# Residential Youth Care and Treatment Research: Care Workers as Key Factor in Outcomes?

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## Abstract

Residential child and youth care is not only the oldest but nowadays also one of the least 'sexy' forms of assistance for children and young people in need. Among other things, questions have been raised as to the effectiveness of residential placements, especially in comparison with well-conceptualized non-residential alternatives. The empirical proof for the ascribed lack of effectiveness is small. Outcome studies indicate a moderate-high level of change, i.e. reduction of problem behaviour in children and young people.

It is likely that the care and assistance provided by group workers is a key factor in bringing about positive change. In this article we investigate care worker functioning, their job satisfaction and their working methods in this discipline. Our focus will be on the quality of the social interaction and the working relationship between child and care worker. Research points to the importance of this common treatment factor.

In addition to broadening the study of outcomes, in terms of both measurement type and time, we argue for a greater emphasis in research and practice on the status and personal characteristics of residential workers, partly in relation to the needs of children in their care.

Key Words: residential care, care worker, process, outcomes

## Introduction

The following quote comes from a survey among children who have been admitted to a children's home: 'Mary was a true mother figure. Yes, she was simply very nice, and very involved. When you came back from school, she would immediately ask: "How did you get on at school?" She tried to make it lovely and cosy. Homely and as normal as possible' (Meerdink, 1999). This quote gives an indication of the way in which the majority of children who stay in residential care regard group workers. Around 65% to 75% of the children express more positive than negative opinions about the residential staff when asked (Berridge & Brodie, 1998; Fletcher, 1993; Jansen & Feltzer, 2002). In any reflection on the significance and future of residential care much attention ought to be paid to the profession of care workers.

Residential child and youth care is not only one of the oldest but nowadays also one of the least 'sexy' forms of assistance to children and young people in need. In the USA '... it has fallen

out of favour with influential segments of the mental health community' (Leichtman, 2006, p. 285), whereas in Europe it '... was criticized for providing out-of-date education and repressive regimes that failed to meet the individual needs of children and young people' (Colton, Roberts, & Williams, 2002, p. 66). Hellinckx (2002) observes that during the last two to three decennia the number of residential centres has been reduced considerably in most of the (Western) European countries. He explains this evolution by pointing to five developments.

1. The target population has changed. In contrast to a few decades ago, children usually do have parents nowadays and, as a consequence, a more family-oriented service may be preferred. In stating this, Hellinckx implies that residential care is not directly a 'family-oriented service'.
2. Alternative, less drastic forms of professional support have been developed. For example, research performed by Veerman and Janssens (2005) indicates that more than 90 different methods of Family Preservation Services were applied in the Netherlands in 2005. They could, however, be grouped into a limited number of variants.
3. The social position of children and parents has been strengthened. Assistance is increasingly oriented towards reinforcing the positive forces and possibilities of the clients – this is also referred to as 'empowerment' (Verzaal, 2002) – and to promote the situation in which they themselves actively participate in deciding about matters of assistance (Knorth, Van den Bergh & Verheij, 2002). In this context, the placement of children in care centres might be seen as a form of 'disempowerment'.
4. Financial considerations are at stake. Placements generate relatively high costs. But this is also the case, for instance, with hospitals, schools and homes for the elderly. So, the issue is not 'What does it cost?', but rather 'What does it cost to achieve certain results' – the so-called cost-effectiveness question – and 'Do we think it is worth it?'. Very little research has been performed on this theme so far within the domain of child welfare (Knapp, 2006).
5. Research seems to show less positive outcomes.

This paper will deal with this last and most important argument in more detail. The work of the *primary care-givers* in residential settings will be covered in particular: the group workers. After all, the children in care have to interact with these people day in day out. In addition, a brief reflection will follow on the extent to which the other care-giving 'party', the parents and family of the child, is or should be involved in the residential care process (see also Hill, 2000).

The article is in the main about research on residential services in the Netherlands, supplemented by selected studies from elsewhere.[1] Dutch residential services target children[2] with severe internalizing, and in particular externalizing, problem behaviour such as defiant, anti-social or disruptive behaviour, often in combination with attention and concentration problems. These problems are always accompanied by problems at school and with leisure behaviour and relating to friends (Scholte & Van der Ploeg, 2006). In an estimated 70-85% of cases, there are also dysfunctional family relationships (Geurts, 2010) and parents who are unable to cope with their responsibilities (Wells & Robbroeckx, 1993).

Within Dutch child and adolescent care, roughly 5% of all children who come into contact with psychosocial care – over 500,000 children – spend some time in a residential setting (SER, 2009). These facilities range from open residential groups for 6 to 12 children to in-patient settings for intensive psychiatric care or closed judicial juvenile institutions. This article will focus on open settings.

## Outcomes

Questions have been raised as to the effectiveness of residential placements, especially in comparison to well-conceptualized non-residential alternatives. It is remarkable, however, that empirical proof of the ascribed lack of effectiveness is rather meagre. Taking the period 1990-2005

as an example, we have not been able to detect a single (experimental or empirical) study that allows us to formulate *causal* inferences related to the effects of a residential treatment programme (Knorth, Harder, Zandberg & Kendrick, 2008).

It is striking that there are so few reviews and meta-analyses of outcomes concerning residential child and juvenile care services. Nevertheless, the research that is available does show that residential placements probably *can* contribute to the positive development of some children with serious behavioural and/or emotional disturbances.

A survey by Bates, English and Kouidou-Giles (1997) concluded that, although residential treatment is often viewed negatively, empirical evidence did not suggest differential levels of effectiveness compared to non-residential alternatives like Intensive Family Preservation Services, Treatment Foster Care Arrangements, and Individualized Services Programmes.

