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Katie Barclay, Dee Michell and Clemence Due

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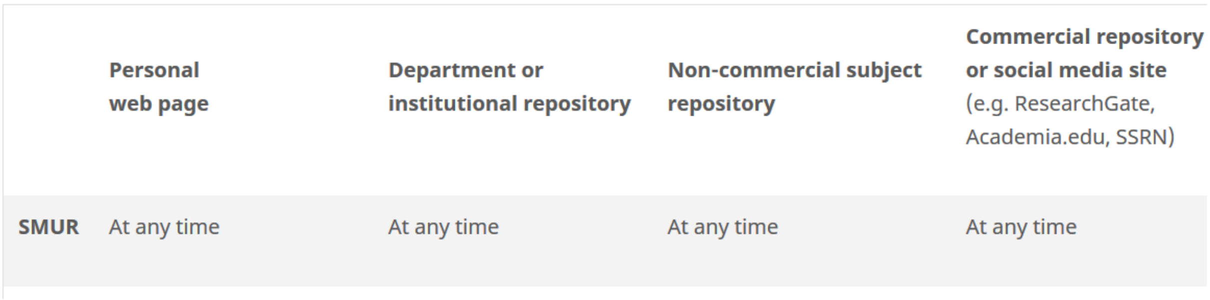

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Providing Care for Children: How Service Providers Define and apply “Care” in Contemporary South Australia

Katie Barclay, Dee Michell and Clemence Due

University of Australia

While a wide array of service providers and academic scholars apply the use of “care” in their work, the concept of “care” itself remains largely undefined. This has widespread implications for applied work with children and young people, particularly since institutions such as schools and non-governmental organisations are increasingly being expected to “care” for or about children. In this paper we use thematic analysis to report on interviews with representatives from four service providers and organisations responsible for the “care” of children. In our analysis, we explore both how care is defined by these organisations, and the implications for practice when working with children and young people.

Keywords: care, children, best practice, service providers, education

A wide array of scholars – from educational psychologists to health professionals to ethicists and sociologists – use the concept of care within their work (e.g., Held, 2006; Schochet, 2014; Chapman, 2011; Dare and O’Donovan, 2002). Yet, despite widespread usage, “care” often remains abstract or undefined. A number of scholars begin their works with an apology on the complexity of providing such definitions and pointing to “common usage” meanings (e.g., Held, 2006; Monchinski, 2010). Others, interested more in promoting a universal ethic for human relationships, see care as a mode of being and an approach for interacting with “the other”. Marion Barnes, for example, summarises her understanding of care as “being attentive to needs and making sure needs are met to in order to enable people to flourish” (2012, see also Noddings, 1982; Mahon & Robinson, 2011). How care should be operationalised however, particularly in services for children and young people (CYP), is a notable gap in the literature with only a few exceptions (Steckley and Smith, 2011; Barnes, 2007; Holland, 2010).

This is a particular issue as the recent growth in childhood and youth studies reminds us that relationships between adults and CYP cannot be assumed to mirror those amongst the adult population. Instead, there is a push within well-being literature to consider CYP in the context of both their developmental and social positioning (Blazek and Kraftl, 2015; Due, Riggs & Augoustinos, 2014). That some models of caring cannot simply be transferred from the adult to child population comes most to the forefront in discussions of care that emphasise reducing hierarchies of power in social relationships without consideration for contexts. A key example of the limitations of transferring such models of care can be found in schools, where discipline is significant to socialisation and wellbeing (Monchinski, 2010).

Moreover, endorsements for greater care when working with CYP are situated against a historical backdrop of sexual, physical and emotional abuse within institutions that make such "caring" relationships problematic and often strictly limited by policy (CARC, 2004). For example, teachers and service providers are often placed in a context where they are directed to care for and encourage emotional bonds with students (Chapman et al, 2013; Nickerson et al, 2011). However, this care and connection must occur within strict boundaries, and with little training or advice in how to balance these demands (Gilligan, 2000). In South Australia and a number of other geographic contexts, these concerns might be considered particularly pressing given that teachers and service providers have a legal "duty of care" towards their charges that requires them to take the concept of "care" seriously, but are currently primarily advised to focus on physical safety and bullying reduction. In order to consider the concept of "care" further, this paper is drawn from pilot research exploring how "institutions", construed broadly to include schools, charities and other service providers who provide "care" for children in a professional context, understand and define "care" in their work.

As such, this paper contributes to both our understanding of how care providers operationalise care in their work and to our understanding of the application of best practice principles. Remarkably whilst a number of scholars and practitioners promote a particular approach, methodology or ethic as “best practice” in a particular field (for example Herbert & Bromfield, 2015; Stanley & Mills, 2014), there is almost no literature on the concept of “best practice” or how it is understood or applied by practitioners. An exception is Kessler et al (2005) who, in arguing for the use of evidence-based studies as “best practice”, highlight that best practice has variously been understood as: “practice wisdom” (driven by practitioner’s experience); “emulating other systems”; “expert consultants”; “professional guidelines” (produced by professional bodies); and “evidence-based practice” that draws on empirical studies. It is not our goal in this paper to argue that a particular approach to best practice is superior. Indeed the field of disability studies has added some very cogent reminders of the limits of even evidence-based practices in enabling “care” (Beresford, 2010). Instead, our aim here is to explore how examples of best practice are put to work in services for CYP.

Like Steckley and Smith (2011) in the British context, we were struck by the significance of “discourses of care” to the shaping of the narratives of our interviewees. As a result, our analysis not only required engagement with the literature on “care” and best practice emerging from ethicists, social workers and CYP studies, but also with the sociological literature on “risk society”, individualism and reflexivity in late modernity. For example, a number of sociologists have provided commentary on the post-9/11 period as marked by particular anxiety, a conservative attention to risk, and a pathologisation of “normal” human concerns and emotions, often through the language of “trauma” (work epitomised by Beck, 1992; Beck & Beck-Gernsheim, 2002; Giddens 1991). Indeed, considerable attention has been given to this in the field of childhood studies where ongoing debates exist around whether children are too sheltered from “normal” childhood risks, whether “ordinary” childhood developmental variation is being pathologised; and whether experts pursue trauma or medical diagnosis in contexts where it is unnecessary (Furedi, 2002; Daniel, 2010). These questions have been particularly cogent for children who live in state care, where institutions across the Western world have typically been risk-averse in interpreting their legal duty of care. For example, the state often places considerable boundaries and limitations on the lives of children who live under state guardianship, with these limitations often identified as being in tension with “normal” childhood experiences and development (Milligans & Stevens, 2006; Steckley & Smith, 2011).

