**Residential Child Care: Learning from International Comparisons**

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**Introduction**

Over recent years, residential child care has come under increased scrutiny, and there has been marked ambiguity in policy debates about its roles and functions within the range of child welfare services. Considerable concern has been expressed about the institutional abuse identified in countries around the world. Questions have been asked about the effectiveness of residential care in comparison with alternative services. The often difficult experiences of children and young people leaving residential care – particularly those leaving care to independence – have raised questions about policies and practice. The ongoing focus on the importance of the family and family-based care settings has been contrasted with the ‘institutional’ nature of residential care. These discussions have played out in different ways across the world. It is the aim of this chapter to highlight the main issues to see what lessons can be learnt from comparison with residential care in other countries. The potential scope of this endeavour is huge and we have therefore had to be selective in the examples used, but we hope to contribute to the positive development of residential care.

International comparison of policy and practice can challenge assumptions and bring contrasting perspectives to similar social problems and solutions (Francis, Kendrick and Poso, 2004; Peters 2008). It highlights the very different issues which residential services may have to address in diverse social contexts. In an increasingly globalised world, international comparison can also guide us with developments in our own countries, as with residential care of unaccompanied asylum seeking children in the UK (Kendrick, 2008a).

The diversity of residential child care across the countries of the world cannot be underestimated, nor the often rapid pace of change (Courtney and Iwaniec, 2009). Nevertheless, it is important that overarching trends in residential child care are recognised. For example, in the developed world there has been a move away from large-scale, institutional care to smaller, residential provision, and to foster care and community services (although these trends are not necessarily uniform across countries). The issues addressed by residential care also vary widely. In certain countries, residential provision has developed in response to problems such as disaster relief, caring for the orphans of AIDS, and addressing widespread poverty and deprivation. In other countries, the focus is much more on child protection, offending behaviour and family welfare. Models of care differ widely, from large scale institutions providing basic care and education for children to specialist small scale provision offering therapeutic services. Standards and quality of residential provision are at different stages of development, as are the education and training of residential child care workers.

Underpinning this diversity of provision, however, it is important to acknowledge the underlying principles of the United Nations Convention on the Rights of the Child (UNCRC). While there are serious debates to be had about impact of cultural, social and economic contexts on the provision of residential child care, the UNCRC makes clear statements about children’s rights to provision, participation and protection, and we will locate residential child care in this children’s rights framework.

**Issues in International Comparison**

While international comparison can provide us with useful lessons and help us question the way in which we approach residential services and practice, we must also acknowledge significant difficulties in such comparative analysis.

There is a lack of comparable cross-national statistical information, particularly in the developing world. Colton and Williams (2002) noted the dearth of adequate information om Europe on basic questions such as the number of children entering and leaving residential care each year. Courtney and Iwaniec (2009) comment that “the nature and availability of historical and empirical literature on residential care varies considerably from country to country” (p. xiii). Interpretation of this information is made difficult by the use of differing terms and definitions; or the different meanings attached to similar practice. Cameron and Moss (2007, p. 23) highlight the difficulties posed by language in their research on care work in Europe, and state that it is difficult to find a satisfactory solution to this problem. The definition of residential child care is problematic in itself, and the different models of care emphasize this. The overlap between residential care and other forms of institution – such as hospitals, boarding schools or penal establishments – will vary according to local context.

Another important issue is that the context of residential care also varies widely in terms of political history, economic arrangements, and legal and administrative frameworks (Colton and Hellinckx, 1993; Sellick, 1998). Residential care cannot be considered in isolation from these wider factors and it is sometimes problematic to work out the full implications for residential policy and practice. This also means that markedly different populations of children and young people use residential care in different countries. This may be most obvious in the use of residential care in the developing world for very young children, but even comparison of residential care in the countries of Western Europe identifies significant differences in the residential care population (Francis, Kendrick and Poso, 2004; Cameron and Boddy, 2008).

