

'Crying for home: Who really cares?'

A critical analysis of care giving in the context of Victorian residential care

Submitted by

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STATEMENT OF AUTHORSHIP AND SOURCES

This thesis contains no material that has been extracted in whole or in part from a thesis that I have submitted towards the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgment in the main text of the thesis.

All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committees (where required).

Paul Chalkley: [Redacted]

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Abstract

Residential care provides for approximately 500 children and young people in Victoria each year, yet the dynamics of providing care within this system have received little scholarly attention, at least in part because it forms a much smaller part of the system than home-based care – in 2014 there were 5,900 children and young people in foster care and kinship care in Victoria. It has long been recognised that, despite being highly traumatised and vulnerable, young people placed in the care of the state are often exposed to further distress, instability and torment because of the nature of the out-of-home care system, and the available literature confirms that this is certainly true in residential care. Central to the care these young people receive, and their experience of being ‘in care’, are the agents through which the care is delivered: residential care workers. This thesis fills a gap in knowledge by examining the perspectives and practice of residential care workers, asking how they understand their ability to support good outcomes for children and young people within the restrictions of residential care settings which are far from perfect.

This thesis presents the findings of a qualitative study of interviews with twelve residential care workers that was guided by the principles of grounded theory. Led by the themes which emerged from these interviews, this project examines the pillars of good practice as residential care workers themselves understand them – both those which they can directly articulate, and those which are part of their tacit knowledge.

The findings point to three key areas. Using the framework of ‘care’ as provided by Tronto, the three areas that emerged were (i) caring about, (ii) taking care of and (iii) care giving. At the heart of these areas are the concepts of being rooted in genuine relationships, trauma informed practice and connection to the community. These findings point to guiding principles that residential care workers see as helping them to be effective in not only doing their job, but also in providing authentic and personal care to the young people.

Introduction

“As a result of the pervasive inattention that group care has suffered, model development, treatment innovations, development of treatment and training protocols, and controlled studies of residential group care have languished”.

(Whittaker 2000, p. 66)

The experiences of young people who have been (or who still are) in the residential care system, along with those who are charged with delivering care in this environment, have attracted a high level of public debate and attention in recent years. National media outlets have focussed on contentious residential care issues with headlines such as: “14 Y.O. girl sold for sex” (Flower 2011) and “Mum at 13 shock” (Buttler & Flower 2011) and then in 2014: “Crisis hits kids” (Campbell & Johnston 2014), “Fiends prey on children in care” (Campbell 2014) and “Children left to predators” (Herald-Sun 2014). These sensational headlines tell a story of risk, danger and poor care, and it is an important story that deserves to be told, but it is not the only story. This thesis sets out to explore the conscious and tacit knowledge that is embedded in the practice of residential care workers and, in doing so, come to a greater and broader understanding of the nature of care giving in the current day residential care environment.

A casual observer could be forgiven for questioning if the response to the needs of the young people who are in need of this care is, at best, impulsive, disjointed and careless, and, at worst, inept, unskilled and harmful. It could reasonably be asked if the young people are worse off for being placed in the care of the state, and whether or not any lessons have been learned from history. As will be described, the historical care experiences of young people who were placed in institutional ‘care’ outside of their families is well documented, and these institutions are now infamous for the lack of care they provided (Musgrove 2010; Swain 2015). These institutions presented themselves as being benevolent in nature and interested in the promotion of the welfare of children. It is now known that there is another side to the story, and this provides reason for the claims of the current care system to be regarded with some caution.

Removing children from their birth family and placing them into the legal care of the state is a judgment that should be informed by the belief that the decision will lead to better outcomes, and better care, for the young people. This should also be done with the intention of reducing exposure to risk and harm, and in the expectation that the safety and wellbeing of the young people will be enhanced, not reduced, by the decision. Readers of newspaper articles, such as those mentioned above, would be entitled to ask whether or not placing a young person in residential care does in fact, in any way, go towards achieving that goal. This study investigates the experience and self-reflected understandings of practitioners who are care givers to young people living in residential care in Victoria, Australia, and seeks to identify elements of good practice that workers use to deliver meaningful care, despite the fact that tabloid headlines typically characterise residential care as a place where *real* care is absent.

Background to out-of-home care in Australia

The dominant paradigm that exists around the experience of young people in residential care paints an often discouraging picture. Rustin (2004, p.9) states that the “services responsible for the care of

children ... [have], on many occasions, over recent years, been brought to public attention by disastrous failures to protect children". Lonne and Thompson (2005, p. 87) add to this by noting that "the history of child welfare is littered with inquiries which have identified failures that have resulted in harm to, or the deaths of, children ... These have been quasi-judicial in nature, with hearings and findings geared to identify those who were at fault, or contributed to the failure to protect ... [and] the public condemnation of social workers' actions has been breathtaking". A body of literature suggests that young people who have been in the care system have generally experienced instability (Gil 1982; Moore et al. 1997), trauma at an early age (Hughes 2004; Smith et al. 2008), a lack of security and difficulties in developing secure attachments (Cunningham & Page 2001; Hawkins-Rodgers 2007). As is described by Thomson and Thorpe (2003), children in the out-of-home care system have a high prevalence of domestic violence, problematic drug and alcohol use, mental illness and young motherhood. Euser et al. (2014, p. 64) found that "twenty five percent of all participating adolescents [in out-of-home care] experienced physical abuse, which is a nearly threefold increase in risk compared to the general population". Given this context, it is surprising that the skill, practice and perceptions of those charged with delivering care to these young people has hitherto received such minimal attention.

Historically, the public perception and understanding of young people living in out-of-home care in Australia has not been a positive one. "In both the nineteenth and twentieth centuries children in 'care' found themselves sifted to the bottom of the social hierarchy. Consequently, Australian society as a whole paid little attention to the life outcomes for children in 'care', except for during periods of public anxiety about 'dangerous' children or nation building" (Musgrove 2013, p. 161). Cousse and Williamson describe to us that from "time to time there comes a period of social pedagogical embarrassment... [where] social integration is simply not sufficient to preserve society's cohesion. These moments of embarrassment create a new round of social pedagogical upheaval questioning the relation between young people, education and society and calling for a more efficient approach" (2011, p. 224) which introduces the concept of social pedagogy. Originating from Germany in the 19th Century (Cameron, 2011, p. 187), social pedagogy can be defined as "a perspective, including social action, which aims to promote human welfare through child-rearing and education practices; and to prevent or ease social problems by providing people with the means to manage their own lives, and make changes in their circumstances" (Cannan et al, 1992, pp. 73-74). Social pedagogy refers to a relationship based method of working with young people, and can be particularly applied to working with young people who are living in institutional care. It has been "seen as a possible new direction in the field of social care in the UK for the last fifteen years or so, particularly in relation to residential care and looked-after children, but it is also starting to attract interest in Australia" (Crociani-Windlan, 2013, p. 127).

It is now well documented that young people living in out-of-home care have been unwilling participants in, and victims of, abuse whilst living under the 'care and protection' of the state (Gil 1982; Shaughnessy 1984; Groze 1990; Scott & Swain 2002; Musgrove 2013). For decades, scholars have identified significant and entrenched problems with out-of-home care systems and resultant negative outcomes for those who lived within their constraints. As far back as the early 1980s, Gil wrote that "while the intent of the social welfare and juvenile justice systems is to protect and care for these children, they have not fulfilled their promise" (1982, p. 8). Care institutions have often failed in their remit to deliver care. Social pedagogy offers a lens through which to consider framing care inasmuch as whilst it doesn't offer techniques or methods of care (Crociani-Windlan, 2013, p. 132), it does provide guiding concepts for care. Social pedagogy looks for, and describes, four overarching aims. These four aims are wellbeing and happiness, holistic learning opportunities, authentic relationships and community support for empowerment (Eichsteller and Holtoff, 2011, p. 176).

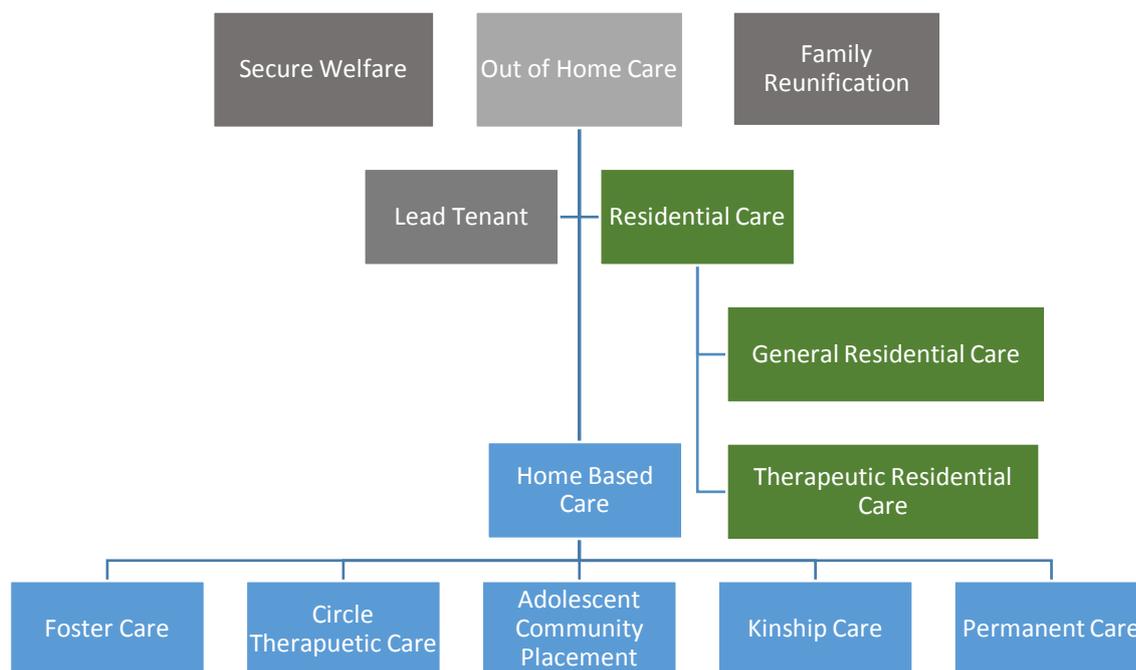
Holthoff and Eichsteller further describe that social pedagogy is "based on profound respect for human dignity and an image of human beings as inherently rich in potential, competence and skills – an image emphasizing the positive aspects that form the foundation for further development and relationship building" (2011, p. 173). Central to this is a mindset of care which "expresses an emotional connectedness to other people and a profound respect for their human dignity" (Eichsteller and Holthoff, 2011, p.54). This fits well with the personal and professional attitudes displayed by participants in this study. They consistently described a genuine attitude of care and respect for the young people they work with. This aligns with the mindset approach of social pedagogy (called the *Haltung* in German) and is known to be "a moral and ethical position that the person takes and which runs through the person's personal and professional life and is evident at all times in their actions and opinions" (Haltoff and Harbo, 2011, p. 215). Despite the attitude towards care from the interviewees in this study, it remains a fact that broadly speaking, institutional models of care have been lacking.

The nature and style of care giving clearly demanded greater scrutiny and accountability in recent decades because what was provided was inadequate. Gil further stated that the "assumption that a child is removed from an abusive or neglectful home and placed in a safe environment can no longer be taken at face value: the fact is that children are often physically abused, neglected, exploited, sexually misused, and disregarded in placement by caretakers appointed to provide a positive rehabilitative experience for them" (1982, p. 8). It is now understood that care giving to young people in residential and out-of-home care systems has been flawed and, coupled with the findings of recent royal commissions, the call to improve the experience of being in state care has never been stronger. However, public debates about twenty-first century care systems have tended to coalesce around responses to scandal rather than examinations of the systems themselves. This study seeks to contribute to that void and in doing so critically analyses the practice of contemporary residential care givers.

The out-of-home care system

The out-of-home care system in Victoria has three key arms: lead tenant, home based care and residential care. The focus of this investigation is the practice of those staff who work with young people who are living within the general residential care arm of it. The current model of residential care in Victoria is historically unique and is the manifestation of current public and political policies and procedures. Under this current format, houses are staffed twenty four hours a day, seven days a week, with a rotating roster of permanent and casual staff. These staff are employed to deliver the care that is at the centre of this study, and the complexity of this will be explored further in the literature review. Most residential care houses will have an average of four young people living in a house which, from the curb side at least, appears to be a typical domestic dwelling. Apart from features such as fire sprinklers, alarms and a staff office, the house will have few other differences to any other four or five bedroom house in any street in any town or suburb. For this study, the terms 'residential care' and 'care' will be used interchangeably to reflect this particular aspect of the out-of-home care system. So too will the terms 'residential care worker', 'worker', 'care giver', 'staff' and 'residential care staff' be used to describe those who are employed to deliver the care.

Diagram One: Model of out-of-home care in Victoria



(Source: State Government of Victoria, 2017)

While they are not directly connected within the above diagram, Secure Welfare and Family Reunification both have a place within the Victorian out-of-home care system. Secure Welfare is residential model of protected accommodation where the movements, and therefore liberty, of the young people is limited. It is a temporary restriction of freedom to ensure safety and wellbeing, and is often seen as a 'last measure' which requires court ordered permission to enforce. The young people

who are placed here, albeit temporarily, are often from within the residential care system and have been displaying high risk taking behaviours. Family reunification is a specific order that indicates the desired outcome of an out-of-home care placement is for the young person to return home. This is not always the case for young people who live in residential care.

In contemporary Australian society, those who discover children being harmed are expected to report this to the relevant state-based child protection agencies. Young people who are reported upon include those who are suspected of being neglected, abused or harmed, or those for whom the risk of such harm being perpetrated is likely to be realised (Auditor-General 2014). If deemed 'at risk' these children can be removed from the home and placed in out-of-home care; and for a small percentage, this will mean going into residential care. Young people who are placed into residential care "are predominantly aged between 10 and 17 years, of either gender, whose behaviours range from disruptive and delinquent acts through to serious aggressive and violent acts. These behaviours are often linked to mental health (including self-harm) and substance abuse problems arising in many instances from abuse and neglect" (Ainsworth & Hansen 2005, p. 195).

Residential care differs from the most common other form of out-of-home care (home based care) in that it is an institutional model that generally provides care services to a smaller age range of young people, usually those aged in their teenage years. According to the Australian Institute of Health and Welfare (AIHW), at a national level, nearly 30,000 young people live in out-of-home care; this is approximately nine children per 1000 or 0.9% of all young people. Within this figure, only 5% of the young people "were living in residential care [and] residential care is mainly used for children who have complex needs" (AIHW 2017, p. 45). More locally and in relation to the focus of this study, in 2014, of the more than 6,400 young people in out-of-home care in Victoria, 504 were in residential care, 211 of which were female and 293 of which were male, and 65 of these were under the age of 12. The average age of all young people experiencing residential care was 14 years, and 29% of those first experienced residential care before the age of 12 (Auditor-General 2014). According to Bath (2008, p.8), residential care is often seen as the "poor relation of the Australian out-of-home care sector", yet it "provides a critically-needed option for some of the most disadvantaged, vulnerable and challenging young people in the care system" and so "the neglect of this care modality in the literature is hard to understand". Residential care clearly provides intensive support and care for some of the most marginalised young people in society. This study responds to the void that is present in current social research in this area and seeks to contribute knowledge and understandings about what constitutes good care giving practices in this environment.

Residential care is funded through the Victorian Department of Health and Human Services, but often administered through non-government agencies who actually deliver the service. These providers have paid staff 'on shift' at all times who are responsible for the care and wellbeing of the young people assigned to the houses they manage as part of their service delivery (Bromfield et al.

2005). This particular form of out-of-home care deserves specific attention, for as Salnas et al. (2004, p. 150) argue, when the different types of out-of-home care “are analysed separately, differences in patterns of risk factors occur. For a more advanced analysis of these patterns it is necessary to have more detailed data on types of care”. This study provides one such analysis. Residential care provides a model of care that is fundamentally different in that most other models of out-of-home care are provided in the home of the carer, whereas in residential care, it is the workplace of the carer. It is the work of these paid carers that forms the basis of this investigation. From the outset, one of the central claims of this research has been that there is something distinct about the nature of the relationship between the carers and the young people in residential care which is different from other models of out-of-home care.

Significance and contribution to knowledge

The role of the residential care worker is complex and can be difficult to delineate. It “is multifarious and requires the ability to establish collaborative relationships, comprehend and describe the nature of interactions, influence transactions, facilitate constructive problem solving and to be able to interpret the effects of behaviour from one individual to another” (Pazaratz 2000, p. 35). This multifaceted role requires a broad skill base to meet a range of challenges, and the training and qualifications of workers can be as diverse as the backgrounds of the young people in care. Given this environment it is, perhaps, surprising to find an apparent lack of research into this specific area of care provision in the past 15 years, especially given that the work of residential care givers plays an integral role in shaping the quality and nature of the care that is given.

Some scholars have called attention to this gap. Heron and Chakrabarti assert that:

although the low level of qualifications amongst staff and the ongoing failures of the residential system are well documented, there has been much less research on the staff’s perceptions of children. This is perhaps surprising given that the way staff perceive children is likely to be crucial in understanding what actually goes on in community-based children’s homes.

(2003 p. 81)

De Swart et al. (2012, p. 1823) further found that “the characteristics of group care workers, such as professionalism and relationship skill, constitute an important moderator of positive treatment outcomes”, yet they also found that studies into these aspects of residential care workers’ practice continued to be lacking. This observation, that research into the work by residential care givers is scarce, is also reinforced by Salnas et al. (2004, p. 150), who furthermore found that, within the existing literature, little attention has been paid to exploring how those delivering the care in the residential care environment perceive their work – how they contextualise it, how they place meaning on it and how they understand it. Veerman and Van Yperen argue that there is a “growing consensus that interventions carried out in youth care practice should be evidence-based. Both the standards of good

practice and professional ethics call for such interventions. In addition, policy makers and financiers should demand interventions that are clearly evidence-based in order to attain maximum value for taxpayers' money" (2007, p. 212). It is the intent of this study to address some of this gap.

Recent studies of the sector have revealed that residential care is overloaded and often not meeting its goals of providing good care and outcomes for children and young people. The 2014 Victorian Auditor-General's report into young people living in residential care found that the system is operating over capacity, with the overall number of children in out-of-home care increasing 60% in ten years, and the number of young people in residential care growing by 10% in that period (Auditor-General 2014). The auditor general found that in the year prior to the report being published, the Department of Human Services (DHS) planned for 459 young people to need beds in residential care, and yet they placed over 500 young people in residential care beds that year. The report argued that one of the system's greatest problems was this overload, stating that:

Insufficient capacity affects the quality of care children receive. For example, placement decisions are often based on bed availability, rather than on matching the needs of highly vulnerable children with the needs and behavioural characteristics of the children who are already in residential care units. Poor placement can lead to an incompatible mix of children in a residential unit, with implications for safety and children's ability to achieve positive outcomes.

(Auditor-General 2014, p. xi)

The report also describes how diversion strategies away from residential care and towards foster care are only partly successful for a number of reasons, not the least of which being that "the number of children in foster care is declining because there are fewer foster carers available" (Auditor-General, 2014 p. 2). Perhaps most pertinent to the intent of this study, the report found that "the outcomes for children in residential care are poor across a range of indicators, including health and education. This reflects the transience of staff, their lack of qualifications, skills and training, and the level of support provided to them" (Auditor-General 2014, p. 2). This report by the Victorian Auditor General could be considered damning in its appraisal of the residential care system – and with good reason. What this investigation seeks to add is a contribution to the commentary that is grounded in the lived experience and practical knowledge of residential care workers, asking how they understand their work and what they see as good practice within that environment.

The pressure on residential care continues, and so the importance of understanding how to strengthen its workforce remains a priority. Although 2016 saw a reduction in the number of young people being placed in residential care in Victoria – with the Victorian Auditor General reporting that at January 31st, 2016, there were 442 young people residing in residential care across the state, a reduction of 72 since the previous report – the reasons for a young person being placed in residential care remained the same, and they are the most challenging, complex and at risk young people within the state's broader out-of-home care system (Auditor-General 2016, p. 1). This aligns with the findings of Ainsworth and Thoburn (cited in Bollinger 2017, p. 2) who "speculated that the lower the rates of

use of residential care, the more 'pointy end' young people are being accommodated, which can inflate the behavioural difficulties seen and possibly poorer outcomes observed". Such conclusions confirm the importance and relevance of the focus of this study.

The appropriateness of the model of residential care itself has also been questioned, with one study identifying that "institutional youth care is carried out in 24 hour group living facilities that are not licenced as hospitals and offer care or mental health treatment for children and adolescents with serious behaviour problems, including law violations" (De Swart et al. 2012, p. 1818). Inadequate risk assessment, poor relations with family, low levels of staff training and supervision along with a failure by staff to follow procedures are commonly found to be contributing factors in support of these challenges to the residential care model (Lonne & Thomson 2005, p. 87). Despite some limited research indicating that residential care can be a positive experience for young people (Hillan 2006), it is generally understood that residential care has a myriad of inherent risks but may also hold the promise of at least some hope that calls for further investigation. Knorth et al. (2008, p. 123) argue that "there is the view that a residential placement can contribute to the positive development of some youth with serious behavioural and/or emotional disturbances. In this context, it is remarkable that there are so few reviews and meta-analyses of outcomes of residential child and youth care services".

As will be described throughout this thesis, there is a range of valid and useful research available on the broader topic of young people living in out-of-home care that is not necessarily on the specific residential care focus of this study (Hayden 2004; Manso et al. 2008; Esposito et al. 2013; Mendes et al. 2014; Meckstroth et al. 2014; Leonard & Gudiño 2016; Mendes 2018). There is literature available, both international and Australian, that is centred on the residential care experience (Ainsworth & Hansen 2009; Higgins 2015; Jones & Loch 2015; Bath & Smith 2015, Barker 2016; Huscroft-D'Angelo et al. 2017; Eltink et al. 2018), but even that research has limited value to this investigation due to the nature of its focus either being solely on the young people or having a different focus altogether. The specific focus of this study – on the work of care giving in residential care as understood by the care givers themselves – has limited existing scholarship, and hence, this study has a significant Australian voice and provides an opportunity to contribute to knowledge.

Despite this acceptance of the limited range of research in this subject area, there is one stand-out exception that has been drawn upon regularly throughout this research. James Anglin is a Professor and Director of the School of Child and Youth Care at the University of Victoria, British Columbia. His seminal book, *'Pain, normality and the struggle for congruence: Reinterpreting residential care for children and youth'* (Anglin 2002) stands alone in this field of research. His book, like this study, is a comprehensive investigation into residential care (albeit in Canada) and was based on grounded theory research. He investigates and articulates a framework for understanding care within such an institutional context. He describes patterns of behaviour, pathways to healing and the daily struggle of providing good care in a residential care environment which is often traumatised. This thesis

contributes to that same discussion and adds to it through its focussed investigation of how care is understood by the care givers.

The work of Joan Tronto has also been used as a constant theme, a scaffolding, throughout this thesis. As the data was collected, collated and sorted, themes emerged from the interviews that indicated an alignment with the care-theories of Tronto. Consequently, Tronto was used as a supporting framework that complemented the findings, but not as frame within which the findings were made to fit. Her work, driven by a feminist critique, challenges democratic and political institutions to become more conscious of care and the need to integrate caring thinking into our political discussions. As a theorist, she seeks to provide critical frameworks for all who “are looking for another way to understand and act against the continued injustices of our world” (Tronto 2009, p. ix). In the introduction of her seminal book *‘Moral Boundaries; A political argument for an ethic of care’*, Tronto argues that the notion of care has been marginalised in modern democratic societies, and writes that she hopes to provide her audience with “a glimpse into a different world, one where the daily caring of people for each other is a valued premise of human existence” (2009, p. x). Tronto argues that in order to provide real care, we need to be willing to consider it at both an intimate and a political level. In what she describes as an encumbrance that we must all consider shouldering, she suggests that as citizens who share a common purpose, we must consider care democratically. She argues that “to be a citizen in a democracy is to care for citizens and to care for democracy itself ... Citizenship, like caring, is both an expression of support (as when the government provides support for those who need care) and a burden – the burden of helping to maintain and preserve the political institutions and the community” (2013 p. x).

The theoretical and conceptual model which emerges from this approach fits well with the study of residential care because it interrogates what it means to provide care through, and within, social and political institutions. Although Tronto’s significant body of work goes well beyond the specific context of child protection (especially Tronto 1987; Tronto 1989; Fisher & Tronto 1990; Tronto 1995; Tronto 2001; Tronto 2009; Tronto 2010; Tronto 2015), her work is based on direct connections between her political analysis and her own personal experiences of care. She states that “one comes to appreciate care best by being involved in relationships of care” (2009, p. xii). Thus her work presents a framework for understanding care which unites the personal, the political and the institutional, which resonates with this thesis’s concern with how care can be provided by individuals within the residential care system. The findings of this study resonate with Tronto’s work in concluding that, when embedded in authentic relationships, care is able to take hold, bear fruit and ultimately, facilitate growth and change in the lives of those involved in the care experience.

Method and methodology

This study is one of the first in Australia to look at what delivering care means for those who work in the residential care system. This section will outline the theoretical interests underpinning the study and provide a rationale for the research design. Tronto is used as a thread throughout the thesis and as a guide for articulating the findings, so to begin that, let us consider her words describing what may be called the practitioners' 'unconscious knowing':

A high school teacher told me that she can tell the quality of a school she has entered within 10 minutes of being in the building. 'How?' I asked. 'Oh', she replied, 'you can just tell which buildings have caring principals and teachers.' While I am sure that this teacher is correct, those of us without such tacit knowledge, and, more generally, citizens in a democratic society, also want to be able to judge whether institutions provide good care. Is there a way to articulate the basis for such judgments more systematically?

(2010 pp. 158-9)

Tronto's story suggests that the tacit knowledge possessed and understood by experienced and intuitive teachers engenders an understanding of the unspoken practice of an institution. Schon calls this unspoken knowledge an "indescribable practice" (1983, p. viii). If this knowledge can somehow be articulated, it may lead to more defined and deliberate practice, and when contextualised (in this case, in residential care settings), perhaps even to standards of best practice. As far back as 1983 Schon called for an "inquiry into the epistemology of practice" (1983, p. viii). Anglin provides commentary on this concept of wanting to have a deeper understanding of the epistemology of practice that is specific to the provision of residential care. He states that "this approach holds that work that is consistently being done well is being done in accordance with good theoretical principles *whether or not the practitioners are aware of them or can articulate them*" (2002, p. 25). Anglin goes on to say that "much of the good practice exhibited by child and youth care workers is the result of such tacit knowing. It is well known that skilled crafts people and athletes often cannot articulate precisely how they do what they do" (2002, p. 25). At the heart of this study is an exploration of the tacit knowledge that resides in the method of experienced residential care workers, with the intention of at least beginning to articulate the inherent practice-based knowledge that is embedded in the day-to-day machinations of their work.