Such debates tie closely to discussions concerning the relationship between the individual and society. Specifically, both neoliberal economies and cultural discourses that emphasise personal responsibility and the individual are thought to result in greater personal anxiety and so more risk-averse behaviours (Beck-Gersheim, 1998). In the context of child care, this relationship has mainly been discussed with respect to the greater emphasis on parental choice and individual responsibility for children. This emphasis on choice has arguably placed pressure on parents to ensure their children are school-ready, to select the “right” schools, and to support education with extra-curricular activities to give children an advantage in an increasingly competitive environment (Furedi, 2002; Campbell et al, 2009). In addition, some literature suggests that this focus on child performance also influences decisions concerning medical and social interventions for so-called “underperforming” children (Timimi, 2014; Conrad, 2007).

Individualist models also underpin considerable discussion on child-centred approaches to learning or living by “caring” institutions and service providers. Such approaches often view the “individual” child as the key point of analysis in shaping engagement with care, learning or socialisation (Smith, 2011), although they frequently overlook similar consideration to the wider ecologies that children are being shaped for. That is, it becomes important for children to achieve at school, if necessary through tailoring the curriculum to their needs, but not for the curriculum itself to be rethought or re-evaluated. In such debates, the child is both highly individual, but also required to submit to considerable conformity to be viewed as “successful”.

Debates around the individual in modernity are accompanied by those around the growth of the “reflexive self”, where people are encouraged to be analytical of the self, and to work at constructing a coherent, but constantly re-evaluated and reworked narrative of identity (Giddens, 1991; for its limits in child protection see Scourfield & Welsh, 2003). This is associated with the growth in self-help literatures that encourage people to seek help in creating narratives out of their experiences, and through that regulating their emotional and social behaviours (Giddens, 1992). The significance of this model of self to childhood, and particularly childhood education, has been well recognised with children located as “autonomous learners” “not only obliged to shape their own learning, but also take responsibility for this shaping” (Kryger, 2004, pp. 154–5; Smith, 2011). Such models of education have sought to be more child-centred, but can sit at tension with the needs of children to be supported in their decision-making and the need for conformity amongst children by institutions providing services to them (Smith, 2011). As might be expected, that these fractured discourses of care underpin discussion of the service of care leads to tensions in the narratives of care providers, as we explore in this paper.

Method

In order to explore how service providers who provide “care” for children in a professional context understand and define “care” in their work, we undertook a small qualitative research project in our home state of South Australia, conducting interviews with employees of four different organisations. As this is a scoping study, an interpretive (rather than critical) lens was used to understand the lived experiences of the research participants (Fossey et. al, 2002). The study was granted ethics approval by the University of Adelaide’s School of Psychology’s

Human Research Ethics Sub-committee. Semi-structured, open-ended interview questions were developed, based on the existing literature around best practice concerning care for children, as well as open ended-questions pertaining to how the participants defined “care”. Examples of the interview questions include “how does your organisation define ‘care’?”, and “how are children cared for in your organisation?”.

Purposive sampling was used to recruit people working within organisations identified as responsible for the “care” of children in some capacity. Specifically, interviews were conducted with four representatives from four separate organisations (all senior members of staff), all of which have been anonymised in this paper and provided with pseudonyms. Organisation 1, *Second Chance*, is an educational institution offering educational services to marginalised young adults who wish to return to school. Organisation 2, *Secondary School*, is a large regional high school mandated, as all state schools are, to cater for diverse learning needs in the classroom; our interviewee worked in a specialist unit within the school aimed at supporting CYP with additional support needs. Organisation 3, *Caring Community*, is a non-government organisation (NGO) responsible for a range of services, including foster care, support for children with disabilities, and support for newly arrived families; while Organisation 4, *Welcoming Diversity*, is a small grassroots non-profit program designed to support gender and sexuality diverse young people. Further details about all these organisations are provided in the sections below.

Interviews took place at a time and location of the participant’s choice. Each interview was audio-recorded and transcribed verbatim, and the data was analysed using a deductive thematic analysis, following the guidelines laid out by Braun and Clarke (2006). The first stage of analysis involved familiarisation with the data through multiple readings of the transcripts. The second and third stages involved thematically coding the data, with particular attention being paid to themes that were relevant to the research questions concerning: 1) definitions of care for children; 2) how such definitions are put into practice in organisations responsible for providing services to children and their families, and 3) the limitations of delivering services in line with definitions of best practice care. Finally, the themes were reviewed and collated according to these research questions, and are presented below with representative extracts. One of the authors undertook the primary thematic analysis, with all authors agreeing to the final themes. These themes are presented below

Results

Defining Care on the Frontline

Care was driven for all our practitioners by their organisational aims and objectives. Therefore *Caring Community* sought a safe and stable family life for children in care; *Welcoming Diversity* desired an inclusive sociality where CYP felt as if they "belonged" and could be themselves; whilst *Secondary School* saw care as offering an individualised program of education that enabled CYP to achieve under the broader state curriculum requirements. These goals not only shaped the service that was provided but, as will be explored below, what they considered the concept of "care" to be in their service. As this suggests, care meant quite different things to different service providers, and whilst they shared certain broad assumptions around what care should mean (notably child-centredness and a sense of belonging), there was variation in the application. Therefore, whilst much work on care ethics has sought to provide an over-arching definition, or "ethic", that would hold together care in a vast array of different contexts, in practice, care is often locational. This is not necessarily problematic, with Raghuram (forthcoming) suggesting that a sensitivity to the ecological contexts of care allows for a broader range of models for caring to emerge, particularly from marginalised groups.