Another review, five years later, by Frensch and Cameron (2002), focused on 15 effectiveness studies concerning child and youth care in residential group homes and treatment centres. The study highlighted the importance of aftercare and working with the child *and* the family, if the aim is to improve the effectiveness of residential care.

A third review, another three years later, by Hair (2005), reading up on 18 outcome studies, concluded that children and adolescents with severe emotional and behavioural disorders can benefit and sustain positive outcomes from residential treatment that is multi-modal, holistic and ecological in its approach.

Knorth et al. (2008; also Harder & Knorth, 2009) reported on research into 110 outcome studies, published in the period 1990-2005. The application of strict inclusion and selection criteria yielded 27 pre-experimental and quasi-experimental studies (PE and QE), covering the development and outcomes for just under 2,500 children and young people. In the case of seven studies with a pre-experimental design, it was possible to calculate an overall effect size (ES). The weighted mean ES ranged from .45 (for 'internalizing problem behaviour') to .60 (for 'externalizing problem behaviour' and 'behavioural problems in general'), indicating a moderately high level of change, i.e., reduction of problem behaviour (Table 1).

**Table 1**
Weighted mean effect size on outcomes of residential child care in PE-studies

| Outcome measure | K studies | N total | Effect size (*d*) | 95% Confidence Interval | Homogeneity (*Q*) |
|---|---|---|---|---|---|
| Problem behaviour general | 5 | 434 | + 0.60 | $0.50 < d < 0.70$ | 132.1 |
| Internalizing problem behaviour | 7 | 540 | + 0.45 | $0.36 < d < 0.54$ | 64.8 |
| Externalizing problem behaviour | 5 | 434 | + 0.60 | $0.50 < d < 0.70$ | 128.8 |

Quasi-experimental studies indicate that residential programmes applying behaviour-therapeutic methods and focusing on family involvement show the most promising short-term outcomes. There is little evidence concerning the long-term outcomes of residential care. Many studies lack a specific description of the residential intervention programme. They evoke thoughts of a 'black box', where it is not quite clear what is going on and recorded inside. However, we can be certain about one thing: the box can only function thanks to the care-giving staff in the residential community (Knorth, 2003a; Harder, Kalverboer & Knorth, 2010).

## Care Workers

As mentioned, care workers represent the most important, most influential discipline within residential care. They are the ones that fill in 'those other 23 hours'[3] with children by means of the situations they arrange in the group and beyond, by means of the social climate they cre-

ate, and – not least – by means of the way they shape the relationship between themselves and the children (cf. Kok, 1997). Or, to quote Clough, Bullock and Ward (2004, p. 118): 'It is not surprising that the quality of the *relationship* between adult carer and child is frequently cited as a key factor in successful practice in (...) residential care'. But what do we actually know about these care workers in residential settings?

## *Functioning*

In the Netherlands Van der Ploeg was one of the first academics to perform empirical research on the role and significance of the group leadership in residential care (Van der Ploeg, 1984; Van der Ploeg, et al., 1981). Around 30 years ago, he initiated a study that examined which factors might explain the fact that some care workers function much better than others. In this setup, he applied the assumption that the chance of making a positive contribution in the development of a child in residential care will decline in proportion to the degree to which the care worker emits signals that he or she is performing the work under too much stress (Van der Ploeg, 1984, p. 9). Stress is inherent in the work of the residential staff. When a care worker cannot handle this, there is a real threat of dysfunction and – in the long term – a burnout, which is a phenomenon that refers to physical and emotional exhaustion as a result of the excessive demands that are made upon the possibilities and resources of a working person (cf. Freudenberger, 1977).

In Van der Ploeg's study, the functioning of the care workers ($N$ = 239) was determined by means of diverse criteria. The two most important of these were (1) the *judgement* that the group worker him or herself gives, as well as the judgement of others on this functioning, and (2) *feelings* of wellbeing/distress, and of satisfaction/dissatisfaction that the group worker experiences. The following factors appeared to enhance the chances of functioning poorly as a group worker. They have been divided into four levels, in order of importance:

1. Personality of the group worker – with the indicators:
   a. Risk personality (referring to aspects such as structural anxiety, negative self-image, neurotic complaints, and inadequate, passive coping style)
   b. Drastic adverse occurrences or 'life events' in one's own life, with which one has not come to terms
   c. An authoritarian personality, or the inclination towards one
2. Team – with the indicators:
   a. No support from direct colleagues
   b. Perceived tension within the team/organization
3. Community or group – with the indicators:
   a. Presence of many 'extremely unmanageable' children[4]
   b. Negative appraisal of group climate by the children
4. Organization – with the indicators:
   a. Too much or too little influence on decisions in the organization
   b. Many staff changes within the organization

Van der Ploeg himself said it was remarkable that the 'level of education' factor did not play a role as a predictor of the capacity to function well. He consequently formed the conclusion that the professional training for this activity (at the end of the 1970s) apparently did not make a clear contribution to the level of functioning of group workers, at least not to the extent that this led to recognizable differences.

## *Job satisfaction*

In later research Van der Ploeg and Scholte (1998) focused on a single aspect of functioning, namely the job satisfaction of residential workers. This study indicated that those who were best educated were the least satisfied, probably because residential work offered too little status and insufficient career opportunities. The results of this second research confirmed the importance of adequate supervision and support (cf. level 2), and a balanced participation of workers in the organization (cf. level 4).