The methodologies for this research were qualitative in nature and grounded in the contention that the views and assessments of the research participants are valid and hold a truth that is of equal value to any statistics and commentary created about them. Qualitative inquiry is guided by the belief that, when trying to ascertain the lived experience of those whose lives are impacted upon by the social world, the insights and understandings of those people must be noted and recorded. It is, as Babbie (2010, p. 393-394) says, the "non-numerical assessment of observations made through participant observation, content analysis, in-depth interviews ... for the purpose of discovering underlying meanings and patterns of relationships".

In addition to qualitative research methods, use of grounded theory was also employed. Grounded theory does not start out with a specific theory to test, but rather it allows “theory to emerge from the data” (Tisdall et al. 2008, p. 95). When working with grounded theory, it is “important that the framework being sought... emerge from the actual research data to the greatest degree possible and not from prior formulations” (Anglin 2002, p. 6). It is an approach that “insists that theories ought to arise from (in other words be ‘grounded’ in) the empirical data produced by fieldwork. It opposes experimental approaches in which hypotheses are developed in advance and then tested through fieldwork. As such, it is an inductive methodology” (Tisdall et al. 2008, p. 225). Such a methodology enables the voice and perspectives of the participants to be recognised and help shape the findings, for it “allows the relevant social organisation and social psychological organisation of the people studied to be discovered, to emerge – in their own perspective” (Glaser 1992, p. 5).

Returning briefly to the concept of social pedagogy, according to Cousse and Williamson (2011), social pedagogues must reflect with a critical eye on the purpose of their work and the nature of the role that their work plays in society. Eichsteller and Holtoff (2011, p. 175) argue that social pedagogues must be “highly reflective both in their direct practice and on the role they play within the larger system”. This thesis sits somewhere in the middle of this understanding. In some ways, the research interviews played the role of a social pedagogue where reflection on practice and the role of care giving was considered and investigated. What makes this thesis not entirely a study that uses social pedagogy is that the interviewees themselves did not identify as social pedagogues – they saw themselves as care givers. Their participation may have been an unconscious act of social pedagogy, but this in itself did not make them social pedagogues. Consequently, the broader approach of this thesis is one that is guided by the principles and method of grounded theory where the tacit knowledge and self-understandings of the work of residential care givers is considered to find meaning and give voice to methods of good practice.

This provides a segue for the introduction of phenomenology. Phenomenology considers the lived experience of an individual and how that experience helps define meaning (Sloan and Bowe, 2013, p. 1292). This approach has similarities to the grounded theory approach adopted for this research project, and, as such, is worthy of recognition. Gallagher describes that phenomenology seeks to uncover the knowledge that is already present in the world of the subject, of the “lifeworld that we take for granted” (2012, p. 2) and here we find connection to the desire to uncover tacit and perhaps unconscious knowings from research participants. As a general rule, phenomenology is a qualitative approach to research that “focuses on peoples’ perceptions of the world or the perception of the things in their appearing” (Sloan and Bowe, 2013, p. 1293). Edmund Husserl, the founder of phenomenology, described how understanding the small and sometimes overlooked ‘little things’ construct such meaning and that “the world comes to be experienced within [and from] the various situations that make up our lifeworld” (Gallagher, 2012, p.2). The lifeworld of a research participant

can be difficult to describe and indeed, phenomenology as a research method “is difficult because, as a methodology for analysis, is difficult to get right” (Sloan and Bowe, 2013, p. 1292).

There are further limitations to using a phenomenological approach to a study such as this one. Phenomenology “reduces a subject’s experiences with a phenomenon to a description of its essence ... and so a qualitative researcher will identify a phenomenon as an object of human experience and give voice to it” (Sloan and Bowe, 2013, p. 1293). This points to the tension that phenomenology brings to this study, and a main point for it not being the guiding research method. Phenomenology seeks to identify and give voice to the essence of an experience. In and of itself, that sits comfortably with one aspect of this investigation — to give voice to the tacit knowledge of residential care givers. The flipside of the tension, however, is that this study seeks to not only give voice to knowledge, to inherent understandings of practice, but as was described by Anglin (2002, p. 6), for “theory to emerge from the data”. The phenomenologist “is not concerned about how things actually are in reality; the phenomenologist is rather concerned about how we experience things” (Gallagher, 2012, p. 8). This research is concerned with both how the care givers experience care giving and also with how good care looks in reality. As such, the grounded theory approach, which seeks to allow the emergence of theory, which in turn can contribute to articulating a framework to guide good practice, aligns more comprehensively with this investigation.

Grounded theory allows for the emergence of connection and synchronisation, as it involves “a process of inductive analysis where both the elements of the research area, as well as the linkages between the elements are explored and described” (Raymond & Heseltine 2008, p. 200). In relation to the focus of this study, the description of Charmaz is also applicable:

Grounded theory methods offer a set of general principles, guidelines, strategies and heuristic devices rather than formulaic prescriptions. Thus, data forms the foundation of our theory and our analysis of these data generates the concepts we construct. Grounded theorists collect data to develop theoretical analyses from the beginning of a project. We try to learn what occurs in the research settings we join and what our research participants’ lives are like. We study how they explain their statements and actions, and ask what analytic sense we can make of them.

(2014, p. 3)

This is very much in alignment with the sentiment of this thesis, which attempts to make analytic sense of the working lives and daily practices of residential care workers. Once again, the work of Anglin is pertinent to this discussion. He explains that “central to the grounded theory method is the search for a main theme, often referred to in the research literature as a ‘core category’ or ‘core variable’ in relation to which most other aspects of the phenomenon of interest can be understood and explained” (2002, p. 50). The design of this research is such that the findings are driven by the raw content provided by the research participants and responds to the identified need for research to contribute to the gap in knowledge about how to best care for the young people living in the care of the state.

The following chapters of this thesis describe the central themes, the core categories, that emerged from the research interviews.

A reflexive approach

It is essential in any investigation to be aware of the influence and affect the person of the researcher may have on the research itself. In considering my own connection to the subject and topic of the investigation, it is important to note that despite the inherent differences between myself, the interviewer, and the participants, the interviewees, I also personally hold a position within the residential care sector as a residential care giver. In addition to working as an academic, I have been a residential care worker since 2012 and during that time I have worked in a variety of residential care houses and with a vast range of fellow care givers. This 'insider view' helped develop rapport and a sense of common ground with the participants and assisted in the use of a commonly shared language. It seemed to help interview participants relax and feel safe in their participation once they felt I understood 'where they were coming from' and that this research was grounded in a belief that their work practice held inherent value and worth.

In addition, an important step was to acknowledge other power differences between myself and the participants. It is understood that an imbalance of power is apparent at all stages of the research process (Bourdieu 1996 cited in Block et al. 2012) and the concept of analysing this power relationship is well recognised (Block et al. 2012, p. 71). Chapman (2011, p. 74) reminds us that simply recognising the existence of such imbalances in power is only a starting point to guide a reflexive approach by the researcher and consequently, through all of this, I am mindful that there were specific power imbalances inherently involved in this research. At all times I needed to maintain an awareness of the differences present between myself and the research participants, and ensure that any biases or perceptions I may carry did not taint the research experience or disadvantage the interviewee in any way. Block et al. (2012, p.71) argue that it is imperative that when the researcher comes from a different 'life world' ethical reflexivity needs to be employed. It could be argued that as a residential care giver myself, my 'life world' may not be so different to some of the participants. In reality, the combined effect of me being the researcher, a professional peer and an employed academic, creates a situation that not only beckons, but requires, reflexivity and a constant awareness of any and all differences.

Research has the ability to play an instrumental role in addressing inequalities, yet so often reifies injustice and fails to foster much needed social change (St John 2013). An epistemological framework exploring the way knowledge is understood, valued and prioritised, guided this project. Through all of this, care was taken to constantly consider the message the findings conveyed, remaining ever cognisant that the research aimed to understand the practice of the participants and operated with the belief that the interviewees held valuable expertise and contextually important knowledge. In all aspects, it was "exploratory, seeking to open up new areas of social enquiry [and knowledge] and

address limited research focusing on marginalised young people” and those who work with them (Couch et al. 2014, p. 17). Good reflexivity requires the researcher to reflect on his or her experiences, the impact of the research on the participants and the effect it has on him or herself. It is the “process involved in making sense of events, situations, or actions that occur... [and] emphasises a thoughtful approach to understanding experience, whether in real time or retrospectively” (Oelofsen 2012, p. 3). Reflexivity is about recognising that one’s own value set and personal views can play a significant role in shaping the style and technique of the study, and requires critical thinking about one’s actions and a willingness to adjust accordingly (Freegard & Isted 2012, p. 294). Throughout this study it was my task to remain ever cognisant of these competing forces and always strive to deliver a fair, balanced and accurate representation of the voice of the participants.

Ethical approval, sample size and recruitment

This research project received ethical approval and clearance from Australian Catholic University in 2015 (ethics approval number 2015-128E). Upon the receipt of this approval, the research project was able to proceed and the process of gathering participants began. The final sample size for this study was 12 residential care workers who were gathered through snowball sampling. The first interviewee was a residential care worker that I, the researcher, had previously worked with at a different organisation. This participant now works for a different service provider and was willing not only to participate, but also to suggest the name of a potential second interviewee. This recommendation proved fruitful and thus began the process of snowball sampling. The original desire was to source interview participants from more than one service provider, all of whom had worked in residential care for a minimum of six months on either a full time or part time basis. The 12 participants who eventually participated in the study work for a total of seven different service providers, all work full time and constitute a mixture of genders and qualifications.

All participants were provided reassurances that their identity and the information they provided during their participation would remain anonymous. Consequently, pseudonyms have been used throughout this document. Participants were comfortable disclosing such information as age, gender and ethnicity, and the following table provides some more in-depth data:

Table One: Research participants

Gender	Age	Pseudonym	Training	Ethnicity	Length of service
F	40-50	Simone	Cert IV Comm. Services	Maori	5 years
F	20-30	Linda	Dip Youth Work	Anglo Australian	4 years
M	40-50	James	Cert IV Comm. Services	Pacific Islander	3 years
M	30-40	David	Dip Comm. Services	Sri Lankan	3 years

F	40-50	Lisbeth	Dip Comm. Services	Eurasian (Indo/English)	3 years
M	30-40	Andrew	Dip Comm. Services	Samoan	3 years
M	30-40	Kyle	B Youth Work	Anglo Australian	3 years
F	30-40	Katherine	B Youth Work	Anglo Australian	3 years
F	20-30	Brittany	Dip Youth Work	Anglo Australian	2 years
F	20-30	Crystal	Dip Youth Work	Anglo Australian	2 years
F	20-30	Amy	Dip Youth Work	Anglo Australian	1 year
F	50-60	Eileen	B Sociology	Anglo Czech	1 year

It may appear that the working history of the participants is relatively short. This is indicative of the regular turnover of staff who work in this sector, and is representative of the issues of staff retention faced by the industry. High turnover of staff in residential care environments is recognised as a global issue and similar figures are also reflected in other countries. Discussing findings from America and in the United Kingdom, Colton and Roberts (2007, p. 144) state that “recent estimates suggest that annual nationwide turnover rates for child welfare staff range from 30% to 40%, while average time in post is less than 2 years”. These figures suggest that the retention rates displayed in this sample was slightly above average.

Building trust with participants

The trust of the research participant is of fundamental importance, not only because it is an indication of mutual respect and confidence, but ultimately because participants “themselves act as gatekeepers of their involvement in a study” (Carey et al. 2002, p. 328). In line with using a grounded theory approach to qualitative research, interviews for this research were semi-structured in nature and undertaken in an informal environment. The guiding questions, which were used as a catalyst for the interview discussions, are attached in Appendix 1. These questions are indicative of the framework from within which the questions and discussion arose; that is, they served as a guide and prompt, not as a rigid structure.

Trust needed to be established early in the research process to ensure the support of the participants and to enhance the likelihood of snowball sampling being successful. Liamputtong advises that “building trust and rapport is a necessary ingredient for conducting sensitive research with vulnerable populations” (2007, p. 240). As an experienced youth worker, with significant experience in the residential care sector, I believe I have an established set of skills that assisted in this process. Time was spent building rapport with participants before the formal process began. This involved greetings, small talk, introductions and the creation of an appropriate interview environment (O’Leary 2013). The physical environment was deliberately informal and relaxed, with access to food and water as needed.

The actual spaces ranged from locations as diverse as cafes, work place offices, TAFE cafeterias, my kitchen table and libraries. Each interview went for approximately 45 minutes and during this time privacy and confidentiality were safeguarded by the pre-determined location ensuring that whilst the interview may have been situated in a public place, at no times were the words of the participant able to be overheard by any person other than myself. Participants were asked to refrain from using the name, or any other identifying factor, of the young people they work with, and equally, not to disclose the name of their employer. All participants were able to successfully achieve this.

Consistent with my educational and professional background as a tertiary qualified youth worker, the methodology, data collection and presentation of findings was guided by values of empowerment and advocacy. "Youth workers provide opportunities for young people to have a voice and a positive impact on the ways in which decisions are made. Participation can improve existing services or make demands for new services to address community needs" (Sapin 2013, p. 145). It is not unreasonable to anticipate that participants may experience a sense of empowerment through participation in the research process. This approach is informed by theoretical underpinnings which focus on each person as an individual, work in voluntary relationships, is non-judgemental and start where [participants] are 'at' rather than where some would like them to be (Ingram 2001). This reinforces "the importance of establishing trusting relationships to overcome the predisposition of the [interviewees] to present what they believe they are 'supposed to say' in a research context" (Harcourt & Sargeant 2011, p. 428). My approach to the interviews, and the rapport I established with the participants, was crafted in such a way that it was hoped that interviewees felt free and able to speak their truth and articulate the reality of their daily work practices. Throughout the interviews it was not uncommon for participants to express feelings and sentiments that suggested that the interviews, if not empowering, were at least cathartic, and that the process itself held some value for them. Finally, the participants were provided with a \$30 gift voucher as a way of recognising their time and contribution to the study.

As part of the process of gaining fully informed consent, participants were made aware of their right to withdraw at any point, as well as the responsibilities of the researcher in regard to disclosure of information they share. In the case of disclosure, there are several variables which can contribute to this situation. Wiles et al. describe that "researchers might be expected to break the confidence of a participant if they disclose having committed or being about to commit a crime. In addition, researchers may feel a moral duty to disclose information if a study participant reports being a victim of crime or if a study participant is perceived as being at risk of harm" (2008, p. 419). Wiles et al. go on to explain that this can become problematic when negotiating the process of disclosure to a third party if the participant does not agree to it. "The decision to break confidentiality was one that was taken very seriously and was only undertaken where this was seen to be in the best interests of the person involved" (2008, p. 419). It is worth noting that at no time did any participant feel that it was necessary

for them to withdraw from the interview process, nor was there any reason to take steps to disclose or report any of the information that was shared.

Finally, the interviews were recorded using a voice recorder and later transcribed by a professional transcription service, with a total of 68,300 words being recorded as a result. The content of these transcriptions was then categorised using a process that included thematic analysis and qualitative themed grouping. Due to the relatively small sample size, it was decided not to use a software package (such as NVivo), but rather, similar manual processes and categorisation processes used by such programs were utilised to achieve a foundational framework that reflected the emerging themes of the research. The themes were eventually grouped into common topics and the resultant findings are what constitute the body of this thesis.

Thesis overview

It is recognised that the turbid history of residential care, coupled with the difficult workspace that it is, can result in an environment that is not conducive to the delivery of best practice. Speaking on the topic of residential care, Steckley and Smith argue that a consequence of this “has been to dissipate the moral impulse that draws people to want to care in the first place. A justice voice that speaks a language of risk, rights, protection, best practice, evidence, standards and inspection crowds out a care voice that struggles to murmur of love, connection and control” (2011, p. 184). This thesis seeks to delve into the tacit knowledge of residential care workers, with intention of giving voice to their (potentially) otherwise unspoken and unarticulated skill set, and opportunities for a better delivery of care can be observed in the findings. This is in accord with the findings of Herron and Chakrabarti who assert that “ascertaining the views of residential staff has the potential to provide key insights into the nature of relationships between staff and children and hence the quality of care provided” (2003, p. 83).

Over the coming chapters the thesis that is developed contextualises care giving in the residential care environment. After a literature review that considers care and care giving in both a contemporary and historical context, Chapter Two examines the importance of providing individualised and particularised residential care within a trauma informed framework. Chapter Three examines the nature and importance of relationship based practice within that framework and Chapter Four examines how a focus that moves through and beyond meeting day-to-day needs and seeks to establish social capacity creates a clearly defined and acceptable broader purpose of care within the residential care environment. Across the thesis the ‘murmuring voice of care’ that speaks of the craft of delivering good residential care giving practices will be heard, analysed and presented in a framework that is both informed by the work of Joan Tronto and guided by a desire to present the authentic voice of those workers who deliver care on a daily basis.

Chapter One
Literature review
'Care'

“Care helps us to rethink human beings as interdependent beings ... care offers us a powerful way to reconceive the shift in paradigms, to undo current moral boundaries, and to allow us to move towards a more just and caring human society”.

(Tronto 2009, p. 21)

The contemporary understanding of care and care giving in the specific context of residential care is central to this thesis. The experiences and perspectives reported by residential care workers in the process of this research reveal that their work is shaped by several key concepts relating to care which are not always easily integrated with one another. Amongst the participants in this study there was a common perception that they are stretched to really deliver care to young people within the constraints of a flawed system, yet, conversely, they described a practice-based work ethic that is rooted in a belief that their working relationship is a vehicle for delivering care. However true this may be, it is significant that these workers were far more likely to critique the daily minutiae and practical limitations of the system in which they operated, than to analyse the fluid, amorphous and at times conflicting meanings attached to the very concept of care. This literature review explores notions of ethical care giving in the specific context of the residential care environment and unpacks some historical and contemporary specifics that surround such a discussion when considering care that is delivered as a service of the state.

Defining the concept of care

Young people living in the care of the state are potentially some of society's most marginalised and at risk young people. The importance of creating an environment that enables them not only to live safely but also to develop as people with a sense of agency is of fundamental importance. The residential care environment, the parameters of which are broadly defined and enforced by the state, is animated and brought to life by those carers whose job it is to deliver the care. Definitions of care are constructed such that "boundaries are differentially drawn around what constitutes care, with the effect of excluding or including sets of social relations in definitions of caring relationships" (Thomas 1993, p. 649). Pertinent to this study is the observation by England (2005, p. 381) that "some jobs involve providing care for pay; child care providers, teachers, nurses, doctors and therapists all provide care. Some care is provided without pay; for example, parents rear their children and adults care for their disabled kin". The notion of 'care for pay' heralds the arrival of care into the marketplace, and gives rise to the boundaries as defined by Thomas (1993). These boundaries are informed as much by legislation and organisational policies and procedures as they are by personal boundaries and social norms. Steckley and Smith state that this combination has led to "legalistic and instrumental discourses that dominate public policy, [and] children have become more 'cared about' than 'cared for' – subject to a benign neglect and denied the more intimate relational care that they need" (2011, p. 186). This almost sterile-sounding critique of the residential care environment suggests a neutrality on behalf of not only the system itself, but by the care givers too. The findings of this study, however, challenge such conclusions.

In recent decades there has been some discussion around care and what care giving means; however, this has largely been situated within the fields of philosophy and policy development (Reich

1995). Care has “a long history in Western philosophy and culture” states Fine (2005, p. 247), although the “social phenomenon of care has only recently begun to receive the serious attention it deserves from social researchers. This neglect appears to be the result of care being understood primarily as a family responsibility” (2005, p. 247). Young people living in the care of the state are no longer solely in the care of their family, and often have no contact with family at all. This in itself warrants further investigation to discover the nature and reality of care when institutionally delivered in an environment that may, or may not, be a pseudo family-like experience.

The concept of care outside of a family setting is broadly used across a range of professions and activities (Sevenhuijsen 2003). It is intertwined with personal and social obligations, for as Held (2006, p. 10) states, the focus of much care discourse is “the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility”. Specifically, the treatment of young people who are in the care of the state has increasingly attracted attention over recent decades, with the “notion that there are young people who cannot be contained within a family living situation [generating] public and political concern” (Emond 2002, p. 322). How this notion is understood, however, is highly subjective and the delivery of the care is affected by the constraints of the system within which it is situated. “Many terms have been used in the literature on residential care to refer to the direct, hands-on work, and the term ‘care’ itself has been questioned in this context” (Anglin 2002, p. 97). Fundamental to the definition of care is the recognition that “human beings are dependant for many years of their lives, that the moral claim of those dependant on us for the care they need is pressing, and that there are highly important moral aspects in developing the relations of caring that enable human beings to live and progress” (Held 2006, p.10). The findings of Manso et al. speak to the specific focus of this study. They found that carers whose practice was to establish positive working relationships with young people in care were able to fill some of the functions of care that were similar to parenting. “In other words, by demonstrating accurate empathy, listening, and commitment, being forthright and honest, and by establishing structure and expectations, they are functioning as a good parent would” (2008, p. 68). The concept of residential care work being akin to parenting is explored in greater depth in a later chapter. What is of interest at this point of the study is the location and interpretation of care giving and its place in the social world.

As far back as 1983, it was observed that absence of care from the agenda of social researchers was largely due to the fact that care continued to be viewed as a domestic, private and overall female concern (Graham 1983). The conceptual understanding of care remained “not uniformly defined, nor its epistemological status clear” (Thomas 1993, p. 649). There has been a particular interest in care giving, and the ethics of such work, from writers in previous decades (Hochschild 1983; Abrams 1989; Daly & Lewis 2000; Held 2006; Tronto 2010), but as Fine asserts, there has been a dearth of focused and deliberate sociological research where care is identified as a core sociological topic (2005, p. 249). Fine continues to assert that, to date, care “remains a topic that has commanded little mainstream

interest at the level of theory” (2005, p. 262) and challenges researchers and theorists to remedy this, and invest a renewed level of interest into researching theories of care. It is here that the focus of this study sits. Drawing on research into the disciplines of nursing and aged care, some comparative analysis may be found in the work of Twigg (2000), Goyder (2001) and Lawler (2006). Twigg, Goyder and Lawler all propose that care work that is closely connected to caring for the human body is perceived as low status care work, and the value of not only the work itself, but of both the giver and receiver of it is considered undesirable and as a result, does not have a high social value placed on it. Twigg (2000) emphasises that the closer the care work is connected to caring for the body and its associated functions, the lower the value is that is placed on the work.

This places residential care work in a unique position, and this thesis argues that this position deserves some greater scrutiny. The work of a residential care giver, as will be discussed through the coming chapters, is holistic and broad reaching. Through the interviews, participants described attending to care tasks that very much reflect work that is often physically close and can include caring for bodily functions; tasks such as changing soiled bed linen, cleaning car seats that had been urinated on, mopping vomit off floors and cleaning bathrooms. However, for the participants, providing care was much more than just physical care for the bodies and environments of young people. The interviewees described the importance of their work through small and subtle experiences of success that ranged from growth in personal confidence in the young person, family reunification, reduction in violent behaviours, returning to regular school attendance and perhaps most significantly, to healthy participation in community events such as sport and employment. Care work is often misunderstood and considered as ‘low level’ work by society, and investigations into new theories of care are needed to challenge this and to bring to light the complexity of the work and the subtle importance of it.

Specific to this study, it is generally accepted that the process of delivering care to young people is “the most complex, demanding and important aspect of residential life, and yet the literature consistently acknowledges that, paradoxically, it is the least respected, valued and understood element in the provision of residential care” (Clough 2000, p. 36). This devaluing of residential care giving, and the effect it appears to have had on research into that area, has resulted in a paradigm that is skewed towards the negative. The “social and political understandings of residential care for children and young people have tended to perceive those who require such a service as, if not troubled, then certainly ‘troublesome’” (Emond 2003, p. 321). Anglin found this too, describing that “the social devaluing of the staff in group homes is associated with the societal devaluing of their residents. There appears to be a general perception amongst members of the public ... that the residents of group homes must have done something wrong to be there” (2002, p. 98). Care giving in this complex environment needs to be understood with equity and balance if what constitutes good and appropriate care is to be comprehended.

Care, childhood, the family and the state

In order to place this discussion of care into a bigger social picture, it is helpful to consider care in the context of shifting ideas about care and its connection to childhood and youth. As will be explored in the coming chapters, for some young people, their family cannot meet their needs or protect them from harm. Historically, the legitimacy of intervening in such families has been recognised for some time: since at least the mid-nineteenth century child rescue and child protection movements in Australia campaigned for powers to remove children from 'dangerous' family environments, though the grounds on which family homes might be deemed 'dangerous' have shifted over time (Scott & Swain 2002; Swain & Hillel 2010).

Historical studies have shown that social constructs of childhood, and our understandings of it, have changed. In the period between 1500 and 1900, the Western experience of childhood, and the hitherto understood functions of care giving actions associated with it, changed quite profoundly. "At the beginning of the period, childhood for most children from about the age of seven consisted of a slow initiation to the world of adult work. At the end of the period in nearly every country regular schooling was compulsory for all children" (Cunningham 2005, p. 81). Throughout this period, care was a domestic undertaking with responsibility for it largely falling to the female population of the house, usually the mother (Tronto 2015), yet, as Hendrick (1994; 2003) has shown, there was a parallel expansion of state and charitable organisations' involvement in providing care for impoverished children. Yeo (1996) has argued that during the nineteenth century a generation of middle-class women used social assumptions about women as carers to claim a space for themselves within public provision of care for children, arguing that women were innately qualified to ensure the wellbeing of children and their families. This aligns with observations that continued into the twentieth century, with critics of early feminist theories such as Phillips (2007, p. 78-9) arguing that "unpaid carers were invisible to feminists in the 1960s and 1970s ... [with] debates conflating mothering with caring and treated them together". The complex topic of care being largely a female concern, a domestic priority but also sometimes a state responsibility, is further described by Phillips when she says that the placement of care both inside and outside "of institutions has also been an area of continuing debate in relation to children in need. Bowlby's work and findings of the Tavistock Institute (1951-80) in relation to maternal bonding strongly emphasized the location of 'home' as the ideal environment to raise children" (Phillips 2007, p. 108). The question of where care belongs is a topic that still requires examination, but for the sake of this investigation, it is important to note that where it is located has implications regarding who is responsible for delivering it.