What did emerge across the interviews was the distinction between "caring for" CYP and "caring about" them, a division made by Nel Noddings (Steckley & Smith, 2011; see also Tronto, 1994), where to "care about" CYP is to want them treated kindly, but to not necessarily be actively involved in providing care, “caring for”. The abstract nature of “caring about” can lend itself to ensuring that policies and procedures are in place, for example, but the distance between the abstract and the material provision of care means that care is not necessarily achieved in practice. However, if being “cared for” means another person(s) taking responsibility for a CYP in a custodial sense (Beresford, 2010) or in restraining the autonomy of individuals (Smith, 2011), it is worth noting that some CYP may prefer to be “cared about”.

Caring Community represents a service provider which epitomises the link between abstract principles of “caring about”—enshrined in state legislation—and the practical component of “caring for” children. Contracted to provide stable long term care for CYP in a foster care situation, *Caring Community* source foster carers and then train and support them to provide a nurturing environment for children in state care. The representative we interviewed from *Caring Community* stated that in this family environment, care involves an opportunity for “a sense of belonging in family, connections with obviously birth families, community and culture so yeah it’s about belonging, connectedness, security”, closely mirroring Steckley & Smith’s description of good practice residential care as enabling “bonding, strengthening attachments, working through fears or resentments, and developing a sense of competence and basic worth” (2011, 187). *Caring Community* therefore “care about” to allow carers to “care for”, where care is tied to close, familial-like bonds that provide belonging and identity.

Caring Community’s emphasis is on providing what they call “specialist and therapeutic care” for a particular group of CYP aged five to 17 who have been assessed by the relevant child protection agency as having “either moderate or significant needs and or disabilities”:

> Well I guess we’re coming from a therapeutic perspective, it’s about placing children in a safe, stable, nurturing environment that allows or enables the child to recover

> from the abuse and trauma that they”ve experienced and to move forward in life and develop.

In seeking suitable foster carers to provide the daily “caring for”, *Caring Community* is governed by a number of mandated requirements. For example, they are obligated to place only one child per placement and the foster family home “has to have a spare bedroom for the child”. *Caring Community* must also follow a mandated screening and assessment process, which can take between five to twelve months from the recruitment of a potential carer to placement of a CYP with them. This includes both following up on practical details—such as contacting referees and ensuring that carers have police checks in place and have undertaken first aid training—and professional assessments of a carer’s “capacity to demonstrate and provide a safe environment, that they can provide nurture and care”, and are no longer responding from their “own grief and trauma issues”. In addition, *Caring Community* is required to visit a foster care family once every fortnight, which some carers find intrusive as “there’s probably a lot of eyes looking in on a family at any one time” because of “support workers, clinicians and respite carers” coming and going.

The latter occurs because of the team approach *Caring Community* use to support the foster carers in “caring for” CYP:

> I definitely think one of the main points of differences [between *Caring Community* and other similar service providers] is having our own clinical team who are immersed in the day to day goings on of the placements and can go out and respond straight away and walk the child and carer through that de-escalation, bring the child down and then we do the follow up which we call last stage interview, which is a reflection on what happened the day before and what might we do differently next time to avoid that.

Care here then requires significant professional expertise and intervention into the caring relationship (between foster carer and CYP) to enable a form of familial care to happen, and to achieve the goals of belonging, nurture and community that *Caring Community* understand as key to care. The measure of success at *Caring Community* is a low placement turnover rate in a field where high rates are notoriously common—85% of placements at *Caring Community* are stable ones where the CYP placed remains with the foster carer(s) until they "age" out of the system. Here "stability" becomes a proxy for the achievement of care.

The support *Caring Community* provide to foster carers who do the daily "caring for" CYP contrasts with the perceived lack of support for those teachers "caring for" CYP in increasingly complex teaching environments. At *Secondary School*, "caring about" CYP at the school level means both a "duty of care and educational development": "…in that context students have sort of the right to feel safe at school because they spend a lot of time here and they have a right to an education". Here the legal duty of care is defined very narrowly in terms of safety, as other studies have suggested (Milligans & Stevens, 2006), and educational development is situated as an additional form of care, perhaps similar to the "nurture" identified as important by *Caring Community*.

At the program level known as the "One Plan" (targeted at students who are Aboriginal, under Guardianship orders, or who have disabilities), there is a tailoring of those overarching principles to meet the needs of particular students:

> I see the main role as those two things [duty of care and right to education] which in terms of a One Plan it's about giving an individualised student-centered approach. The program is developed for students if they're trying to engage with a mainstream curriculum despite learning disorders or disabilities, then it would perhaps be best to take in their perspective, what works for them, what teaching approach that they're interested in.

The program includes meeting with students before they transition into *Secondary School*, working out a plan for them, keeping in touch with them and their support teams (including parents), and updating the plan as necessary. Whilst our interviewee Daniel formally saw care in terms of child-centred education, during the interview he suggested other measures of care taken by teachers working with children in the program, including sensitivity in filling out paperwork: "things like domestic violence or substance abuse … you can't write things that would be explicit in it but you can explain why a student may have difficulty sitting in class". Here teachers demonstrated care through balancing confidentiality, and possibly an eye to readership (with One Plans available to parents), with a need to provide the fullest form of personalised support in the classroom.

Similarly, the program coordinator of a regional specialist education centre emphasised a combination of individualised education, along with smaller, more personalised and non-mandated measures of care for wellbeing. At *Second Chance*, young people (YP) who have disengaged from the mainstream school system, often for a long period of time, are encouraged to complete their secondary education with the understanding that this will provide them with a better future. In the interview, it became apparent that *Second Chance* staff have an attitude of "caring about" YP, particularly in relation to wanting to steer them away from a life of disadvantage and poverty, but try to encourage the "caring for" to be performed by students for themselves. Here, YP are "treated like adults" and given the responsibility (within clearly defined limits of age and time commitments) to work with staff to develop an individualised plan to complete the state curriculum. These plans mean that students are not required to fit into school timetables, but rather that timetables are adapted to individual students:

> We're cutting out a lot of the issues by simply saying that we're not there all day, you don't have to sit in front of five teachers in the day and listen to this and that you may

> not be interested in listening to, so that is our biggest success in that we say ‘Hello Susan, this is going to be, we are going to set out your program, it is your program of learning, it’s not mine, it’s not the teacher’s, it’s yours. Now what are we going to do?