Studies on job satisfaction and the corresponding problem of staff turnover among group workers have been carried out in many countries over the past few years.[5] Data from the Netherlands and the UK show that the proportion of group workers who are (moderately to extremely) satisfied with their work ranges from around two thirds to three quarters of the staff.[6]

According to Tham (2007), job satisfaction is mainly determined (or threatened) by factors at organizational level: an insufficiently supportive or cohesive climate in the organization is more often cited as a factor in job dissatisfaction and staff turnover than the challenging nature of work in child welfare (see also Petrie et al., 2006).[7] In agreement with these findings, Colton and Roberts (2006) established by means of logistic regression that, in a sample of 129 residential childcare workers, job satisfaction could be well predicted by the following four (compiled) variables:

- *Training* – items concern the available training possibilities, the general attitude toward training and education, and the feeling of being sufficiently trained oneself
- *Recruitment and staffing needs* – items concern the deployment of extra staff where necessary, the staff turnover, and consultation with the management on such topics
- *Communication* – items concern being informed of current affairs, the accessibility of and support from the management, and contact with colleagues
- *Support systems* – items concern participation in staff meetings, case discussions, and evaluation meetings with parents and children.

An analysis with these predictors resulted in a model with significant reliability which produced, taken as a whole, 84% accurate classifications of satisfaction/dissatisfaction among group workers. The first two variables – (1) the organization's acknowledgement of training requirements, and (2) ensuring good staffing – were the strongest predictors.

Colton and Roberts (2006) also established, partly to their own surprise and probably to their own disappointment, that a *high* score on job satisfaction was no guarantee whatsoever for group workers staying in the job. They refer to other factors – like status of the job, salary levels, alternative career opportunities, and family commitments – as also having an influence on such decisions (see also Smith, 2005).

The literature suggests that job satisfaction is an important precondition for high-quality care. However, this says little about *the way* group workers *actually perform their duties*. Questions that arise in this context include: What is the precise content of the social care activities of the group workers? Do they apply a certain approach? Is this aligned to the needs of the children? And which outcomes does it produce? Such questions penetrate to the heart of residential care. We shall deal with this in the following section.

## *Working Methods: Relational Dimension*

Three recent studies will be discussed that shed some light on the issues raised: the first of these is of a more general nature while the other two focus on a specific, relational aspect of the working methods of residential care workers. There is reasonable evidence to suggest that it is this relational aspect of care that has a major impact on outcomes. We will therefore take a closer look at it.

### Responsibilities and Approaches of Care Workers

The first study, performed by Petrie, Boddy, Cameron, Wigfall and Simon (2006), involves comparative research on the working methods of residential care workers in Denmark, England and Germany. Based on interviews with 144 group workers, a survey was made of their work in terms of tasks and responsibilities. The most common responsibilities (freq. > 10%) are listed below (see Table 2).

**Table 2**

Reported responsibilities of residential staff in the establishment (percentages)

| Staff responsibility | England ($n$ = 51) % | Germany ($n$ = 49) % | Denmark ($n$ = 38) % | Total # ($N$ = 138) % |
|---|---|---|---|---|
| Daily responsibility for a particular group of young people* | 88 | 71 | 90 | 84 |
| Administrative tasks such as record-keeping | 69 | 74 | 82 | 74 |
| *Key worker* for one or more individual young people* | 49 | 71 | 74 | 64 |
| Liaison with other agencies/professionals | 51 | 67 | 68 | 62 |
| Liaison with families** | 31 | 51 | 71 | 49 |
| Particular activities (e.g. swimming, art, sports)* | 10 | 33 | 18 | 20 |
| Particular methods of working or interventions | 14 | 18 | 24 | 18 |
| Management, including pedagogic management | 8 | 16 | 18 | 14 |

* $p < .05$, ** $p < .001$; # missing cases = 6

*Source*: Petrie et al. (2006)

The vast majority of those interviewed have daily responsibility for a group of children (84%) and also carry out administrative tasks such as record-keeping (74%). Two out of three (64%) are 'keyworkers' or counsellors of one or more children. Around half of the respondents (49%) have a task in maintaining contact with the family. This last aspect is clearly more prevalent in Denmark than in Germany and – particularly – England.

According to Petrie '...a key role for staff working with children in residential care is, or should be, supporting them through difficult events and processes. This is one function of care-giving' (Petrie et al., 2006, p. 77). The London team examined the way in which care-givers apply this responsibility in practice – in this case, the way in which they offer *emotional support* to children. Informants were asked to reflect on the last time they had provided emotional support to a child. Table 3 provides an overview of the results.

The responses have been compiled into three clusters, referred to as an 'empathic approach', a 'discursive approach', and an 'organizational/procedural approach', respectively. On average, the *empathic approach* – with the categories of 'listening', 'naming feelings', 'cuddling' and 'companionship' – is more frequently applied than the *discursive approach* – with its categories of 'discussing/talking', 'suggesting strategies' and 'attempting to persuade' ($M_{emp} = 0.37$; $M_{disc} = 0.34$). The *organizational/procedural approach* is applied least frequently ($M_{org/proc} = 0.24$). The empathic approach is most prominent in Denmark and least prominent in England. According to the researchers, this approach is essentially child-centred, having its origins in a personal relationship.

We wish to examine this relational approach further, partly because literature has long indicated that the relationship between the child and the professional – the same applies to adult care – is a key factor in generating emotional and behavioural changes (cf. Boendermaker, Van Rooijen & Berg, 2010; Daniël & Harder, 2010; Van Yperen, 2004).