The shift from childhood being an initiation that funnelled the young person into (often prescribed) adult roles and into independence, to it being a period of extended dependency, is of significance for this thesis because it denotes a change in the social understanding and placement of care. "One of modernity's cardinal features is the special importance that it has granted to childhood

in the discourses on being human. As a result, the apparatus of the modern state is dedicated to unprecedented levels of service, regulation, protection and segregation” (Ryan 2008, p. 553). The industrial revolution saw work becoming increasingly separated from homes, which in turn saw some of the broader aspects of care giving gradually become separated from households and the immediate local community. Traditional “tasks that had been organised around the household and around local institutions such as churches (for example, tasks dealing with birth, death, education, and provisions of clothing and shelter) moved outside the home and became professionalised” (Tronto 2015, p. 18).

It is generally accepted by historians that the point of compulsory, institutionalised schooling is a marker for when families moved from a peasant economy to an industrial one (Cunningham 2005) and with that came a shift in how, when and where some aspects of the care giving experience occurred. As Fine argues, care in the second half of the twentieth century was “brought into the public domain as the cumulative effect of a series of fundamental changes [that] reached a point where the availability and provision of care became an even more contentious aspect of modern life” (2005, p, 248). This is especially true when talking of vulnerable children and young people who were no longer able to be cared for in the home due to the absence of key adults at home, and of the smaller domestic communities prior to the industrial revolution (Hendrick 1994). Although patterns and timelines differed, across much of the Western world it was religious and philanthropic groups who first took responsibility for providing care services for children who could not remain with their families. From the late 1800s there was:

A tipping of the balance in action on behalf of children from philanthropy to the state, and a growing involvement of professionals and experts in the task of saving children. By the end of the century it was coming to be felt that that only state action could secure a childhood for all children, and states began to take over ... Saving the children involved moving them somewhere close to the centre of the political agenda of the state.

(Cunningham 2005, p. 140)

This was associated with a gradual movement of care into the ‘professional’ arena and a preference for institutional, larger scale, corporate models of care for young people in need. This lasted for some time, and up until late in “the 20th century, there was a primary emphasis on institutional care. Large numbers of young people were housed in orphanages, industrial or training schools, hospitals for the mentally or physically disabled, or boarding school” (Anglin 2002, p. 9).

Following World War II, new ideas about developmental psychology became more influential. Up to this point, the dominant view of childhood was that it was essentially a physical transition, evolving from biologically immature and dependent stages, to the independence of adulthood. This shift “emerged out of a strong critique of the dominant child development and family studies paradigm, with theorists ... arguing for the social construction of childhood rather than normalised development” (Tisdall 2012, p. 181). The evolution of the understanding of childhood is by no means finished, with recent developments in social analysis describing a social world of children and young

people that is no less radical or confronting than it was in previous decades. Authors such as Kehily (2010) and Moran-Ellis (2010) have argued that the past two decades have seen increased social debate about the increased risk and vulnerability that young people now find themselves in. Some researchers have identified a discourse that suggests that young people are in need of greater care now than ever before. Barr et al. (2012, p. 302) found that “instances of actual, potential and imagined risks to individual children often appear in public discourse as examples of broader familial and social deterioration. In such debates, society is represented as no longer constituting a safe space for childhood, and childhood is, in turn, constituted as posing social risks of its own”. This is not without relevance, for as Kehily observes, “it is possible to suggest that the crisis in childhood exists as a reflection of adult anxiety and insecurity in ‘new times’” (2010, p. 183). These ‘new times’ are the times that young people in residential care are living in. The combined social discussion about the nature of childhood and the socio-political pressures that inform public policy all have an impact on the formulation and the constraints of how residential care is delivered.

Despite significant changes in thinking about what kinds of care children needed for healthy development, large scale, institutionalised group care of young people in need remained the norm in most Western societies until at least the 1960s. At about that time, ideologies that centred on deinstitutionalisation, non-intervention and normalisation emerged and the state’s response to those in its care moved towards smaller, community based housing, and smaller scale group homes gained a foothold (Anglin 2002, p. 9). This brought into sharper focus the purpose and design of residential care for young people. Historically, residential homes that were designed with the intent of caring for young people have taken a variety of formats and it is difficult to make a definitive claim that they were established to achieve any one specific care-related goal. It is at least generally accepted, however, that homes and centres for children and young people have long satisfied a range of needs. These needs, however, are both those of the young people and of the socio-political environment of the time:

Residential homes fulfil functions for society and exist within the structures, expectations and demands of society. To think about life and work in residential homes without recognising the way in which external factors influence their use will lead to distortion. In particular, separating residential homes from their context results in a simplistic picture of life within the home, one in which it would appear that staff have the responsibility for practice and are to be held responsible for what happens. [The] homes themselves fulfil functions for society and are influenced by that society.

(Clough 2000, p. 49)

What is that function? To provide care. Social commentators such as Clough have noted that, over recent decades, the most basic premise of group homes was to “offer education and training, they provided housing and protection; they also removed from the streets young people who appeared to pose a threat” (Clough 2000, p. 46). The topic of the young people in residential care being a social threat will be further explored shortly, but Clough’s description of what institutional care seeks to

provide hints at the broader agenda that sits behind any model of residential care. The young people in the care of the state are, to a certain degree, ultimately shaped and influenced by the care that is delivered to them.

As social scientists turned their attention to children in the twentieth century, they helped develop the idea that particular forms of care – for instance institutional care versus foster care – could be used to effect different types of social reformation of children and families, and late in that century the child rescue movement played a pivotal role in establishing the idea that governments could and should intervene in the lives of families even if they had not sought out assistance (Swain & Hillel 2010). Little et al. observe that even within institutional care (as opposed to home-based care such as foster care) “during the last century, a general move towards family style living has occurred” (2005, p. 203). Phillips argues that this a positive step and sees the ongoing development of these models as a positive progression, describing that “moving ‘care’ from a patronising and protectionist approach of ‘keeping safe’ and ‘looking after’ to a more person-centred and self-determining approach has recently surfaced in policy and increasingly in practice” (Phillips 2007, p. 137). However, it is wise to be cautious of overly triumphalist or progressivist views of these developments. For instance, when discussing the mode and model of care services, Anglin (2004) found that for some young people who had come from ‘intact’ families and had experiences which held some positive memories for them, they disliked attempts to re-create a family like environment and enjoyed the diversity of the staffing that the residential care home provided to them. Models of care have clearly evolved over time and are likely to continue doing so. The tension between family and state provided care is a significant point and the importance of understanding the contemporary nature of state provided care is as important today as it has ever been.

Across Europe, and in Western society in general, “the family is still an important provider of care, but welfare state policies of individual countries may support and/or supplement the family in different ways, generating different social and economic outcomes” (Bettio & Plantenga 2004, p. 85). Care is often discussed in broad terms such as care for the aged, the frail and the disabled (Rogers 1990; Hugman 2005; McPhail 2008) and what has consistently been identified in such discussions is the fact that the provision of care, once traditionally assumed to be provided by the family, is no longer an assumption that can be relied upon. Families are having fewer children (meaning less progeny to look after aging parents) and adults are living longer and often in more disparate locations (Rogers 1990, p. 8-9). “Whatever the underlying cause might be, the demand, in recent years, for formal, market based care has been increasing just as the sources of supply of unpaid care at home have been most under pressure” (Fine 2005, p. 248). Families that experience trauma, crisis and ultimately breakdown, are often hard pressed to find appropriate and available care for the young people when they can no longer live in the family home. Hence the provision of state-based care.

When families fail to fulfil their duties of care, a gap is revealed, and as yet the state has not constructed an entirely satisfactory response to the question of how it can replace the family in certain types of care. When care moves outside of the home and becomes a service, certain questions around the understandings of care within those services need to be asked. Discussing the increasing bureaucratisation of residential care giving, Steckley and Smith explain how regulation and legislation have come to define, describe and prescribe *standards* of care, but not *care itself*. “The idea of the state as the corporate parent of children in care became a central idea. But while legislation set out where care was to be offered and whose duty it was to provide it, it singularly failed to define care” (2011, p. 183). The care required by a young person in residential care is all encompassing, with Bullock et al. describing that “welfare agencies are entrusted by the state with the duty of seeking to ensure that all the aspects of [care giving] ... are provided in a coherent way to those who need to enter public out-of-home care (2006, p. 1349). It is commonly understood that in Australia, and other similar Western democracies, residential care is failing and this is largely “because any concept of care is rarely seen as visible” (Steckley & Smith 2011, p. 183). Invisible care is not only hard to define, but also hard to discern, evaluate and comprehend. The risk of this is that care can become bureaucratically reduced to the base essentials, for as Cameron observes, “the marked contrast between the potential for care within families as centring on control and love, and the optimum expected from state care which is around safekeeping” (2002, p. 91). Proponents of good care, including participants in this research, argue that safekeeping alone is not enough.

Research in recent decades has brought to light the historical abuse, trauma and disadvantage faced by those young people living in the care of the state (Musgrove 2010; Swain 2015) and this has placed “residential care firmly into the complex and contentious borderland between public and private life” (Steckley & Smith 2011, p. 181). Residential care is a relative newcomer in the field of state provided out-of-home care. As this literature review of care in recent history suggests, models of care giving as a service should be viewed as fluid, not fixed, and as a result, the care given to young people should evolve and grow with the times as well. Care now sits in the public *and* private domain, and has “grown into a major policy issue for many governments ... and forms a ‘new politics of care’ [which] goes hand in hand with a search for new normative frameworks” (Sevenhuijsen 2003, p. 179). The evolution of the movement of care as a private, organic family and community function to one that is – in part – delivered by the state is pertinent to the understanding of care in the context of this study. The state’s role and actions in the delivery of residential care for at risk young people also evolves over time. This evolution is both informed by, and in accord with, policies and competing influences relevant to the dominant social paradigms of the time (Gottesman 1994, p. 2). Anglin poses a pertinent question that is fundamentally important to this discussion, asking whether “the state should be involved in removing children from their homes at all and, if so, under what circumstances” (2002, p. 6). Regardless of the answer to this question, the reality is that the state has taken an increasing role in

providing care for vulnerable members of the community (in this case, of young people), but this transition away from the private family providing care is not complete and remains an evolving, fluid concept. As Sevenhuijsen (2003, p. 179) suggests, “new normative frameworks” are needed, and this thesis seeks to help articulate: a framework for understanding care in the residential care environment.

In more recent decades, evolving social constructs and the conditions in which Western families saw themselves, gave rise to changes in the fabric of how care was understood and where it was placed. “The rise of care as a public issue seems to be the inevitable result of historic processes of social and cultural change. Foremost is the rise of feminism and the associated social and economic changes, of which the large-scale entry of married women into the work force” is possibly the most significant (Fine 2005, p. 248). What is observed here is the fact that, in some of its manifestations, care is shaped by social and political forces. One significant component of that is the development, and influence, of feminist theories. Referring to the work of Tronto, Ward and Gahagan argue that “the feminist ethic of care originated as a theoretical framework to highlight the moral dimensions of care and caring relationships by conceptualising ‘care’ as a political value” (2010, p.210). This politicisation has had an effect on care and care giving. “Now, in the early 21st century, global social and economic forces are reshaping the lives of social groups and individuals, transforming care along with other elements of social life” (Fine 2013, p. 422). Whilst being but one change, the historical significance of it has ongoing affects in contemporary society, and it contributes significantly to the milieu that care now finds itself in. In society women do (and did) “such a high proportion of paid and unpaid care work... [that] increasing women’s employment means that more of the care of children and disabled elders is provided by paid workers rather than unpaid female family members” (England 2005, p. 381). As will be observed through this thesis, the contribution of paid workers plays a practical role in influencing not only the lives of young people living in residential care, but on care itself.

Locating care in out-of-home care

It is well accepted and recognised that placing a child or young person into residential care is a decision that is not made lightly (Anglin 2014; Smith et al. 2013; Tomlinson et al. 2012; Clough 2000). They are identified as being in need of care outside of the family environment and placed in out-of-home care when they are assessed as being in crisis and their safety is at risk (Clough 2000; Tomlinson et al. 2011; Anglin 2014). As the Victorian Auditor general described, “they are in the Out-Of-Home Care (OOHC) system because in most cases the Children’s Court has decided they are at significant risk of harm, abuse or neglect from their own families and cannot remain in the home” (2014, p. ix). Placing a young person in residential care is a decision that needs to be made carefully, and when such a decision is made, it should aim to provide an environment where the risk of increased trauma is minimised, if not eliminated. This aligns with the statement of the commissioner, who said that “we are not serving vulnerable children well by placing them wherever a bed is available” (2015, p. 9). What is of interest

to this investigation is not only what leads the state to decide to remove a young person from their home, but also what constitutes suitable and effective care if they are placed into residential care.

The placement decision will usually only be made once all other avenues have been exhausted, and is often a care placement that is viewed with caution. “Residential child and youth care is a radical intervention that in many countries is perceived as a ‘last resort’ solution that should be avoided if at all possible – not least because of scepticism about its effectiveness” (Knorth et al. 2008, p. 123). Whilst such scepticism is not unwarranted, and may well be appropriate, there are often very few other options available. The Victorian Auditor general explains that a young person “will be placed in residential care if they cannot stay in other home-based placement options either because their needs are too great or because the kinship or foster care options are not available or cannot keep them safe. Residential care is often an option of last resort” (2014, p. ix). Utting (1991, p. 8) identified that residential care was deemed a last resort for most young people, describing that the young people arrived at this ‘end point’ due to a negative experience in foster care, a lack of suitable kinship care options or, as will be explored later in this chapter, because of the resultant behaviours from abusive and crisis driven family trauma. Failure to carefully and strategically place a young person in residential care at best risks the (re)emergence of trauma-informed behaviours and, at worst, of further traumatising the young person.

Residential care, in its modern format, sometimes also called ‘agency homes’ or ‘group homes’, differs significantly from foster care inasmuch as the homes are staffed exclusively by paid workers. The nature and process of the care that is provided in such an environment is still only relatively little studied and, at times, is misunderstood. Anglin presents a key difference between a foster care environment and a residential care environment when he describes this foster care example from his research:

There is also an issue of safety for both the parents and youth and any children or other relatives living in the foster home. Some of the youth in this study who enjoyed living in foster care when things were going well knew at the same time that there were occasions when they were unable to control their outbursts of anger and rage, and realised themselves on these occasions that they were unable to deal with their psychological and emotional problems adequately within a family home setting.

(2004, p. 185)

Whilst noting the risk and potential danger for both the young person and the foster family, Anglin makes a relevant finding – that the family home of a foster care family may not always be the safest, or best, place for young people to be placed. Anglin’s research into the difference between foster care and residential care suggests an opportunity to grasp a unique form of care. He concludes that “in a well-functioning group home, a young person knows that the staff will be able to accept more challenging behaviour, and can offer a safer environment while he or she can, in the words of another former group home resident, “work out a lot of my problems.” (2004, p. 185).

The fact that traumatised young people are placed into state care for their own wellbeing does not mask the fact that, at times, state care is also a way of managing the threat they pose to others. The findings of Little et al. (2005) reinforce that while residential care is often a 'last resort' option, it is also a place to offer safety for both the young people and those around them. This identifies a tension of where care sits in residential care, a tension that not only exists today, but also existed historically. Clough urges us not to disregard this duality of function, describing that "accounts which emphasise just one aspect [of the plurality of the care giving] miss the confusion which may even have been part of the attraction of residential homes: they could be seen as places which were offering improved prospects while they contained people who seemed a threat" (Clough 2000, p. 47). The balance of offering protection to and from the young people in care is an interesting dilemma when considered through the lens of care giving.

The practice of delivering care "takes place in real communities, not on philosophers' desert islands and never behind veils of ignorance, the expression of key values cannot be independent of personal sympathies. In their practical expression... [acts of care giving] are necessarily coloured by local community and tradition, and by the biography and character of their exponents" (Clark 2006, p. 76). This is not a radical notion. It has been recognised by other scholars too, with Emond describing that "research and writing on the subject of out-of-home care stresses the complexity working both with individual young people and with the group" (2002, p. 335). As Tronto (2009) argues, care is equally about the giver as it is about the receiver. Care giving involves the personal contribution of the care giver, and "sometimes it requires more than the competent delivery of standardized service: it also involves modelling ways of life and counselling over morally problematic issues" (Clark 2006, p. 75). Care giving is relational, personal and individual, and therefore, needs to be understood in the context and environment in which it is delivered.

Steckley and Smith (2011, p. 184) state that care giving "is both an activity and a disposition", and in doing so, raise an interesting point. As the state is ultimately responsible for the delivery of the care, residential care workers, acting as its conduit, must not only be able to physically conduct the act of care giving, but be appropriately inclined to do so as well. Referring to Held (2006), Steckley and Smith (2011, p. 184) also state that "a caring person not only has the appropriate motivations in responding to others or in providing care but also participates adeptly in effective practices of care". Tronto describes the potential difficulties of this when she identifies that families "make certain assumptions about the purposes of care, about meeting the particular needs of individuals, and about the internal allocation of power. In formal care institutions, however, there may well be conflicting approaches to purpose, particularity, and power arrangements" (2010, p. 160). It is this point that defines the uniqueness of the residential care giving role, where care is a mode of work practice in an environment that is both the home of the young people and the workplace of the care giver.

Ethical care

State delivered care will be guided by policies and procedures, and as such will be somewhat formalised in nature. At the same time, due to the tension and nature of the care being delivered in a workplace that is also a domestic environment, some elements of that care may be less structured and tend towards informal patterns. A focused study such as this one “offers a doorway to the study of informal systems of welfare” (Chamberlayn & King, 2000, p. 8) and, as was mentioned in the previous chapter, the tacit knowledge of the care givers is the key to understanding not only the ‘informal systems of welfare’ but of the practice of care giving when it is delivered in the complex and dynamic workspace that is state-based residential care. In many ways this study also finds resonance with the work of Larry Brendtro and the concept of the ‘Circle of Courage’ (Brendtro et al, 1990). Similar to the concept of the four social worlds as developed by Martin (2003), this concept is a youth development model that is based on four notions that are pillars for supporting young people. It is based on guiding principles of social and personal support which has its roots in traditional tribal communities in the Americas as well as the findings of contemporary psychosocial research (Brendtro et al, 1990). As Brendtro describes, it “integrates evidence from positive psychology and neuroscience with child care philosophies from traditional native cultures” (Brendtro et al, 2014, p. 10). The four pillars of this model are belonging, mastery, independence and generosity (Brendtro et al, 2005). Brendtro identifies that “using a circle of courage metaphor, many of today’s youngsters have ‘broken circles’” (2005, p. 131). The findings of this investigation suggest that the attitude of the residential care workers who were interviewed correlate well with the framework of the circle of courage and agree that working towards restoring balance, healing brokenness, is of fundamental to the work of good residential care giving.

New solutions to the provision of care have been sought because the demand for formal care as a service and commodity has effectively placed it in the market place. This has resulted in a need for alternative frameworks “to understand the ways in which people make decisions about care, family, work and relationships ... [And] an ethic of care framework has been used to analyse policies and practice relating to welfare reform” (Ward & Gahagan 2010, p. 210). Care has entered the market place, but as Petrie (2012, p. 10) states, “the impact of the market paradigm and performance indicator management in welfare has commodified children in need, undermined the helping relationship and is a significant factor in the well-documented poor outcomes for children and young people” who are, or have lived, in the care system. Whether or not care is a completely commodified entity in society is still a topic of some debate, with Himmelweit cautioning us to regard care as being “part of a whole class of occupations that are not fully commodified, in which workers have motivations that are not purely monetary and also care about the results of their work” (1999, p. 27). Generally speaking, care giving is relationship based and “because of the relationship that tends to develop, paid caring may not be so different from unpaid caring” (Himmelweit, 1999, p. 27).

Again, it is here that the focus for this thesis sits. Care is not static, it evolves in and of itself, with and through the people delivering it, and in the socio-structural forces of the time. This investigation seeks to articulate that complex environment and give voice to current day practice.

Phillips states that “care can be seen as a universal concept but there are tensions in that the diversity and the complexity of care (its context, definition, recipients) means that experiences of care are not universal. The ubiquitous nature of care can also render it meaningless. The question is how should we approach care?” (2007, p. 155). When looking for an answer to the question asked by Phillips, it is helpful to turn to a discourse of care ethics and how to articulate ethical care giving. Keller et al. (2003, p. 40) describe that “care ethics was developed as a philosophical ethic in the 1980s and 1990s, in the wake of Carol Gilligan’s *‘In a Different Voice’* (1982), which claimed that, when confronted with ethical problems, women tend to utilize an ethic of care, while men tend to use an ethic of justice”. While justice will always have a place in any discussion around understanding care giving, it is the contemporary feminist discussion on care that has the opportunity to bring to life the themes of this thesis. Tronto provides a structure within which to understand ethical care and care giving, and in which to frame the findings of this study. In her seminal book *“Moral boundaries; A political argument for care”* (2009), and also in her later work, (Tronto 2010; Tronto 2013), Tronto proposes the “four phases of caring” as a way to understand care giving.

1. Caring about:

“Caring about involves the recognition in the first place that care is necessary. It involves noting the existence of a need and an assessment that this need should be met”

(Tronto 2009, p. 106)

2. Taking care of:

This step “involves assuming some responsibility for the identified need and determining how to respond to it. Rather than simply focussing on the need of the other person, taking *care of* involves the recognition that one can act to address these unmet needs.”

(Tronto 2009, p. 106)

3. Care giving:

“Care giving involves the direct meeting of needs for care. It involves physical work, and almost always requires care givers come in contact with the objects of care”

(Tronto 2009, p. 107)

4. Care-receiving

This step involves recognition “that the object of care will respond to the care it receives...It is important to include *care-receiving* as an element of the caring process because it provides the only way to know that caring needs have actually been met”

(Tronto 2009, pp. 107-8)

Within the residential care setting these four stages are easily identified and have been described through this chapter. *Caring about*: The need to care for children and young people (inside and outside of the family) has long been recognised. *Taking care of*: State and institutional responses have likewise demonstrated a willingness to assume responsibility to ensure that care is delivered. *Care giving*: In the context of this study, the daily work conducted by residential care workers is the act of delivering the care and it is the young people themselves who are the end point as the receptors of the care (*Care-receiving*). Framed within these definitions, this investigation sits in a unique and now well-defined place: on one side is the recognised need to care for at-risk young people in a residential environment, along with the state and institutions who are tasked with delivering that care. On the other side are the young people who, while living in residential care, are receiving the care that is the work of the residential care worker. In the middle is the focal point of this study: The work of the residential care workers who are the care givers.

Tronto's four phases provide a frame from within which the nature and scope of residential care giving can be grasped. In the context of this study, Tronto's phase of 'Care giving: The direct meeting of needs' is the labour of the residential care worker. This aspect of care giving is one attribute within the analysis of care that Tronto describes as being interconnected to the other phases, but is also "analytically separate" (2009, p. 106). Across the next three chapters, the first three phases will be used to present the findings of this study and to demonstrate how they are all analytically separate, yet still fully interconnected and interdependent. As this chapter draws to its conclusion, it is useful to return to the complex concept of both understanding and defining residential care giving. Steckley and Smith identify that attending to the complexities of caring for young people living in residential care is a perilous and often difficult environment to not only work in, but to describe as well. They tell us that, because of these complexities, the descriptive "voice of residential child care has been flattened by a lexicon that has not resonated with the realities of caring for children" (2011, p. 184). This thesis attempts to work through these difficulties and unpack some of that 'flattened lexicon' by giving voice to the craft of residential care giving as understood by those who practice it.

Chapter Two 'Caring about'

"Children in residential care have generally been exposed to multiple traumas in the form of family violence, alcohol and drug abuse, or sexual, physical and emotional abuse since they were very young".

(Victorian Auditor General 2014, p. ix)

"Getting to work with them is quite a big privilege, especially at that point in their lives where a lot of them are in crisis".

(Crystal¹)

¹ Not her real name. This first usage of a reference from a personal interview participant establishes the norm for the rest of the thesis. Each name used hereafter is a pseudonym, and all such data was gathered through personal interviews. All quotes from the participant interviews are italicised.

***“Caring about involves the recognition in the first place that care is necessary.
It involves noting the existence of a need and an assessment that this need should be met”
(Tronto 2009, p. 106)***

Young people in residential care are multifariously disadvantaged and come from environments of crisis. They are disadvantaged through the situation that initially resulted in them being placed in care, through the often turbulent path of various models of out-of-home care they have experienced, and it is not unreasonable to suggest that the very fact of being in residential care is traumatic in itself. They are often in residential care because it is “the end of the road for youths who have ‘failed out’ of less restrictive environments such as foster homes or kinship care” (Hodgdon et al. 2013, p. 679). Tronto’s four phases of caring, as outlined towards the end of the previous chapter, provide a framework for understanding the findings of this thesis; in line with the first of Tronto’s phases, ‘Caring about’ (the recognition that care is necessary), this chapter specifically considers the recognition that some young people are in need of the provision of the specialised form of care, outside of the family environment, that residential care seeks to provide. The young people who are placed in residential care are there because of disadvantage, crisis and exposure to trauma, and it falls to the state to respond with the provision of more appropriate care in its place. This chapter also argues that a contextualised understanding of this background of the young people in residential care must inform practice. This is essential if appropriate, holistic and meaningful care is to be provided.

The recognition that care is needed

A crisis in the family of a young person is not necessarily a pathway to residential care. Crises that are rooted in prolonged trauma, abuse and family violence, however, may be. Coulshed and Orme (2006) argue that the term ‘crisis’ is frequently misunderstood and misused in social welfare discussions. Defining a crisis is a difficult task and any definition needs to be located in the context in which it is being defined (O’Hagen & Smith 1991; Kehily 2010). In line with this, the crisis that will result in a young person being placed in residential care is one which must be understood fully and with empathy in order to make a positive contribution to the way in which the care is provided. As will be seen throughout this thesis, the crisis situation of each young person in residential care will not only look different, but will be experienced differently by each of those young people, and will call for unique and strategic responses by the residential care workers. For the sake of this discussion, crisis is understood as the young person being in a state of risk, where the risk might include neglect, abuse, poverty and family violence (Mather et al. 2007), and the likelihood of that risk being realised and having immediate effect on the young person is probable. In short, the risk is that of ongoing and sustained trauma.