Given these issues, we must be at least a little cautious when we look to apply the knowledge and practices from other countries to our own residential child care settings (and vice versa).

**International Statements on Residential Child Care**

As well as establishing more general rights to participation, protection and provision, the United Nations Convention on the Rights of the Child makes relevant comments in relation to children in state care. Article 3 sets out that the best interests of the child shall be the primary consideration in all actions concerning children, and that “institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision” (UN Convention on the Rights of the Child).

In addition, Article 19 of the UN Convention on the Rights of the Child stresses that all children should be protected from abuse and neglect “while in the care of parent(s), legal guardian(s) or *any other person who has the care of the child*”*.* Article 20 goes on to state that a child deprived or removed from his or her family environment “shall be entitled to *special protection* and assistance provided by the State” (UN Convention on the Rights of the Child, emphasis added). These articles have particular pertinence in relation to the evidence of abuse in residential care which has emerged over recent years (Kendrick, 1998). Article 25 establishes the right of a child who is placed for the purposes of care, protection or treatment to have their circumstances periodically reviewed. These, then, should be established rights for children in residential care across the world.

However, ambiguity about the role of residential child care in the provision of services for children and young people is apparent in two international statements: the *Stockholm Declaration on Children and Residential Care* (2003) produced by delegates to the 2nd international conference on children and residential child care; and the *Malmo Declaration* made by delegates of the 1986 International Federation of Educative Communities (FICE) conference..

The earlier Malmo Declaration highlighted the move from large institutional residential settings to new models of ‘community’ residential care which are treatment-oriented, interdisciplinary, and interacting more positively with parents, social networks, neighbourhood and community.

 “Care in residential settings must continue to provide a positive atmosphere and a comprehensible environment for those who live in them, giving them the opportunity to create their own network of dependable social relationships” (Malmo Declaration, 1986)

The later Stockholm Declaration in contrast stated that:

 “There is indisputable evidence that institutional care has negative consequences for both individual children and for society at large. These negative consequences could be prevented through the adoption of national strategies to support families and children, by exploring the benefits of various types of community-based care, by reducing the use of institutions, by setting standards for public care and for monitoring of the remaining institutions” (Stockholm Declaration, 2003).

The Stockholm Declaration therefore calls on governments to “restructure the system of public care in order to diminish the use of institutions, develop alternative care approaches and strengthen effective community-based preventive and protective social services”. While the Malmo Declaration contrasts institutional settings with new models of residential care, the Stockholm Declaration treats all residential care as institutional and contrasts this with family settings. Courtney, Tolev and Gilligan (2009) suggest that:

“a casual reader of the *Stockholm Declaration on Children and Residential* Care might easily conclude that the nations of the world had declared as a goal a definitive end to a centuries-long period in which dependent children had lived in group settings away from family and that a clear road map existed to a future that would be free of residential care.” (Courtney, Dolev and Gilligan, 2009, p. 191).

Now, there is much in the Stockholm Declaration to be commended and supported, including the emphasis on a rights-based approach to children in public care, the need to adopt standards for public care and proper monitoring arrangements, Indeed, we support development of effective family-based and community-based services for children and young people. However, we must agree with Anglin and Knorth when they counter that ‘for many young people… good residential care is not a last resort, but rather a preferred and positive choice when their developmental challenges indicate the need for it’ (Anglin and Knorth, 2004, p. 141).

As we will see, these two Declarations reflect the ambiguities and tensions in the practice of residential child care across the developed and developing world.

