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Care versus Treatment: Revisiting some Reflections on Residential Child Care in Scotland

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Abstract

'Residential treatment for adolescents' is a term used in the United States to describe something simultaneously similar to and completely different than residential child care in Scotland. This reflective article explores these similarities and differences.

Keywords

Residential treatment, residential child care, care ethics, USA, Scotland

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Introduction

This article began its life in the Goodenoughcaring Journal (2014, volume 1, issue 1), a freely available, online journal for people who care for children and young people. The Journal was founded by Charles Sharpe, who, sadly, died in 2020. I did not know Charles well, but I was always impressed by his generosity, keen insight, and thoughtful nature. I became aware that the Goodenoughcaring Journal is no longer available when I was recently asked for a copy of the article. In re-reading the draft, it was interesting to be reconnected with my thinking, and with circumstances of residential child care at that time. Much remains the same, but some of those circumstances are significantly different, so it seems a good time to revisit the place of care in my career, and in residential child care.

Residential Treatment

In early January 1999, I moved from the Western Slope of Colorado to Edinburgh, Scotland. I was 30 years old and had spent almost all of my post-university working life in residential treatment facilities for adolescents. While I had decided to change the location of my home, I knew I did not want to change the type of work I did. I still wanted to work therapeutically with youth who were experiencing difficulties.

A few months after the move, I was fortunate to land a job at a residential school for boys who, for various reasons, could not live at home. In many ways, the work was the same. Yet it was also different – subtly different and, at the same time, radically different. This paradox was bewildering during those early years.

I got my first bit of traction in making sense of these transatlantic differences by attending to the differing names given to the work I was doing. Before I even started applying for jobs in Scotland, I was strongly advised to refer to my previous work experience as something other than treatment. I was told that

people would misinterpret the use of that word as some sort of medical intervention. While I accepted the advice, it bugged me. Surely the work we were doing was more than just care?

As a result of my time in Scotland, I have come to understand care in a much less simplistic way, both through experiences of direct practice and in studying and teaching care ethics. Through this process, I have come to see treatment differently too. Treatment (as we adults perceived it back in the 1990s) was a safe but challenging haven for youth to come and tackle their problems. We had treatment models, behavioural targets, point-and-level systems. We tried to create environments and processes that promoted a stronger sense of personal responsibility, improved self-esteem and an ability to manage 'out there' in the 'real world'. We wanted to be agents of change, working with youth to improve their lives. We believed in their abilities to change, heal and grow, and we had high aspirations for them. This was the case for most of us, but alas not all of us.

Residential care

Residential care as I experienced it in Scotland was home-like, and indeed the quality of the physical environment was much higher than anywhere I had worked or visited in Colorado. I was immediately impressed by the quality of decoration and furnishings of the residential school in Scotland and what this communicated about how young people were viewed. The staffing ratios were significantly different as well. I went from ratios of 18 to 2 and 28 to 5 (young people to adults) in Colorado on any given shift, to a 10 to 5 ratio in Scotland. There was more money in Scotland for activities and for transporting young people to their families at the weekend and even midweek. We had a cook through the week and a team of domestic staff who not only kept the place clean and tidy but did things like pressing the sheets. I remember initially thinking that so much more was possible with the level of resources we had.

I knew I had to acclimate to a new culture. I didn't want to be a know-it-all American, but I did want to bring my own relevant knowledge and experience to the mix. It was hard to figure out what, from my previous work, was applicable

and what I needed to discard. One of my first realisations was that people thought very differently here in Scotland about what we were doing and why we were doing it. There were no treatment models, no explicit behavioural targets and no point and level system. I had already begun to entertain doubts about the latter, but the lack of clear articulation and referable sources of theory to inform our efforts frustrated me.