The *Second Chance* program provides one on one consultations with staff (again within limits), and the flexibility for YP to study one subject at a time rather than juggle a number concurrently. “Caring about” the YP at *Second Chance* also means realising that some YP may prefer to be in the paid workforce rather than, or while, completing their secondary education. *Second Chance* provide considerable work-readiness support to enable this. As such, formal care here is defined in terms of the institution’s goal in providing educational development, arguably a form of nurturing.

In addition, however, a considerable part of care for *Second Chance* was in developing a space for students to feel as if they belong or are valued:

> …they belong in the place, they feel valued in the place, they are treated as adults, they [are] listen[ed] to, that’s another big thing, they [are] listen[ed] to. I just say to them “nothing is silly just tell me, ask the question, tell me what it is, nothing’s stupid, we will work it out from here” and another big, big tick, we celebrate their success, in reality when they first come to us is tiny, in the whole sphere of things you’d think why are these people going troppo because this kid has finished one unit of maths, that is probably the only unit that that young person has actually completed in school for a long time possibly and possibly the only time anyone has actually patted them on the back and given them a positive response rather than the negative they constantly get because of their behaviour, poor attitude, poor attendance or whatever.

Treating students like adults and listening to them whilst seeking to place the responsibility for learning on the student involves considerable nurturing and support to enable emotional and personal development. Moreover, this form of care is not mandated through policy, but through an awareness of effective nurturing techniques amongst staff.

More broadly, care for *Second Chance* staff can involve ensuring some basic needs are met, through “tapping into other agencies and other supports”:

> We all know that if a young person is worrying about, if a young person hasn’t got a roof over their head that night and they are couch surfing, the last thing on the planet they want to think about is whether they’re going to come in and do maths, and so the wellbeing has to be the first thing that we tackle.

Second Chance also organise information sessions outside their official educational remit – including in relation to navigating systems such as welfare payments, and running weekly cooking lessons. Our interviewee, Christina, noted that such classes underpinned “…our ethos … of caring for the kids … showing them that they matter to us and to provide a safe environment for them whilst they’re in with us”. As Stanley (2010) points out, providing food is likely to contribute to YP feeling nurtured and cared for.

While the service providers discussed above are all funded and endorsed by the state, our final research participant is connected to a grassroots community organisation and provides a social space for LGBTQI YP aged between fifteen and twenty-five. For the coordinator of *Welcoming Diversity*, creating a social space is attached to the larger concept of well-being (as distinct from mental/physical health). Safety for YP in this social space is preeminent; however it is not couched in terms of responding to regulation but in the way in which YP are responded to.

For *Welcoming Diversity* facilitators, “care” can be defined in terms of “not harming” and “providing support for”:

> To me it seems like there’s two things. One is more like a duty of care type thing which is more so about not damaging someone, you know, to make sure that, to make sure that what you’re doing doesn’t have a negative impact on someone. And then the other aspect I think is, is more of a positive thing, a proactive thing of providing someone with the support that they don’t have in other places.

This support particularly revolved around enabling YP to be themselves:

> … it’s a space where people are respected for who they are and who respect other people particularly in terms of obviously sexuality but also gender pronouns, appropriate names, all that kind of stuff and then of course the racism and classism and all those sort of things. That people feel like they’re in an environment where they can be who they are.

They saw this social space as contrasting markedly with encounters in other places where young people feel forced to hide themselves:

> …they might go by completely different persona when they’re in their different environments and maybe even a different name or totally different clothing and then when they come to the drop in they can be who they really are.

Like the *Second Chance* staff, the *Welcoming Diversity* facilitators saw themselves as “caring about” YP through the provision of the social space, while also allowing them considerable autonomy in shaping how care was practised. “Caring for” then became, at least partially, the responsibility of YP themselves, who “can leave at any time, they can rock up at any time. They don’t have to sign up or anything like that”. However, “caring about” QYP also involved “caring for” them while they are at *Welcoming Diversity* events. Food is provided, and the facilitators ensure that the QYP feel welcome and are engaged in the activities provided:

> There’ll be myself and another facilitator there and other volunteers. Throughout the night we just make sure that everyone’s comfortable and safe and you know particularly if someone’s sitting by themselves we’ll introduce them into a group so in terms of being ... the care that we provide is more a social support as well as you know running activities and stuff like that and to socialise.

Influenced by the coordinator’s wider experience in political activism and theatre, and awareness of what he calls “the therapeutic benefit in hearing other people’s stories [whereby] you feel like you’re not alone and can find connection”, *Welcoming Diversity* also includes cultural activities based on story telling:

> For example we’ve done a few sessions where we’ve, we did a session of coming out stories once where the way we’ve set it is that we all sit in a circle and anyone can tell a story if they want to tell it—nobody has to tell a story—and they can tell a story that’s a happy story or a sad story or an incomplete story, as long as it’s appropriate for the group, and we just go around and we kind of bounce off that.

In addition to encouraging connection through storytelling, *Welcoming Diversity* also encourages QYP to create their own culture and community:

> We're creating a culture and a community in a true sense as opposed to a lot of, a lot of the gay community is thrust upon people so there's a reputation that because you're gay or lesbian or transgender that you're a part of a community but it doesn't really mean anything unless there's a sharing of something

As for the *Second Chance* staff, care involves providing a space for YP to enter willingly and autonomously into relationships with service providers and other YP. In both cases, their goal is to create a sense of belonging and community (that in the case of schools will ideally lead to educational achievement, and for *Welcoming Diversity* greater social inclusion), but which is nurtured through some very practical forms of care, including providing food, managing personal interactions, listening to YP's voices, and providing general support.

Best Practice

It is notable that all of the service providers we interviewed were willing to be involved in the research project because they connected best practice with research. They could all be considered "experienced practitioners" (Kessler et al, 2005) who draw on their experience with current and previous work to make assessments about what works, or does not, in their organisations. They all drew on the idea of accountability or outcomes (Kessler et al, 2005) in making an assessment of their organisation's ability to provide "best practice" service to users. In the case of *Welcoming Diversity*, success was measured in the growth in numbers of service users; for *Caring Community* it is a high rate of stability, of CYP being placed in one foster care family and remaining there; for education providers, it is young people successfully completing secondary education or transitioning into paid work. Best practice for all practitioners combined enabling successful outcomes, whilst also ensuring a high quality of "care" (as defined above) for CYP. For Christina at *Second Chance*, "We put learning at the heart of what we do but we don't do it to the exclusion of caring for that young person, looking at their individual needs. So I guess best practice is really tailoring, for us it's tailoring to the needs of that young person and we're fortunate enough that we can do that".

