Myths Surrounding Residential Child Care

In recent decades I have witnessed an increasingly negative perception of residential care develop, which I believe does a disservice to young people requiring specific forms of care (Kendrick, 2013).

Residential care is compared unfavourably with foster care and non-residential care (Bates *et al*., 1997; Melton *et al*., 1998; Iwaniec, 2006). It is seen as too expensive relative to the outcomes achieved, many of which are considered poor. It is perceived as not facilitating attachment formation and providing unrealistic standards of living to children that they won't retain on leaving care. It is associated with scenes of past abuses and a confused theoretical base (Berridge and Brodie, 1996; Jones and Landsverk, 2006; McLeigh and Briddell, 2011). It is seen as oppressive by those advocating the tenets of normalisation, deinstitutionalisation, mainstreaming, minimal intervention and the use of the least restrictive environment (Fulcher, 2007).

This has been exacerbated by two factors:

1. Residential care has been used as a placement of last resort and not used for children most likely to benefit from it – the residualisation of residential care (Corby *et al*., 2001; Edmond, 2004; Foltz, 2004; Stevens, 2008; O'Sullivan, 2009; Smith, 2009). Rather, it is used for young people who cannot receive the support and/or safety they need from their own families or foster families, or who pose a danger to others. (Berridge *et al*., 2003; Whittaker, 2004; Little *et al*., 2005).

The picture today of residential childcare is one of inexorable decline, with a surviving residue of institutional activity now focused almost exclusively on children and young people seen as very hard to serve and a population deemed beyond the capacity of more community-based options. (Gilligan, 2009a:275)

2. There is a tendency for the problem under review to be associated with the child being in care rather than consideration of the factors that resulted in the child being admitted into care in the first place. (McSherry *et al*., 2008)

Several noted publications critical of the merit of residential child care have had lasting impact since the mid-twentieth century. John Bowlby, the noted attachment theorist, was critical of substitute care and very critical of institutional care for children.

It must be noted, however, that the institutional care he was critical of bears little resemblance to today's small group homes. His focus was firmly on the relationship

between the infant and the mother with his famous refrain, “Better a bad home than a good substitute” (Bowlby in Issroff, 2005:88). He did, however, relent somewhat from this position in later years and acknowledged that: Therapeutic residential child care of disturbed children had a role, if not something intrinsically desirable, at least as a practical necessity for the foreseeable future. (Bowlby in Issroff, 2005:89)

However, within this debate the distinction between therapeutic residential child care and institutional care, both physically and culturally, is seldom made clear.

As its name implies, a group home strives to offer a homelike environment not attainable within an institutional setting while removing the intimacy and intensity of a family environment. (Anglin, 2004:178)

Despite his retraction of his earlier unequivocal rejection of substitute care, and acknowledgement of the merit of residential care, Bowlby’s condemnation of institutional care for children has had long-term impact. It still reverberates today in the debate on the pros and cons of residential child care and foster care. Indeed, attachment theory – and in particular Bowlby’s 1951 Monograph for the World Health Organisation – lies at the heart of the English preference for foster care. (Petrie, 2007:77)

Goffman’s (1968) influential book *Asylums,* which developed an understanding of the impact of institutionalisation on human development, was another notable publication that was hostile to residential child care, as was Wolfenberger’s (1972) theory of normalisation (Milligan and Stevens, 2006a; Smith, 2012).

Anglin and Knorth cite the following from another influential publication, *The Stockholm Declaration*:

- There is indisputable evidence that institutional (i.e. residential) care has negative consequences for both individual children and for society at large.
- It is alleged that the UN Convention on the Rights of the Child includes an obligation of “resorting to institutional care only as a last resort and as a temporary response.

(Stockholm Declaration on Children and Residential Care, May 2003, cited in Anglin and Knorth, 2004a:141)

A meta-analysis by Knorth *et al*. (2008) challenges many of these erroneous assumptions, now widely taken as unequivocal, and particularly the Stockholm declaration statements as outlined above. In contrast, they find that residential care in fact improves the children’s psychosocial functioning and they conclude:

… the "indisputable evidence" that this form of care has (mainly) negative consequences for individual children and for the society at large, as stated in the Stockholm Declaration, has not been supported. (2008:133)

Indeed, since the turn of this century there has been an increasing body of research validating the place of residential care in the system of care (Anglin, 2002, 2004; Hair, 2005; Hillan, 2005; Little *et al*., 2005; del Valle *et al*., 2008; Bettmann and Jasperson, 2009; Lee *et al*., 2011; De Swart *et al*., 2012; Kendrick, 2012, 2013).