**Table 3**
Staff reporting how they offered children emotional support, last occasion (percentages)

| WAY OF OFFERING EMOTIONAL SUPPORT TO CHILDREN | England ($n = 49$) % | Germany ($n = 50$) % | Denmark ($n = 38$) % | Total # ($N = 137$) % |
|---|---|---|---|---|
| **Empathic approach** | | | | |
| Listened** | 39 | 56 | 97 | 61 |
| Companionship (e.g. spent time with them)** | 24 | 22 | 60 | 34 |
| Put words to their feelings** | 2 | 18 | 89 | 32 |
| Cuddling them* | 8 | 20 | 32 | 19 |
| **Discursive approach** | | | | |
| Discussed/talked with them | 74 | 66 | 53 | 65 |
| Gave strategies for dealing with situation* | 31 | 20 | 47 | 31 |
| Talked them round to doing what staff thought was best | 6 | 4 | 5 | 5 |
| **Organizational/procedural approach** | | | | |
| Referral to external agency* | 14 | 0 | 13 | 9 |
| Reference to rules or procedures | 8 | 0 | 5 | 4 |
| Other | 26 | 34 | 21 | 27 |

* $p < .05$; ** $p < .001$; # missing cases = 7
*Source*: Petrie et al. (2006)

### Child-Worker Relationship and Attachment Representation

Zegers (2007; also Zegers et al., 2006) recently published an interesting study on relationships between children in residential care and group counsellors or key-workers. Taking attachment theory as her frame of reference, she investigated the attachment representations displayed by the young people and their counsellors, and the way this influenced their treatment relationship. *Attachment representations* – also called 'internal working models' – are defined as '...a set of conscious and/or unconscious rules for the organization of information (regarding attachment-related experiences, feelings and ideations), and for obtaining or limiting access to that information' (Main et al., 1998; in Zegers, 2007, p. 37). The essence is the mental representation of previous experiences of attachment. Within this frame, a distinction is made between autonomous ('secure') and non-autonomous ('insecure') representations.[8]

A characteristic feature of a person with an *autonomous* attachment representation is a coherent manner of articulation when talking about attachment experiences: someone speaks openly and reasonably objectively about the role of one's parents in one's childhood, even if there have been negative experiences; the influence of these early experiences on one's current personality is acknowledged. People with a *non-autonomous* attachment representation lack this openness, objectivity and 'valuation of the past'. Insecure attachment representations can be subdivided into three types: 'dismissed', 'preoccupied' and 'unresolved/disorganized'.[9]

Zegers's study showed that almost no adolescent from her sample (7%) possessed autonomous ('secure') attachment representation; this being in contrast to a non-clinical norm group in which approximately half of the young people (48%) displayed this type of attachment representation. Among the counsellors, more than half (55%) had an 'autonomous' score. This is similar to a non-clinical norm group of adults (cf. Van IJzendoorn & Bakermans-Kranenburg, 1996).

Measurement after three months' stay (the 'initial period') indicated no link between the attachment representations of young people and counsellors on the one hand, and the (perceived) professional relationship between these partners on the other. However, the following results were determined seven months after the end of the initial period among a subgroup of young people ($n = 30$) who had been in care for at least ten months:

- the higher the *adolescents'* score on the coherence dimension – this is the most important dimension for determining whether the attachment representation should be classified as autonomous or non-autonomous – the more the avoidance of contact with the counsellor diminishes and the more there is 'reliance on adults' among the adolescents;
- the higher the *counsellors'* score on this coherence dimension, the more the psychological availability of the counsellors – as perceived by the adolescents – increases and the more these adolescents display 'reliance on adults'.

These results mean that the treatment relationship between young people and counsellors in the medium term is partly influenced by their attachment representations. This could signify that it is more difficult for counsellors with an 'insecure' representation to establish good contact with, and to win the confidence of, their protegés than it is for 'secure' colleagues. With this in mind, Zegers advocates an in-service training that aims at making caregivers more conscious of their own attachment representation, taking into account the consequences of this for the forming of relationships with juvenile clients.

### Social Interactions with Children

Zegers's study showed that the 'personal make-up' of group workers is an important factor in their functioning as social worker. This is also indicated, although indirectly, in the third and last study to be discussed: an observation study on the interaction between care workers and children, performed by Van den Berg (2000; see also Van Houten & Van den Berg, 1997; Knorth 2003b).

Van den Berg made video recordings of the social interaction between children and care workers in two types of communities:

- One type concerned groups in which the *provision of structure*, including the exercise of control, were of paramount importance (abbreviated as STR). These groups comprise children who have problems with the analysis and ordering of their living environment; they particularly show externalizing problem behaviour, such as antisocial behaviour and attention deficits.
- The other type concerns groups in which the *provision of emotional-affective care and support* is of primary importance (abbreviated as EAS). These groups comprise children who have been emotionally and physically neglected and often maltreated. These are vulnerable children who frequently have difficulty with confiding in others.

The difference in approach sketched here is based on the orthopedagogical model of Kok (1997), which is a theory that is often applied in the Netherlands and Belgium as a 'foundation' for the care and treatment offered by group workers (cf. Van der Ploeg & Scholte, 2000).