Only one organisation pointed to the implementation of a particular policy or program as the definition of "best care". Underlying *Caring Community's* work is the ARC model: "all our practice here is underpinned by the ARC model, so that's the Attachment, Regulation, and Competency and we prioritise like the four basic building blocks of good parenting and good care so the achievement of the child, consistency and responses, routines and rituals". The ARC model, initially formulated by Kinniburgh, Blaustein and Spinazzola (2005), operates on an understanding that since CYP in out-of-home care will have experienced trauma and loss and grief, those working with them, including foster carers, need to be trained in both trauma theory and attachment theory: "It's a specific model for therapeutically managing a crisis situation so, looking to de-escalate and prevent rather than get to the stage where a child's in crisis and escalating and more damage is done in the response to the situation, our carers can manage that therapeutically".

Using the ARC model and providing a clinical team to support carers in "caring for" CYP distinguishes *Caring Community* from other foster care agencies, according to our interviewee Heather. Where a placement is difficult, or "bumpy", the team spend more time with the carer and the CYP, training the carer in crisis management and helping the CYP to understand what is happening for them so they can self-regulate in the future.

> We'd go out, probably with our placement support worker and one of our clinicians, and sit with the carer and really unpack the situation and develop what we call an individual Crisis Management Plan so as to try and prevent that happening in the future, or if they do see the child being triggered, they have a response in place. What we would

> do after an escalation as well, not just the Crisis Management Plan, we would go do a life space interview and that’s a part of our therapeutic crisis intervention model, and really that is about unpacking with the child what is going on with them and getting them to realise their physiological symptoms of trauma and to be able to respond to them in the future.

This approach can be contrasted quite explicitly with *Welcoming Diversity*’s rejection of a medicalised program of care for YP, contrasting their service with a “health organisation” that “will sit down one on one with someone in a small white room and they’ll ask you a bunch of questions and not say anything about themselves and then you know you can get a diagnosis or a referral or whatever”. Rather they identified their “novel innovative unique practices” as “cultural activity and how that affects young people”, particularly pointing to the example of group storytelling decribed above. For *Welcoming Diversity,* these “social/cultural elements are a part of best practice”, and moreover “ha[ve] a lot of therapeutic benefit”. Perhaps especially because they work with Queer youth, *Welcoming Diversity* wished to distance queer identity from a pathological condition, whilst seeking to support service users that may have suffered significant exclusion or trauma as a result of their sexual or gender identity.

Both *Second Chance* and the “One Plan” program were implemented as forms of “best practice” by the SA Department for Childhood and Educational Development (DECD), but they were not identified in those terms by the practitioners. Rather, best practice was discussed in terms of *how* they were implemented, rather than the efficicacy of the service itself. As a result, focus on best practice by practitioners looked particularly at staffing and training. Based on his previous experience at a small specifically designed centre for managing difficult behaviours, Daniel believes that rather than have one person – typically a classroom teacher - responsible for a large group of students with increasingly differentiated learning styles and needs (as required by the One Plan), students should be situated in smaller centres, where a team approach can include staff with specialist skills.

In the behaviour management centre, the team included teaching and support staff, but for Daniel what was particularly important was the inclusion of a staff member with social work or psychology experience who acted as a liaison with the family of the student:

> their role was to liaise with the family and to help troubleshoot problems that might be ongoing. I guess contemporary understandings of behaviour, that working with the past isn't so useful as deciding on maintaining an undesirable behaviour. So picking that apart and helping support a nice positive path forward, that was a really positive part of that program, helping heal some ongoing wounds.

Like *Caring Community,* Daniel identified specialist professionals with an expertise in working with CYP around their behavioural and psychological needs as vital to the success of children with additional needs.

A very similar story emerged from *Second Chance* staff who received training in trauma, and then worked as a multi-disciplinary team of teachers and youth workers to support students: "Youth workers, I steer them in that sort of direction [trauma training] because they are the ones that are sort of dealing with – in the main – the wellbeing". For all staff working with children with significant additional support needs, engaging with CYP was informed by an understanding of trauma, that placed an emphasis on educating students, as well as practitioners, in moderating their emotions and behaviour through self-reflection. Indeed, the ability to provide the expertise to train YP in these strategies was viewed as best practice. It is notable that such psychological care was situated as additional to the main service provision for all our interviewees. This approach emphasised wellbeing activities as "crisis management" that enabled students to move into a more normative set of behaviours, relationships and achievement of educational or social outcomes.

As well as providing trained staff with specific expertise in the wellbeing of CYP, a number of organisations pointed to the importance of having staff that were part of the CYP's community. Christina at *Second Chance* pointed to the importance of having members of the local Aboriginal community working as part of the team:

> I've got an SSO [Student Support Officer] in the centre who's an Aboriginal girl… and she's undertaken the case management for the Aboriginal cohort which again I think is a part of our best practice because she is a respected member of the [deleted for purposes of anonymity] people and she is in the community and she knows the community, they know her. If I was to speak to the kids the way that she speaks to some of those kids, my goodness gracious me, but she knows them and she knows how to say it, what to say, she knows who to ring…

Similarly Cameron at *Welcoming Diversity* thought it was a mark of best practice that their staff were "appropriate", by which they meant members of the LGBTQI community: "I think having, having appropriate staff is the first thing, so staff that are ideally from the community themselves or from the demographic themselves, I think that's an important thing". Being part of the CYP's community was viewed positively as enhancing relationships that in turn enabled community building, better engagement and so better results.

As this might suggest, the need for service providers to have expertise in multiple domains and membership of particular communities led to an emphasis being placed on team-work as good practice (in accord with that found in the case of refugee children, see Newbigging & Thomas, 2011). Christina at *Second Chance* described the important role of different members of the team but emphasised:

> we all talk together, we're a team, so that team gives out the information about the young people and how to treat them, what is going on in their life—pullback if you're a teacher, this and this and this is happening with them—without disclosing and breaking the confidentiality of that young person's disclosure to the youth worker.