Children have expressed a preference for residential care over foster care, as evidenced within a study by Sinclair and Gibbs (1998). This study found that one in three children whom they interviewed expressed a preference to be placed in residential care over foster care.

In a European context del Valle *et al*. (2008) find:

The general dismissal of residential care, observed in many countries, has had the consequence of removing this type of provision from the political agendas of priorities in child care. At the same time, the population requiring child care is more and more problematic, and foster care services are finding it difficult to achieve stability and positive results.

The data indicate that residential care can make highly positive contributions, but for this there is a need to define its role (Utting, 1997) and its functions within the child care system. (del Valle *et al*., 2008:22)

Within the UK Kendrick makes the point that:

A number of national enquiries have concluded that residential care is a 'positive choice' for some children and young people (Kent, 1997; Utting, 1997; Shaw, 2007). (Kendrick, 2013:77)

With regard to the misinterpretation of the Stockholm Agreement, Ainsworth and Thoburn (2014) identify the role language may play:

However, while in the English language 'institution', 'children's home', 'group care facility' or 'residential treatment unit' may all be in use (sometimes synonymously but more often to denote different types of care regime), in many languages (Armenian as but one example) differentiation between 'institution' and 'children's home' translate as 'children's home'. (Ainsworth and Thoburn, 2014:16)

Ainsworth and Thoburn also identify that the research carried out in the latter half of the twentieth century which led to these alleged negative effects of institutional care

becoming identified as prevalent were of a design that would not be acceptable by today's research standards. They find that therefore "the conclusions drawn from the research should be viewed with some caution" (2014:16).

A further major factor underpinning the residualisation of residential child care arising from the Stockholm Declaration is the identification of the "least restrictive" placement option as the preferred choice. This has led to child welfare professionals placing children in residential care, which is perceived as a restrictive placement, only after the young person has been placed in a number of less restrictive options, such as kinship or foster care, and only after these have broken down (Hannon *et al*., 2010; Jones *et al*., 2011). Stuck *et al*., (2000) identified a "systemic bias" amongst child welfare professional towards the least restrictive option:

The linear model creates a crisis driven system in which movement along the continuum frequently only occurs after placement disruption. (Stuck *et al*., cited in Owens, 2008:20)

In addition to the above-cited growing body of research that challenges assumptions created by the Stockholm Declaration, in his review of residential child care treatment, costs, placement stability and outcomes, Sunseri (2005) found that: ... when the appropriate level of care is selected at the outset, the majority of residents will exit the residential care system and return home or go to home-like settings. (2005:62)

This, according to Sunseri, resulted in a cost saving for the state over repeated failures within less expensive placements which recurrently break down. It has been my experience that some children prefer residential care over foster care, a point made by Milligan and Stevens (2006) and Kendrick (2013). Furthermore, residential care and social care can be seen to be dominated by social work and legislative paradigms. The latter were introduced via the multiple inquiries into abuse within residential care which occurred in the 1970s and 1980s with the legislature remaining *in situ* ever since (Howe, 1998). It has also been my experience that our profession has become increasingly litigious over this time with insurance requirements increasingly encroaching into practice. For example, a manager might be forbidden to apologise to a staff member who may have been injured at work as this is deemed as an admission of liability by insurers and as prejudicial to the case. This can inflame staff and management relations and foster adversarial practice.

The transition from institutional care to community-based lower-occupancy residential centres was decreed internationally within the Stockholm and Malmo Declarations (Angling and North, 2004), and in the Republic of Ireland in the Kennedy Report (1970) and the Task Force Report on Child Care Services (1980).

The Task Force Report recommended that community-based homes catering for between seven to nine children be established in well populated areas to replace reformatories and industrial schools. However, given that both social work and justice (legislative paradigms) look primarily at the individual, as opposed to the community dimension, this prompts three questions:

1. Current residential centres and residents are often not truly integrated into the local community whilst retaining the hallmarks of institutions and commercial buildings – internal signage, emergency green lighting, self-closing doors, etc. Have we merely moved large institutions into community settings with lower numbers of residents, in essence creating micro-managed mini-institutions?

2. Given the incremental reduction in occupancy levels in residential centres over recent years, with many now registered for three placements, what empirical evidence is there that this reduction is producing better outcomes?

3. Have the aspirations of normalcy identified by Goffman's and Wolfenberger's work been achieved in the move to community-based settings, or has the preoccupation with risk and proceduralism which dominate current practice negated many of the desired benefits in this transition?

