between carer(s) and child, and between carer(s) and family, are critical to the quality of exchanges which follow. Oh, that our practices around beginnings and endings with children were informed more directly by the collected wisdom of learned teachers and elders! Where I live, workers still learn this lesson the hard way, without the benefits of training.

Comparative Variable 6: ***Social Customs and Sanctions***

Social customs involve the behavior expected of residents and workers in residential care. There are public and private customs, as found when observing children and staff together and when observing them when they are engaged in separate activities (Polsky, 1962; Roth, 1963). Interactions between residents and staff in group care settings have been the focus of ongoing study in both the Old and New Worlds since the

Second World War (Ainsworth and Fulcher, 1981; Davies and Knapp, 1981; Fulcher and Ainsworth, 1985), reinforcing the importance of public-private and overt-covert dimensions of group life. When considering sanctions, one examines the rules that frame behavior and which frequently involve economic or political acts by an authority to encourage or coerce others into conformity with norms of conduct and social order. Sanctions also reward behavior, as in sanctioning a treat or outing.

It is pleasing to see that some sanctions used in residential centers during the sixties and seventies, such as isolation rooms and physical restraint, are no longer so commonly used now. When physical restraint is required, such practices are carefully regulated by law. For that, acknowledgement must go to advocacy groups of young people in care for their efforts in promoting children's rights. At the same time, it is important to acknowledge Ugandan policy reforms that have closed exploitative children's homes, thereby reducing the number of deaths of children in care by a significant level in that country emerging from a history of colonial rule (Bukenya, 1996). These, and other advocates, have done much to expose the emotional, physical, and sexual abuse of children, so tragically linked with the history of residential services worldwide. That residential living has the potential to sanction abuse, as easily as it can actively promote the development of children and young people, bears testament to how powerful residential environments can be in shaping human behavior and promoting quality outcomes for children and families.

Comparative Variable 7: ***Social Climate of the Center***

The social climate of a residential service is grounded in the experience of every direct care worker who has "read" subtle indicators in the rhythms of care and taken action with children. Such rhythms of care have physical safety and bodily comfort at the "core of care" and "care for the caregiver" as an essential ingredient of quality child care (Maier, 1979). Many will know how Moos (1976) has devised a methodology for measuring social climate of residential care settings, and how this is now used extensively, in outcome studies of service production in residential care for a variety of clientele. The ***Relationship Dimension*** of social climate focuses on the extent to which people are involved in the environment, they support and help one another, and there is spontaneity and open expression amongst the members. The ***Personal Development Dimension*** focuses on personal growth and self-enhancement in the program environment. This varies from environment to environment, depending on *policy mandate*, funded purpose, and performance objectives. The ***System Maintenance and System Change Dimension*** remains fairly constant across all residential environments, focus on orderliness, clarity of expectations, degree of control, and responsiveness to change. There is still a tendency to take research measures developed in one cultural context, such as North America or Western Europe, and apply these naively in another context, such as South Africa, New Zealand, or

Australia. Those seeking to evaluate performance outcomes in residential care for children often fail to acknowledge how social climate, like personality, is embedded in culture. Different cultures give attention to different variables when trying to ensure that a social climate of care and support is available to their children. Here, the Maori concept of "*tahawairua*" gives acknowledgment to a spiritual dimension of social climate that is not easily identified in European "Old World" measures.

Indigenous people from around the Pacific Rim, in the Americas, and Africa are speaking out more loudly, and using Western law to show how traditional knowledge and practices can replace Western structures with practices that are more culturally responsive for their people. Across the world there is a continuing need to reassess the importance of culture and to preserve cultural values when planning and delivering services for children and families. My travels lead me to conclude that culture frames the quality of outcomes produced for children and families in receipt of services. There are no absolute measures of quality, save those that are accorded meaning within any given culture. Science trips up on this intellectual "banana skin" the world over.

Comparative Variable 8: *Links with Family, School, and Community*

Family involvement in residential services has long been identified with quality outcomes for children and young people in receipt of care (Burford and Casson, 1989). While there is often the rhetoric of family involvement, practice does not always follow the theory. Families still have to go to enormous lengths to stay involved in the care of their children when the State intervenes (Pennell and Burford, 1995). It is in the nature of residential care that family involvement presents a paradoxical reminder that family relationships and circumstances contributed to out of home placement. And yet, successful placement within the extended family network is likely to result in the highest quality outcomes for children long term.