I'm not claiming that there was an especially high level of congruence in terms of shared theoretical understanding that robustly informed our practice in my places of work in Colorado. It was often inadequate. It nevertheless felt light-years ahead of where we were in Scotland. When I would try to discuss a theoretical perspective or would encourage colleagues to read about something we were experiencing at work in Scotland, it frequently became awkward. People seemed to pull down the shutters. I'm pretty sure that sometimes I was coming up against a seam of anti-intellectualism that runs through not just Scotland, but the United Kingdom. The inherent distrust or dismissal of theory was palpable at times. Even the intonation given to the word 'theory' made it sound fluffy, irrelevant, or merely like an opinion. I'm sure my enthusiastic, irrepressible, and often irritating desire to *understand* was probably like nails on a chalkboard to some people's deeply pragmatic ears.

I must stress that I did not experience all of my colleagues this way in those early days. In my 24 years here in Scotland I have encountered many deep thinking, theoretically committed, and critically engaged members of our sector. When I wrote this article nine years ago, I surmised that they were probably not the norm and that this had to do with Scotland's legacy of requiring no qualifications for working in residential child care (prior to 2009). I should have added that this is the case across the globe, and that many advocates the world over are grappling with how to support the development of a workforce equal to the task of robust residential child care.

At the time of first writing, the Minister for Children and Young People, Aileen Campbell, had announced the Scottish Government's commitment to a degree-level qualification becoming the standard for residential child care workers, supervisors and managers in Scotland. This was hopeful news. It was also

threatening news to many, and rightly so. Bringing the workforce to degree level requires significant resources, and it was unclear where these resources would come from. We were also worried about losing those workers who were good with young people but not with reading and writing. My two most overriding concerns were whether curricula would be developed that actually equipped practitioners with the skills, knowledge and capacities needed for restorative, developmentally enhancing care, and whether the whole project would be adequately funded. I ended this part of the article with, 'if the necessary investment in making this project work is not forthcoming, Scotland will have taken a deeply cynical turn'.

It is tempting to shift my focus here to what happened next and the continuing pressing need for a broader, deeper, more rigorous discussion to inform decision making on minimal qualifications for those in direct care and leadership positions in residential care. Suffice to say that the implementation of the above-mentioned commitment was paused in order for an independent review of the care system in Scotland to be carried out. The findings from that review – a review that was and continues to be unprecedented in the way it has been co-produced with care-experienced people – constitute The Promise (The Independent Care Review, 2020). The last three years have seen a well-organised, well-funded project of implementation of The Promise. The commitment to a degree-level minimum qualification for residential child care workers has not been renewed.

In 2001, I had the good fortune to be included in the first-ever cohort on the MSc in Advanced Residential Child Care at the University of Strathclyde. The then Scottish Executive established the Scottish Institute of Residential Child Care (located in the University of Strathclyde) to develop the education and training of residential child care workers, and the MSc was part of this initiative. It should be said that there was no such commitment to the education of residential child care workers in Colorado, and I don't think there has been anything that comes close to Scotland's investment anywhere in the wider United States.

It was through my studies and exposure to other practitioners that I began to understand better some of the other differences between care and treatment. I would characterise one of these differences as a macro-orientation versus a micro-orientation. In trying to make sense of this, I wrote elsewhere the following:

> As an American, I brought my 'can do' attitude to my practice in Scotland and was sometimes shocked at the apparently low expectations and aspirations my colleagues seemed to hold for our residents. Over time and with the aid of my studies on the MSc in Advanced Residential Child Care, I developed a far greater appreciation of the impact of elements of the macro-system … on the development and life-chances of children and young people. I came to understand that my Scottish colleagues also had this greater, albeit often tacit, appreciation than I (or my American counterparts) had had. The more I (re-)engaged with knowledge about elements of these macro-systems and their impacts, the less I felt able to be that positive change agent. Paradoxically, I began to wonder whether our American ignorance of one level enabled stronger, though inadequately informed, optimism and enthusiasm on another. In Scotland, I much more frequently felt a collective sense of pessimism, or at least withering, as we approached our work. This was compounded by the aforementioned lack of therapeutic orientation to residential child care in Scotland. Yet it was not possible or desirable to go back to that former ignorance. Focus on the micro to the exclusion of the macro is problematic; the opposite is true as well (Steckley, 2013).