Trauma is a complex concept and for the sake of this study it requires a clear definition. Weathers and Keane suggest that “achieving a consensus definition of trauma is essential for progress

in the field of traumatic stress. However, creating an all-purpose, general definition has proven remarkably difficult” (2007, p. 108). The *Diagnostic and Statistical Manual* (DSM) is a handbook and reference manual published by the American Psychiatric Association. Despite this thesis not being from within the field of psychiatry, the DSM provides a useful starting point for understanding trauma in the context of this study. The DSM-5 (2013, p. 830) defines trauma as “any event (or events) that may cause or threaten death, serious injury or sexual violence to an individual”. Also important for this study are the definitions it provides for abuse and neglect. It defines childhood abuse as “nonaccidental physical injury to a child ranging from minor bruises to severe fractures or death ... that is inflicted by a parent, care giver or other individual who has responsibility for the child” (2013, p. 717). It continues to define child-neglect “as any egregious act or omission by a child’s parents or other care giver that deprives the child of basic age-appropriate needs and thereby results, or has reasonable potential to result, in physical or psychological harm to the child” (2013, p. 718). These definitions align well with the anecdotes and descriptions as provided by the interview participants during the field interviews regarding the experiences of the young people they work with prior to their arrival in residential care. Despite this alignment, because of the personal nature of traumatic experiences, it is hard to settle on a universal definition of trauma and the effects of it. Herman states that:

Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence and death. They confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe.

(1992, p. 33)

Trauma, in the context of this investigation, is understood as “repetitive, prolonged, or cumulative; most often interpersonal involving direct harm, exploitation, and maltreatment ... by primary care givers or other ostensibly responsible adults; often occurring at developmentally vulnerable times in the victim’s life, especially in early childhood or adolescence” (Ford & Courtois 2009, p. 14). Such a definition sits comfortably with the experiences of young people living in residential care and supports both the content provided by the interview participants and also that of the Victorian Auditor General.

The effect of trauma is even harder to define. It has infinite manifestations and equally infinite definitions because, in itself, it is a personal experience and each individual will relate to that experience differently. Demonstrating this, Dobson and Perry state that:

Children exposed to trauma have increased neuropsychiatric problems (e.g., post-traumatic stress disorder [PTSD], depression, dissociation, conduct disorders), school and academic failure, involvement with the juvenile justice system, drug and alcohol use, antisocial behaviours, and engagement in high-risk sexual behaviour and teenage pregnancy.

(2010, p. 28)

According to Rivard et al., “a large body of evidence has accumulated showing that traumatic life experiences, such as child maltreatment and exposure to family or community violence, are associated

with developmental problems, increased risk of mental health problems, and aggressiveness” (2003, p.137). For some young people, the effects of trauma produce behaviours or needs which cannot be resolved within their family homes, and in those cases residential care may be the response.

In the 2014 report on the state of residential care services in Victoria, the Auditor General outlined a range of ways through which young people in residential care exhibit the impacts of their traumatic experiences. They “generally have significant and complex problems that may include self-harm, substance abuse, overtly sexual behaviour, aggression or violence, emotional disturbance, learning disabilities or disorders, and difficulty forming attachments. They may be depressed, anxious, angry, and/or unable to self-regulate their behaviour” (p. 2). This behavioural description aligns with what Anglin (2002, p. 111) describes as ‘pain based behaviour’. This behaviour is indicative of previous crisis and suggests a lack of resolution in the life of the young person. Anglin describes pain based behaviour as an “acting out or withdrawn nature that is triggered by the re-experiencing of psycho-emotional pain. The existence of this residue of unresolved past traumas makes interactions with youth in such pain often unpredictable and volatile” (2002, p. 111). The social, emotional and psychological factors in the young person’s life are but a few of the factors that will shape the experience of (and response to) trauma. Therefore, a deep understanding of trauma is essential in caring for young people in residential care. Ludy-Dobson and Perry argue that successfully understanding and addressing trauma in a young person is vital because:

The impact of early trauma is so profound because it occurs during those critical periods when the brain is most rapidly developing and organizing. Because the experiences of early life determine the organization and function of the mature brain, going through adverse events in childhood can have a tremendously negative impact on early brain development, including social and emotional development.

(2010, p. 28)

This affected development results in patterns of behaviour that can present as challenging and it is the role of the residential care worker to both respond to this trauma-driven behaviour and to work alongside it. Specific to this study, Anglin (2002, p. xviii) tells us that “responding to pain and pain based behaviour is the major challenge for casework staff in the group care setting”, and the data provided through the interviews of this study support this. Furthermore, this must all take place within an environment which is itself potentially traumatic if the care provided is inadequate or lacking in sufficient structure and process.

The effect of this trauma has broad reaching impacts. Not only are individual young people affected, but so is society in general. In America it was estimated in the early part of this century that the financial cost to that country of child neglect and abuse was in the vicinity of \$24 billion per year (Mather et al. 2007, p. 53). This figure included the cost of providing services to the children who were removed from their homes. More locally, according to the Victorian Auditor general (2014, p. xi) the cost of residential care services to the state of Victoria is over \$100 million dollars annually, with the

average annual cost of an individual placement ranging somewhere between \$162,880 and \$308,028. For some young people, the cost to the state is much higher, with “the key driver of individual placement cost [being] client complexity. Placements for some children with significant and extreme needs cost close to \$1 million for a year” (Auditor General 2014, p. xi). The largest component of these costs is staffing and capital resources. Good residential care giving should not only aim to be cost effective, but also be examined and reflected upon to ensure appropriate and adequate care is delivered by the staff responsible for it. This research aims to contribute to this examination of practice.

Practicing from a trauma informed base

A young person will be placed in residential care, as opposed to the other options for out-of-home care, due to the “extreme needs and challenging behaviours of the child, who is likely to have already experienced multiple placements” (Auditor General 2014, p. 2). The residential care system serves “a vulnerable population [of young people] that can be challenging to engage in services” (Smith et al. 2008, p. 1425). This challenge is exacerbated by the presence of multiple risk indicators. We are urged by Sallnas et al. not to consider risk factors (such as mental health concerns, antisocial behaviour and trauma) in isolation, rather to see them as ‘risk markers’ which, when “in combination substantially increase the risk of placement breakdown” (2004, p. 149), and this can then have consequences on the work environment of the residential care worker. Higgins and Katz note that “a higher number of children in out-of-home care are displaying increasing levels of behavioural and emotional difficulties, with fewer resources available to meet the needs ... [and] there is low morale among practitioners, leading to high levels of staff turnover and significant gaps in service” (2008, p. 44). This identifies the importance of ensuring good organisational practices to support residential care workers, who in turn can provide good care giving. Conradi suggests that good care giving “considers the uniqueness of situations – the particular relationships, communication and personal responsibilities – and the interdependency of human beings ... [and] in order to meet dilemmas it is instrumental to establish, cultivate and strengthen social connections through attentive communication” (2015, p. 117). This resonates with the core discussions contained in this thesis. It is important to consider giving care to young people in residential care both in the uniqueness of the setting and of the young people that populate it. The interdependent “relationships, communication and personal responsibilities” suggested by Conradi (2015, p. 117) are inherently vital if a practitioner is to be successful in connecting the dots that together create an environment that ultimately nurtures the development of good practice – of good care giving.

When working with traumatised young people, Abramovitz and Bloom suggest that it is better to operate with a particular mindset that approaches notions of care giving from a compassionate and informed mindset:

The starting point for a trauma based approach is that it serves to normalise symptoms and behaviours that have traditionally been pathologised and viewed as examples of personal and social deviance. In such a model ... forms of compulsive, self (and other) destructive behaviours are seen as 'normal responses to abnormal stress', originally useful coping skills for a besieged child, struggling to survive. In this way the philosophical emphasis shifts from a sickness to an injury model.

(2003, p. 4)

In line with this, it is important to view aggressive and confrontational behaviour of a young person living in residential care in light of their social context and personal/familial history. Understanding the patterns and behaviours of the young people they work with is imperative for residential care workers to make sense of the work they do. Smith et al. further expand on this concept when they articulate that young people may "seek to defend themselves against anxiety and emotional pain by employing a range of psychological defence mechanisms. They may 'project' onto others what is too difficult for them to hold inside. Unhappy children often express the fears and frustrations of their past by transferring their emotional distress onto residential workers" (2013, p. 22). Discussing his study into residential care, Anglin also noted trauma motivated behaviour, observing that "the swirl of often angry behaviours ... were fundamentally rooted in the generally under-acknowledged and largely unaddressed psychoemotional pain of the residents" (2002, p. 109). Participants in this study observed this pain and its resultant behaviours, and, as will be discussed in the next chapter, described the ways they seek to address it.

Throughout the data gathering phase of this research it became obvious that each worker had an appreciation of the traumatic backgrounds of the young people in their care. Many stories of traumatised young people presenting with aggressive, violent, antisocial behaviour were told. In accordance with the literature, for some young people, this behaviour has become a necessary survival mechanism. The participants in the study demonstrated a sound grasp of this complex nature of the young people they work with. Andrew explained that the young people are "*in care because they've either been neglected, they are exposed to family violence, sexually assaulted or that they're exposed to drugs and alcohol*". Lisbeth further reinforced this by describing that each young person in care is suffering "*from trauma: physical, mental, sexual ... just not feeling loved*", and this trauma presents in a range of behavioural ways. Workers understood that their relationship with the young people is grounded in trauma and that they need to incorporate this when responding to the behaviour presented to them.

Using trauma informed care as a starting point for practice, workers can bring a holistic world view to the space in which they build their relationship with the young person. Kyle observed that the young people generally "*don't want to be in care ... I think for every kid that I've worked with, all they want is to have a mum and a dad. That's the only thing they want; they just want family. I still think that every kid, no matter how bad the parents treated them or their upbringing, every kid just wants their mum*". This, however, can often cause the young person to experience an inner conflict which

can lead to even greater stress. McMahon and Ward state that “for children who have experienced the trauma of rejection, neglect or abuse, their inner world is often in a greater turmoil than the ‘real world’ around them” (2014, p 14). Anglin further explains this when he articulates that his interviews (in residential care units) revealed:

That the painful experiences of the residents could erupt into outbursts and explosions or lead to a wall of protectiveness aimed towards all adults. [This could result in] various combinations of the following: grief at losses and abandonment, persistent anxiety about themselves and their situation, fear or even terror ... depression and dispiritedness at a lack of meaning or a sense of purpose in their lives.

(2002, p. 109)

Thus, vulnerable young people who are living in residential care will often present with behaviours that may be seen as dangerous, either to themselves, their peers, society or those employed to work with them. The residential care worker must contend, and cope, with a range of traumatic presentations and an awareness, and acceptance, of the volatile work environment is essential for good practice by the care giver. Smith et al. argue that “carers cannot allow themselves to become overwhelmed by children’s past experiences and resultant anxieties, but need to respond confidently and spontaneously in the here and now to children’s behaviour. This is rarely straight forward and may at times involve conflict between adults and children” (2013, pp. 23-24). Crystal described in very real terms how this can look on a daily basis. *“I’ve had young people pull knives on me ... I’ve had to break up fights between young people. I’ve been screamed at various times. I guess you just roll with it. It’s kind of almost expected in that sort of an environment”*. Moore et al. state that most residential care workers “have witnessed youth in apparently uncontrollable rages striking out at everyone and everything. Perhaps even more disturbing is witnessing grief, rage or fear turned in; youth who self-harm or destroy things they value” (1997, p. 2).

In harmony with Moore et al., Lisbeth also described how trauma can manifest in a variety of ways. It can present as frustration, observing that *“they’re withdrawn, they’re mostly angry, angry at the world, angry at everybody”*. It can turn inwards, *“Sometimes they hide it and then they internalise it and then want to self-harm”*, and it can project outwards, *“Then you get the violent ones, you get all manner of things ... all manner of things”*. Sound and effective care giving needs to be flexible and versatile, able to react to and accommodate all of these presentations and workers must consider the wellbeing of themselves and the young people simultaneously. As Eileen stated, *“the most difficult aspect is being exposed to high risk on a daily basis. How do you actually deal with that? How do you deal with someone who is in your face, and exhibits those really high-risk behaviours and abusive behaviours at times? ... You have to have very, very straight boundaries”*.

Despite the complexity of this work environment, interviewees also observed the rewards of working through difficult behaviour. Katherine described working with a girl who, when *“she arrived, was 11. She had been in 22 placements in the last two and a half years – not even three years; 22*

placements including being in an adult disability unit. She's 11. So she ended up [with us] and the highlight was working with her and watching her go from throwing chairs, abusing staff members, all that sort of stuff, multiple times a day to really settling in". One broader observation that emerged from this study was that this requires resilience of the workers themselves. Speaking of the young people she had worked with, Crystal described that *"They push the boundaries a lot ... A lot of them are in pretty bad points of their lives and they can tell you to get stuffed every second of the day. If you're going to get anywhere with them (in their care needs) you need to be tolerant of that and to stick with it and to let them know that they can call you every name under the sun but you're still going to be there".* Practicing from a trauma informed base means that residential care workers act with an intention of safety, security and predictability both for the young person, and for themselves.

Providing care in the traumatised environment

One of the common themes that arose in this study was that of the need for a worker to interpret the presentation of aggressive behaviour as one which is sending a message. Young people in residential care have typically experienced dysfunctional homes, behaviours and relationships, and this often becomes normalised. "Youth who have been through trauma often come from homes in which chaos and unpredictability appear 'normal' to them, and they may respond with fear to what is actually a calm and safe situation" (Perry 2006, p. 55). The traumatised young person who has been placed in a relatively calm and quiet residential care house may struggle with this environment.

Being familiar with volatility and unpredictable adult behaviour, the young person may attempt "to take control of what they believe to be the inevitable return of chaos, they appear to 'provoke' it in order to make things feel more comfortable and predictable. Thus, the child behaves defiantly and destructively in order to prompt familiar screaming and harsh discipline. Like everyone else, they are more comfortable with what is familiar" (Perry 2006, p. 55). The familiar, whilst potentially damaging and harmful, is at least recognisable and something with which the young person is accustomed. "Children with early neglect histories and subsequent attachment-related problems rarely feel safe when placed in new, healthy care giving situations. Instead, they work to avoid close relationships, often becoming aggressive and controlling as a way to protect themselves from further hurt" (Ludy-Dobson & Perry 2010, p. 38). The young person in residential care is largely out of control of his or her physical environment, and such an attempt to exercise some control over it will most likely present as aggressive and confrontational and will be a challenge to the care environment and the people within it. On close inspection, it is ultimately a desperate attempt to assert some power and create a sense of normality.

Working with traumatised young people brings its challenges. Rose posits that a young person who has "experienced poor care, life threatening actions and/or rejection at a young age may develop an impaired understanding of herself, her carers and the world in general. These beliefs can act as the

default concept for the rest of the child's life" (2012, p. 49). This conditioning has dramatic and immediate effects on the young person's experience of the world they live in. A sound, a smell or an action that in itself may be innocent or well-intended can act as trigger for a traumatised young person. "A child who has experienced persistent violence from her father when he returns from the pub will register a smell, and when the smell is perceived again, the child (who may now be an adult) will react. This reaction could be a memory, an action or a response that can be automatic" (Rose 2012, p. 49). This automatic response is a self-protective one that may well include aggression, violent outbursts and confrontation. The participants in this study echoed Rose's position, and emphasised that having this insight was vital in situations where the young people themselves could not articulate or even understand the connections between their past trauma and their current behaviours. Brittany observed of one particular young person:

She's experienced a lot of trauma at a young age, and ... she has no understanding of that. The effects of her trauma – she doesn't even have warning signs to when she's about to feel and act a certain way. It needs to be therapeutically approached in order for her to heal, and form her own understanding of her triggers, and why she behaves in a manner that she doesn't want to behave in. She can become quite aggressive, because she's been triggered by a sense of smell, a noise, an action by someone, a sentence. She's unaware of that, and she can hurt others in that process.

One of the challenges of residential care work is to observe the 'pain based behaviour' and seek to understand it in the context of the individual situation. An informed worker will notice patterns of behaviour and triggers that suggest that the trauma is being revisited. "If they're angry there's always something behind it you know. With these kids you have to go deeper to understand why they're behaving this way and it takes a long time to connect with these kids" (Andrew). The participants of this study demonstrated an appreciation of what trauma-informed behaviours are and showed a willingness to see through them to relate to the young people as individuals with unique and fragile histories. "When I look at them, I see highly damaged young people that often have incredibly challenging behaviours as a result of their trauma and abuse and also the system that they find themselves in" (Katherine). As evidenced by their observations, such a perspective by residential care workers will facilitate the response of that worker to be one that is shaped by informed compassion rather than strictly attempting to control the situation, and this may help achieve good care outcomes. Anglin argues that "responding with understanding and respect does not necessarily prevent outbursts, it can increase the likelihood that they can be turned into learning opportunities for the youth" (2002, p. 110).

Being a residential care worker places the staff member in a space where the intimate machinations of the daily life of the state's most vulnerable young people is lived out. Although residential care settings are in some ways unlike a typical domestic setting, they are the homes of the young people who live there, and workers are therefore engaged in all of the daily needs of home life.

In attending dutifully to the 'everyday' tasks in a mindful and genuine manner the 'care space' is reinforced as a safe space and offers an experience of a safe and predictable home environment. *"It needs to be as homely as possible for them, giving them the nurture they need. They need love, they need to be guided and taught the appropriate types of affection, they need to be supported, they need to never, ever, ever, ever feel any sense of rejection from anything or anyone in the workplace"* (Brittany). Providing such an environment, one that is predictable, inclusive and 'non-rejecting', can be difficult to achieve.

The need for an authentic sense of the residential care unit being a home, not just a workplace, was raised by more than one participant. This is not always an easy task in practice. A demonstrated appreciation that the workplace of the residential care worker is also the home of the young person seemed important in the delivery of 'good care'. Crystal identified this when she observed that *"Security and consistency is huge. If we could find a way to make them want to stay and feel secure by having more a homely place to be, rather than it just being a place that they go to sleep and eat"*. As Moore et al. describe, *"for a residential care unit to feel safe, young people reported that they needed workers to realise that it was their home, and that it was the workers who were visiting their space rather than vice versa"* (2016, p. 35). Each ingredient of the experience that fosters a genuine connection with a home base, and caring people within it, works towards achieving a greater sense of security and belonging for the young person. As Brittany observed, *"It's about finding that balance in guiding them into independence but also caring for them, because they are still children. You make their dinner every night, you make them feel like it's a home"*. Reflecting on his understanding of his unique role, Kyle observed that *"they felt safe around me. They could disclose, they could even behave in an angry manner if they wanted to. You're in their home and you've got to treat it like it is their home because it is. I'm just working there but it's their home; they're there 24 hours a day – that's where they sleep, that's where they eat, that's where they talk on the phone to their friends, that's where they shower and all the rest of it"*. The worker is there to provide a diverse array of support and care, ranging from personal, holistic, social and emotional care to daily care tasks such as cooking, cleaning and recreation – all within a volatile and trauma informed environment.

One aspect of prolonged childhood trauma is that of missing nurturing care that shapes normative behaviours (Barton et al. 2012). Through the interviews, the participants demonstrated an understanding that the behaviour that they dealt with was a sign of something much deeper. Speaking of his experiences working with various young people in care, David said that *"even if they do right or wrong they didn't realise that because there wasn't anyone to respond to their actions. So most of the kids, even if they do a wrong thing, they don't realise it. They think it's okay because no one had said anything about it and they kept doing it. It becomes one of their behaviours"*. Andrew described that he saw *"lost kids. They have no place in society, they're just following others because they feel that's the only way to do that stuff. They can't rely on themselves to do things on their own; they have to rely*

on other people to direct them". When asked to expand on this concept of 'lost kids' he went on to say that he observed that one young person he worked with looked like a lost kid in terms of *"when we're out in the community he needs to be told what to do ... it's sad"*.

The desired approach to residential care giving, as described by several of the interview participants, could be portrayed as one of informed understanding, desiring to deliver stability and consistency. When asked how they see the young people they work with, most respondents aligned with the sentiment of James who said that he saw *"broken kids, that's what I see. I see broken kids and I see potential in a lot of them ... it's just tough ... I think the hard part is trying to break that barrier that they have"*. When asked what that barrier might be, the response was simple. *"Fear, fear of disappointment, in trust, not being able to trust anyone, the fear of not having stability"*. In these circumstances, an informed worker understands that central to the care that they give is the wellbeing and safety of the young person.

As will soon be described, residential care work can sometimes also provide opportunities for the worker to experience immense satisfaction and a sense of great purpose in what they do. It can help *"heal people that have [had trust] taken away from them in the past, and teaches them that it's not always going to be like that ... they need that chance to feel like they can be supported by you, and have the security of that"* (Brittany). As Lisbeth suggested, *"You just have to give the kids a second chance"*. Linda went on to provide an example of how she saw the value of this being realised in the choices of one high-risk young person she worked with:

I had a boy who was 12 when he came into care. He turned high risk within weeks of living in care. He's got a really traumatic childhood and fell into drugs straight away and began assaulting carers. It was so hard to go to work because his behaviour was so unpredictable and the rest of the place at the time was high risk as well so you had a mix of children, like ones that were doing hard drugs, heavy drugs and assaulting and trashing so it was a very hard time. He ended up growing up and getting off the drugs and focusing on starting school and he was actually attending school. He stopped assaulting staff, he is doing great now. He's in an independent living facility [attached to a residential care unit] and he's started working as well. No-one ever saw that coming! He was so traumatised and he had no trust for any adult but he's worked through it and it's awesome to see. When you see that, like, that's massive.

Care giving in this environment can take many forms, and for some interview participants, this often took the form of quite practical and immediate action. *"I went into one house and all the furniture was just trashed, so it was like 'okay we need to sort this out so they can actually sit down' and I realised how important that was"* (Amy). Whilst many participants told stories of successes that were built on slow, but long-term, changes in the life of the young people in their care, some workers told stories of more immediate impact. As Eileen described, simply by attending to the requirements of her role, she had a significant impact on the life of a young person in her care:

This young person, 14-year-old, was a heroin user, and whilst I was caring for the young person, she overdosed in her room. It was very fortunate that myself and my colleague had found her

just in time to call the ambulance, and she was transported to the hospital and she was on life support for a period of time, but luckily, because we found her within the critical period of time she survived, and without any physical damages or long-term damages. I think it was really satisfying to be sitting by her bedside, and being the person who saved her life.

Working with traumatised young people in a residential care setting can present both the residential care worker and the young person with a myriad of challenges. The challenge is that the residential care worker is required to ensure immediate support and safety whilst attempting to instigate long term changes in the life of the young person in a volatile and often explosive environment. There is “a need to integrate trauma-informed approaches in the milieu that go beyond individual or group therapy because [residential care workers] are often on the ‘front lines’ in helping youth to manage the high levels of dysregulation that lead to reactive aggression, self-harm and run-away behaviours” (Hodgdon 2013, p. 680). As Crystal observed, this can be a reality on a regular basis. *“It sucks when it does happen because it undoes your relationship to that point and what you’ve worked on. It’s a bit of a kick in the teeth and you can’t take it as personally. If they’re having a shit day, it’s not necessarily directed at you and it’s not a criticism of what you’ve done, but it’s just the way they’re expressing themselves that day”*. The young people bring a diversity of emotional realities to the environment, and often *“the fear factor comes into play. They’ll start to question themselves, saying ‘I’m not good enough to be in this world, no-one wants me’”* (Andrew). Once again, herein lies one of the challenges of sound and effective residential care giving – how to secure attachment and trust with a young person whose instinct is to avoid it?

The importance of connection

It is widely accepted that attachment concerns and a response to childhood trauma are two of the most important issues in the life of a young person living in residential care (Moore et al. 1997; Zegers et al. 2008; Hughes & Burnell 2003; Smyke et al. 2010). Zegers et al. describe that “in the case of frightening parental care giver behaviour, children may be so overwhelmed that attachment representations and behaviour patterns become disorganised” (2008, p. 92). In reference to the social context in which this occurs, Gonzalez and McLoughlin point to a structural failure at both a familial and social level. “Experiences of family violence, abuse and neglect also take place in a wider social context, where there have been failures to provide adequate protection, care and support for children at multiple levels” (2014, p. 56). Young people who have come from an environment which provided poor, neglectful, inconsistent or harmful care giving “build internal working models of attachment relationships which guide their attention and behaviour to minimize rejection and distress, or to maximize care giver attention” (Zegers et al. 2008, p. 92). Gonzalez and McLoughlin (2014, p. 56) further state that “as a result, many traumatised young people [in residential care] develop a sense of the world as being unsafe, unjust and unpredictable. This may lead to further problems in forming

healthy, trusting relationships, and having core needs met". Excessive and prolonged avoidance of attachment will "lead to insecure attachment patterns together with altered neurological development, which can have long-lasting repercussions affecting their ability to learn, self-regulate, use impulse control and form trusting relationships" (Guishard-Pine 2017, p. 32). Many young people who present with such behaviours will demonstrate self-protective actions that inhibit the development of attachment within a relationship, especially within the power imbalanced situation such as a residential care home.

The relational nature of caring for young people in residential care places attachment as a central issue. Hughes argues that young people will most likely come to living in residential care with "a complex array of deficiencies and symptoms that reflect both the traumatic effects of maltreatment as well as the effects of their failing to develop a coherent pattern of attachment behaviours toward their care givers" (2004, p. 263). This lack of attachment often becomes an ingrained pattern and the "young people carry with them extensive track records of failed relationships, unfulfilled attachments, serious deficits in social skills, low self-esteem, multiple school failures" (Smith et al. 2013, p. x). These patterns of behaviour that a young person in residential care may develop are often reinforced through residential placements that are not ideal.

Indeed, the very nature of residential care is not a space in which a young person with poor attachment behaviours might easily learn to change. With a rotating roster of shift-working staff, and a high turnover of workers, the structure of residential care lends itself to disorganisation of attachment patterns, and hence, it can be very difficult for the young person to receive the stability of relationships and support they need. "In short, placement in residential group care becomes most likely at a time when a young person is least ready for it" (Smith et al. 2013, p. x). Despite the seeming inevitable necessity for a model of care such as residential care is, this point cannot go unnoticed. Heron and Chakrabarti express this well when they say that:

Placing a child who has extreme emotional difficulties and/or behavioural problems with a group of children with similar problems is the essence of residential care. This mix of children, with so many staff, is the root cause of the failings of residential care ... To place a 'normal' child with a healthy and stable background in a children's home would probably be extremely detrimental to his or her emotional well-being. Why then, are some of the most disadvantaged children placed in such environments?

(2003, p. 94)

There seems no easy answer to the stark question asked by Heron and Chakrabarti. The participants in this study described many examples of the challenges of working in this environment, but also gave examples that demonstrated strategic and personal care giving, and ultimately, of hope.