**Residential Care in International Contexts**

*International Trends in Residential Child Care*

Courtney, Tolev and Gilligan (2009) stress that the pathways and development of residential child care in different countries of the world results from the interplay of a series of economic, political, ideological and cultural factors in conjunction with what they term ‘precipitating events’ such as abuse scandals or disease. Economic development creates the demand for residential care because of the break down in family and community structures. It also can create the supply of residential care because of economic surpluses which go into public welfare services, although “… the relationship between national prosperity and the use of residential care is complicated by the fact that nations can invest their wealth in very dissimilar ways” (Courtney, Tolev and Gilligan, 2009, p.193). Political, religious and cultural factors also play a significant part. Religious organizations have been central in the development of residential care, sometimes through colonial or foreign religious organisations. These have played a significant part in the most negative uses of residential care in relation to the relocation and resocialization of indigenous populations, for example in Australia, the USA and Canada (Ainsworth and Hansen, 2009; Miller, 1996). Broader cultural norms can affect the balance between the use of residential care compared to foster care. For example, traditional views of the family in Japan have led to the predominance of residential over foster care – in 2007, less than ten per cent of children in state care were in foster families (Ocheltree, 2010). Political ideology can most readily be identified in the development of institutions in the communist states of eastern Europe after 1945, and attempts to move away from institutions with the breakdown of communist states (Courtney, Tolev and Gilligan, 2009).

‘Precipitating events’ such as disaster and disease have made significant impact on the development of residential care in some areas: “… the worldwide HIV/AIDS epidemic has been one of a number of contributors to the demand for residential care in some places and may prove to be a decisive factor in others” (Courtney, Tolev and Gilligan, 2009, p.199; see also Morantz and Heymann, 2010). While such events may be drivers for the increase of residential care, other factors have resulted in a reduction. Abuse scandals have negatively affected the development of residential care in a number of countries, More positively, the increasing focus on family involvement in residential child care has been another important factor in driving forward agendas for change (Barth, 2005; Hill, 2000; Shaw and Garfat, 2003).

*Developments in the UK*

The focus of this chapter is on international comparison, but a feature of the UK is that social work and child care is a devolved matter, and residential child care has developed differently across the four nations. Mirroring trends in other countries of the developed world there have been significant changes in residential child care across the UK. Most significant, perhaps, is the marked reduction in the size of the sector across all the countries – linked to the shift towards preference for family setting and the concerns raised by inquiries about residential care (Bullock and McSherry, 2009; Kendrick, 2008b; Mainey *et al.* 2006). However, there are marked differences too. The sector in England and Wales has seen a marked increase in private provision, so that in 2004 almost two thirds of residential establishments were owned privately. In contrast, there were no privately owned establishments in Northern Ireland, and few in Scotland. Here the majority of establishments are run by the statutory sector (Mainey *et al.* 2006; see also, Bullock and McSherry, 2009).

All four jurisdictions have seen an increasing focus on improving the quality of residential care provision. Services must be registered with care commissions, and they are subject to regular inspection against national care standards. The workforce has to be registered, and there are standards of conduct and practice and codes of practice. The councils are empowered to discipline individuals and, ultimately, remove them from the register (Mainey *et al*, 2006; Kendrick, 2008b).

An important difference among the countries of the UK is the qualification standards of residential child care staff. In England, Wales and Northern Ireland, the minimum qualification for care workers is the National Vocational Qualification (NVQ) 3 in Caring for Children and Young People, while in Scotland care workers need to hold both a Scottish Vocational Qualification (SVQ) or NVQ, and an HNC or equivalent. Managers in Northern Ireland must hold a Diploma in Social Work (DipSW), those in England, Scotland and Wales a DipSW or S/NVQ 4 (Campbell, 2006). Interestingly, in practice Northern Ireland has a much higher proportion of qualified staff, with half holding a professional social work qualification (Campbell, 2006).