We shall return to the first question in the next chapter and consider in more detail the issue of the location of children's residential homes. There is, however, little doubt that the move away from large institutions played a key role in eliminating the abuses that formerly occurred in these institutions. The location within more public community-based settings was an important factor in achieving this essential outcome. Here, greater visibility of the operation of these centres, and therefore protection to the children, was an important factor. The absence of mechanisms for children to voice what was happening to them in the former institutional settings was identified as a significant factor in facilitating the abuses that occurred. The promotion of children's rights, with robust complaints procedures now enshrined in all residential centres, has also addressed this issue, though ongoing vigilance is essential to ensure implementation. However, these abuses were not universal occurrences within residential care (Smith,

2009) and we need to be wary of universalising what is (or was) the particular (Bourdieu, 2000).

Many of these shocking abuses were not associated with the residential or group care model; rather, they were associated with the management, staffing, location, structure, practices, cultures, oversight and regulation of these institutions. Consequently, the move to smaller occupancy centres was but one strand of multiple processes which jointly resulted in the elimination of abuses. Effective recruitment, vetting and training of staff with double-cover staffing becoming the norm, where each staff acts as an observer of the other's practice, combined with robust management, child protection structures, culture improvements and inspection and monitoring regimes remain key factors.

What impact have the State's responses to the systemic abuses within the former institutions and the role of Religious Orders in this abuse had on the development of residential children's services in the Republic of Ireland?

Have these responses contributed to the current imbalance in the tension between a child protection or child welfare orientation to social policy and social services (Spratt, 2001; Hayes and Spratt, 2014)?

If so, now that this systemic abuse has been eliminated is it time to re-evaluate this relationship given that there is a growing body of data highlighting the negative potential of policies more orientated towards child protection than child welfare (Lonne et al., 2009, Munro, 2011, Featherstone et al., 2014 cited in Smith, 2014)?

A recent research report by Biehal *et al*. (2014) investigated the issue of abuse and neglect of children in care in the UK. Encouragingly, recent studies of children's homes in the UK have not evidenced abuse by staff, although these studies did not have a particular focus on allegations (Bridge *et al.*, 2008; 2011; 2012). (Biehal *et al*., 2014:123)

Notably, this research found no incidence of sexual abuse within residential care reported to the researchers from the sample group of 211 Local Authorities in the UK during the period 2009-2012.

The research identified that there were between 1,100 and 2,500 allegations of abuse or neglect within residential care each year with 21 to 23 per cent of these confirmed as abuse or neglect.

This means that there was an estimated 250 to 300 confirmed cases per year during the period under investigation. It is noteworthy that more than half of the cases concerning residential staff were categorised as either physical abuse or use of excessive physical

restraint. These cases were similar in nature, generally involving staff reacting inappropriately to episodes of challenging behaviour by young people. The fact that this does not include abuse by peers or those outside of the centres is noteworthy. Additionally, many of the cases reported occurred in secure settings where restraint may be more frequently employed, and challenging behaviour more frequently exhibited, and there is no way of determining how many of these cases related to general residential care.

In foster care they found that there were on average 2,000 to 2,500 allegations of abuse or neglect each year with 22 to 23 per cent confirmed. This means that there was an estimated 450 to 550 cases confirmed per year. The abuse confirmed within a subgroup of 118 confirmed cases comprised 37 per cent physical, 30 per cent emotional, 17 per cent neglect and 11 per cent sexual (another 15 were reported to concern poor standards of care falling short of abuse). The lack of oversight in foster placement was cited as a likely factor for the actual number of cases being higher than that recorded. The frequency of social worker visits and time spent alone with the foster child were also identified as significant factors in facilitating disclosure of abuse by foster children. In addition, foster children in long-term placements were identified as requiring ongoing opportunity to make disclosures. Almost half of the foster carers involved in cases that were substantiated had been the subject of previous allegations.

There are many variables that require factoring in before making determinations based on these findings. For example, children placed in residential care, especially residualised residential care, may present with different propensities for making allegations than those in long-term foster care. However, this report does contribute valuable knowledge to an under-researched area and highlights where further research might be needed.

From the limited evidence currently available, it is not possible to tell whether the apparently higher rates of allegations or confirmed abuse or neglect in foster care reflect a real difference in the extent of actual abuse in different settings, or simply differences between settings in the level of reporting of abuse or neglect. (Biehal *et al*., 2014:31)

The failings of foster care are being identified on an ongoing basis within the Republic of Ireland (Children's Rights Alliance, 2010a; EPIC, 2011a; HIQA, 2013, 2014) and internationally (Doyle, 2007; Smith *et al*., 2013).