Residential care workers will often see the daily manifestations of previous harm and poor attachment. On more than one occasion, participants identified that, at least initially, many young people were hesitant to engage with them. "*They push, push, push, so that people won't be there for them... 'See nobody stays in my life, nobody does that for me' and they push and push and push till they*

think you're going to break and not be there for them" (Lisbeth). This behaviour is most likely a self-protective response attempting to prevent further trauma, making the goal of 'good' residential care giving all that much harder to attain. Kyle explained that *"they're angry at the system, they're angry at the police or they don't know how to deal with their anger, because they haven't been taught how to deal with their anger appropriately"*. For many young people living in residential care, the starting point in an argument or discussion is often what many would consider an end point, and there may seem very little room for movement. Negotiation is a vitally important skill for any residential care worker who wishes to navigate around conflict and towards successful engagement (Anglin, 2002). Without the ability to see through the name calling, aggressive behaviour and self-protective behaviours displayed by the young people, a worker may not be able to enter the space that allows for the development of rapport and attachment. Despite its inherent challenges, the residential care environment provides a unique opportunity for the care givers to provide alternate role modelling and promote more healthy behaviours. This was caringly described by Brittany when she said:

I feel like I can give them a lot of love and nurture in an appropriate way, to teach them the balance between appropriate [and inappropriate] affection and that behaviour should, and can be, prevalent in their life. Everyone needs affection. When kids have experienced sexual abuse and they have sexualised behaviours, sometimes it can be just deemed such a negative thing. I just don't want any of these kids to grow up thinking touch is not okay, because appropriate touch is okay, it's needed for survival... A huge part of my job is creating that safe space, and trying my best to teach them appropriate love and affection, so that they can grow up and receive it in return, and not struggle with it.

Providing gentle support through the relationship they establish, many workers described what may be considered mentoring, or role modelling, for the development of a positive outlook on life. *"These kids are street smart, but just trying to get through to them that life can be better if you just have a different way of looking at things. Let them come through the trauma. It's not always bad ... there's life at the end of the tunnel"* (Simone). In responding to trauma informed attachment patterns, a worker has the opportunity to deliver care in subtle, simple, careful and meaningful ways. Alluding to a concept that is discussed in a later chapter, Smith et al. state that *"the task for workers in such situations is, like good parents, to try and understand why a child might be behaving in a particular way, to process their feelings and give them back to the child in a way that will reassure him or her"* (2013, p. 23). On a more practical level, Lisbeth explained the manner in which she responds to such situations. *"They're upset and they just need a shoulder to cry on, or they've had an access cancelled or some bad news or anything like that. They've not had that love of a parent and sometimes you have to stand up and say 'here comes a hug'"*.

Interview participants described a variety of approaches to their work, supporting the concept that a 'one size fits all' approach to residential care will not achieve consistent or satisfactory results. When discussing this concept, Katherine stated that *"each young person is different, each young person has highly individual needs, each of them have incredibly different journeys and because of that*

their care needs are incredibly different". To try and bring a rigid style of service delivery to residential care work raises potential challenges. Brittany suggested that the best approach to supporting the traumatised young person, and the subsequent attachment behaviours that they present with, is one that is guided by patience. She observed, having *"patience with that person – finding ways in which to calm them down, rather than creating obstacles in their way which sometimes makes the behaviour worse"* allows for the development of preventative behaviours rather than reactionary ones. Brittany also suggested that *"learning how to prevent [aggressive behaviour] in a nurturing way gives them the opportunity to heal, and the biggest thing in that is being empathetic as a worker and teaching them empathy within themselves"*. Andrew stated it quite simply when he said that *"there's also the need to be loved. I don't think a lot of these kids are exposed to that, they don't come from a background where they're told that 'we love you' and maybe because they are so focussed on all the negative stuff, they can't handle their behaviour"*. The modelling of appropriate behaviours takes time, reinforcement and good communication:

I was hesitant at first [but] I've somehow created good boundaries without making them feel embarrassed. It's about introducing the touch, affection and love when you are invited into that circle of trust. Before that I was just firm 'Please ask me if you want a hug, and please don't hold on for too long, because it makes me feel uncomfortable'... This helps me create a space where I can be affectionate with them, but they know the boundaries and the limits, and they won't tend to push them much... unless they want to irritate me!!"

(Brittany)

Attachment patterns, and the lack of them, is a formative factor in the life history of young people in residential care. How it manifests is going to be unique to each young person, and so too will be the response from a skilled residential care worker. With the right skills, training and support, a residential care worker has the opportunity to instigate real and effective change in the life of the young people they work with. As McMahon and Ward describe, "the worker who attempts to achieve communication with the child's inner world is operating in highly sensitive territory; here, timing, patience and an ability to demonstrate real empathy are essential" (2014, p. 14). To do this though, it is imperative that a worker appreciates the vulnerable space the young people are coming from. An ever-present mindfulness of the value, and volatility, of this space is important if consistent and helpful care is going to be delivered.

In Tronto's first phase of caring, 'Caring about', she identifies that the first phase involves the recognition that care is necessary (2009, p. 106). This chapter has outlined what that looks like for a young person who is placed in residential care. State based residential care is populated by young people who have been identified as being in crisis, are at risk of ongoing trauma and consequently, have established negative attachment patterns. This creates a care need that is now met by the state, and aligns with more recent writing of Tronto who states that the professionalisation of care has "led to the creation of many forms of institution outside of the home to perform caring duties that used to

be met in the home” (2013, p. 2). Given this, the challenge for the residential care worker is how to go about working with and amongst this trauma to achieve the desired care goals. The next chapter explores the vehicle through which to achieve that: the relationship between the young person and the residential care worker.

Chapter Three

'Taking care of'

"I think all work is done through the relationship and that's why it's so crucial to have a positive working relationship with the young people. Do they feel safe? Do they feel hurt? Do they feel validated? Do they feel that you're on their team?"

It's through that relationship that you can work with the young people to achieve outcomes".

(Katherine)

***“Rather than simply focusing on the need of the other person, taking care of involves the recognition that one can act to address these unmet met needs ... Taking care of involves notions of agency and responsibility in the caring process”
(Tronto 2009, p. 106)***

The previous chapter established that young people living in residential care are multifariously disadvantaged and have typically experienced significant trauma in their lives. Continuing to use Tronto’s framework as a guide, this next chapter moves from recognising the need to provide care to providing a response to that unmet need. Of fundamental importance to this process is the medium through which that response is delivered and the specific context in which it exists. Describing the mechanics of care, Tronto explains that care “is by nature relational, existing in the relationships among people rather than in individuals themselves” (Tronto 2013, p. 50). The relationship is a commitment on the part of the actors and, in that commitment, a responsibility is assumed. It will be argued that the relationship between the young person and the residential worker is key to achieving effective care giving in the residential care environment.

Relationships are of fundamental value to all humans. Perry tells us that “the most important property of humankind is the capacity to form and maintain relationships” (2001, p. 1). In the context of this study, we observe the value of relationships in a variety of ways. Describing young people living in residential care, Anglin argues that “building rapport and relationships with youth helps them to develop a sense of belonging and connectedness with others” (2002, p. 128). Such connections will always be located in the specific context in which the relationship is based, and that context (in this case, in residential care) must be understood and valued. This is in accord with the statement of Bessant et al. who state that any work with young people needs to be located “with the whole person in their social context” (1998, p. 235). Tronto tells us that when considering an ethical model of care giving we must remember to view care in the context of the social world of the individual people involved, and that those “individuals are conceived of as being in relationships. It makes little sense to think of individuals as if they were Robinson Crusoe, all alone, making decisions. Instead, all individuals constantly work in, through, or away from, relationships with others, who, in turn, are in differing states of providing or needing care for them” (2013, p. 31). To achieve this, workers must “engage in meaningful practice which makes sense of the uniqueness of individual’s experiences and behaviours. In doing so, the focus of interactions is not simply on their content but on the process and dynamic involved” (Ruch et al. 2010, p. 21).

Care work is a fluid entity, it moves with and through the people participating in the care process, but it is always embedded in some form of relationship. Earlier chapters in this study considered the evolution of models of state-provided care that have been observed in society in recent history, and reflected that there never seems to be a ‘right’ way for the state to provide care to vulnerable minors. Tronto encourages us to us to be optimistic about care, and observes that as a

political force, it has the potential to transform society (2013, p. 11). Such a transformation, rooted in a caring society, can (and perhaps should?) begin with the transformation of the most marginalised members of a society, and young people in residential care are certainly placed within such a category. Working in this manner can act to help individuals “to tolerate uncertainty and retain their curiosity about what is taking place within their social systems [and] is central to relationship-based practice” (Ruch et al. 2010, p. 33). This often difficult work should not be seen “primarily in terms of the clashing of rights and interests, but in terms of the way patterns of relationship can develop and sustain both an enriching collective life and the scope for genuine individual autonomy” (Nedelsky 2008, p. 146). A residential care worker who is able to achieve such goals is on a pathway to caring not only for the young person, but ultimately for society itself.

The value of the relationship as an instrument for delivering good residential care deserves greater scholarly attention. In 2016, Barker observed that there is an absence of documented literature on this topic, saying that there is “a dearth of research that investigates children and young people’s relationships, perspectives and experiences with adults within the context of out-of-home care, let alone within residential care more specifically” (2016, p. 5). Noble-Carr et al. describe findings on the value of connectedness through relationships that are in accord with this, telling us that “young people’s experiences uncovered that connectedness lies at the heart of [the experience], and is therefore the pathway for vulnerable young people to attain positive identity and meaning” (2014, p. 389). The findings of this study suggest that personal connections, through healthy and appropriate relationships, are core to the practice of good residential care work. The relationship concepts described by Noble-Carr et al. align with other broader concepts identified by rights-researcher Jennifer Nedelsky. She found that “the relational approach shifts the focus from protection against others to structuring relationships so that they foster autonomy” (Nedelsky 2008, p. 146). It is here that the discussion around residential care giving broadens to include such concepts as those mentioned above (positive identity, meaning and autonomy) as indicators of good practice that is grounded in relationships. Providing care, safety and protection for the young people in residential care is obviously fundamentally important, and it is argued throughout this chapter that the relationship is not only the vehicle through which such care is delivered, but ultimately, that it also has the potential to help realise even greater outcomes.

Strategic relationships

Whilst the work of a residential care worker is undoubtedly complex, according to some theorists, the formula for doing it effectively may be relatively simple. Describing the nature of working with young people from a youth work perspective, Martin asserts that “there is no single skill associated with youth work ... It is the place of relationships that define youth work” (2003, p.15). Martin’s description is directly applicable to the residential care environment. It is important not only to understand this,

but also to strive to achieve it, because staff working in residential facilities “may often be more influential than therapists, as they have the most direct contact with children in residence and, therefore, the greatest opportunity to make a lasting impression ... This treatment is neither magical nor mechanical – it is people interacting with people” (Moses 2000, p. 474).

Rodd and Stewart make a similar finding, stating that the “relationships that youth workers offer young people are just as valuable as the practical outcomes that youth workers seek. That is, the relationship a youth worker establishes with a young person may be even more helpful than the traditional indicators of successful youth work” (2009, p. 4). Rodd and Stewart do not stand alone in this line of thinking. Bruun and Hynan observe that “there is considerable evidence available which suggests that the formation and maintenance of working relationships between practitioners and clients has therapeutic value” (2006, p. 20). Used effectively, this therapeutic value can add value to the life and experience of the young people. Anglin (2014, p. 18) discusses how the “quality of life of younger children [in residential care] is heavily dependent upon how they are cared for day-to-day” and Parker concludes that “a concern with more distant outcomes should not be allowed to obscure that fact. After all, it is precisely the quality of these intimate and daily experiences that are widely assumed to shape the longer term outcomes” (1991, p. 31). Such a method of practice for residential care giving is indeed a relatively simple formula: establish and maintain good relationships; and whilst this may often be hard to achieve, it could well be one that has far reaching consequences.

As has been mentioned previously, the residential care environment is a unique workplace. Sapin (2013, p. 58) describes that, in normal youth work practice, a worker will create a sense of welcome that “respects and accepts young people as individuals [and] is an important first step in establishing a voluntary relationship. Recognising that young people may feel uncomfortable in new situations, youth workers will notice when new members arrive and monitor their responses”. Herein lies the unique nature of the residential care role and the space that the work occupies. Sapin’s description of good practice assumes that a youth worker is working from a place of power, such as running a program at a youth drop in centre. It is not necessarily useful for a residential care worker to think of themselves as in charge of the space they work in because the workplace is the home of the young person. The challenge for good practice is less about creating a welcome, but rather, more about making themselves welcome.

As a result of this, the development of the relationship cannot be rushed and must be conducted in a manner that is both respectful to the young person and grounded in patience. Achieving this is a subtle art form and requires persistence and a willingness to engage in activities and practices that will take time and, if viewed in isolation, may seem challenging and slow moving. As Andrew described, rapport and meaningful connection does not happen straight away. *“You can’t just come in as a greenie and expect it’s going to be smooth sailing from the start”*. Katherine added to this understanding when she said that many *“young people need a lot of time to warm up to staff members,*

they need a lot more space and that's actually a really positive thing". Across many of the interviews, a concept that emerged was that the slowly built relationship that is reliable and has a consistent presence with the young person is of real worth. The importance of a relationship that is built slowly was reinforced by David who said that rapport doesn't suddenly appear, and that *"it's going to take a very long time... For some [residential care workers] it depends how they work, how they build that relationship. As soon as you build that, it's easy. My work pattern is I take that time to make the relationship"*.

It almost seems counter intuitive to suggest that in order to achieve goals, to assist the young person to move towards independence and autonomy, a worker needs to be willing and able to engage in seemingly menial activities such as making quality small-talk, but this really is an essential element of good relationship building. Many workers will "engage in light banter with young people rather than thinking that social education of problems need to be the starting point. Taking time to listen and learn more about the young people before engaging in more serious conversation can provide a context for hearing and understanding what a young person is saying" (Sapin 2013, p. 62). The importance of this technique was quite tangible for many workers in this study and, as Amy described, it can be achieved through simply being with the young person during difficult times: *"Part of it is having our support there and just being able to sit with them through the hard times ... sometimes it's just sitting out the hard times with them and letting the time pass"*. Once established, the relationship is a pathway to achieving valuable outcomes, as David described when he said that *"there are lots of situations where you can win [with] the kids, the way they think, to win their heart"*. Sapin (2013, p. 145) describes that an effective and well-functioning relationship with a young person can enable growth in that young person. A residential care worker who both listens to, and promotes the independence of, the young person within their relationship has the opportunity to foster the development of skills and confidence. This is the foundation not only of making oneself welcome, but also for instigating change.

Clough explains that central to residential care work is the importance of genuinely respecting every individual young person. He argues that "recognising the value and dignity of every human being differs from politeness. It is an active state in which others are taken seriously; workers strive to understand, they do not patronise. The process of 'striving to understand' is important in itself for it shows that we are concerned for others" (2000, p. 106). This concern is a pathway to creating the much needed working relationship. A residential care giver is not automatically guaranteed a (positive) relationship with a young person; being in the presence of young people in residential care is a starting point, not a conclusion. Tronto (2013) tells us that merely being human does not obligate us to be in relationship with another person, and that relationships require deliberate and constructive attention, which may at times require the worker to practice a variety of skills, not the least of these being non-judgement. For youth workers "who are venturing into new cultures or communities, particularly when going into other people's homes, a non-judgemental approach to different ways of living will enable

learning about what is going on and positive relationships to develop” (Sapin 2013, p. 44). Being open to learning from the young person, allowing them to have a sense of power in the relationship, is of great importance in developing and sustaining the relationship.

In residential care the relationship between the residential care worker and the young person is more than an element of a good working environment, it is a cornerstone of professional practice that enables the work to be successfully undertaken. From their study of youth workers, Rodd and Stewart quote an interview participant as saying that “the most important thing that a youth worker can do is establish a positive relationship with the young person ... the relationship is the tool, it is my workplace, if I don’t have the relationship I can’t achieve much” (2009, p. 6). The relationship may well be understood to be a tool in the toolbox of a competent and capable residential care worker. When speaking of the importance of the relationship with the young people in the house, Lisbeth said that *“It’s for their benefit and your benefit. Sometimes it makes your day go a little easier, it makes your shift a little easier. You get to know the young person, what makes them tick, what sets them off, and you don’t want to set them off”*.

Considering the relationship as a tool was sometimes a difficult topic for participants to focus on. When asked to consider whether the relationship was a tool of the workplace, Simone was hesitant to describe it in that way because *“I wouldn’t like to say I’m using it as a tool because I would feel like I’m just being false. I do actually care about these clients and love coming to work. But it is a tool that you do need. If you didn’t have it you wouldn’t be able to do the job”*. Kyle acknowledged that the relationship was a tool, but also did so reluctantly, describing that he saw the relationship as a tool that could achieve certain ends. *“I hate saying it like this – but to get [them to do] things that they don’t really want to do. That might be even going to school. You know, sometimes they can’t be bothered going to school or it might be going to see their DHS worker. Usually they don’t want to do things like that if they’re having a bad day. It’s the relationship that does help them do positive things”*. James also acknowledged the discomfort of describing it this way, but stated that having the right intentions within the relationship is of equal importance. *“I think as soon as you can break the barriers down and you have that rapport, then you run with it. I’ll try and get the maximum progress with this child”*.

The concept of the relationship being a tool, a vehicle, through which change can be instigated, was touched on more than once. However, the reluctance of several of the participants to describe it in this manner hinted that, whilst it was recognised as a tool at times, it was something more important and personal than that. The changes it could achieve were often described around concepts such as social and emotional skill development. This fits well with the work of theorists in this field, and is seen in the words of Pazaratz who says that “it is critical for youth in [residential] treatment to develop social skills rather than be reactive” (2000, p. 1). Relationships can play a vital role as an agent of change when used effectively in care work and can assist in facilitating growth in the young people.

The importance of this is not necessarily a new topic, for as was discussed in the previous chapter, it is commonly accepted that young people in residential care will often take steps to jeopardise the forming of relationships. This is likely due to fears and deep anxieties related to previous trauma that come from close relationships. It is important for a worker to have an understanding of this fact because “central to relationship-based practice is an understanding of the role played by anxiety in response to distressing and uncertain situations” (Ruch et al. 2010, p. 30). Describing how traumatised young people will often act to minimise new and intimate connections, Howe and Fearnley describe that:

Close relationships are the one thing that these children avoid. Their developmental agenda is to control and not engage people. This denies them exposure to the very experiences they need. So long as they remain unable to relinquish control and relate fully and accurately with their carers and therapists, the children make little emotional or developmental progress.

(2003, p. 380)

The challenge for the residential care worker is to work with, and through, these responses.

As will soon be demonstrated through quotes from the interview participants, healthy and meaningful relationships are possible in residential care, and these may be of significant value to the young people. Katherine suggested that fundamental to establishing these relationships is being attentive to the young people and what they say. She said that “*probably the biggest part, the main part, is listening. Being available and listening to what they have to say*”. In a study on relationships in residential care, Gallant also found that “genuineness, strength of character, positive attitude, honesty and dependability were also considered necessary” (2003, p. 14). Writing from a youth work perspective on boundaries, Sapin (2013, p. 57) suggests that because relationships in this field are “generally more informal than those that young people have with other adults, care needs to be taken to find appropriate balance between approachability and professionalism”. The skill of a capable residential care worker appears to lie in achieving the mid-point of this balance. The findings of Barker also support this:

The most prominent finding across all of the included literature was the centrality and significance of a positive relationship between a child/young person and their worker... It is apparent that all other skills, attributes, behaviours, knowledge and qualities that make a good worker, according to children and young people in the research, either create and/or are a product of this ‘positive relationship’.

(2016, p. 8)

This is now beginning to be recognised at a more formal level, with McLeod describing that “policy initiatives have begun to recognise something that has long been indicated by research findings and by studies of young people’s views: that, for children in local authority care, having a positive and sustained personal relationship with their social worker promotes their well-being” (2008, p. 772). Despite the research of McLeod focusing on the context of social workers (which most residential care workers are not), the message is consistent with the findings of this study – that the relationship

between the young person and the worker is of fundamental importance and promotes positive outcomes, or as Tronto (2009) described, is a way of acting to address unmet needs.

The importance of relationships

The young people in the residential care work place, and the relationships within it, are delicate. The relationship is an essential element to success in this environment, but to achieve it, the relationship must be created with a genuine and authentic personal presence. In short, the worker needs to bring a real part of their 'self' to the role. This bringing of the 'self' to the work is an indication of the unique nature of residential care work. It is perhaps through such a personal contribution that a worker can find connection with the 'self' of the young person, yet workers are required to make genuine connections with numerous children and young people at once, and in settings which are not always conducive to establishing rapport. James described the daily reality of how diversely this may present, observing that a necessary skill of a residential care worker is to adapt their relationship building to suit the needs of the young person. *"One day I might find myself speaking with a teenager so I'm trying to connect with them that way, in terms of terminology and cracking some jokes, and then the other day I might be playing with an eight year old with Barbie dolls"*. In responding to the delicate nature of the work place, a residential care worker must bring a diversity of skills and a willingness to apply them to meet the individual needs of the young people in their care.

Youth work researchers (Rodd & Stewart, 2009) found that the relationship between the young person and the worker is the 'glue that holds the work together' and it is through that connection that growth may be both instigated and observed. The notion of the relationship being a glue, a bonding agent, is significant and has the opportunity to shape the residential care experience of the young person. These positive relationship experiences have the opportunity to fill a gap, to provide an alternate experience of adult/child relationships. Young people in residential care "often have not experienced healthy or successful relationships with peers or adults in their past, contributing directly to difficulties and struggles in the clients' lives. By forming relationships with clients, workers are providing a model of appropriate behaviour and allowing clients to feel safe, secure and supported in their growth and development" (Gallant 2003, p. 14). Research by Moore et al. found that young people in residential care felt "safe when workers had time to develop relationships with [the] young people, were 'on the floor' and watched out for threats. [The young people] thought staff should be well trained, approachable, available, should act to prevent problems and skilfully respond when issues arise" (2016, p.52). Once a healthy, positive and professional relationship is established, the care work of the residential care worker has the potential to affect real change in the life of the young person. This change may well be growth towards the positive identity and meaning that was described by Noble-Carr at the beginning of the chapter.

The findings of Stevens et al. provide “an argument for relationship based, long term service involvement with young people with complex needs which complements or supplements family relationships particularly when these are inactive” (2014, p. 447). To do this fairly and effectively, both the young person and the residential care worker need to be present and engaged over an extended period of time. As Morton et al. (1999, p. 14) state, “there are a number of children and adolescents in care, who have suffered traumatic early environments, for whom care is not enough to effectively address the aftermath. It is argued that these young people need consistent and high quality care which offers continuity of positive relationships”. The care Morton et al. refer to is a care that reflects connection and engagement. In their study into residential treatment centres, Smith et al. found that young people “who were more engaged ... tended to have more positive outcomes” (2008, p. 1425), and such outcomes reflect a deeper, more genuine connection with the workers employed to provide care.

Research tells us that young people are well aware of the difference between surface relationships and relationships that offer a deeper level of care, and Noble-Carr et al. describe this, stating that during their life, many vulnerable young people felt that “they did not have anyone who cared about them ... [that many] had people who provided care *for* them, but it was the depth of care *about* them (representing a more meaningful bond or connection to them), that the young people perceived was missing” (2014, p. 392). The relationship between the young person and residential care worker has the potential to be restorative, but, equally, it has the potential to be harmful. Residential care work must be done with the intention of respecting both the young person’s willingness to share and the fragility of that sharing. Even when genuine relationships are formed, they themselves are fragile. The bonds of relationship can be broken easily and in a variety of ways – most of which are out of the control of the young person. Katherine explains this in a very obvious way when she talks about staff members choosing to cease their employment: “*In residential care you hope [the young people] form a bond and a relationship with one worker and you hope that one worker doesn’t leave*”. When a residential care worker leaves, at best the relationship is broken, but at worst, the young person experiences abandonment, potentially reinforcing past traumatic experiences. This is an inherent risk in residential care practice, and one that needs to be managed carefully and strategically by the worker if no further harm is to be done.

A firmly established and genuine relationship between the worker and the young person has the potential to be healing and transformative, but must be grounded in some genuine and authentic principles. As was discussed in the previous chapter, “abused and neglected children are often found to have insecure internal working models of attachment, understood as adaptive responses to an unreliable or even dangerous interpersonal environment” (Moses 1999, p. 476). An effective residential care worker will acknowledge this and will operate in a manner that has long been recognised as good practice. In his seminal work, Carl Rogers (1951) described that a good practitioner

will be focused on the (young) person, promote the building of individual and personal strengths, demonstrate empathy and will treat people in their care with unconditional positive regard. Once a mutually respectful relationship between the residential care worker and the young person is established, the worker has the opportunity to see the young person through the lens of that relationship, and that can be an important component in the transition of the young person seeing themselves differently too. Living in the residential care context, many young people benefit from experiencing:

a sense of family life and family-like relationships characterised by a sense of belonging, caring, respect, loyalty, trust, generosity and so on... It would appear that one of the strengths of staffed group homes is that they are well-suited to providing a sense of intimacy without much of the usual emotional baggage associated with living in a family.

(Anglin 2002, p.131)

Providing a secure, safe and reliable relationship is integral to a young person feeling able to begin to form the attachment that was discussed in the previous chapter.

A healthy relationship allows for comfort, challenge and growth in the young person. This echoes the sentiment of Crystal, who said, *“Security and consistency is a big part of resi care that they don’t necessarily always get. To know that someone’s there if they need to speak to somebody, to know that they have somebody that they can trust ... just to know that that person’s there is a big part of their care”*. The participants of this study gave numerous examples of ways in which their relationship with the young people was able to have a positive impact, and apparently simple interactions can hold great significance. Speaking of one night when he was working, Kyle described how the relationship he had with the young people created what he now considers to be a particularly special memory:

There was no doubt in my mind that they were getting ready to go out and I said, all I said to them was “Mate, at least have something to eat before you go”. And this rarely happens – every single 16 year old boy – there was four of them, you know, all different personalities, all different circumstances – I cooked ... I can’t even remember what I cooked that time but I cooked it and all of us, every single one of us – me and another worker – six people, four boys, sitting around and we were just eating like a “family” and, you know, this was one of the kids he had no attachment to anyone, no attachment at all. He did not care what he did and he sat there and ate his meal, just sat there and ate it, washed up afterwards and then went off. You know, and he never did that ...

Whilst this may present as somewhat mundane experience, for Kyle it demonstrated a significant moment of care. Kyle concluded this recollection by saying that *“He was always out ... I guess at that time I was creating how it would feel to be in a family”*.