Van den Berg made 88 video recordings, each lasting 15 minutes, in which the social interaction of one child and one care worker – a so-called 'interaction dyad' – was filmed. Ultimately, 24 children (average age 10.2 years) and 16 members of staff participated in the study. The video recordings were all documented in writing and analysed by means of the SASB category system (Benjamin, 1993, 1994). According to this Structural-Analysis-of-Social-Behaviour model, social interactions can be analysed on the basis of two dimensions: mutual attachment ('affiliation') and mutual dependence ('power'). The poles of the first dimension are 'hostile' and 'friendly'. In the second dimension, Benjamin makes a further distinction with reference to the extent to which the focus of the interpersonal behaviour is directed towards the *other person* or towards the *subject him or herself*. With an orientation towards the other, the poles are 'give autonomy' and 'control'; with an orientation towards the person him/herself, the poles are 'be separate' and 'submit'. Figure 1a depicts the main dimensions, figure 1b the sub-dimensions.

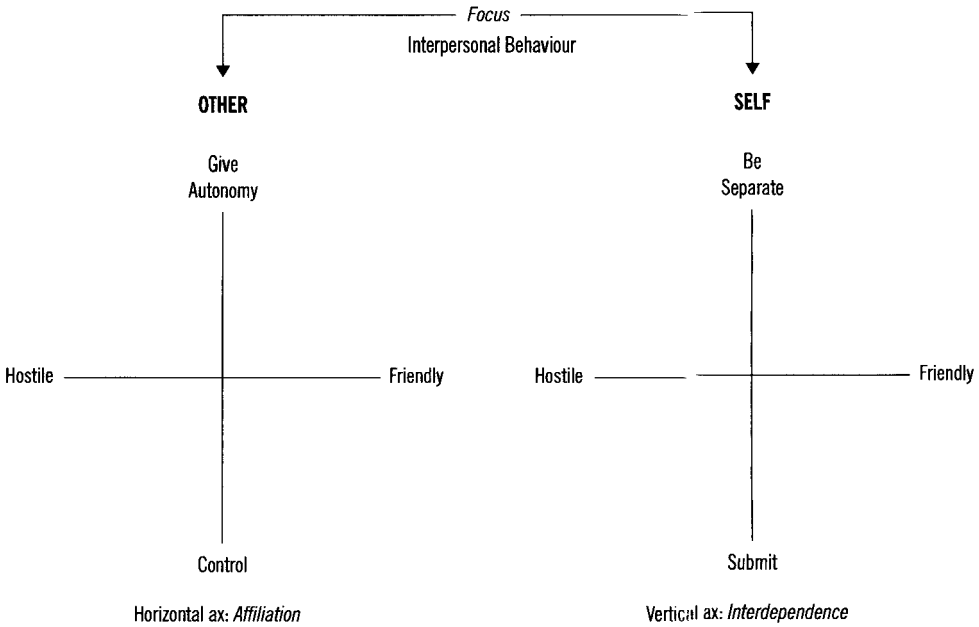


**Figure 1a**
Dimensions SASB-model

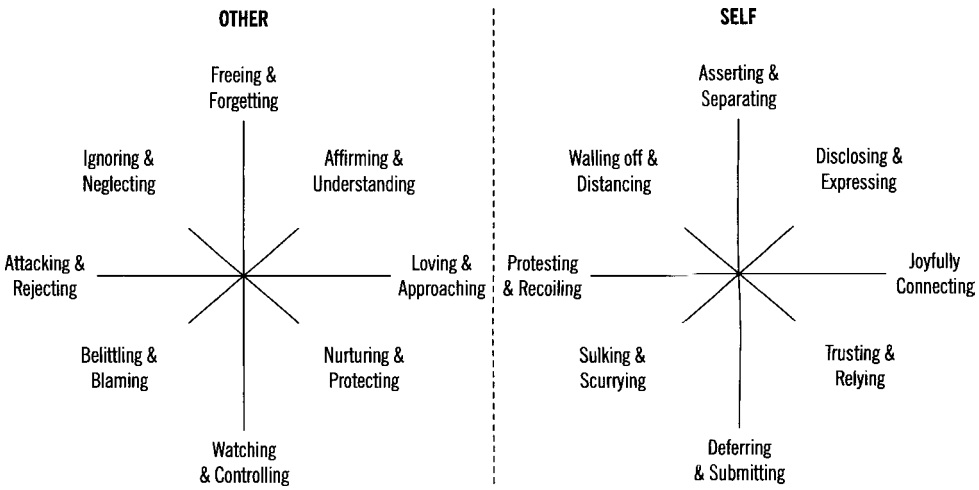


**Figure 1b**
16 Clusters SASB-model

Codes were assigned to almost 30,000 'interpersonal behaviours'. Van den Berg's two most important conclusions were:

1. Contrary to expectations, in terms of patterns of interaction between the care worker and the child there were many more correspondences than there were differences between the types of treatment. As an example the scores of the workers are shown (see Figure 2); there is hardly any difference between the length of the bars in dark and light grey.