One cannot avoid making links with the formal education system if seeking to provide quality care for children awaiting plans that will place them more appropriately elsewhere. One must live in hope that no child is now admitted to care, for no matter how short a period, without someone checking with that child and family members about literacy, numeracy, basic communication skills, and learning abilities that may be shaped by deafness, speech impairment, or specific learning disorders. This aspect of residential practice highlights interdisciplinary activity, where different professional boundaries and roles have to be crossed in order to focus on the needs of individual children (Hopkinson, 1985). In my part of the New World, there is not much that is positive to say about the links between special education, health, mental health, and welfare providers in support of children and families in need of care. Links with the local community remain central to the production of quality outcomes for children. Whether that community is welcoming, is responsive, is inclusive,

or is reactive to the needs of children and families is still vital to successful post-placement adjustment. In most places, community involvement just happens whether actively considered by residential staff or not.

Comparative Variable 9: ***Criteria Used for Reviewing and Evaluating Performance***

In most parts of the Western world, those involved in residential services are now required to evaluate the services they produce with clients. This takes time and involves a lot of paperwork! One finds criteria ranging from vague comparisons of one young person being like another, to elaborate schemes that monitor and evaluate psychosocial development and behavioral competencies. *Length of stay* is one performance criterion upon which most agree, and this has dropped over the past two decades. In some places, like New Zealand for example, the legislated length of stay for young offenders is now 8 to 12 weeks without further court action. While length of stay has become an important criterion in the evaluation of residential services, it is difficult to argue with scholars (Scull, 1977; Davies and Challis, 1986; amongst others) who have shown how cost has reduced length of stay more than any other influence.

As a practitioner in this field, experience has shown it is much easier to describe "Quality Outcomes" than it is to produce quality outcomes for children and families with any consistency over time. But the emphasis now is on measuring outcomes, and quality outcomes are essential when funding is dependent on performance. Children and families should benefit from such measures, so long as quality is measured in ways that involve them and take their views seriously into account. In New Zealand, service objectives for children and families are now linked with performance bonuses for staff in the post-1990 industrial relations arena (Harbridge, Crawford, and Kiely, 1996). Ironically, the more that is known about this field, the less one finds that practice wisdom readily available to front-line caregivers. Most still work from the heart (Guttmann, 1991).

Comparative Variable 10: Theoretical or Ideological Determinants

The technical, moral, and philosophical justifications used by the **"producers"** of a service to account for their activities with the **"consumers"** of that service are not always open to scrutiny. Justifications given by a junior staff member to a supervisor concerning his/her actions with a child are framed in very personal terms that reflect basic attitudes, beliefs, and moral values. Justifications can also be found embedded in religious beliefs (the Rudolph Steiner movement), theoretical orientations (behavior modification), political philosophy (kibbutzim) or indigenous practices (language nests). Israeli writers (Eisikovits, Beker and Guttmann, 1991; Arieli and Kashti, 1991; amongst others) have shown how collectivist ideology, which underpins the kibbutzim movement, is closely linked to the child-rearing practices found in these social laboratories

today. The same can be said of the New Zealand Kohanga Reo movement where "language nests" for Maori children, and those wishing their children to learn Maori, are guided by traditional knowledge (tikanga) and practices (kawa) handed down by the ancestors (tipuna) as treasures (taonga) from the Old Worlds of before. Immigrants to the South Pacific made various attempts to understand the ways of indigenous peoples. However, they set about establishing institutional structures that made sense to their Old World political and economic ideologies. Papua New Guinea offers a tragic example of how colonial rule by first Germany and Britain, then Australia until 1975, put legal and administrative structures in place that still have little meaning to the peoples of some four hundred mini "nation states," each with its own distinctive language group. Most living in the Northern Hemisphere will not know that Pidgin English is a corruption of German, English, and traditional dialects, and is the only way of communicating as one moves around Papua New Guinea.

One still finds in both the Old World and the New, that few residential centers have *a formal statement which articulates the knowledge and value base which informs practice in that service.* Collected wisdom (Philpot, 1984; Wagner, 1988; Kahan, 1989) substantiates the importance of a mission statement or statement of purpose which details and communicates a vision (Casson and George, 1994). More commonly found is how *the knowledge and value base which informs practice in residential care is dependent upon a particular carer or carers* and little is written down. In an era of cost-benefit analysis and measurement of service outcomes (Knapp and Robertson, 1989), only those programs that are clear about what they do and why, survive.

Comparative Variable 11: *Cost Factors in the Delivery of Care Services*

No single variable has impacted more on the quantity and quality of services for children in our modern World than the variable of cost. Whether one focuses on the plight of children in the refugee camps of Africa or Asia, or who pays for a young person requiring specialized residential treatment as a sex abuser, the outcomes are almost always now framed in financial accounting terms. Families able to pay for specialist treatment or with insurance coverage can now access the best services available anywhere. For those families who cannot pay, the situation is very different.

The New Zealand economic experiment (Kelsey, 1996) is one that has been closely followed by the international community. Fundamental to that economic experiment has been the notion of "purchaser-provider split" where the "purchaser" of services (usually government) is not responsible for the actual "provision" of services. Somebody else is and it is their responsibility, not that of Government! The dual role is now considered politically and fiscally incorrect, even though such dual roles have worked quite effectively in the Old World. One also finds in New Zealand a separation of functions in the state sector between policy and

operations, such that a standing joke confirms the right hand not really knowing what the left hand is up to, other than shuffling paper and answering ministerials.