Once the relationship between the young person and the worker has been established, tested, and proven to be safe, the worker may have the opportunity to experience a response from the young person that was described by Brittany in almost intimate terms:

Without words they invite you into their circle of trust. Before we get to that point, it’s not [just] them trusting me, it’s also me trusting them. And then you find a perfect balance of power, or respect, because they want you to trust them, and you want them to trust you, and it works, it

just correlates really well, and you get to a certain level of understanding, and it's really rewarding. I suppose that point is them inviting you into that space of their life.

This sentiment is supported by Perry, who states that relationships such as these “are absolutely necessary for any of us to survive, learn, work, love and procreate ... Within this inner circle of intimate relationships, we are bonded to each other with ‘emotional glue’ – bonded with love” (2001, p. 1). The power of such relationships may then be seen through the beginning of changes in the lives of the young people.

Andrew noted that the relationship that extends over time can have valuable social and personal consequences. *“It’s really important to have that relationship with these children because how else are they going to evolve as adults? If they cannot build a relationship with adults, then they are not able to form the same relationships with other young people or other adults. They’ll just shut themselves away from the world, really”*. Not only is the relationship a tool of the residential care worker, it is a means through which healthy connections and a sense of identity can be formed. Brittany described the relationship in terms of it almost being a tangible object, a place of safety and refuge. *“It’s so important in giving them a sense of belonging, a sense of being loved and cared for. Once you have a connection with somebody that you can trust, you can help them find their own identity and place in life”*. This aligns with recognised theoretical research, with Moses telling us that “a secure relationship is based on an effective bond that reflects and responds to the unique and specific characteristics of those involved” (1999, p. 476). This can then lead other positive outcomes for the young person. Perry states that “a solid and healthy attachment with a primary care giver appears to be associated with a high probability of healthy relationships with others” (Perry 2001, p.2). As will be described in the next chapter, this is an important step in achieving not only the ‘taking care of’ aspect of good care, but also the ‘care giving’ element as well.

Building a trusting and effective relationship

Many participants in this study described the importance of being ‘present and available’ to the young people. Kidd et al. describe the importance, when working with at risk young people, of “meeting them where they are at” (2007, p. 18). Brittany explained how the value of being present over time can add to the positive memories that the young people will carry into the rest of their lives. *“They’re belonging to a genuine and significant relationship in a chapter in their life that they will always belong to ... within them they did belong in that moment, with that person, and there was impact on both parties”*. The impact on both parties (care giver and young person) within the relationship can hold great value. *“We all have people coming in and out our lives, but we always remember the ones that have changed us a little bit, and that’s when you feel like you belong to something”*. The slowly built and strong relationship between the carer and young person may have long term benefits. *“The best thing is that hopefully you have made a difference to the young person... hopefully you have given them a glimpse*

of a world that they haven't experienced in terms of relationships" (Eileen). This 'glimpse of world that they haven't experienced' may well be the doorway to future relationships that they are yet to establish.

The importance of a residential care worker seeing the value of each young person, and working towards developing a trusting relationship, was a concept that appeared through many of the interviews. As James stated, the value of the work was often as simple as *"just building that trust with that particular child"*. Trust needs to be understood within the traumatised history and life experience of the young people in question. More than one participant described the value of providing a stable and trustworthy relationship with the young people. Linda observed that *"you need to have some form of bond. In order to help them, they need to be able to communicate with you and feel comfortable with you and in order to have that you have to have a relationship. Trust is a big thing for each kid so if they don't trust you, there's no way that you can help them"*. As Moses (1999, p. 475) states, the majority of young people in residential care *"have backgrounds of abuse, neglect, or chaos, have not experienced the consistent relationships that serve to promote a sense of trust and security"*. Despite this, Barker found that *"due to the range of experiences that may have led them into care, many of the children and young people yearn for stable and trusting relationships"* (2016, p. 8). This provides for a challenging starting point for the residential care worker trying to establish a trusting relationship, but one that is of great importance for *"the development of trust between practitioner and young person, along with the provision of accessible and reliable support, have long been the cornerstones on which working relationships have been built"* (Bruun & Hynan 2006, p. 20). Interestingly, it was repeatedly reflected by the research participants that a trusting relationship was not only core to this business, but was also an enjoyable aspect of the work. *"The best part is working with young people and building that rapport and that relationship and actually seeing them beginning to trust you and believe in you"* (Katherine). Batsleer describes some benefits of developing this trust, stating that establishing trust *"enables young people to show themselves as ignorant, weak and vulnerable and therefore open to change and open to learning"* (2008, p. 98). It is here that the seeds of change are sown.

The development of a trusting relationship between the worker and the young person can be hard fought, but it is of enormous value, and leads to the delivery of good care if it is genuinely individual and tailored to each young person. As Ruch et al. assert, each *"encounter is unique, and attention must be paid to the specific circumstances of each individual"* (2010, p. 21). Katherine touched on the difficulty of achieving this when she described the challenges of working with this cohort of young people. *"I think they're the young people that it's hardest to build a relationship with. They're so damaged, and they've been screwed over by so many adults, and they're constantly being screwed over by adults, all the time, left, right and centre"*. To change this experience, indeed, to change this reality for the young people, workers must provide personal and tailored care. Crystal

described this as each residential care worker *“doing it differently ... To give the same care from every care worker would be almost impossible ... I think it would be quite monotonous and it’d probably feel like they were talking to robots if we all had the same answers and did the same things”*. Sincerity, genuine care and trust within the relationship mattered to Crystal, as shown when talking about how her work may be perceived by the young people: *“I would hate to think that that’s what they think of us, as resi care workers, that we don’t really care. They care for the next eight hours and then that’s it’. I think that to me that would break my heart if that’s what they saw”*. This point was also reiterated by Kyle:

The relationship is really important. If you’re there consistently, you do get to build that relationship up ... they can rely on you and the only way they can rely on you is if they see you there. They see you through thick and thin. If they’re having a bad day and you’re there, you’re that consistent person there for them then. A good relationships is based on trust and they start to trust you and then you can provide a positive experience for them.

Throughout the interviews it was observed that being honest with the young people and presenting with predictable behaviour are key ingredients to the ongoing success of the relationship. *“It’s really important to be very honest with the young person. Don’t give them mixed messages. When you say that you will do something, you just need to follow through. You need to be this role-model for that young person”* (Eileen). Other researchers have found that young people themselves describe a ‘good care giver’ as *“someone who cares for youth, helping to solve problems, listening and talking to them but, at the same time, being consistent, disciplined, and mature, acting as a good role model for self-control”* (Manso et al. 2008, p. 61). Brittany described how she saw this have an effect on the young people, saying that for the young people it is *“an opportunity to flourish, an opportunity to rebuild and develop within themselves, and the only way they can do that is by building trusting relationships and connections with you as a worker”*. A residential care worker who is consistent in the delivery of their work will offer relationships that reinforce and sustain this. When talking of one specific young male he worked with, Andrew described, *“When you give him that regular attention and praise it builds his confidence in adults to trusting, and you have a connection with him that he’s able to come to you. He can just express how he’s feeling or his frustration at the world, or his frustration at staff, or frustration at other kids”*.

The relationship also provides the opportunity for a sense of connection and belonging. Brittany explained that she *“might see it differently to other people, but the way I see it, when they’re belonging to a relationship, they’re belonging to a sense of being loved and being cared for”*. Brittany’s interview often moved towards a language of love, which stands somewhat alone in the interviews that were conducted, but by no means is out of context. Morley and Ife describe this very concept when they discuss that welfare work such as residential care work, which is both a public and private activity, seeks:

to cross the boundary between the public and the private in a very confronting way. It requires our understanding of 'love' to move beyond the personal and intimate confines of conventional usage, and similarly requires our professional actions and identity to be equated with the most important of human emotions, and indeed to be grounded at the very heart of humanity

(2002, p. 71)

Brittany went on to suggest that even belonging "*to that moment and that memory*" can be significant and can be a "*change in their life, because they don't have a family unit and they're used to rejection. If you can build a relationship and give them a sense of belonging for how it may be, that is enough impact then, you know, it's enough to make them feel worthwhile*". This again connects to the discourse of Morley and Ife who continue to describe that "love is more than simply values, world view and feeling good about one's humanity. It is also about action. To love is not only to feel, but also to do, and it is only in the *living out* of one's essential humanity that love can be realised" (2002, p. 71). That sense of belonging – of being loved and known – may be an otherwise rare experience in the life of a traumatised young person who is in the care of the state.

Focussing on strengths

The willingness and ability of the residential care worker to see each young person as an individual and as a possessor of redeemable qualities is perhaps another key ingredient for successful care giving in this setting. Higgins (2015, p. 36) described that "residential care workers need to actively foster positive relationships through focusing on the young person's strengths, rather than difficult behaviours". This resonates with the observations of Kyle, who said, "*They've all got something good about them. Every single one of them, no matter [that] they might be off in the streets, like stabbing people – one of them has actually stabbed people. Some of them have burgled, but when they come back, I just remember them as they've always been, because I showed them respect and they've always been respectful towards me*". Despite inherent challenges such as this example indicates, and the complex work environment in which they manifest, the general sentiment expressed by the participants of this study was one that expressed a willingness to see the strengths and qualities of each young person. "*We come into here working because we want to develop these kids and to hone in on their skills and what talents they have, and the potential that they have. We can work together to make sure that they feel needed, they feel like they're being listened to and 'we're going to help you go through this. Whether you fail or succeed, we're always going to be there for you'*" (Andrew). The dichotomy of this risk-filled environment that is also full of the potential for hopeful relationships may almost seem unreal, yet it aligns with the findings of Anglin who observed that it was important to remember that, whilst residential care is:

created for the primary purpose of providing a caring and developmental environment for young people in distress and pain and in this sense is not a naturally occurring arrangement, the relationships and experiences within the setting are, and always will be, fully real. While

human interactions that take place within the home will always be real experiences involving real persons and relations, there can be a wide range in the developmental or therapeutic value of these interactions.

(2002, p. 126).

From birth, humans are fundamentally programmed to be in relationships. Discussing the fact that as infants we are dependent on others to care for us, Tronto states that only through relationships “with others do humans become capable of making choices, and that the quality of those relationships will help or hinder one’s capacities. Human autonomy is an achievement, not a starting premise, and it is an achievement that requires many years” (Tronto 2013, p. 125). Participants observed that the development of appropriate life skills, transferable to life away from residential care, is integral to a young person having a positive outcome from their residential care experience. As David described, he saw the role of a residential care worker as “*setting the kids to a good future, like teaching them the skills and the normal disciplines which they didn't receive... They have missed lots of attention... So we've got to make sure we fill that part as much as we can*”. This view supports the findings of Manso et al. who found that “many children in residential care fail to adapt personally and socially. Neither their personal competence nor their social functioning are adequate” (2011, p. 1986). Simone described a similar concept when she said that her view of engendering life skills is that:

once they move on they are able to cope with normal society and normal cooking, cleaning. Some of them have never had that before. There's one girl I work with and her issue is personal hygiene, keeping her room tidy, she had never been taught that because she came from a house where she lived with no parental care, she urinated in her room on the floor and just certain things like that. To her that's probably normal.

A worker may recognise the absence of what may be considered essential life skills and will integrate the normalisation of these into the daily routines of the residential unit. Andrew asked:

If we're going to be coming in here and looking after these kids, well, why not teach them what we would teach our own children in our home? The values of being respectful, getting up and brushing your teeth, showering, making sure they're wearing the appropriate clothes and that you're using your manners like an everyday thing that you're trying to teach your own children at home.

As Lisbeth described, a successful experience of living in residential care will result in being ‘on par’ with other members of society. “*It's to make sure that they're healthy and their mental health is good, their physical health is good, their teeth are good, that's one less thing they have to worry about. Give them good life skills, teach them to cook, to actually have a conversation with adults, [know] the social norms, just to give them an equal footing to other kids that have a normal life*”. This aligns with the findings of Ludy-Dobson who found that “through this consistent, predictable and repetitive nurturing the child develops the capacity to self-regulate emotional states as well as to communicate his or her emotions” (2010, p. 31). The development (in the young person) of an ability to regulate emotions and of similar social skills to those of their mainstream peers, may act as a springboard into healthy adult life and beneficial participation in society.

Throughout the interviews, the importance of routine was often mentioned by the participants:

The reason why they're in residential care [is] because their parents or family members can't look after them or don't have the capacity to look after them. Routine creates stability too for them because, if they've got a routine of 'Okay, I'll get up at 8:30, go to school by 9:00, there till 2:00, come back, have afternoon tea, do some homework, might see some mates and then they go to bed and that's all like that again. It creates stability for them; it feels like they're going somewhere.
(Kyle)

That sense of 'going somewhere' is vital in the socially appropriate development of the young person. This is supported by Anglin when he writes that "establishing structure, routine and expectations with youth assists them to develop a sense of order and predictability in the world, as well as a sense of trust in the reliability of others" (2002, p. 128). One theme that emerged from the interviews was the way in which a sense of purpose, of belonging and of success in daily life were important in the healthy growth of the young people. Rutter found that "experiences of success in one arena of life led to enhanced self-esteem and a feeling of self-efficacy, enabling them to cope more successfully with the subsequent life challenges and adaptations" (1985, p. 604). Katherine described a simple and practical example of this when she declared that a regular routine of "*household chores is really important for young people to learn life skills – learn how to brush their teeth every day and all those things. Hygiene, basic cooking skills, all that comes through the relationship with the carer*".

The residential care worker has the opportunity to provide occasions for young people in their care to experience what Brooks and Goldstein describe as 'islands of competence'. They described that "researchers and clinicians have emphasised the significance of recruiting selected areas of strength or 'islands of competence' in building self-confidence, motivation, and resilience" (2008, p. 124). Identifying opportunities for the young person to feel useful and capable may allow the young person to begin to consider him or herself as being of value. Katz (1994, p. 10) described, "being able to showcase our talents, and to have them valued by important people in our lives, helps us to define our identities around that which we do best". Crystal brought this concept to life when she observed:

If they have a passion, it's something you can work with. If they have something in their lives, even if it is BMXs and pulling them apart and getting bits and then putting them back together, it's something that he enjoys and it's something you can work with. Why not get him an apprenticeship at a bike shop? It's something you can work on. I find it astonishing how a lot of people work with young people and forget to find their talents or their one thing that is right there and quite obvious that you could do a lot with.

When describing the turnaround in the behaviours of one particularly aggressive young girl, Katherine recalled an 'aha' moment. "*Just watching her change was one of my light-bulb moments going 'Shit, these kids are incredible'. That was a real highlight for me: realising that they are incredibly skilled, incredibly skilled and valuable to the community – which people don't see. People treat these young people like scum because they are in resi care and I hate that*". As can be observed through Katherine's example, when seeing the young people through the relationship they have with them, residential care workers are able to see the young people through a lens of hope and positive regard. Simone described

that by *“just actually standing back [and] showing them some respect, you’ll see them for who they are as well, not what you think they are”*. ‘Seeing them for who they are’ provides a window into the life of the young person, and a residential care worker who is able to consistently and calmly do this is offering a unique relationship through which health and healing may begin.

Care giving in any environment cannot be considered in isolation; it must be viewed in context and within relationship. Tronto tells us that “what is important to keep in mind is that claims made about individuals that do not place them in a relational setting will be incomplete” (Tronto 2013, p. 37). The argument of this chapter has been that in the residential care environment, ‘acting to address unmet needs’, or ‘taking care of’ is enabled through the relationship between the young person and the care giver. A residential care house that is founded in good relationships and has a solid foundation of home-based routine provides the opportunity not only to identify the strengths of the young people, but also to introduce greater social and community engagement; and this is understood by Tronto. She describes to us that the connections between a young person and their “primary care-taker are formative in how they continue to interact with others throughout their lives” (2009, p. 123). Here we begin to observe the pathway that is enabled through the relationship – from rapport and connection to the development of positive identity and meaning. This now leads us into the next chapter where the importance of fostering a genuine sense of being part of the broader community is discussed, with a particular focus on understanding the nature and place of the relationship within that.

Chapter Four
'Care giving'

"It is like being a parent with certain boundaries – a parent that does case notes!"

(Simone)

“Care giving involves the direct meeting of needs for care. It involves physical work, and almost always requires that care givers come in contact with the objects of care. Delivering food to camps in Somalia, volunteers arriving with culturally appropriate meals for AIDs patients, someone washing laundry, are examples of care giving. So too are the examples of care that spring most quickly to our minds: the nurse administering medication, the repair person fixing the broken thing, the mother talking with her child about the day’s events ...”
(Tronto 2009, p. 107)

Tronto’s framework for understanding care continues to offer valuable structure and a scaffolding from which to comprehend the findings of this thesis. This chapter focusses on the third element of Tronto’s framework, the concept of ‘care giving’, and, as will be observed, notions such as ‘directly meeting needs’ and ‘talking with a child about the events of the day’ are easily observed in the practice of residential care giving. This chapter begins by exploring the role, and ability, of the state to be a corporate parent and the family-like care contribution it strives to make by proxy through residential care workers. Extending from that, and drawing on the work of the previous chapters, this chapter then goes on to explore how good residential care giving can address care needs that move beyond practical day-to-day needs. In doing this, and in conjunction with the content provided by the interview participants, a greater contextual depth is added to Tronto’s framework. It will be argued that, in this light, care giving can also be understood as addressing more complex social needs as well as those (sometimes more pressing) immediate day-to-day needs.

As has been reinforced several times throughout this thesis, residential care is at once the domestic realm of those living in it, the workplace of those employed to work there and an institutional place of care. Such an environment presents a challenge when deciding not only how to define care giving, but how to deliver it. Referring to the work of Noddings, Tronto suggests that traditionally it has been understood that “the best way to think about care institutions is to model them upon the family” (2010, p. 159). This traditional approach has long held merit, with Schorr making findings that are similar to Tronto, describing that in “their responsiveness and willingness to ‘hang in there’, effective programs [that support children] are more like families than bureaucracies” (2011, p. 231). As this chapter will explore, residential care giving has elements of practice that together make a whole that is at once ‘family-like’ and at the same time can never actually be truly ‘family’. Tronto states that simply being *like* a family is not enough in itself, arguing that “while we can turn to family life to intuit some key elements of good care, to provide good care in an institutional context requires that we make explicit certain elements of care that go unspoken and that we take for granted in the family setting” (Tronto 2010, p. 159). Herein lies the challenge to understanding good residential care, one of the core goals of this thesis – to make explicit the best possible elements of residential care giving.

Using aspects of family life as a basis for good practice, whilst long appreciated as an effective model, has its limitations. Understandings of what constitute ‘good’ family and parenting experiences are subjective and are dependent on social, cultural and economic forces, and, in the case of young

people living in residential care, the often traumatic experiences that family life has previously been. Notwithstanding these facts, Tronto describes that it still seems intuitive to turn to healthy experiences of the family for a model of practice: “in part because most people’s explicit experiences of being in care relationships are rooted in the family, [therefore] we often take family care as paradigmatic of all care relations” (2010, p. 161). Attempting to explicitly critique such a paradigm presents a dual challenge: how to define its components and how to give them a practice framework in which they can be contextualised. Tronto invites an analysis of any care model that is fixed in a template of family life when she asks:

What is it that makes family care so desirable? In the first instance, family care seems somewhat automatic. No one questions seriously the purpose of family care: helping the members of the family to flourish together and, often in our culture, as individuals. In the second instance, while this care appears to be automatic, in fact, family care rests upon clearly understood lines of power and obligation: children and parents, spouses, aunts and uncles, servants, know what they owe to one another. In the third instance, family care is highly particularistic: each family evolves its own ways of doing certain things, and part of the pleasure in being cared for by someone in one’s own family is that the family member is likely to understand and act to accommodate those peculiarities.

(2010, p. 161)

Tronto identifies the seemingly automatic nature of (healthy) family care, the often hidden rituals and commitments this carries, and the fruits of this when individuals feel known and accepted. Such outcomes are the result of a complex array of obligations and expectations that have been satisfactorily met, but such an adequate meeting of needs cannot always be assumed when that model of care is transferred to an institutional setting.

In many ways the family is a socially constructed institution through which we are accustomed to giving and receiving care (Ruspini 2016), but it is not necessarily the model of the family itself which enables care. We must, therefore, think about the functions and dynamics of care that the family enables rather than just mimicking the family and expecting that this alone will mean that care is provided. It is important to remain cognisant of this fact, for, when doing so, an opportunity is presented to shape the care paradigm and also the vernacular that surrounds it. Held writes on this topic, describing that those who are “thoughtfully involved in the work of bringing up children or caring for the dependent may design better public institutions for child care, education, health care, welfare and the like – not just in terms of efficiency but in embodying the relevant values” (2006, p. 78). This aligns with the interest of this investigation, but to achieve this, key aspects of the model of care itself need to be carefully understood.

Is residential care work parenting?

Care giving in the residential care context is unique, particular and complex. Young people living in residential care are placed there under court orders, placing them in the legal care and guardianship of the state. In this setting, residential care workers act on behalf of the state to fulfil that guardianship

role and the duties associated with it. Consequently, in their daily practice, residential care workers may find themselves fulfilling a role and performing tasks that might usually be associated with family practices and, more specifically, with parenting. Discussing the concept of the state acting as parent in the context of out-of-home care, Bullock et al. ask an important question:

How far does the fact that they can act as 'good parents' compensate for the fact that they are not in certain respects 'real' parents? And, what else needs to be done to make the compensation more effective? Is it conceivable that the state can ensure the myriad benefits derived from a life-long relationship with good birth parents for the children for whom it carries responsibility?

(2006, p. 1348).

The sentiment expressed in this question posed by Bullock et al. forms the basis of much of the discussion contained within this chapter. As will be explored over the coming pages, participants in this study were somewhat divided on the topic of the work of residential care being parenting, but somewhat more united on the importance of trying to provide some of the 'myriad of benefits' normally gained from healthy and life-long relationships with parents.

On the topic of the work being like parenting, the divided position of the interview participants aligned with the findings of other researchers too. Manso et al. describe that "the opinions of researchers and experts in residential care have widely varied about whether professional caring can be equated to parenting, with some equating residential work with good parenting and others stating that residential staff cannot be thought of as surrogate parents" (2008, p. 68). Kahan suggests that "residential staff are not and cannot take the place of parents, but like care staff in boarding schools and nursing staff in hospitals they do have to, or should, fulfil many of the roles and tasks which parents would do if the children were at home" (1994, p. 327). Modern residential care attempts, where possible, to work in conjunction with parents and families, but equally, will often operate independently of the family of the young person. Anglin urges us to strive for a better understanding of this topic. He states that "the degree to which a residential home can and does fulfil family functions and nurture the emotional development of the young residents, and to what extent there is shared 'parenting' with the natural families of the children, needs to be better understood" (Anglin 2002, p. 14). This study, in part, responds to the call made by Anglin, and contributes towards an answer.

The tension of this concept of residential care givers acting both as parents and yet not as parents is perhaps best condensed by Held, who encourages us to focus on a key element within the care relationship: the strength of the bond between the carer and cared-for. Held then casts that bond in the light of a parenting paradigm, asking us to "consider mothering or fathering in the sense of caring for a child, or 'parenting' if one prefers this term. This is probably the most caring of the caring practices since the emotional tie between carer and cared-for is characteristically so strong" (2006, p. 40). At this point it is helpful to return to the discussion on this topic by Bullock et al. They make some strong and definitive claims, which reinforce some of the tension that this topic contains:

The 'state' as an impersonal entity clearly cannot provide the day-to-day care that would normally be taken to constitute 'parenting'. Secondly, it has to assume responsibility for ensuring parenting whether it wishes to or not, otherwise children might die or roam the streets. Welfare agencies are entrusted by the state with the duty of seeking to ensure that all the aspects of parenting ... are provided in a coherent way to those who need to enter public out-of-home care.

(2006, P. 1349)

Despite the inherent difficulties in residential care work, the findings of Bullock et al. challenge us to at least consider the work as being like parenting if not exactly parenting per se.

The interview participants described situations that align with the literature, often recalling performing duties that were akin to what a parent would normally do in the home. Throughout the interviews, each worker had their own understanding of whether or not their role was similar to that of a parent, with responses to the concept often being quite varied. Brittany described her work as filling a gap and *"giving an opportunity to the young people who are in care, and teaching them things they won't receive from their mum or their dad in normal life"*. She went on to provide a description that expressed both the depth and ordinariness of the role, and how, in many ways, it requires the worker to perform duties that a parent might otherwise undertake. *"You make sure they have clean clothes, you make sure they have a comfortable room, you make sure they have things they need, just like any other family. And you make sure they are educated with the level of education they're capable of doing"*. On a more fundamental level, the depth of the care giving experience was summarised when she expressed the complexity of residential care giving into one succinct statement:

If you were to simplify it, because every day is so different, and every hour and minute can be so different, it's just like [caring for] any other human being. You are there to care for them, and that comes with daily living skills, bringing them up, teaching them how to live independently, with you guiding them. And it's no different to any other home, you are there to be their carer, just like a mother or a father.

Once again in accord with the literature, several interviewees alluded to the fact that although their role assumed some of the characteristics of parenting, it was not the same as parenting. David observed that his intentions were focused on delivering the best parent-like care he could despite the imitations set by the system he worked within. He suggested that *"it's not actually parenting. It's kind of ... how can I say that ... You care about one of your kids, like another human being. You are trying to help another human ... you're trying to help another person to set their life to a good future. I mean, it's one of the best things you can do to another person"*. Without such intervention and caring support, David suggests that the young people *"are not going to improve themselves ... the future is not going to be a good one for these kids in the residential care. We give everything that a normal parent gives ... love, accommodation, transportation, education, everything. They need everything"*.

Asked whether or not she felt her role was in any way like parenting, Amy responded by saying *"I think in some extent it is, but in others it's not. We make sure they're eating healthy and making sure if they're injured they go get checked out at the hospital or go see a doctor or keep up with their*

appointments. We make sure that they're okay. We can never replace their parents or can never be their parents for them so I guess in that way it's not the same". Eileen felt that the role was parent-like, and that the care given would shift according to the age and development stage of the young person, describing that "the support is almost like being a pseudo parent, where you look after the children depending on their developmental stage, but if it's younger children, it's very much full on 24-hour care". This resonates with the response of James, who observed that "there is a certain degree of parenting in the role. Some of these kids are six, seven years old, even younger sometimes. Absolutely, there's some parenting in there, for the simplest of things [such as] teaching them how to go to the toilet. That's basic parenting, eating, eating well and eating right, basic education and their health needs".