*Residential Child Care in the Developed and Developing Worlds*

The factors that have led to the decreasing use of residential care in the UK, have led to a similar trend across the developed world (Colton and Hellinckx, 1993; Courtney and Hughes-Heuring, 2009; Hellinckx, 2002; Sellick, 1998). As we saw above, in countries such as Australia, Canada and the USA, the role of residential care in the forced assimilation of indigenous peoples has also had significant repercussions for the use of residential care. This included the marginalisation of residential child care - ‘what is left of the residential care systems arouse suspicions and a sense that they are no more than a necessary evil’ (Hellinckx, 2002, p. 76). Ainsworth and Hanson (2009) argues that in Australia, this has been taken to such an extreme that:

 “Australian children and young people who might well have been placed by child care and protective services in residential programs are in desperate circumstances when foster care fails, as no other alternative exist,” (Ainsworth and Hansen, 2009, p. 147).

Use of residential care, however, varies widely. In the USA, about one-fifth of abused and neglected children are in residential care (Courtney and Hughes-Heuring, 2009). In Europe, in some countries like UK and Norway, most children and young people are placed in foster care. In others such as Denmark, France and the Netherlands, there is a more equal balance in the two types of provision. However, in Southern, Central and Eastern Europe, residential care is predominant, although del Valle *et al.* (2008) note the rapid recent changes in residential provision in Spain. Even within countries there can be wide regional variations (Colton and Hellinckx, 1993; Sellick, 1998). Moreover, trends are not uniform. Knorth (2002) notes that in the Netherlands, despite explicit government policy to reduce the use of residential care, provision increased by more than ten per cent between 1991 and 1999. Sellick (1998) highlights the much slower pace of change in Central and Eastern Europe.

The issues involved in comparing residential child care provision is equally pronounced when the focus moves from the developed to the developing world. Similarly, the tensions reflected in the Malmo and Stockholm Declarations remain evident. From some of the literature available what is perhaps most apparent is the wide variability in provision and the dominant role of ideology and ‘precipitating events’ in influencing this.

In many developing countries, the largest child welfare problem is that of orphaned children and much of the residential provision which exists, along with other kinship and community based responses, are a direct consequence of disease, notably HIV/AIDS (Maundeni, 2009; Morantz and Heymann, 2010; Stout, 2009), natural disasters such as the South Asian tsunami of 2004 (Wanat *et al.*, 2010); war (Wolff and Fesseha, 2005); Although the extended family is considered the best place to care for children, social and economic changes and the large increase in the number of orphaned children caused primarily by HIV/AIDS, has resulted in recent growth in residential provision (Maundeni, 2009; Stout, 2009). There has been a significan involvement of NGOs in the establishment and delivery of residential provision in Africa. This is mirrored in other parts of the world, particularly in countries such as Cambodia where political and social upheaval has left a continued legacy of orphaned, abandoned and vulnerable children (Emond, 2010). However, as exemplified in the Malmo and Stockholm Declarations, there is continued disagreement regarding the role of residential care. There is concern that residential establishments are developed inappropriately, with a lack of quality which damages children’s development and jeopardises their rights (Swales, Geibel and McMillan, 2006; UNICEF, UNAIDS and USAID, 2004).

The attitudes in Botswana and elsewhere that oppose residential care contrasts with the history of countries such as Brazil. Here there is a long established tradition of residential provision, albeit one which is being increasingly questioned as a consequence of a shift in attitudes regarding the rights of the child (Rizzini and Rizzini, 2009). Significantly, recent research conducted in Cambodia, Ethiopia, India, Kenya and Tanzania concluded that in terms of health, emotional and cognitive functioning and physical growth, outcomes were no worse for institutionally-based children than those experiencing community living (Whetten *et al.,* 2009). Wolff and Fesseha’s (2005) study of Eritrean war orphans takes us back to the Malmo and Stockholm Declarations. This research compared the outcomes for children in four settings: home reared children with their own mother, reunified orphans and their host mother; orphans in small group homes with their host mother, and orphans in a large institution. Those placed in smaller group homes had fewer signs and symptoms of emotional distress and greater adaptive skills not only compared to those in orphans but also those who were reunified. Indeed, they had fewer symptoms of emotional distress than home-reared children. While acknowledging that this was an expensive option, Wolff and Fessaha conclude that:

a dedicated society raised on principles of self-reliance can create humane, sustainable, and culturally appropriate programs of residential group care at the community level that do not depend primarily or exclusively on the technical guidance and financial support of international relief agencies (2005, p. 482)