Looking back, I can't help but wonder whether sometimes my colleagues' shutters came down because all I was talking about in those early days was focused on the young person and his family. The impact of poverty, disadvantage, stigma, and social exclusion rarely if ever were topics of discussion in Colorado (or in my early days in Scotland). Not only did our treatment models pathologise young people, placing an inordinate focus on problems and deficits, they were implemented with an inherent blame of families and blindness to their social conditions. We talked to young people about

making choices in such simplistic, unintelligent ways: 'You can make better choices.' No wonder they responded with 'Fuck off'.

An appreciation for the often-grim social circumstances of families whose children end up in residential care sometimes comes at a cost, however. I remember hearing this cost referred to as 'The soft bigotry of low expectations'. What a compelling form of words. After a short search I found that this compelling phrase has been used by political figures who consistently dismiss or avoid the very real impacts of poverty, disadvantage, stigma, and social exclusion. What does that tell us? I think it highlights how difficult it is to hold the big picture and the small picture in mind at the same time. It's hard enough not to shield ourselves from the pain and despair our young people bring to the therapeutic encounter; how are we meant also to be present with the pain and despair that comes with really seeing the entrenched social structures that perpetuate poverty, disadvantage, stigma and social exclusion?

Care

The answer is care: good care at the micro-level and an understanding of how care operates at the macro-level. My irritation at being told to refer to the work I had done in Colorado as care was rooted in a superficial and simplistic understanding of the word. I have come to genuinely believe that providing good care is actually more complex and demanding than providing good treatment. The roots of development and recovery are in the rich soil of good care experiences. A care perspective is more holistic and requires a more robust involvement of the self of the caregiver (and, I would argue, those purporting to provide quality support to direct care givers). Fundamentally, care is about meeting the needs of the other; if these needs are complex and require advanced skills, knowledge and capabilities, then good care means developing those skills, knowledge and capabilities. And over the last two and a half decades, I have witnessed a growing consensus that residential child care is complex and requires advanced skills, knowledge and capabilities.

Care has also become a significant focus in analysing the entrenchment of poverty, disadvantage, stigma and social exclusion, often through the lens of

care ethics (see Gilligan, 1982; Held, 2006; Tronto, 1993 for seminal writing on the subject). The positioning of care as private, feminine, individual, and peripheral to the central concerns of society was a key revelation for me in studying care ethics – especially because this positioning works to keep the vast majority of those who give and require direct care in the least powerful positions in society. There continue to be growing numbers from a variety of disciplines who are challenging the way care is thought about and how it serves to preserve inequalities of power and privilege. They are moving care from the periphery to the centre of human and political concern.

The Promise is part of these growing numbers. In privileging care and the experiences of care so clearly and straight-forwardly, it is taking the oxygen out of arguments that prioritise rules at the expense of relationships and is nailing the lid on the coffin of no-touch policies. Its funding of local initiatives for implementing The Promise shows an appreciation of the importance of local contexts. Whether it leads us to properly equipping and supporting the workforce is still to be worked out.

At the same time, in many ways it feels like our world has become a more uncaring place. Despite residential child care's embrace of The Promise, it is operating within a wider managerial context where procedures, techniques and risk-aversion still hold sway. Local authorities' financial predicament is increasingly challenging, and public trust in political institutions continues to be badly damaged on an almost daily basis. Moving care to the centre of public life and social concern is needed more urgently than ever.

Conclusion

My experiences of this journey to care have enabled me to hold a bigger, more complex picture of what we are trying to do and why than when I was operating under a treatment perspective. A robust, theoretically informed care approach melds the macro and the micro – the big picture and the individual encounters within it – in a more profound way than treatment can offer. A deeper, more

critical understanding of care is giving us a way to hold the specific, intimate needs of individuals to heal and flourish while also holding in mind and taking to task elements of that bigger picture. Residential child care workers need entry-level training and education to support them to do the same. They also need one that enables the development of a professional identity deeply rooted in the restorative power of everyday care. We are still a long way off from making that knowledge and vision manifest for all children who spend time in care. In some ways it feels like we are getting closer, and in others, I worry we are losing ground.

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