The tension of the parent-like dichotomy of the role was further described by Brittany when she said that *"I think you have to be really careful with saying you're filling a parent role, because it's not fair on the kids. You're not, but you portray a lot of roles that a parent has. Because at the end of the day, the majority of these kids love their parents, and they can't see their parents, and you are not their parent. But you will do as much as you possibly can to not replace but fill that role in the day or night or week that you have with them, so they have a sense of a mother or father".* Expressing a similar sentiment, Kyle recalled a memory that was clearly important to him and his practice:

You get to see growth, you get to see them on their happy days, not just their angry days. You get to share things, you get to share their birthdays. I remember one [young person], it was her birthday. We went out and bought a stereo – DHS bought it – but I went out and bought it with her and I just went and set it up with her. I just listened to her play it and the role I was trying to model is what a good parent would do, you know, sit there with her, explore it with her, play with the stereo with her because she was excited about it.

For Simone, the role has similarities to that of a parent, but with some notable differences. *"I nurture them like a parent. I show my motherly ways by offering advice, encouragement. What else would a parent do, being there for them, saying 'No'. It doesn't hurt for them to hear the word no, just like any child. Being a residential [setting] ... it is like being a parent with certain boundaries – a parent that does case notes!"*

Embedded within this discussion on parenting is a topic that must also be noted. As will be touched on again in the conclusion, there is an inevitable termination of the residential care relationship that is in stark contrast to the accepted nature of 'real' parenting. In residential care, the relationship will have an end point, and while it may change and evolve within a family, the parent role is not one that has an end point. Regardless of their position on the question of the work filling a parent role, all participants described a myriad of opportunities in which they, and the young people they work with, were able to encounter positive and 'family-like' experiences.

Building social capacity

As has been discussed previously, young people living in residential care come from family environments that are not ideal. Such environments have a significant impact on the life and behaviour of the young people, for “the family is the most influential social group and the primary source of models for prosocial and antisocial behaviour ... these children tend to have greater difficulty developing positive relationships with peers and other adults and tend to have a limited repertoire of social skills” (Le’Roy et al. 2000, p. 65). The willingness, and ability, of residential care workers to positively act *in loco parentis* may be the key to successful growth and social interaction by the young people they care for. This concept connects back to the discussion in the previous chapter around the notion that the residential care worker, and the role they fulfil through the relationship they have with the young person, can be a tool that can help achieve certain ends.

The residential care relationship requires the formation of attachment and safety, and the craft of good practice is to enable enough attachment to form to foster trust, but that trust must then be carefully used to enable the young person to venture out beyond the parameters of the relationship with the worker. In this understanding, we see the residential care worker as being an agent of change for the young person, facilitating the development of certain skills through the genuine safety that exists in their relationship. Stanton-Salazar (2011, p. 1075) describes the residential care worker as being ‘an institutional agent’, saying that “an institutional agent can be defined as an individual who occupies one or more hierarchical positions of relatively high-status, either within a society or in an institution”. He goes on to state that:

Many individuals, acting as institutional agents, embrace the challenge of devising individual and collective strategies that counter the exclusionary forces inhering in societal structures... The importance and utility of this idea is that people are able to accomplish meaningful goals through their access to resources not their own ... Empowerment is constituted in terms of forms of institutional support provided by agents who are motivated to go against the grain, and to enable the empowerment of low-status individuals in need.

(2011, p. 1086)

Residential care workers have the opportunity to play an important, and powerful, role in the life of the young people they work with – that of being an agent of empowerment and change.

Connection to community outside of the residential care house may be key to assisting the young person establish and affirm healthy social relationships that can be ongoing outside of the residential care placement. Portes states that “involvement and participation in groups” (2000, p. 2) is a valuable and practical way through which to engender social stability in the young people, and this is of paramount importance given the poor track record that residential care has for providing stability for young people. Curran et al. (2013) explain that good youth work practice aims to promote participation by young people with services, organisations and communities. They continue to describe that “if young people’s needs for participation are not satisfied, the effects can interfere with other aspects of their life. For example, if young people are disempowered or alienated, the sense of

belonging and self-esteem that comes with identity can be adversely affected” (2013, p. 139). This is an important fact in the life of a young person living in residential care, and offers an opportunity in the practice of residential care work.

It is not uncommon for young people in residential care to display antisocial behaviour, and this behaviour can have repercussions, not the least of which may be alienation from community and some social networks. Leichtman and Leichtman found that “the most significant weakness of residential treatment as a modality has been in the limited attention given to helping adolescents negotiate the transition back into the community” (2008, p. 22). Practically speaking, the development of social competence is alluded to in the findings of Anglin when he describes the value of young people being empowered to make real choices. His research found that “the notion of letting young people make choices, helping them to learn what good choices are, and supporting them to make better choices appeared to be one of the key differentiating characteristics between well-functioning homes and poorly-functioning homes” (2014, p. 117). Mathur and Clark (2014, p. 713) declare that it falls to the care workers to “consistently work in collaboration with community partners to generate and sustain the resources and awareness necessary” for improved social integration. Healthy social integration is the foundation of the development of a social capacity that enables personal growth, community connection and an ability act together to achieve goals (Smith & Kulyrch 2002). The findings of this study indicate that these resources are personal, and include the ability to establish, and sustain, healthy relationships outside of, and beyond, the residential care environment.

For young people living in residential care the value of possessing such resources is significant, as it can provide role models and relationships that may otherwise be absent from their life. Jarrett et al. describe that:

an important feature of adolescent development is the formation of personal relationships between youth and adults in the larger community. In making the transition through adolescence into adulthood, young people need and benefit from relationships with a range of engaged adults outside of the family. These relationships can provide resources and benefits that helps youth connect to and eventually make the transition into the adult world.
(2005, p. 42)

Here the concept of the relationship with the residential care worker being a pathway to community involvement can be observed and recognised as being of significant formative influence. Establishing familiarity and a sense of safety between the young person and community groups/activities can allow the young person to establish their own community identity and relationships with adults within that. This familiarity can then be seen as an opportunity that allows for the maturation of the young person, and for the young person to contribute to society in a manner which allows them to see themselves (and be seen by others) as more than a liability. This is in accord with Zeldin et al. who argue that, “when communities provide an adequate degree of support, youth are capable of far more than society currently expects” (2012, p. 88). This is further supported by

Jarrett et al., who also found that “through relationships with prosocial adults, youth are socialised into shared norms, encouraged to develop meaningful social roles, and prepared for leadership roles within their local communities and the larger society” (2005, p. 42). Such relationships and connections outside of the residential care environment can form the scaffolding for personal growth.

This highlights a significant issue for the young people at the centre of this research, and within that also sits a challenge for the residential care workers whose goal it is to support them. Whilst it is recognised that community participation is important, for young people living in residential care, they may be starting from a position of disadvantage. “The way youth issues are framed for public consideration has severe consequences ... How the public thinks about social and political issues, and what policy solutions they regard as appropriate and compelling, are largely determined by the way these issues are framed in the media and public discourse” (Gilliam & Bales 2001, p. 2). The challenge this presents for young people in residential care is that they may encounter difficulties integrating themselves into mainstream community groups if they are seen to be different or a potential risk to that group. For the residential care worker, it is a challenge to work consistently to overcome the risks that limit healthy social participation by the young person. Without these, both the young person and society are lesser for it, for “when there are limited occasions for youth and adults to connect, societies miss an opportunity to move forward with a new generation of adults fully socialised for active community life and civic participation” (Jarrett et al. 2005, p. 42). If successfully achieved, this lays the foundation for the development of an individual’s sense of social identity.

Connection to community

Discussing the work of Coleman, Jarrett et al. (2005, p. 42) explain that valuable social connection experiences are “embedded within social structures and [they facilitate] the actions of individuals or corporate actors within those social structures. For Coleman, social structures included dense, overlapping social networks characterized by common standards, trust, and reciprocity”. Social structures such as sporting clubs, employment and recreational groups are the ideal pathway through which young people, especially those living in residential care, can practice and develop attributes such as those described by Coleman. As can be observed through this next example from Andrew, despite the significant effort it may have taken to achieve, connection to community can be as simple (and as valuable as) joining a local club:

We have a 14 year old boy here who doesn't really like interacting with strangers, doesn't like them at all no matter who comes in, he's really negative with them. But to be able to go out there and to do bowling and join a bowling club is a massive step. It started off with those small encouragements, taking him there, and then for him to go there by himself and to stay there is a big step for him.

More than one participant in this study observed similar experiences. Describing a young woman she worked with, Brittany said, “It’s all about baby steps I suppose, just trying to get her involved. She’s just

started basketball, so that's a bit touch and go, just trying to get her connected to various aspects of the community". Katherine described a similar experience in a joyful way when she recalled taking a young boy to Auskick (junior football training) every week. "He was so happy and I loved watching him really enjoy interacting with other kids. He had a lot of behavioural issues as well ... he'd never been in any organised sporting clubs, he'd never had anything because he was too busy being moved around different units". Katherine touches on a salient point that directly relates to the concept being discussed. Without placement stability, long term social and communal connections will be almost impossible to maintain.

As has been discussed previously, the ability of young people in residential care to enter into healthy social relationships such as those discussed in this chapter is severely hampered by the traumatic experiences of their earlier life. Without appropriate care and support during a placement in residential care, this may only be intensified, and may result in poor social engagement after leaving the care environment. Goyette (2007, p. 89) found that for young people "who leave an alternative living environment at the outset of adulthood, [social] integration is made all the more difficult by psychosocial and health factors and a lack of support in preparing for independent living and employment". Residential care is one such 'alternative living environment', and poor practice standards will leave the young people under prepared for healthy independent living and integration into society at large.

The role of the residential care worker provides unique opportunities to support young people, but in order to ensure that the prospect of seeing these opportunities realised exists, certain aspects of the care experience must be challenged and improved. One such aspect is that of placement instability experienced by many of the young people. Hodgdon et al. describe that young people in residential care regularly experience "multiple placement transitions and attachment disruptions" (2013, p. 679). With such multiplicity of moves between houses in their formative years, it is not surprising to hear the participants in this study say that the young people they work with struggle to establish strong links to community and society. The importance of stability is reinforced by Runyan et al., who state that "the benefits accrued from social connectedness in communities and within families impact the development and wellbeing of children.... [Especially] those aspects of the social structure – personal relations and networks of relations – that facilitate actions within the structure" (1998, p. 12). Without stability, and therefore consistency, these social relationships and local connections may never develop past the point of being introductory in nature.

Placement instability and regular changes of placement houses (and therefore geographical locations) leads to reduced opportunities for the development of strong social and communal connections. Young people living in residential care can "internalise experiences of instability, insecurity and marginalisation and they can come to predict, anticipate and act out what they are socialised to see as objectively probable or 'for the likes of them'" (Barker 2016, p. 665). Placement

instability can intensify such responses. Ludy-Dobson describes that “we move traumatised young people from therapist to therapist, school to school, community to community ... Indeed our systems often exacerbate or even replicate the relational impermanence and trauma of the child’s life” (2010, p. 39). The findings of this investigation suggest that the normalisation of relational impermanence, magnified through placement instability, hinders the growth and development of the young people who are supposed to be receiving care. Stability of placement allows for the formation of long term relationships with the staff of that house, which then can expand to connection to adults and other role models in the local in community. Johnson and Mendes found that young people in residential care who had routinely experienced placement instability also “had been denied opportunities that their peers take for granted. Yet despite these experiences, they had not lost their desire for a normal life” (2014, p. 19). It was common for the participants in this study to express a desire that supports this. Interviewees would often describe a keenness to support the young people in their care to feel connected to appropriate aspects of their community that could create that sense of a ‘normal life’.

The residential care worker who aims to facilitate the development of community connection, to foster the realisation of a ‘normal life’ in the young person, must step back and allow the young person to participate in the social engagement on their own terms, and this can bring with it challenges. Beck identifies the risk associated with this: “the planning of one’s own biography and social relations, gives rise to a new inequality, the inequality of dealing with insecurity and reflexivity” (Beck 1992, p. 9). This is a challenge for young people living in residential care, for the passageway towards community integration and stability is also a pathway towards adulthood, and that transition is not necessarily a straightforward experience. Valentine describes the way that, for most young people in Western society, “distinctions between the states of childhood and adulthood are not clear-cut, nor are transitions a one-off or one-way process” (2003, p. 37). Young people living in residential care often have an intensified experience of these transitions, as the move from the family home to residential care often brings about some early experiences of independence that are adult-like, yet they remain in a regulated, managed environment that is very much not a mainstream experience. Referring to the work of Beck and his concept of individualisation, Valentine argues that:

Traditional agencies such as the nuclear family, school, church and so on are no longer key agencies of social reproduction, channelling individuals into set roles. Thus Beck (1992) suggests that this destructuring of young people’s situations is placing them in a state of ambivalence. Whereas previously young people could see what possible futures awaited them now they cannot see where they are heading ... With these opportunities also come increased risk for young people, in the form of guilt or blame if they end up on the margins of society as a result of their own choices.

(2003, p. 40)

This is a salient point for, as the participants in this study often observed, a young person in residential care may often feel a lack of hope and direction in their life. The starting point of a young person living in residential care for developing social connections is further disadvantaged because,

unlike Valentine's suggested negative conclusion of 'ending up on the margins', for a young person in residential care, it is more likely to be the starting point. The research of Raffo and Reeves found that "actions and choices made by our young people are not completely open and free. Choices are often constrained by a practical knowledge and understanding of what is possible – a knowledge and understanding that is clearly mediated by locality, gender and class" (2000, p. 149). Disadvantaged young people, as those living in residential care are, are therefore operating from a position of increased limitations. Beck states that "the ability to choose and maintain one's own social relations is not an ability everyone has by nature. It is ... a learned ability which depends on special social and family backgrounds" (1992, p. 9). It is here that the crux of the challenge for the young person in residential care is highlighted, for "many young people were torn away from their social networks and family when they entered residential care, and their new networks were limited to other residents who were involved in risk taking behaviours" (Bruce & Mendes 2008, p. 8). Fostering an ability to form healthy connections with the broader social world in which they live, and providing genuine opportunities to experience it, are central to the work of good residential care giving; if they are achieved, the young person may begin to observe changes within their life and within their self.

On a day-to-day level, this work can appear mundane and very ordinary, but the value of it cannot go unrecognised. Barker and Thompson (2015, p. 131) posit that "through social networks and connections to other people, individuals gain access to valued resources". Talking about one particular young person, Brittany described how it is all about small steps, but small steps that are in the right direction. Describing a young girl she worked with, she observed that "*she struggles with making friends, and we're trying to teach her how to ... she's very much a child, but she's a teenager, so we've been taking her to the Girl Guides so she can still have that part of her life [once she leaves residential care]*". Such progress is achievable, repeatable and easily accessible. It is the 'ordinariness' of such experiences that may well be the key to their being successful. Some participants also saw fostering a level of familiarity and social comfort with the local resources of the neighbourhood as important. James saw this as having positive outcomes, and explained it as constituting activities that were relatively easy to coordinate. He described it as "*taking them to skate parks, bike riding ... or going to the local trampolining place*" and outlined how "*for some kids it'll be just going outside and kicking the ball. The simplest of interactions with kids is a huge, huge thing, even kicking a ball or playing catch, things like that was huge in terms of connecting with the children and building the trust with them*".

When talking of a young 15 year old male, Crystal described the value of encouraging his love of bike riding. "*You can't buy that. You can't go and sit in a doctor's chair and get that. It's a passion that you have for a certain activity that can remove yourself from everything else that's going on, which, if a young person can find, that is something pretty important to tap into I think*". The importance of the development of skills and the ability to grow their own social competence was not lost on Brittany, who saw it as a fundamentally important aspect of the work. "*You need to connect*

them, you need to 'outsource' them to the community and other people. And if they struggle socially, you need to help them work on that, so they can be socially accepted and have an opportunity to have relationships". This observation by Brittany resonates with the discussion of Barker and Thompson who say that for an experience to represent connection to community, it must constitute three components: "(1) Contact with a group of people (or a person); (2) access to valued resources (such as to economic, cultural, or social capital); and, (3) trust or shared norms of obligation" (2015, p. 133). The recognition that this can be a fundamentally important aspect of the residential care worker's role is one that, once recognised as integral to long-term good practice, can have positive and long lasting effects for the future life of the young person.

According to Pazaratz, when a young person in residential care is able to move away from "anger and become conscious of obtainable opportunities in the real world and see themselves capable of functioning in it, then change may occur" (2000, p. 42). This change can provide a pathway for the young person to engage more fully with the community and society at large. Describing findings from their study into vulnerable young people, Noble-Carr et al. (2014) identified five critical domains for building positive identity and meaning: caring relationships; participation and contribution within their communities; achieving a sense of belonging; competence and hope. This resonates with the work of Vacca, who found that young people in state care lacked access to "extracurricular clubs and sports, and other activities that are vital to obtaining a well-rounded education" (2007, p. 1080). A 'well rounded education' that has roots in healthy social engagement has immense value. Mathur and Clark explain how achieving this connection to community, especially through groups, can lead to measurable results. They found that collaboration and social connection "can improve educational success and youth engagement" (2014, p. 714). In line with this, the participants in this study did see achieving healthy connection to society and community as an important end point for the residential care relationship, but they also described that appropriate connection to education was a significant component in achieving this.

Connecting to education and measuring growth

The importance of the connection to education was undisputed across all interviews, and this is in union with what research says, too. According to the findings of Vacca (2007, p. 1082), young people who live in institutional care are much more likely to struggle academically due to contributing factors such as frequent moves, lack of support and unmet social needs. Crawford and Tilbury found that:

Young people in the care of the state are reported as having generally poor education and employment outcomes due to such factors as high rates of school exclusions and non-attendance, frequent placement moves with consequent school disruptions, deprived pre-care backgrounds, lack of coordination between education and child protection personnel, lack of attention to educational needs by professionals, and low expectations held by caseworkers.

(2007, p. 308)

The effect of this was supported throughout the literature. Zetlin et al. state that young people in state care “demonstrate a variety of academic difficulties including weaker cognitive abilities and lower academic achievement and classroom performance compared to nonmaltreated children” (2005, p. 812). This lower level of academic and educational achievement has consequences, with Zimma et al. (2008) finding that a disproportionate number of children living in out-of-home placements manifest signs of behaviour problems, poor academic achievement and school failure. Stone (2007, p. 140) summarises that “research consistently finds associations between poor educational performance and child maltreatment and placement in out-of-home care”. In addition, young people in residential care will often have a poor connection with formal education regardless of their ability to achieve academic milestones. Given this, it comes as no surprise that the importance of education and connection to the school community was commonly described across all interviews.

When discussing what progress with the young people he works with might look like, James responded that *“for the most part, with a lot of the kids that I work with, it’s just getting them to school. Then from getting them to school, branching out again and going to more classes and being more active at school, then there’d be sports, get them involved with sports activities and [activities] out of school as well”*. It was noted by most interview participants that an increased connection to schooling is viewed as success, even when the steps towards it are small. Andrew described how *“a young man that we have here doesn’t go to school at all. [The staff] have little incentives for him when he does decide to go school. That just means we’re not giving up on him you know and he’s not giving up on himself”*. Returning to school after a long absence could be what Eileen called *“a glimpse of change within the young person”*. Regular attendance at school can offer more than a connection to education, it can offer a pathway to ongoing social and emotional support. Eileen went on to support that theory by observing that *“a young person who has been isolated from education, and their social networks, with the worker’s support can be linked to education, and that’s a positive outcome”*. As Simone described, *“If they don’t have an education now they will never be able to get a good enough job. Schooling – it’s social skills, and education can teach your life skills as well”*. Describing the commencement of a ‘morning shift’ Linda described how she appreciated the ‘normalisation’ of the young people attending school:

I walk through the door and the kids are usually getting up and eating breakfast for school. They greet you at the door with either a big hug or some form of “hello” and then it’s the school run. This is my favourite time – watching the kids go off to school and then picking them up. I just really enjoy wishing them a good day and seeing them complaining [about going] to school because they don’t want to go but are then happy when you pick them up. And it’s just normal.

More than one participant observed that they considered connection to education as being important, but the commitment of David indicated that his rapport and closeness with a particular young person allowed him to notice the absence of some fundamental skills:

She was going to school. We didn't have any problem with her schooling because she was going to school full time, five days a week, and we didn't even have any trouble taking her to school ... Once I started working with [her] I realised even though she goes to school every day she hasn't learned anything. I mean, nothing, even her reading, nil. Her writing skills, nil. She is eight years old at that time and don't even know ... she didn't even know to write one, two, three – one to ten. When I had the chance to [give my] full attention to her, every day after school we did an hour of learning ... During the way back home we discussed all the stuff, "What do you want to have for dinner tonight?" We have that conversation and, okay, what are we going to watch this movie and that movie, okay. Before we all do that we've got to do a bit of homework, which she don't really like. She started crying, don't want to do anything, but I just do my kitchen work and stuff and she just played around and then the next 10, 15 minutes she knows she's not getting my attention. She can't do anything and she's like, "All right, let's do this then." And it took me about a week for her to teach from one to ten. She started learning how to do one to 10 and then 10 to 20. Then she sort of learned the pattern, like how it's going to be 30, 31, 32, 40 and then I sort of told her, "Okay, this is the same pattern up to 100. All you have to learn is this." She clicked, gets the pattern. It's like she's, "Wow, this is easy." And then she likes it. She's very happy ... It was amazing work. I loved it.

The work of Fine offers some specific direction that encourages the residential care giving to be seen in the light of such outcomes that are derived from the relationship. Fine asserts that care “needs to be seen not simply as a one directional activity undertaken by the care giver, but as the outcome of a relationship between the different parties in which mutual respect, and the fostering of capabilities and autonomy of the recipient, are foremost” (2005, p. 257). Parent and/or family-like or not, the relationship between the young person and the care giver can provide an opportunity to promote autonomy, independence and healthy social connections that very much reflect a ‘directly meeting of needs’.

At its simplest, and possibly clearest, it was perhaps summed up best when Lisbeth said that a good outcome (for the young people) meant *“Being a participant in our community, having a job, having purpose, having a meaning to get up, to get up every day, to be part of society. That’s all you can hope for, you know, that they’re doing their civic duty, they’re doing what they need to be doing, they’re functioning [in areas] where it’s not been very functional in their lives”*. Runyan et al. also support this understanding, and report to us that their findings “suggest that those interested in the healthy development of children, particularly children most at risk for poor developmental outcomes, can intervene to reduce isolation and nurture interpersonal relationships in a variety of ways” (1998, p. 18). These outcomes, especially when based in a connection to community and education, may become protective factors in the lives of the young people, or to put it more simply, as Putnam (2001, p. 296) says, healthy connection to community “keeps bad things from happening to good kids”.

Igniting an authentic interest in education, and a connection to the schooling system, is one indicator of good practice for residential care workers. It is a practical and observable measure of growth and a measure of success. Measuring social engagement is of equal value, but somewhat more challenging to measure. Discussing the concept of measuring social connection and it being a multidimensional concept, Runyan et al. (1998, p. 18) state that measurement of social connection is

a difficult concept to grasp and “can include a number of factors ranging from features of household composition and aspects of family relationships to community support and affiliation. The best constellation of criteria to measure [social connection] has yet to be determined”. In the realm of young people in residential care, the findings of this investigation suggest that the strength of the relationship between the young person and the residential care worker, and the extent to which that relationship has been used to encourage and create healthy social and educational connections for the young person, are important indicators.

In concluding this chapter, it is perhaps fitting to return to the observations of Brittany who articulated a succinct and practical understanding of this topic. She said that good residential care practice is *“not just setting them up somewhere and leaving them. You go with them, and you support them to try and form connections outside the residential care system, because one day they will leave, and they need to be prepared for that”*. This chapter, indeed this thesis, has not been about what is wrong with the current model of state-based care. It has, rather, been about identifying positive aspects of care contained in the tacit knowledge of the residential care givers and in doing so, contributing to the knowledge base that helps articulate good, practical and genuine care that prepares the young people for a life beyond residential care.

Chapter Five

Concluding analysis

“To recognise the value of care calls into question the structure of values in our society. Care is not a parochial concern of women, a type of secondary moral question, or the work of the least well off in society. Care is a central concern of human life. It is time that we began to change our political and social institutions to reflect this truth”.

(Tronto 2009, p. 180)

“Why is care not a central category of social analysis? Care and its component pieces are discussed and thought about in our society, but they are not considered in a systematic form. Without a systematic way to think about care, the opportunity to gain a critical perspective is lost”.
(Tronto 2009, p. 112)

In concluding this thesis, I return to some of the guiding principles that have been present throughout the investigation. Tronto urges us to consider care analytically with the intention of arriving at an informed and critically evaluated systemic understanding. This thesis has developed its study of care in the context of the system of residential care in Victoria, Australia, and as such, it provides a unique perspective on a particular experience of systemic care giving. The framework for understanding care that is provided by Tronto has been utilised throughout this study and the first three parts of her four phased framework have provided a lens through which to grasp and locate concepts of care that are essential to the practice of good residential care giving. As each chapter explored, these three areas are (i) caring about, (ii) taking care of and (iii) care giving. At the heart of these areas are the concepts of being rooted in genuine relationships, trauma informed practice and connection to education and the community. These findings point to guiding principles that residential care workers see as not only being effective in performing the technical minimum requirements of their job, but also in providing authentic and personal care to the young people.

This investigation has not been without its limits and there remain opportunities for further research. What has been examined throughout the preceding chapters has built a discussion that is informed by theory and also the lived experienced of those whose work it is to deliver care in the residential care environment. Those ‘lived experiences’ have been a valuable source of information and, using the guiding principles of grounded theory research, the tacit knowledge contained within them has contributed to an increased appreciation of the complexity of residential care work and the potential value contained within it. The grounded theory methodology provided a supportive model of investigation that allowed not only for the voice of the care givers to be heard, but for it to be recognised as containing valuable and authentic knowledge. This knowledge, gained through daily practice, may at times have been so implicit that it might otherwise have gone unspoken. This supports an essential tenet of grounded theory research in that, at the heart of its philosophy, grounded theory has “a belief in the embedded nature of theory. That is, a substantive theory of practice is implicit in good practice” (Anglin 2002, p. 27). This thesis has aimed to give voice to that unspoken knowledge and begin the shaping of it as theory.