We have shown elsewhere (Fulcher and Ainsworth, 1994) how the ideology of contemporary service reform in New Zealand has been shaped by monetarist economic policy and commercial accountancy practices, with little regard for notions of best practice about services for children (Mason, 1992). Professional supervision of practice is now, in many instances, extra to the employment contract. Quality outcomes for New Zealand children are largely measured now through public inquiry into deaths of children in care, disclosures of abuse and neglect by former carers, teacher shortages, long-term expulsions from schools, and a youth suicide rate that locates New Zealand highest of all OECD countries!

The so-called New Zealand economic miracle may not warrant all the positive international attention it receives, although the first election under Mixed-Member Proportional representation in 1996 introduced a new set of political ground rules around how "the miracle" gets managed. These days, unless individual children and families are targeted for special consideration, and thereby labeled and stigmatized as a family or child in need, they are on their own. There are no universal services. Everything is conditional upon user pays.

Comparative Variable 12: ***Organizational Turbulence External to the Center***

Legislative change and the restructuring of residential services at neighborhood level, as well as on a regional and national scale, has become commonplace in New Zealand, Australia, and South Africa over the past decade, just as happened in North America and the United Kingdom a decade earlier. Research offers important conclusions about how residential services are controlled externally, offering explanation for the way organizational turbulence external to residential services impacts on the quality of outcomes produced (Pfeffer and Salancik, 1978; Emery, 1977; Fulcher, 1988).

Rapid political and economic changes are being watched in countries like South Africa with large immigrant populations living with indigenous minority or majority populations seeking self-determination under the law concerning the affairs of their people. Few situations are more worrisome than community unrest relating to the care of children. As the political and economic ground rules change, so too, do the organizational and institutional structures that support children and families. Behind the rhetoric of political slogans like "Welfare to Wellbeing" lurks the face of institutional racism that reinforces social control through economic and public sector restructuring of opportunities for working class and indigenous populations. In New Zealand, public employees are expected to identify the Minister of State as their client, not the children and families to whom they provide services. Replays of "Yes, Minister" can be found operating in all Commonwealth countries and reassurances for children and families no less hollow.

Changing care in a changing world is another way of saying that organizational turbulence is now commonplace in the provision of residential services for children. There is less that is predictable in our world now, and there is much that is turbulent. The world stood still in numbness as images from the massacre of children at Dunblane Primary School in Scotland were beamed instantly to the world. All were touched by that unpredictable moment in time, just as we were stunned again by the massacre at Port Arthur in Australia, by a former youth in care. Similarly, our lives are touched by the media portrayal of frightened and hungry children in Africa, and the organizational turbulence associated with decolonization and tribal self-determination in the affairs of their world.

That child and youth care is a political activity is nowhere more evident than in the former Balkan republic where policies of ethnic cleansing have separated children from three cultures–each with significant religious, political, and military alliances–into Serbia, Bosnia, and Croatia. Organizational turbulence unleashed by the restructuring of state infrastructures, whether by military dictate, political mandate or market forces reform, continues to have a dramatic effect on children in both the Old World and the New. There is much to learn about how to sustain quality care in the midst of organizational turbulence and uncertainty. The alternative means accepting that children will keep being used as cannon fodder in the crossfires of revolution, civil war, or agency restructuring, where the ends always justify the means, no matter how many get hurt along the way. What price for the life of a child or the emotional impact of caring for a family member without support (Opie, 1992)?

Conclusion

An attempt has been made to describe the general situation facing residential child and youth care services in the Old and New Worlds, while making observations about the quality of service outcomes produced by these services. Twelve comparative variables underpinning the production of quality outcomes in residential child and youth care were used to highlight contemporary international themes in group care practice with children. These included:

1. Social Policy Mandate
2. Siting and Physical Design of the Center
3. Personnel Complement and Deployment
4. Patterns in the Use of Time and Activity
5. Admission and Discharge Practices
6. Social Customs and Sanctions
7. Social Climate of the Center
8. Links with Family, School and Community
9. Criteria Used for Reviewing and Evaluating Performance
10. Theoretical or Ideological Determinants
11. Cost Factors in the Delivery of Care Services, and
12. Organizational Turbulence External to the Center.

Mass media images of changing care in a changing world are beamed to us daily, offering momentary glimpses of suffering and terror in the eyes of children whether in cities, shanty towns, or the rural areas of our World. Also, the dreams of care still find expression in personal encounters between children and their carers everywhere. For those who still dream about quality care services being a reality for children and their families in your world, ***"May the Force be with you!"*** And ***"take care!"***

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