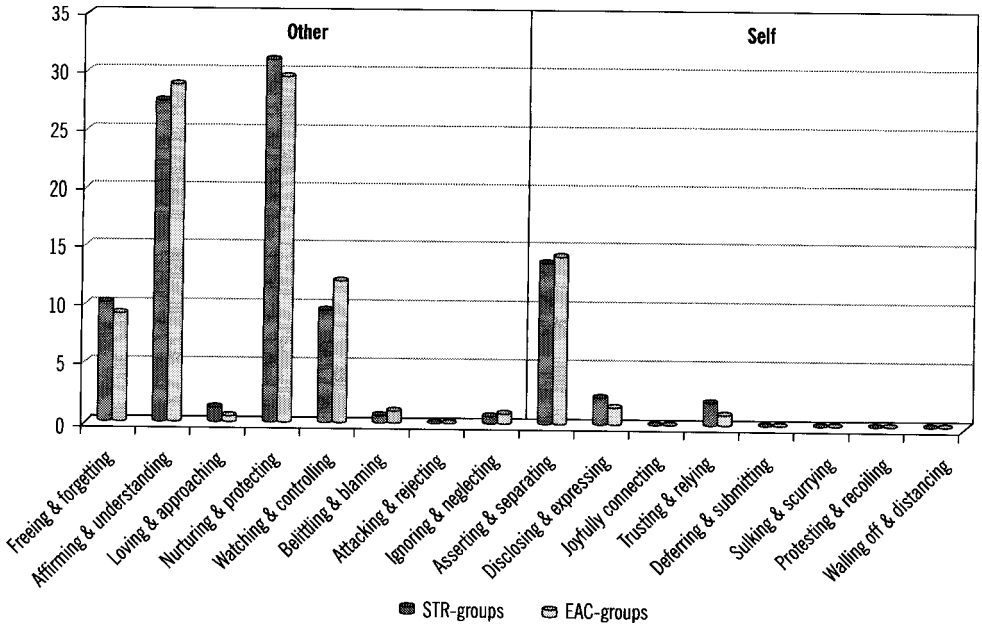


**Figure 2**

Relative frequencies of observed interpersonal behaviour of *residential care workers* (n=16) in STR-groups and EAC-groups, with focus 'other' [on the left] and focus 'self' [on the right]

2. The interpersonal behaviour of care workers, active within the same type of treatment approach (STR or EAS), displayed just as much mutual difference as the interpersonal behaviour of care workers, active in different types of treatment approach.

According to the researcher, these two results signify that the care workers tended to act on the basis of their own *personal style* rather than on the basis of a methodical approach that was supposed to be characteristic of the type of community – STR or EAS – in which they were working.

However, there were also other factors. People do not just do whatever occurs to them. On the contrary, there were clear patterns in the care worker-child interactions.

1. Care workers were primarily oriented toward the children (82%), whereas the children were primarily oriented toward themselves (94%).
2. The behaviour of the care workers showed that the following five categories could be applied to 94% of the interaction dyads:
   - *Nurturing and Protecting* (31%): teaching the child something in a friendly way, protecting and taking care of him or her
   - *Affirming and Understanding* (28%): allowing the child to speak out and trying to understand the statements with a show of attachment, even if there is a difference of opinion
   - *Watching and Controlling* (11%): ensuring that everything takes place as it should, taking control where necessary, and making sure that the child sticks to the rules
   - *Freeing and Forgetting* (10%): releasing the child to be and do what he or she pleases, without having to be too worried
   - *Asserting and Separating* (14%): knowing what you want, following your own path independent of the child.

   Here we observe that, in almost 60% of their interactions (covering the first two categories), the care workers displayed genuinely friendly behaviour. This means that they created a

positive living environment and social climate, which is something that will benefit the developmental opportunities of these children (Theunissen, 1986).

3. The opposite of friendly behaviour, referred to as *hostile behaviour* in the model, occurred extremely seldom among the care workers: only 1.6% of all recorded instances of behaviour. In such cases it involved rejection, condemnation, punishment, or disregard. This way of behaving appeared to be a reaction to children who were excessively submissive, angry or dominant in a certain situation.
4. The study did not support the occasionally heard statement that care workers are little more than wardens (see Grubben, 1994, for example). The authoritative function was certainly present (as we have seen previously), but the 'granting of autonomy' to children ('freeing and forgetting' – 10%) and the 'seizing of autonomy' by children ('asserting and separating' – 26%) was much more prevalent in the outcomes.
5. The research data showed the high prevalence of interactions according to the *principle of complementarity*. This principle states that the patterns of social interaction between people often evolve in such a way that the behaviour of one person evokes complementary behaviour in the other.[10] The principle of complementarity ensures stability in inter-human relationships. In the community of the group, this meant that the care workers became largely *predictable* for the children, and realized an important part of their care responsibilities: the provision of safety and security (Schuengel, 2002). Van den Berg observed that the reverse of the principle of complementarity, the *principle of antithesis*, could have been applied a bit more because of its assumed potential to evoke behavioural change in children.[11]

On the basis of these outcomes, Van den Berg asks whether it might be just as important for a child and the problems he or she is facing to link these to the merits and personal qualities of a key worker as it is to apply a particular method of care or upbringing.

### Involving Parents

One of the less prominent tasks of care workers is to involve parents in the residential care process. In the research performed by Petrie et al. (2006), around half of the respondents indicated that they regarded this as one of their responsibilities (with a great difference between Denmark – where around three-quarters of the care workers are engaged in this activity – and England, where this applies to less than a third of the staff).

Regardless of the question of whose responsibility it is to involve the parents and perhaps the rest of the family in the care and treatment process, we do see research results being published – albeit rather sparsely – that could be characterized as 'promising'. Here are a few examples.

In a study of 48 British children's homes, Gibbs and Sinclair (1999) reported a significant positive correlation between the emphasis that was placed by the management on a family-oriented approach – represented by the adequate provision of information to parents, involving them in decisions concerning what ought to be done, and mediating between parents and children – and the improvement of the emotional bond between the child and the parents. This emphasis was not coupled to more contact between the parents and child.

Research performed by Landsman et al. (2001) in Iowa (USA) on the so-called REPARE programme – this is a family-centred residential treatment model with much emphasis on cooperation with and support for parents – demonstrated that, in comparison to 'residential treatment as usual', the children participating in this programme were in care for shorter periods (8 instead of 15 months), were moved back home more often (49% instead of 19%), and experienced more stability in their domestic environment after reintegration.