Throughout all the interviews, we also observed that those on the front-line were passionate and positive about the CYP they worked with, a recognised facilitator of good practice in caring environments (Newbigging & Thomas, 2011). *Caring Community* staff, who did not always work directly with CYP, were committed to finding carers with such an attitude.

Constraints on Best Practice

When asked to articulate constraints on best practice, staff in three of the four organisations pointed to limited resources, particularly staffing issues. In as much as they identified a lack of knowledge on caring best practice, this was highlighted as a lack of staff training, rather than an absence of the knowledge that would enable such high-quality care. The service provider at the large regional high school found that the teachers who need to accommodate and implement a number of individualised learning programs have very little support for the additional work involved:

> So what that could mean is that you can have a class of mid 30's which would involve quite a degree of differentiation, perhaps three degrees from the mean each way, or you could end up with a smaller class, some 20 perhaps which is full of students with quite extensive educational needs and now in that instance that might seem more reasonable, and that might seem as though you can target support in terms of SSO allocations a

> great deal more effectively, but what it essentially means is that you have one teacher in a room with 20 individuals who need quite a degree of one to one support.

Similarly, *Welcoming Diversity* found that one of the downsides of their success was that the group was becoming too large to manage with current staffing levels, so that staff may not be able to continue providing the same level of either “duty of care” or support “care”:

> now we’ve spread from the main room to the front café, sometimes we’ll run two activities at the same time. Sometimes people will just go out the front and hang out the front because that’s where they feel like where it’s just them and they enjoy that. So the challenge is to…make sure that we’re not mothering them or you know giving too many parameters, but at the same time there’s still safety…we can’t ensure safety if they’re on the front porch for example but that’s what they want.

In both cases, a lack of resources to employ additional staff not only limited the application of best practice, but potentially impinged on the provision of a basic service, including the duty of care. Adequate staffing was also raised by the *Second Chance* staff member, although she pointed to this as a geographic concern, rather than a result of limited resources:

> people do not want to come out there, people do not want to come and work there and we really have to get a pick from a smaller pool of people and that’s not always, we find there’s been a turnover every year of staff because we’ve got to get the right person to be in that centre with the kids. We are truly getting there, but it’s hard.

A related concern mentioned by all organisations was appropriate training levels of staff or in the case of *Caring Community*, carers. The *Second Chance* worker felt that the regional nature of their campus made ongoing professional development (particularly around YP and wellbeing) more difficult, as training was typically located in Adelaide. Not only did Daniel express concern about the difficulties for isolated teachers in large classes, but he also thought that teachers are not appropriately trained for contemporary complexities. In his own case he found his two bachelor level degrees were inadequate for the classroom and he subsequently and voluntarily undertook a Masters degree as well. Other evidence he cites for the inadequacy of preparation is the number of teachers who leave the profession and that there's far more complexity to a CYP's development than can be covered "in a brief conversation… especially in these marginalised kinds of conditions".

Daniel also felt that students received inaccurate or only partially accurate diagnoses of their support needs, making implementing appropriate and tailored care challenging. Autism in particular was singled out, as Daniel sees problems with that being "flavor of the month" and, because it overlaps with post-traumatic disorder, the latter might not be noticed. The consequences for the CYP is what he calls "diagnostic overshadowing".

> I guess what I mean by diagnostic overshadowing is inappropriate behavioural initiatives, or even medications that are issued, which are sometimes quite confusing and which represent quite a setback for the students. So I guess managing that is a big part of what we do [in the Special Education unit], trying to incorporate that into plans and not second-guessing information.

Daniel reiterated that a team approach which included professionals other than teachers—for example social workers and psychologists—might offset some of these difficulties.

For *Welcoming Diversity*, the informal environment is both fundamental to the way in which it works and why it has become successful, and yet also problematic as the staff do not have the training to feel certain that they are providing appropriate information and support:

> The challenge is to make sure that, that we're doing everything that we need to do to support them and that we're not, particularly because I'm not a social worker or psychologist or anything like that, to make sure that we've got the right information to refer people on to deal with things, I think that's a hurdle or an ongoing thing that we have to be careful of.

Caring Community felt that their own staff were generally well-trained and in terms of improvements "it's probably more around the skill level of the staff" and working on developing that; however they recognised that as much frontline care was provided by carers, that limitations in knowledge could cause problems. They pointed particularly to more ambiguous parts of foster care policy around what decisions carers were allowed to make about the children in their care and noted that: "I know that the carers struggle with that a lot, with what decisions they can make and what they can't, and even though they've got a guideline it's still very blurred".

Caring Community also raised a distinctive concern around the intrusive nature of the mandated, thorough and lengthy assessment practices for carers before they could have children placed with them: "I think it's a very intrusive process to open up your whole life to the assessor and talk about your whole history and how you've become to be who you are today and where you are today, and to demonstrate that you can care for a child". Yet, it was not so much the initial assessment that they saw as problematic but the ongoing nature of the interventions in foster family life. Not only is there the aforementioned host of "eyes looking in on a family at any one time" but there is also the additional and ongoing screening that is mandated by the government agency: "I guess and I know why it's gotten to the place it has, but the whole risk and nature of carers, we have to screen regular household guests which, I understand why that needs to be done, but it's very intrusive". This was viewed as a particular concern as it acted as a restraint on “normalised” family life for the child, something explicitly viewed as a goal for foster children.

Discussion

One of the striking themes across all our interviews was the role that caring service providers played in producing the late modern subject, as defined by sociologists such as Giddens (1992) and Beck & Beck-Gernsheim (2002). The organisational goals of all our groups was to produce adults who are well-educated, psychologically healthy, comfortable with their own identities and able to narrate a coherent self, that in turn allows them to achieve in contemporary society. For the Department for Education and Childhood Development, who is a major funder of three of these organisations, this was explicitly tied into not just child welfare (it’s good for the child to be well-educated and healthy), but also to benefits for the state, as such citizens are less likely to be a drain on state resources due to unemployment, poor health etc (DECD, 2014). In this sense, these organisations participated in the production of low-risk citizens; those who in being high-functioning were also low cost, at least as adults.