**Ways of Understanding the Work of Residential Child Care**

While residential child care is located under the broader umbrella of social work in the UK, in many European countries people who work in residential child care are trained as, and consider themselves to be, social pedagogues—a distinct discipline from social work. Social pedagogy can be defined as the education of children in the broadest sense (Petrie, Boddy, Cameron, Wigfall, & Simon, 2006), promoting “wellbeing through broadly based socio-educational strategies” (Smith & Whyte, 2007).

 In North America, South Africa, New Zealand, Australia and some parts of South America, residential child care falls within the child and youth care (CYC) profession, which is also a discipline distinct from social work. CYC can be defined as the development of relationships with children in their lifespace, and in the context of those relationships, helping them to “find different ways to live—ways … less painful for them and those in their lives” (Garfat, 2009, p. 57).

Shared ideas amongst all three of these traditions are not new, though wider contexts of globalisation and technology appear to be increasing the volume of collaborative, “cross-fertilized” thinking and writing about residential child care practice. The most dominant and overarching of these themes is the centrality of relationship to good practice. Relationship has long been seen as the heart of residential child care practice in the UK (Ward, 2007), and the “conscious use of relationships between the Social Pedagogue and the young people” has been identified as the “essence of social pedagogical practice” (Bengtsson, Chamberlain, Crimmens, & Stanley, 2008, p. 9). Similarly, CYC has historically located relationships with children and their families at the centre of practice. As the field has developed, notions of providing therapeutic relationships have evolved to a more sophisticated form of *relational practice*. From a CYC perspective, relational practice is more than a worker simply having a good relationship with a child or family member; it involves the joint, explicit focus on the experience and maintenance of that relationship, and offers prototypes for future relationships (Garfat, 2008).

A second theme dominant across the three approaches is lifespace. Keenan refers to lifespace work as a “therapeutic discipline of its own” (2002, p. 221) involving deliberate use of everyday activities and events in children’s living space (Smith, 2005).

Relationships and lifespace work are not ends in themselves, but serve broader aims. CYC and social pedagogic traditions emphasise the overall development of the child as the ultimate aim (Coussee, Bradt, Roose, & Bouverne-De Bie, 2008; Phelan, 2008). In the UK, the potential for relationships and activities within the lifespace to promote children’s resilience has become an important focus (Gilligan, 2008), resonating with the strength-based approaches in CYC literature (Rudolph & Epstein, 2000).

Provision of reparative experiences has been an explicit purpose of relationship-based practice and lifespace work in the UK (Ward, 2007). Garfat (2004) highlights the numerous opportunities within the lifespace for CYC practitioners to engage in a process of co-creating meanings, with children. This meaning-making work can, for instance, begin to repair internal working models that construct all relationships as exploitative, hurtful or inevitably abandoning. The very similar concepts of therapeutic containment (Bion, 1962) and holding environments (Winnicott, 1965) have been applied to lifespace work in a more holistically repairing way (Woodhead, 1999). These concepts illuminate how significant disruptions to early care experiences impede children’s cognitive and emotional development. Many of these children experience enduring difficulties with managing their feelings and behaviour as a result, affecting most realms of their lives. Therapeutic containment and holding environments offer organising frames for understanding how relationships and lifespace work can be comprehensively utilised to enable children to overcome the impact of early trauma and deprivation, helping them to regain developmental ground.