In the Netherlands, Geurts recently finished research on a residential treatment programme in which, in cases of placement, the involvement of parents was strongly encouraged (Geurts, 2010). The analysis indicated that this method appeared to have more 'impact' on experiential outcomes than on behavioural outcomes; a high score on 'family-centredness' of the work was the best predictor of a high parental score with regard to the 'perceived effectiveness'. A high degree of parental involvement was also positively associated with the realization of family and

competence-related treatment goals, and with client satisfaction (Geurts, 2010; Geurts, Knorth & Noom, 2008).

Finally, a German research team under the supervision of Schmidt et al. (2003) performed comparative research on five forms of juvenile care, including residential treatment. This research convincingly demonstrated that good cooperation between workers and parents and children – such as extensive consultation with them concerning the required approach, for example – was the best predictor for the improved functioning of the child and for a decrease in family problems. In contrast, an absence of cooperation with the parents was the best predictor of premature termination of the child's stay in the care setting (see also Gabriel, 2007; Knorth et al., 2009).

**Summarizing**

The studies discussed show that there is variation between care workers in terms of their 'pedagogic' actions in the residential community:

- They may differ in the degree to which they place the emphasis on an empathic/relational, a discursive or an organizational approach.
- As a result of their own attachment representation, they may differ in the degree to which they are 'psychologically available' to the children and can win their confidence.
- They may differ in the degree to which they place the emphasis on the provision of structure or emotional support, and the extent to which they display complementary or antithetic responses.

What we do not know so much about, in empirical terms, is what the effect of all this acting of care workers actually is on the outcomes, i.e. the development of children in care. We have plausible hypotheses but no hard evidence.

In addition, although promising results have been achieved by involving parents in residential care, this does not mean that the encouragement of parental involvement and participation has now become a regular feature of care (see also Conen, 2007).

# Conclusions

Given the negative image of residential youth care and treatment mentioned at the beginning of this article, the question of 'Does it have a future?' arises. The response could be: *of course* there is a future for this form of care because – to paraphrase Frensch and Cameron (2002, p. 337) – there simply will always be children who require (temporary) placements and, as such, residential treatment will remain an integral component of a comprehensive system of care for children and youth with serious emotional and behavioural disorders. However, the true academic issue deals with whether or not residential care can be anything more than a last resort, or – as Wozner (1990) once wrote – a 'container' in which unmanageable juvenile troublemakers are dropped (see also Whittaker & Maluccio, 2002).

## *Outcomes*

Various reviews, including our own meta-analysis, show that, for the majority of the children, residential care generally results in a reduction in problem behaviour. In this respect, the outcomes are certainly just as good as those of other, less intensive forms of child care (Bates et al., 1997). Positive outcomes appear to be stimulated by explicitly involving the family in the treatment of the child. Our own review also indicates that specific training and therapy for the child, oriented toward the reinforcement of cognitive, behavioural and relational skills, can strengthen positive behavioural results (Harder et al., 2006).

Research on outcomes tends to concentrate on the behavioural functioning of children. The reduction of the child's (externalizing and/or internalizing) problem behaviour is by far the most

frequently applied operationalization of outcome measurements. Alternative indicators such as improved family functioning, the realization of pre-set treatment goals, sufficient customer satisfaction, a reasonable quality of life, and prevention of premature drop-out (cf. Whittaker et al., 1988) were hardly encountered. We also noted that outcome measures often involve short-term outcomes, with very little being known about results in the longer term.

We therefore see a need for research into outcomes involving both behavioural and experiential variables for the child, the family and the environment. Such research should look not just at short-term outcomes, but at longer term outcomes as well.

We have seen that not all children show improvement. Bates et al. (1997, p. 13) estimate the number of children who do not show evidence of improvement (and occasionally even get worse) after residential care as lying between 20 and 40 %. Even with children who do show improvement, not all problems are resolved by the time they leave the care residence (see Smit, 1994; Stein & Munro, 2008, for example). In view of the complexity and severity of the problems with which they enter residential care (Hellinckx, 2002), one should not expect this to be the case. This immediately demonstrates the importance of after-care. According to Bates et al. (1997, p. 18) '...empirically based after-care programmes would help ensure that the positive influence of residential treatment is maintained in the child's daily environment'. However, this after-care is not always available, so that the achieved results may soon be threatened (see Schmidt et al., 2002, for example).

Partly on the basis of this last observation, we can state that residential care and treatment – in the long term – can only have a positive outcome when the implemented programme is anchored in a broader entity of non-residential, community-based care provided to both the child and the parents. A child's stay in a residential care and treatment setting is only one link in a chain of care aimed at supporting vulnerable children and inadequately functioning family systems. Or, as Pinkerton (2006) states in his continuum of care model: the results of 'in-care' are to a large extent determined by the results of 'pre-care' and 'after-care'. All links in the chain are essential. To a greater extent than has occurred thus far, research must demonstrate *how* and *why* the 'residential link' works. The results of such studies will partly determine its future.

## *Workers*

In this paper, much attention has been devoted to the responsibilities of group workers, but what their precise share in the 'production' of behavioural improvement is cannot be given on the basis of empirical research. What we do know is that their work substantially impacts on the quality of care for the children being looked after. In a residential setting this quality involves not only physical-material matters, but also pedagogical and psychological care. This is expressed in aspects such as the provision of emotional security, the promotion of a positive attitude towards one another, the protection of privacy, the stimulation of cognitive development, paying attention to the individual child, the correction of unacceptable behaviour, et cetera (see also Anglin, 2002). This type of 'basic care' (Knorth, 2005) given to children and young people is the professional field of the residential workers. If they do not perform their work properly, the quality of residential care is immediately threatened.