This can be construed as a valuable service, but it required CYP to be educated in certain forms of self-regulation that have notably been tied to constructions of modernity and risk society. Most obviously, the emphasis that all our organisations placed in “dealing with trauma” through teaching CYP to recognise their emotions and behaviours and then regulating them, located emotional distress and disorderly behaviours in a psychotherapeutic register. This required resolution through high-levels of personal reflexivity and behaviour management – a model that less “troubled subjects” are expected to engage in through popular therapies, self-help literature and similar interventions across their adult lives (Giddens, 1992). Throughout such discussions, both emotions and subjects were construed as things that could be known – CYP “can be who they really are” – rather than, say, a postmodern subject that is dispersed, relational or produced (for example Butler, 1999). As something that could be known, both emotions and the self could be narrated coherently (Giddens, 1992; for emotions as practice see Scheer, 2012). Through various therapies, CYP were actively provided with the skills with which to produce and maintain this modern self and their coherent inner world.

Less overtly, an emphasis on “child-centred” programs, individualised-learning, and “treating them like adults” reinforced the modern person as both a unique individual and autonomous subject. Interestingly however this discourse significantly disguised the level of support and community that underpinned the production of such individualisation. And it is here discourses of care come into tension with the modern self that current caring practices are trying to produce. Whilst our organisations all framed care in terms of the achievement of their organisational goals through child-centred, tailored experiences, they also placed significant emphasis on both the formation of group identity and on mundane, practical care in enabling this to happen.

All of our organisations pointed to “belonging” and “community” as significant to both CYP feeling cared about and for and in enabling them to be autonomous selves. Being part of a family, a school or an LGBTQI community required an emotional connection (Collins, 1993, 208; Collins, Pratesi and Runswick-Cole, 2011, 245), that promoted solidarity and acted to motivate CYP to participate in organisational activities, and so achieve larger organisational goals. For *Caring Community*, a feeling of belonging to the family was viewed as a key measure of success of the program; both *Second Chance* and *Welcoming Diversity* similarly sought to promote sociable communities, that enabled belonging, and through belonging achievement of a coherent, educated, socially-included self. *Second Chance* were particularly proud that their students choose to wear uniforms to display their connection to the organisation, understanding the key role such belonging played in sustaining educational participation for CYP (Stanley, 2010).

To enable such “belonging” and a sense of being cared about and for required more than the provision of the key services provided by the organisations – a family, an education, a place to find similar young people – it required very active “caring for”, including providing food, psychological and social supports, basic needs (such as housing), structured sociability (actively intervening to make connections between young people, or between adults and young people), training in emotion management, and more. And whilst this was tailored to individual CYP, with a considered effort not to view CYP evidencing non-normative behaviours as “bad” but rather unwell or “traumatised”, it was also a form of regulation that educated CYP in how to be part of a community as modern individuals. In doing so, such communities were expected to be welcoming to certain forms of diversity and difference (i.e. disability or LGBTQI identity), although not at the expense of rejecting the project of low-risk modern societies – society was not required to conform to the traumatised child.

As a number of feminist scholars have pointed out, the modern, autonomous self has often been lauded at the expense of the substantial care, emotional and practical, that enables its production, often viewed in gendered and classed terms as women’s, and increasingly poor, immigrant women’s, work (Stephens, 2015). Similarly here, the emphasis on child-centred services that lead to the production of low-risk adults disguises the labour that enables their production, and where – such as in the case of CYP with additional needs or who sit outside “the norm” – the financial cost of this labour requires it to be explicitly acknowledged, such labour is viewed as compensating for “trauma” or “social exclusion”, rather than simply being a requirement of the production of the modern subject. In this, social difference is pathologised and the care needed to enable conformity medicalised. Once social difference is “solved”, through caring intervention, CYP are able to be productive citizens.

The tension this produces for care workers then is that in trying to articulate best practice around care in their organisations, they have to split formal organisational understandings of care, which can be construed as “nurturing” CYP as modern subjects through individualised programs, with what they know works for many CYP – the provision of mundane and practical caring. Increasingly, this is resolved through the language of “trauma” and “therapy”, with such “caring for” aimed at and justified as “crisis management”. Yet, only one of our organisations, *Caring Community*, has actively built this into their systems as best practice through the production of the ARC model, and they are an organisation whose explicit remit is to work with CYP who have been categorised as needing particularly high-levels of interventionist care. It may be that the inability of *Secondary School* and *Second Chance* to articulate their own programs as “best practice” is partially because such “practical care” is not explicitly articulated as an organisational goal, but is instead something that emerges from practitioner experience of what works.

This work is based on a small sample, but there are larger implications for understanding best practice. Standards for care that are modelled around the production of the low-risk modern subject through child-centred, individualised care, but which fail to acknowledge the practical and mundane care required to produce such subjects, cause problems for care workers in their implementation. This problem, at least partially, seems to emerge because of the focus at a policy level on outcomes (i.e. organisational goals, such as education or stability rates) and not on the social practice of care that achieves those outcomes. In “caring about” the modern subject, “caring for” has been side-lined as an additional extra.

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References

Barnes, M. (2012). *Care in everyday life: an ethic of care in practice*. Bristol: Policy Press.

Barnes, V. (2007). Young people’s views of children's rights and advocacy services: a case for caring advocacy? *Child Abuse Review, 16*(3), 140-52.

Beresford, P. (2010). Re-examining relationships between experience, knowledge, ideas and research. *Social Work & Society, 8*(1), 6-20.

Beck, U., & Beck-Gernsheim, E. (2002). *Individualization: institutionalized individualism and its social and political consequences*. London: Sage.

Beck-Gernsheim, E. (1998). On the way to a post-familial family: from a community of need to elective affinities. *Theory, Culture & Society, 15*(3), 53–70.

Beck, U. (1992). *Risky society: towards a new modernity*. Munich: Sage Publications.

Blazek, M. & Kraftl, P. (Eds.), (2015). *Children’s emotions in policy and practice: mapping and making spaces of childhood.* Basingstoke: Palgrave.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Butler, J. (1999). *Gender Trouble: Feminism and the Subversion of Identity*. London: Routledge.

Campbell, C., Proctor, H. & Sherington, G. (2009). *School choice: how parents negotiate the new school market in Australia*. Sydney: Allen & Unwin.

CARC (2004). *Forgotten Australians: a report on Australians who experienced institutional or out of home care.* Canberra: Commonwealth of Australia.