Making care accessible

As has been described throughout this study, the role of the residential care giver is a diverse one. The care that is delivered ultimately manifests itself in a myriad of ways, with each aspect of the work having a different care dimension to it, and it is often more than simply a functional interaction despite the fact that it might appear so at a surface level. Time and again it became apparent that a residential

care worker needs to be flexible and versatile in their practice, with Amy describing that, *"I don't think I've ever had a 'normal shift'. Every shift is different, like you never know who's going to be home, what's going on in the house"*. The ability of the residential care giver to be effective in their care giving often rests upon their own flexibility and responsiveness to the environment which they encounter in their work place. Katherine described how busy a typical day may be when she observed that *"You cook for them, you do basic cleaning, you run them to appointments, you make appointments, you take them to school and family access ... You often liaise with medical practitioners, you often liaise with DHS workers and other external agencies as well"*. Lisbeth explained how she felt that each aspect of the diverse nature of this care giving work is as important as the other: *"As a care giver, you play many roles, you can be a taxi service, you can be a mentor, you can be a counsellor, you can be a friend, a semi-parent, you can be a shoulder to cry on, a person to give encouragement, somebody who's always there to back you up"*. Good residential care giving is delivered in a dynamic environment and a worker must adapt their practice to suit both that environment and the young people.

When talking of the value of the work, some workers described how acceptance and the reception of care can be displayed in subtle ways, and it takes an awareness on the part of the worker to appreciate that. Brittany touched on this this when she said, *"They engage with you and they respect you, and they help, they let you help them. That is them appreciating your impact. They will come to you and want to talk to you about stuff that's really upsetting them, and that's them respecting what you have to give, and that's them appreciating it as well. They don't know how to show it, they don't know how to say 'Thank you so much', instead they probably do the opposite!"*. More than one interviewee expressed how taxing the work can be on the individual carer. It's *"exhausting but it's exhausting in a good way as well. I feel like my time is for the greater good in a way, I'm giving my time to other people that need it, so that's important"* (Linda). The resilience of workers like Linda is noteworthy. When asked why she saw the work as important, the response was clear. If she could *"just make a difference in a kid's life. Give them a second chance, don't let them feel like they're cursed and destined for a traumatic, hard childhood. Teach them that there are things out there that are good and not everyone is going to hurt them"*. Linda saw her role not only as having intrinsic value, but also as being an agent of change.

According to the participants in this study, an attentive residential care worker will adapt their practice to suit the young person, with the concept of 'time' often being referred to. Simone described that *"time is one of the main things. It's what they like. Giving them some time, by just sitting on the couch watching a movie with a client, going for a chat, for a walk, trying to cook nice meals ... Some of them don't get time, have never had time. They yearn for just some attention ... That's all they want, is your time"*. The notion of how this offers a genuine and personal experience to the young people in her care, was stated clearly by Linda when she too said that a carer needed to *"give them your time. You've got to be passionate about what you're doing otherwise there's no point, [or else] you're just*

like another person that's going to leave them or not really care for them. You've got to find what works for them and just put everything into it".

Throughout the interviews, it was common for participants to describe the value of recognising individuality and the differences of each young person. Amy said that she sees *"them all as individuals. I don't compare them to each other. They're all their own person ... I don't see the young people as a problem"*. Such a perspective is one that celebrates the uniqueness of each individual young person. Crystal recalled working with a young man who had significant behavioural difficulties, saying that *"he was 15 when I was working with him, and to be able to just let all that go and just ride his bike and just be completely carefree in that moment. They're the moments that I treasure because everything else can be so chaotic in their worlds and just to be able to be that person that they want to hang out with, and you don't have to say anything for two/three hours, you just exist together, and that's pretty cool"*.

Katherine described how authentic, personal experiences of genuine care were able to be provided to one young girl in her care when she was prepared to challenge the constraints of her workplace: *"Another highlight was taking her for drives in the car. She used to love going for drives and we'd drive for two hours and we got in trouble – and this is the bureaucracy – we got in trouble for driving because it was too much money on petrol. We did it anyway because she would take her toys and she'd take her blanket and we'd put on her CD and she would talk for two hours straight. Again, about trivial stuff, but we'd see the sunset and we'd walk along the beach. Yeah, so all those moments are just, they're little treasures"*. More than one participant described the therapeutic value of providing creative ways for the young people to communicate. Crystal recalled working with one young person who loved painting, describing that she would get *"her a couple of giant canvases every few months and saying 'Hey, go crazy'... because the amount of emotion and feelings that she was putting out on to those canvasses is crazy. That's worth 3,000 conversations, what she's putting on to that canvas"*.

Apparently simple acts such as watching television with a young person often provided avenues for greater depth within the relationship. As Rodd and Stewart (2009) found, activities such as television watching or driving in a car with a young person were valuable passageways into relationship. Kyle described one such example of how this turned into a valuable care giving experience:

Even sitting there watching TV with them ... because that's when you get the little disclosures. There was this one kid and we were sitting there just watching TV and we were watching Undercover Boss and there's always these emotional endings and all that. Me and this tough kid, we were sitting there watching and we were both silent and this kid's starting to get tears in his eyes, and goes 'Oh for fuck's sake. Why does it have to be so emotional?' and we're both sitting there, and we both started laughing, saying 'Look at us two men sitting here crying over a TV show'. But that kid actually had his dad's friend have sex with him ... this is a kid that's had sexual abuse and he's just sitting there [crying] because something good was happening to someone else on TV. So that was good, and that's just by doing the everyday things.

The value of 'everyday things' like Kyle's description of watching television was observed by others too. When asked what this looked like for her, Linda described how she saw that it was the small things that add up. *"I may leave a Post-It Note in their lunch box and just wish them a good day. Those simple words on a daily basis could really make their day, even if they won't admit it which is generally what happens but if you miss a day and they realise, they're like 'Where's my note?' Small things like setting the table and eating around the dinner table, even sitting on the couch next to them, folding their clothes and putting them on their bed or asking them how their day was – simple things like that really shows that you care about them, and can really make a difference"*. Linda also described how she started a tradition of playing card games with a few young people and this went on to them having the games set up and ready for her to play at the commencement of her shift. When asked why she thought this was significant, and what it might represent, she suggested that it was *"showing them a different experience. Something so simple and so small can really change the way they're feeling – it's positive and teaching them how to work together, and respecting each other as well. Some might be crap at the card game but it gives them a whole new way of being occupied rather than going out and doing illegal things"*.

It is apt here to return to the previously discussed concept of the relationship being a tool. Such a concept is necessarily limited. The relationship, albeit genuine and sincere when constructed with the care and authentic regard that was discussed in previous chapters, can only ever be a transient entity. Young people will eventually leave residential care, as too will the staff who work within it, and in that departure, the relationship will always experience a conclusion. While it exists, however, it has purpose, meaning and a role. It facilitates the opening of the space in which the real and authentic work of best practice residential care giving can be animated and brought to life. As the examples provided above suggest, the relationship, if indeed it can be considered a tool, is an instrument that promotes greater outcomes. A gentle and caring vehicle, it provides a safety in which real and genuine human interaction, growth and healing can be experienced.

Working in a team environment

This research has engaged with a depth and breadth of literature which, in turn, has been enhanced by the input provided by the interview participants. I will now turn to areas that emerged that are possible avenues for further research. One theme that arose from this study, and which deserves further investigation, was that of the challenge of delivering personal care whilst working within a team. At times, participants described the benefit of having a team to deliver the care, whilst at other times, it was described as a hindrance to good care giving. Essential to good care giving in a residential care environment is that staff *"create and maintain cultures that are strong enough to withstand and contain children's anxieties and to give them experiences and tools that might help them establish healthy and intimate relationships in their adult lives"* (Smith et al. 2014, p. 24).

Given the centrality of genuine relationship development for the participants in this study, maintaining that when relying on other team members who see their work as a financial exchange in which their care work is merely a commodity, was a challenge for some workers. Tronto cautions that there is “great danger in thinking of care as a commodity, as purchased services, rather than a process” (2010, p 164). Yet some participants in this study identified that this was the reality for some of their colleagues and, as part of this reality, sometimes there are people employed to deliver care whose intentions are not ideal. In this vein, participants often described that the experience of being a residential care worker who must work as part of a team is filled with many challenges.

For some participants in this study, having younger people on the staff could, at times, be a hindrance to providing good care. Katherine explained the importance of appearing calm when faced with a tense situation, and how sometimes her co-workers were not able to deliver effective and appropriate care at that time. *“I’ve seen a lot of young staff members ‘lose it’ with the kids because they don’t probably have enough maturity and experience to have an awesome poker face. I think that’s probably the thing that I learned the most in resi care – developing a poker face. They’re losing the plot, they’re throwing chairs, they’re going to kill you and everybody else and you’re just being ‘No mate, it’s okay. Just calm down. It’s all right. Let’s go for a walk’, but I’ve seen a lot of other staff members lose it back”*. The young people living in the units would experience this inconsistency too. At times, as was described by Katherine above, this would be to the detriment of the young people, but at other times, they would use it their advantage. Kyle described how some *“workers let them get away with nothing – nothing at all – and some other people let them get away with everything. And then they always start to use ‘Oh such-and-such did that, such-and-such did this’ and they start using the workers against each other”*.

The frustration of those workers whose practice was fuelled by good intentions was almost palpable in some of the interviews, and this was no more present than when they were describing their experiences of working with a team that did not have a similar focus. *“I think it’s important to know why you want to do this job. You’ve got to be able to be passionate about what you’re doing because I’ve seen a lot of staff members that come and go that aren’t in it for the children and you can see it and it’s really disheartening, especially when you’re a worker that would give anything for those kids”* (Linda). Working in the team environment that they do, residential care workers will ultimately work with colleagues of varying skills and intentions. Some will come with different levels of qualifications (this is observed as being true even in the small sample that made up this study) and many will have different considerations for what is important in the daily work. Lisbeth described her frustration with this when she articulated that *“some are here for the wrong reasons, some are here just to collect a pay cheque, for others it’s a stepping stone to something else, to a bigger and better job or just to get experience up”*. David stated that one of his greatest challenges was working with those who were ‘only in it for the money’ because he personally cared about doing the job. He said

that “you have to be really passionate about the work you do. Some of the workers, they are not really passionate about the work they do. They just want to come and earn some money. Honestly, in a word, be passionate about what you're doing”. In support of this sentiment, Linda summed up the attitude of more than one interviewee when she said that she sometimes “wouldn't even call it a job. It's simply caring for people that are worth it”.

Despite the, at times, challenging nature of working in an imperfect system, and sometimes in an imperfect team, Simone voiced a trust in the inherent benefits of the system. “A lot of people go, ‘Don't you find it hard. These kids are gone from these bad situations. Don't you find it hard leaving?’ I say, ‘No, because I know the next person's come on. They're getting cared for. They're not in that situation anymore. They're safe, so I don't freak out when I go home’”. The value, and importance, of an effective team of workers cannot be underestimated. “They have your back. Sometimes you're not as fast on your feet as you think you are and you need somebody just to back you up. They may have a better solution, better plan, better to bounce off somebody else and if you work as a team it's so much easier. And the kids see that you're a team, the kids see it” (Lisbeth). Simone described the value of having a cohesive team of residential care workers. “It's very important to have a very good strong team that will work together, and as an individual to be able to work as a team, and not to want to do everything and to get all the praise, have respect for your other work friends, come up with ideas together ... I love the team I work with ... that keeps me coming to work”. Simone went on to describe how this can also have equally positive effects on the young people in the house. “It shows through the house if your team is strong ... the clients know this is a happy place to come if each team member gets along with each other or work together. The clients see that there's stability there. They can trust us. They can rely on us because they know that we're here for them. If the team's breaking down or there's cracks in the team, the clients can actually see that, which can cause problems, cause them to play up”.

The diversity, and difference, amongst residential care workers can be both an asset and a liability. Good practice amongst a team of staff in any given residential unit will ensure that workers ‘look out for each other’ and support the decisions made by peers. Andrew described that good residential care is about “having a good team, a good solid team that understands each other's weaknesses and strengths and using them. If you're able to grasp onto that and use those strengths, then it's able to filter down to the kids, and the kids can feel safe and comfortable”. Ultimately, the effectiveness of the relationships between staff members has a direct impact on the quality of care that is delivered to the young people, and this concept deserves greater investigation.

Working with constraints

The residential care system has significant constraints and limits within which it can operate. Whilst these are often essential for the delivery of good practice and the safety of the young people living

within it, it can have an impact on the practice of the residential care worker, as Andrew described *“there are a lot of restrictions around it as well and I feel really frustrated about that”*. The challenge of working in ‘the system’ was mentioned by some participants as being one of the restrictions that held them back in their work. James also touched on this, saying that *“We’re restricted in so many ways, in how things are run and we don’t always have control. As a staff member we don’t always have control on outcomes [for the young people]. It can be tough to get to where you want with these kids when we feel like we’ve got our hands tied because there’s certain things we can and cannot do for the kids”*. Linda described that working so close to the young people allows for what she considered privileged access to the life of the young person, but such access does not mean that the worker can always effect change. *“One of the hardest ones is not being able to do as much as you want to do for those kids. Being a residential carer, we’re very limited with our decisions and the power to really change the kids’ lives ... It’s hard when you feel like your hands are tied and the kids would really benefit from something that you’re thinking of but there’s no way it will happen”*.

Many interview participants expressed frustration at the system that residential care operates within, describing inherent flaws and structural challenges. One major challenge observed was the difficulty of correlating instructions from supervisors and managers with workers’ perceptions of what is needed. A worker may often feel quite powerless, and this was commonly described by a number of participants. *“What’s frustrating me the most lately is the decisions that have been made and feeling like I don’t have any control. I understand that these kids need something totally different to what they are asking us to do. The consistency in staff that need to be in these units or across the board really in all the other units. I just don’t understand why staff get placed in different units again and again”* (Andrew). It was also generally accepted by the participants of this study that those whose job it is to case manage the young people in care are often too far removed from the young people themselves. This can result in decisions being made that affect the life of the young which can seem nonsensical or inappropriate to both the young person and the worker. Katherine describe how *“they’re making decisions based upon the paperwork in front of them, not on actually knowing the young person and that I think makes them highly vulnerable... [and the young people] have to just put up with whatever anyone else decides and those people often don’t know them”*. Katherine went on to say that *“as a worker, you don’t have any power and trying to advocate is very, very challenging”*.

Describing the frustration at feeling powerless to assist a young person in the way they feel is most needed, Linda stated how she felt that the system itself can be detrimental to the young person despite any good work that may have been done within it. For the young person this may mean being made, or allowed, to *“go back with family members that you feel are not quite stable enough yet. That fear of that kid just backtracking or being exposed to more traumas and there’s nothing you can do about it. Watching how kids are made to leave at 16, before their time, and then they’re left alone from what we’ve built – which is a family environment – and people that they can rely on to. They’re on their*

own – that’s hard, and then not having complete contact [with them anymore] and seeing some of their choices just fall through”. Despite how strong a relationship may be between a worker and a young person, ultimately, the worker must be ever cognisant of the fact that they are not in control of the life of the young person. *“When a young person went back to their parents and it wasn’t the best, it wasn’t what I personally thought should have happened. I don’t think the parents were ready and subsequently the child went back into care”* (Lisbeth). This concept of powerlessness and feeling constrained by the system that residential care givers must work within to deliver care is an opportunity for further investigation

Complementary further research expansions

The extent to which participants in this study reflected consistent and overlapping views suggests that the sample size was adequate for a study of this scope, however the project was deliberately narrowly focused on ‘traditional residential care’. There is at least one other model of residential care, that being therapeutic residential care. Future research may benefit from comparing and contrasting how care is understood by those who deliver care in the different models. Residential care is an evolving model of practice and at the time of writing, I am aware of at least one new form of residential care, the K.E.Y.S. model (Keep Embracing Your Success) which I am aware of due to being a practicing care worker myself. The K.E.Y.S. model is a pilot program for the state’s most high-risk young people who are living in residential care. It involves greater specialist intervention and support, along with higher staffing ratios. The reality of emerging and different styles of residential care means that forms of care itself will continue to evolve and any future studies would benefit from also investigating these new and emerging models.

Finally, while this study has considered the first three phases of Tronto’s framework, it was beyond the scope of this work to examine the fourth: Care-receiving. This “final phase recognises that the object of care will respond to the care it receives” and Tronto (2009, p. 107) argues that it is “important to include care-receiving as an element of the care process because it provides the only way to know that caring needs have actually been met”. The research conducted for this project suggests that the question of whether children and young people’s care needs are met is important not only from the perspective of building good practice and good out-of-home care models, but also in relation to worker satisfaction and retention. Researching this, however, would require another large research project with considerable risk from a research ethics perspective, and was beyond the scope of this Masters research. The absence of this phase from this research does not diminish the findings. The tacit knowledge of the care givers that has been explored and considered through this study has credibility and is of real value. To complete a full and more comprehensive understanding of the total care experience, future research would do well to interview young people living in residential

care to gain an appreciation of how they themselves understand what constitutes good residential care.

Conclusion

No form of out-of-home care is without its risks and challenges, and this is certainly true of residential care, yet it has merit for some young people. As Anglin found in his research, one young person explained that “in a foster home I am expected to fit in; here, they work to fit in with me” (2002, p. 103). As this study has described, residential care work is particular, it needs to be shaped in response to individual young people, and it needs to achieve this within an often rigid institutional model. As the data from the interviews was collated, it was discovered that the work of Tronto aligned with the findings. Consequently, her theoretical approach was leant upon as another piece of scaffolding used to articulate the findings of this study. At no time were the findings shaped to fit any theoretical perspective presented by her. Tronto asks if there is a way to bring “purpose, properly balanced power, and attention to particularity back into caring practices if they are organised institutionally?” (2010, p. 166). According to the responses of the participants of this study, despite the limitations of institutionally provided care, the answer is a resounding yes.

Supporting the findings of this study, Tronto identifies three elements of family-like care that should be present if institutionally provided care is to be provided, and provided well: “first, a clear account of power in the care relationship and thus a recognition of the need for a politics of care at every level; second, a way for care to remain particularistic and pluralistic; and third, that care should have clear, defined, acceptable purposes” (Tronto 2010, p. 162). In the specific context of this research, these elements are that good residential care is rooted in genuine relationships, is a trauma informed practice and works towards connection to education and the community. This aligns with Tronto’s framework for clearly and deliberately articulating good care practices: (i) genuine relationships respect and recognise the power of (and within) the relationship, (ii) trauma informed practice allows for individualised and particularised responses to the needs of each individual young person, and (iii) connection to education and the community is a clearly defined and acceptable purpose. Tronto (2010, p. 162) says that these elements must be “worked out consciously. This does not make these elements less achievable, but it does mean that they become more visible and require a deliberate, political process to enact them”. It is hoped that this research contributes to that deliberate process and the resultant increased visibility of good care practices.

It is fitting, now, to return to the voices of those who participated in this research. It was consistently apparent to me, the researcher, that those people who did residential care work as their ‘day job’ were both skilled and often humble workers who are worthy of accolade. More than one participant observed that they felt lucky to work in this field. Andrew said that *“It’s rewarding and I always have to think that this is such a great opportunity to be in a workforce that entices you to focus*

on these kids and you can actually make a difference... I'm just happy that I'm in this work". Many times throughout the interviews remarks were made that showed the depth of understanding the workers had, and the value they placed in the relationship they have with the young people. *"You don't so much see the changes in the young person's circumstances, but you see the change in them. They'll open up to you and that's where I think the change is mainly seen"* (Kyle), or as Katherine said in recognising the strength and resilience the young people display despite the adversities they have faced *"I see kids that I would want on my team ... you'd want them on your team because they're incredible"*.

Residential care has its limitations. These limitations, however, should not cloud the hard work and genuine care provided by many dedicated residential care staff. Anglin, whose work has provided support through this study, tells us that what well-functioning residential care homes can offer is:

An intense, supervised, staffed, structured, less emotionally charged and more consistently responsive environment for promoting personal growth and development of youth who require such intensive care and support. If such a service is to be utilised, then we need to know how, when and for whom it can best be used and value it as a positive choice in these circumstances. A service that is considered always to be an unsatisfactory or second-rate option will inevitably deteriorate and will ultimately reflect these self-fulfilling expectations. (2002, p. 105)

Tronto, whose guiding voice has provided a scaffolding for the findings of this thesis, offers one last piece of advice. She declares that "non-family care can be outstanding in its quality, but only if organisations that provide care also care about their own ways of working" (2010, p. 169). The findings of this study suggest that what is also true is that when the care givers themselves display this level of care about their ways of working, we are able to begin to understand the elements that make up good care giving. Anglin (2002, p. 163) concludes his book by stating that "our young people are asking for and deserve the best group homes that we can provide". This study, in some small way, has contributed a response to this statement. Good residential care must be intricately understood, contextually appreciated and systemically supported. Understanding the skill of those who work within it has helped give voice to the unspoken practice that helps shape the experiences of those young people who depend on it. Best-practice residential care will be authentically delivered, personally experienced and ultimately, crafted to respond to the individual needs of the young people it is designed to support.

Throughout this thesis I have often turned to words and concepts such as 'subtle', 'ordinary', 'mundane' and 'simple' to describe the accessible nature and 'everyday normality' of what good residential care looks like in everyday practice. Such terminology perhaps hints at the challenge of having residential care recognised for the multifaceted work that it is. Good residential care is delivered in such a manner that those receiving it are able to access it and respond to it easily and without complexity. This subtle art form of delivering good care may be its best asset, but also its greatest challenge. Tronto (2009) explains that care and care work is generally devalued in society, and Clough (2000) and Anglin (2002) further describe that residential care and those associated with it are

typically seen as problematic and are to be viewed with caution. Effective residential care is not easy or basic, but to the casual observer, it may appear so. It is my hope that this thesis might contribute to shifting that paradigm by placing the language of good care giving practice into the forum in which it belongs.

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Appendix One: Guiding interview questions

1. Answer short written questions (See next page).
 2. What does being a Residential Care Worker (RCW) mean to you?
 3. How did you end up working in residential care?
 4. What are the care-needs of the young people you work with?
 5. How do you “see” the young people?
 6. What is the most difficult aspect of your work? What is the best?
 - What support do you need/receive/desire?
 7. How would you describe the ‘care’ that you deliver as part of your job?
 - Describe some of the activities you do that make up the ‘care’ you offer to the young people you work with
 8. Tell me about your experiences of being a RCW?
 - Ask participant to relate experiences that seem significant/meaningful/important to them
 - How did they feel about these experiences? Why do they seem important/of interest at this point?
 - Prompt for a ‘highlight’ and a ‘challenging’ situation.
 9. How do you think the young people you work with experience this ‘care’?
 - Ask them to describe the connection they see between themselves, the young people, and the care they give
 - Does the care occupy any specific/unique/important space?
 10. Does the ‘care relationship’ between you and the young person look the same, or different, from young person to young person?
 - Do you feel that the care you deliver the same as that of other workers?
 11. Do you ‘construct’ or ‘use’ your working relationship to achieve certain goals?
 12. How does the work you do make you ‘feel’? How do you think it makes the young people ‘feel’?
 13. How do you manage the relationship between yourself, the young person and their biological family?
 14. Is there anything you might like to add that we have not covered in regards to your work, care giving and/or the young people you work with that you feel may be of value to our discussion?
 15. Why do you do this work?
- Thank you for your time. Do you have any questions that you would like to ask of me?
- *Summary/thanks/debrief/where to from here*

Appendix One (continued)

Short introductory questions:

1. What is your gender? Male / Female / other

2. What is your ethnicity?

3. Are you a parent?

4. What age bracket do you belong to:
(please tick)

a. Under 20 _____

b. 20 – 30 _____

c. 30 – 40 _____

d. 40 – 50 _____

e. 50 – 60 _____

f. 60 + _____

5. Do you have any formal training?

a. Yes/ No

i. If yes, please describe what it is:

6. How long have you worked in residential care for?

Date of interview:

Name of interviewee:

Paperwork signed: Yes / No

Appendix Two: Ethics approval

From: [Kylie Pashley](#) on behalf of [Res Ethics](#)
To: [Jen Couch](#); [Paul Chalkley](#)
Cc: [Res Ethics](#)
Subject: 2015-128E Ethics application approved! **Date:**
Tuesday, 21 July 2015 3:16:42 PM

Dear Applicant,

Principal Investigator: Dr Jennifer Couch

Co-Investigator: Dr Nell Musgrove

Student Researcher: Mr Paul Chalkley, (HDR student)

Ethics Register Number: 2015-128E

Project Title: Crying for home: Who really cares?

The care experience of young people in residential care as understood by those who give the care.

Risk Level: Low Risk

Date Approved: 21/07/2015

Ethics Clearance End Date: 30/06/2016

This email is to advise that your application has been reviewed by the Australian Catholic University's Human Research Ethics Committee and confirmed as meeting the requirements of the National Statement on Ethical Conduct in Human Research.

The data collection of your project has received ethical clearance but the decision and authority to commence may be dependent on factors beyond the remit of the ethics review process and approval is subject to ratification at the next available Committee meeting. The Chief Investigator is responsible for ensuring that outstanding permission letters are obtained, interview/survey questions, if relevant, and a copy forwarded to ACU HREC before any data collection can occur. Failure to provide outstanding documents to the ACU HREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research. Further, this approval is only valid as long as approved procedures are followed.

If your project is a Clinical Trial, you are required to register it in a publicly accessible trials registry prior to

enrolment of the first participant (e.g. Australian New Zealand Clinical Trials Registry <http://www.anzctr.org.au/>) as a condition of ethics approval.

If you require a formal approval certificate, please respond via reply email and one will be issued.

Researchers who fail to submit a progress report may have their ethical clearance revoked and/or the ethical clearances of other projects suspended. When your project has been completed a progress/final report form must be submitted. The information researchers provide on the security of records, compliance with approval consent procedures and documentation and responses to

special conditions is reported to the NHMRC on an annual basis. In accordance with NHMRC the ACU HREC may undertake annual audits of any projects considered to be of more than low risk.

It is the Principal Investigators / Supervisors responsibility to ensure that:

1. All serious and unexpected adverse events should be reported to the HREC with 72 hours.
2. Any changes to the protocol must be reviewed by the HREC by submitting a Modification/Change to Protocol Form prior to the research commencing or continuing.
<http://research.acu.edu.au/researchersupport/integrity-and-ethics/>
3. Progress reports are to be submitted on an annual basis.
<http://research.acu.edu.au/researchersupport/integrity-and-ethics/>
4. All research participants are to be provided with a Participant Information Letter and consent form, unless otherwise agreed by the Committee.
5. Protocols can be extended for a maximum of five (5) years after which a new application must be submitted. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).

Researchers must immediately report to HREC any matter that might affect the ethical acceptability of the protocol eg: changes to protocols or unforeseen circumstances or adverse effects on participants.

Please do not hesitate to contact the office if you have any queries.

Kind regards,

Kylie Pashley

on behalf of ACU HREC Chair, Dr Nadia Crittenden

Ethics Officer | Research Services

Office of the Deputy Vice Chancellor (Research) Australian Catholic University

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