We have known for some time that many foster carers have not been subject to adequate checks and that large numbers have not been trained. This has proven a risk to the safety

of children and recent proceedings in the high court have established that the risk is in fact a reality (IFCA, 2012).

Alarmingly, a HIQA Follow-up Inspection on the Implementation of National Recommendations to Health Service Executive Foster Care Services (2011a) found that of the twelve overarching recommendations made in 2010 only one was fully met. A further nine were partially met and two continued to fail to meet the required standard. Of the 58 sub-recommendations made in 2010, 33 remained not met with 21 partially met in 2011. The conclusion of this report states:

The inspection process highlighted continuing deficiencies in the HSE foster care service that may compromise the safety of some children and effectiveness of service delivery. Therefore, considerable improvement is required in the implementation of many of the recommendations of this report, including:

- the implementation of Children First: Guidelines for the Protection and Welfare of Children;
- the development of national registers of children in foster care and their foster carers;
- assigning every child and foster carer a social worker;
- assessing and vetting of all foster carers;
- assessing the needs of children with disabilities in foster care;
- developing a care plan for all children in foster care.

Internationally, Jones and Landsverk (2006:1153) make the point:

The empirical literature on foster care has not demonstrated that the presumed problems with residential care have been solved by foster care. The reality is that for some young people residential care is the best option, and this has proven to be the case internationally where, just as within the Republic of Ireland, there has been a concerted drive to minimise, if not eliminate, residential care (Iwaniec, 2006). Through my practice experience I have known young people who struggled in foster care settings but thrived in residential care. For some, as with Keith, they remained emotionally connected to their parent(s) and/or family who, for whatever reasons could not adequately care for them. These young people may not be able to tolerate adults who they perceive as attempting to recreate or replace their parents or family. For them, residential care is appropriate as multiple adult carers best meet their needs

(Ombudsman for Children, 2013). It may be that the levels of intimacy are more tolerable for these young people in residential care with its often unappreciated "'extrafamilial home' dimensions" (Anglin, 2004:178). For some: ... residential care can allow a space for insight into previous experiences that can emanate from family frustrations which a repetition of family-based placements does not allow. (ICHA, 2014:12)

There are also young people with complex needs where the availability of resources within residential care, with qualified staff rotating every 24 hours and thus continuously refreshed, is preferable.

Anglin (2004) identifies the personal ownership of property implicit within foster care, as opposed to the organisational ownership implicit in residential care, and the impact this has on carers' ability to tolerate property damage. He also identifies supervision of residential staff, which foster parents do not receive, as another significant factor. Additionally, children placed in foster care are often expected to fit within the family routines which, for some, can be problematic. In residential care the routines of the centre are adapted to fit the needs of the child.

A Save the Children study in Scotland by Monica Barry (2001) substantiates many of these points:

Most of the sample had experience of both foster and residential care, whether as respite, short-term or long-term placements. Many respondents felt that they could not relax in foster homes, partly because it was someone else's house but mainly because they were wary of carers usurping the role their own parents should have been taking. They often felt that the carers own children were given preferential treatment, leaving them feeling alienated. Foster care was seen to have more rules and idiosyncrasies than residential care, with carers often being older people with limited training in childcare or counselling. There also seemed to be a higher incidence of neglect or physical abuse in foster care than in residential care.

Residential care, on the other hand, was seen to be less intense. One could blend into the background more easily in a unit than in a family – and there were always other young people around and a wealth of different adult personalities and perspectives. (Barry, 2001:13)

Therefore, minimising the usage of residential care based on erroneous assumptions and fiduciary agendas has the potential to deprive some young people of being appropriately placed. This weakens the entire care system, causing further and unnecessary harm.

Australia is one such example where residential care was so reduced that, when needed, appropriate placements were no longer available for some children, as identified by Ainsworth and Hanson:

Australian children and young people who might well have been placed by child care and protective services in residential programmes are in desperate circumstances when foster care fails, as no other alternative exists. (2009:147)

The place of residential care within the system of care is of major importance when considering the outcomes of care leavers. Stable placements and meaningful relationships in care are indicators of positive outcomes (Clough *et al*., 2006) and residential care has a key role to play in meeting the complex needs of many children requiring out-of-home care. The residualisation of residential care needs to be redressed and the service utilised as placement of choice for those children who will benefit from such placements (Anglin, 2002; del Valle, 2008; Kendrick, 2012; Ombudsman for Children, 2013).

Residential care cannot be seen as a last resort as this is a grossly unfair message to young people. It indicates that it is their fault that they are in care and residential care and does not provide a sense that residential care is a positive option for them, a decision they made in the interest of their life chances. (Hillan, 2005:4)