Chapman, R.L., Buckley, L., Sheehan, M., & Shochet, I. (2013). School-based programs for increasing connectedness and reducing risk behavior: a systematic review. *Educational Psychology Review, 25*(1), 95-114.

Chapman, R.L., Buckley, L., Sheehan, M., & Shochet, I. (2011). The impact of school connectedness on violent behavior, transport risk-taking behavior, and associated injuries in adolescence. *Journal of School Psychology, 49*, 399-410.

Collins, R. (1993). Emotional energy as the common denominator of rational action. *Rationality and Society, 5*(2), 203-30.

Conrad, P. (2007). *The medicalization of society: on the transformation of human conditions into treatable disorders.* Baltimore: Johns Hopkins University Press.

Daniel, B. (2010). Concepts of adversity, risk, vulnerability, and resilience: a discussion in the context of the ‘child protection system’. *Social Policy & Society, 9*(2), 231-41.

Dare, L., & O’Donovan, M. (2002). *Good practice in caring for young children with special needs*. Cheltenham: Nelson Thornes.

DECD (2014). *Innovative Community Action Networks* [brochure]. Adelaide: SA Department for Education & Childhood Development.

Due, C., Riggs, D.W., & Augoustinos, M. (2014). Research with children of migrant and refugee background: a review of child-centered research. *Child Indicators Research, 7,* 209-27.

Fossey, E., Harvey, C., McDermott, F., Davidson, L. (2012). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry, 36,* 717-732.

Furedi, F. (2002). *Paranoid parenting: why ignoring the experts Might Be Best for Your Child*. London: Bloomsbury.

Giddens, A. (1992). *The transformation of intimacy: Sexuality, love and eroticism in modern societies*. Cambridge: Polity Press.

Giddens, A. (1991). *Modernity and self-identity*. Cambridge, UK: Polity press.

Gilligan, R. (2000). The key role of social workers in promoting the well-being of children in state care–a neglected dimension of reforming policies. *Children & Society, 14*, 267-76

Held, V. (2006). *The ethics of care: personal, political, global*. Oxford: Oxford University Press.

Herbert, J. L., & Bromfield L. (2015). Evidence for the efficacy of the child advocacy centre model: a systematic review. *Trauma, Violence & Abuse* [Online first]. Retrieved from: http://tva.sagepub.com/content/early/2015/05/12/1524838015585319.abstract.

Holland, S. (2009). Looked after children and the ethic of care. *British Journal of Social Work, 40*(6), 1664-80.

Kessler, M.L., Gira, E., & Poertner, J. (2005) Moving best practice to evidence-based practice in child welfare. *Families in Society, 86*(2), 244-50.

Kinniburgh, K., Blaustein, M., Spinazzola, J. & van der Kolk, B. (2005). Attachment, Self-Regulation, and Competency. A comprehensive intervention framework for children with complex trauma. *Psychiatric Annals, 35*(5), 424-430.

Kryger, N. (2004). Childhood and new learning in a Nordic context. In: Brembeck, H., Johansson, B., & Kampmann, J. (Eds.), *Beyond the competent child: exploring contemporary childhoods in the Nordic welfare societies*. Roskilde: Roskilde University Press, 153–76.

Mahon, R., & Robinson, F. (Eds.), 2011. *Feminist ethics and social policy: towards a new global political economy of care*. Vancouver/Toronto: UBC Press.

Milligan, I., & Stevens, I. (2006). Balancing rights and risks: the impact of health and safety regulations on the lives of children in residential care. *Journal of Social Work, 6*(3), 239-54.

Monchinski, T. (2010). *Education in hope: critical pedagogies and the ethics of care*. New York: Peter Laing.

Newbigging, K., & Thomas, N. (2011). Good practice in social care for refugee and asylum-seeking children. *Child Abuse Review, 20*, 374-390.

Nickerson, A., Hopson, L.M., & Steinke, C. M. (2011). School connectedness in community and residential treatment schools: the influence of gender, grades, and engagement in treatment. *Children and Youth Services Review, 33,* 829–37

Noddings, N. (2012). The language of care ethics. *Knowledge Quest, 40*(5), 52-57.

Noddings, N. (2012). The caring relation in teaching. *Oxford Review of Education, 38*(6), 771-81.

Noddings, N. (1982). *Caring: a feminine approach to ethics and moral education*. Berkeley: University of CA Press.

Pratesi, A., & Runswick-Cole, K. (2011). 'Not-So-Usual Families': Overlaps and Divergences in the Practices of Care Within Disabled and Same-Sex Families. *International Journal of Sociology of the Family, 37*(2), 243-62.

Raghuram, P. (forthcoming). Dis-locating care ethics? Place, race and geography. *ACME: An International e-Journal for Critical Geographies*

Monique Scheer, M. (2012). Are emotions a kind of practice (and is that what makes them have a history)? A Bourdieuian approach to understanding emotion. *History and Theory, 51*(2), 190-220.

Scourfield, J. & Welsh, I. (2003). Risk, reflexivity and social control in child protection: new times or same old story? *Critical Social Policy, 23*(3), 398-420

Shochet, I., & Smith, C.L. (2014). A prospective study investigating the links among classroom environment, school connectedness, and depressive symptoms in adolescents. *Psychology in the Schools, 51*(5), 480-92.

Smith, K. (2011). Producing Governable Subjects: Images of Childhood Old and New. *Childhood, 19*(1), 24-37.

Stanley, J. (2010). Discussant piece: linking, bridging and bonding: the importance of a psycho-social perspective for Children in Public Care. *Children's Geographies, 8*(3), 261-64.

Stanley, T. & Mills, R. (2014). 'Signs of safety' practice at the health and children's social care interface. *Practice: Social Work in Action, 26*(1), 23-36.

Steckley, L. & Smith, M. (2011). Care ethics in residential child care: a different voice. *Ethics and Social Welfare, 5*(2), 181-95.

Stephens, J. (2015). Reconfiguring care and family in the era of the 'outsourced self'. *Journal of Family Studies, 21*(3), 208-17.

Timimi, S. (2014). *Pathological child psychiatry and the medicalization of childhood*. London: Routledge.

Tronto, J. (1994). *Moral boundaries: a political argument for an ethic of care*. London: Routledge.