For those doing lifespace work with children who have experienced trauma and deprivation, the establishment and maintenance of developmentally enhancing, reparative relationships makes significant demands on the self. An emphasis on the importance and challenges of ‘presence’, an elusive but necessary quality practitioners must maintain in order to connect with children, runs across all three traditions (de Oliveira & Montecinos, 1998; Kruegar, 1999; Ward, 2007). A focus on self awareness (Ricks, 1989) and reflective practice (Petrie et al., 2009; Ruch, 2005b) also dominates discussions about how use of self is understood. Pedagogic traditions offer a simple, tripartite model for understanding use of self called The Three P’s: the private, the personal and the professional (Bengtsson, Chamberlain, Crimmens, & Stanley, 2008) 2008). This is a useful shift away from more dichotomous constructions of a personal/ professional divide that can inhibit authenticity and spontaneity within relationships. The previously mentioned concepts of containment and holding environments have also been applied to understanding staff needs (Ruch, 2005a), highlighting the strong emotions provoked by the work and offering ways of understanding and addressing their impact.

Therapeutic communities provide an illustrative, international example of an approach to understanding the work of residential child care that integrates the above mentioned themes. While there are various definitions of therapeutic communities, Ward (2003) argues that all can be thought of as a specialised version of group care for traumatised children and their families, where the focus is on enabling all of the community’s members to realise their potential to help and be helped. Key elements include a commitment to individual therapeutic relationships with children; an emphasis on groupwork for decision making and therapeutic gain; a utilisation of everyday interactions in the lifespace for therapeutic communication; an engagement with areas of the child’s life outside of the lifespace, including family, education and health, towards addressing the whole development of the child; a commitment to full systems of support for staff; and the use of psychodynamic frameworks (often alongside behavioural or cognitive approaches) for understanding and organising direct practice and the complex systems that surround it (ibid, p. 34). Across the UK, staff have indicated a desire to be more involved in therapeutic work with the children they care for (Kendrick, 2006); the therapeutic community approach integrates these shared ways of understanding the work of residential child care into a coherent, focused model.

**Conclusion**

This chapter aimed to review international trends, debates and issues in residential child care policy and practice, in order to learn lessons and question the assumptions about current practice in the UK. While there have been common factors which have affected the development of residential care across different countries, there are also clear differences in professional approaches. We have seen that there is a continuing ambiguity about the role of residential child care in most countries which has led to significant changes over recent years. The negative experiences and poor outcomes of children and young people, along with a focus on the primacy of the family, have led to an anti-residential care bias which has had varying impact on the development of policy and practice. This has perhaps been most striking in the evidence from Australia where the reduction of residential sector has led to major consequences for the experience of children and young people (Ainsworth, 2009). This parallels the experience in the UK during the 1990s when certain local authorities attempted to get rid of their residential provision (Kendrick, 1995).

In this regard, it is important to refute the claims of the Stockholm Declaration which imposes such a negative perspective on the role of residential child care, focused as it is on ‘institutional environments’. However, it is also clear that the future role of residential child care requires the adoption of a much more focused and theoretically driven approach to working with children and young people. We must certainly learn the lessons of the past in terms of the abuse which has occurred in residential child care settings around the world, and drive forward the improvement of quality and standards in residential child care. We have therefore identified some key aspects of working with children and young people in residential child care which draws on the different contexts and history of residential care across the world. The most dominant themes of relationships and lifespace provide powerful mediums for enhancing development, promoting resilience and providing reparative experiences. Theoretical frames of therapeutic containment and holding environments bring these themes together, and therapeutic communities are offered as an example of a comprehensive approach that applies them.

While we cautioned in the introduction about the problems of imposing models from other countries into local contexts, we have found a convergence of themes and issues which are highly relevant to the development of practice of residential care. In doing this we hope to build on the debates about particular professional and organizational identities in order to focus on the development of day-to-day practice with children and young people. This is a challenge in the developed world and even more of a challenge in the developing world. However, only in this way do we think that the misconceptions and negative perspectives about residential care can be overcome, and the sector move forward in a positive way for the benefit of all those children and young people who need it.

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