Going by the views articulated by children in residential care, there is no reason to assume that group workers are malfunctioning on a large scale. However, one aspect that does emerge from the above-mentioned studies is that they are in a vulnerable position – they perform difficult and occasionally very trying work but do not always receive fitting esteem and reward for this (see also Lindsay, 2002). This increases the chances of them leaving the job, with the consequent discontinuity in the care of the children as an unwanted result.

We are firmly of the view that the profession of residential worker deserves a much higher status than it currently enjoys in many countries, certainly in the Netherlands. A stronger professional identity is needed. This could be achieved by placing greater emphasis on residential work in

higher vocational and academic training (Bachelor's and Master's degree programmes), by introducing a system of remuneration and accreditation that better reflects the huge responsibilities associated with working with demanding children, and by improving the public image of the residential sector as a whole. Comparative research (cf. Petrie et al., 2006) can show the benefits that will result for care workers and children.

Our overview also showed that the personality, or the psychological 'make-up', of the care worker plays a major role in job performance. This is notably present in features such as stress resistance, psychological availability to children, ability to win confidence, and preferable social patterns of interaction. Research has indicated that the quality of the primary process in residential care is essentially co-determined by the composition of the *personal* qualities of the residential staff. The question that then arises is how these personal attributes either reinforce or weaken the treatment outcome achieved through the provision of a needs-based combination of care and treatment. Research into adult mental health care reveals major differences in the working methods and outcomes of different professionals. Wampold and Brown (2005), for example, found that clients assisted by professionals who were rated unfavourably by clients and colleagues on a number of personal attributes[12] made significant improvements in only 20% of cases, whereas positively rated therapists achieved a favourable outcome for 80% of their clients. We do not know whether this also holds true for residential youth care. We believe that this is a pressing area for further research.

## Notes

1. For a recent international comparative study of residential care, see Courtney and Iwaniec (2009).
2. The term 'children' refers to children and young people between the ages of 0-18 years.
3. This is a reference to the renowned book entitled *The other 23 hours* by Trieschman, Whittaker and Brendtro (1969), in which more than 40 years ago they argued that it is not that 'one hour of therapy' with the psychologist or psychiatrist that ensures the positive development of children in care (even if individual therapy is certainly important to many children), but rather the everyday life - guided by group workers - that has the greatest impact.
4. This factor just tends toward statistical significance.
5. Without attempting to be exhaustive, we refer in this context to countries or regions such as Wales (Colton & Roberts, 2006, 2007), the State of New York (Smith, 2005), England (Whitaker, Archer, & Hicks, 1998; Mainey, 2003), Scotland (Milligan, Kendrick, & Avan, 2004), the Netherlands (Van der Ploeg & Scholte, 1998; 2003), Spain (Del Valle, López, & Bravo, 2007) and – in comparative research – Denmark, Germany and England (Petrie et al., 2006).
6. Netherlands (68%, cf. Van der Ploeg & Scholte, 1998; 63%, cf. Van der Ploeg & Scholte, 2003); Wales (74%, cf. Colton, 2005); Scotland (74%, cf. Milligan, Kendrick, & Avan, 2004); England (75%, cf. Mainey, 2003).
7. For instance, Petrie et al. (2006, p. 61) stated the following: 'It is especially worth noting that few informants (of the 144 interviewed group workers – EJK) said they wished to leave their current post for reasons connected with the young people living in the establishments or with their families – although, throughout the interviews, there were many indications that these could be sources of stress.'
8. This classification has been generated on the basis of data from the so-called Adult Attachment Interview (AAI).
9. With a *dismissed* representation, someone distances him/herself from a (painful) past by means of a 'de-activating' way of speaking, by the absence of recollections, by idealization of parents or by denying the influence of the past. With a *preoccupied* representation, someone

is fixated by former attachment experiences; the manner of expression is one of anger, confusion and/or vagueness. Occasionally people alternately display dismissing and preoccupied representations; this is coded as CC, 'cannot classify'. Finally, there is the category of the *unresolved/disorganized* representation. In this case, the person suffers from experiences of loss or trauma (such as the loss of a loved one, mistreatment, or abuse) with which they have not been able to come to terms and which manifest themselves in a conspicuous, disoriented manner of expression and/or by means of a description of extreme reactions in connection with the loss or trauma in question.

10. For example, when one listens to a child who tends to be self-oriented (the child may say: 'I feel worthless today'), the listener will be inclined to respond by displaying behaviour oriented toward the child ('Well, that's a shame. Is there any particular reason for that?'). A similar level of reaction often occurs in the two basic dimensions of social interaction – affiliation and mutual dependence.
11. What does the *principle of antithesis* entail? Take the behaviour of a child that claims a lot of attention, for example. With reference to the dependence dimension, the child is situated on the 'control' side. A complementary reaction would mean that the care worker should meet the appeal for attention. But this only reinforces the claiming behaviour. An antithetic reaction would be for the care worker to do his or her own thing, and not surrender to the child's desire for control. The aim of this is then to demonstrate to the child that you have no time or do not wish to spare time at this particular moment and that the child should stop demanding excessive attention.
12. These are attributes such as open, warm, non-judgemental, friendly, interested, involved, clear, attentive, flexible, affirming, encouraging, reliable, reflective, focused on client feedback, and avoiding negative interaction, accusations and a disparaging manner.

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