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What is institutionalising for ‘looked after’ children and young people?

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ABSTRACT

We look at the subject of institutionalisation for children and young people who are in residential or foster care. We begin by exploring the concepts of institution and institutionalisation. The concepts have different meanings, which can even be contradictory. This draws attention to the reality that family life can also be institutionalising. We explore, what is important from a child’s perspective? What is the quality of their experience? And most importantly how do their experiences equip them to move towards positive and fulfiling adult life? We believe it is important to focus on the quality of experience and outcomes rather than whether one kind of setting is inevitably better than another. We also recognise that different care environments can meet the needs of different children.

KEYWORDS

Looked after children; residential care; foster care; institution; institutionalisation; therapeutic care; relational opportunities

Introduction

The words institute, institutional, and institutionalising are often used with different meanings. Generally, in the care of children, these terms imply a negative consequence of being in care and one to be avoided if possible. However, the word institute can also be used positively, for example, to refer to the institution of the family or marriage. Oxford Languages defines an institute as,

> A society or organisation having a particular object or common factor, especially a scientific, educational, or social one.

Becoming institutionalised usually means becoming removed from the norms of society. So, an institutionalised person does not know or understand the expectations, rules, and norms of ordinary society. In general, it is healthy for any home, whether family or residential care, to be able to engage positively with society and the local community.

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The interest in writing this article followed conversations between the authors. Our collective experience in human services spans, residential care, foster care, the prison service, and social work, among others. While these are diverse services, we realised we share similar views and concerns about the issue of institutionalisation. Namely, that the term is used simplistically as if the nature of a setting is the determining factor rather than the quality of culture and practice that takes place in any of the above settings. We aim to draw attention to these issues, challenge certain myths, and encourage a more thoughtful and helpful approach.

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One way of measuring how institutionalising a setting is, can be to consider how open or closed it is to the outside world. Neither extreme of open nor closed is helpful. Some institutions are institutionalising because they are too closed and some because they are too open, without boundaries. An ordinary home is usually a place where people must knock or ring a bell before entering. In other words, the home has a clear boundary that distinguishes the inside from the outside. Menzies Lyth (1985, p. 245) explains,

> Effective control over boundaries can have another positive effect on the development of identity. It gives a stronger sense of belonging to what is inside, of there being something comprehensible to identify with, of there being 'my place', or 'our place', where 'I' belong and where 'we' belong together.

Among the most institutionalising settings historically, have been asylums. These were often hidden from society. Virtually no one besides the residents and the workers visited such places and the residents rarely left. While the example of asylums is extreme, all environments including families can also become closed to the outside world. Prisons are not dissimilar. But as Narey (2019) has argued, drawing on his experience of managing Prisons in England and Wales, the negative effects of imprisonment can be ameliorated by treating those we incarcerate with decency, respect and dignity and ensuring, for example, that children in custody, are addressed by their first name.

Institute can also mean something that has become established. It is a social structure in which people cooperate and the behaviour of people is influenced by it. There is no clear reason why an institution cannot provide a positive and healthy setting for the care of children or any other person. The challenge is to ensure that the necessary differences between the institution and a family home, which might include for example, locks on bedroom doors to ensure personal privacy for resident children, do not become part of a broader departure from what one would expect to find in a family environment. Our experiences of some homes, which are fundamentally well-intentioned, is that staff seemed not to notice the inappropriateness of the printed fire safety instructions in every room, the staff log-in board in the lobby, the harsh strip lighting in sitting rooms, the clipboards in bathrooms to say when they were last cleaned, or draconian restrictions on child access to the kitchen.

Language and institutionalisation

Language can be one of the central factors in institutionalising environments. This becomes clear if we consider institutional language as being removed from the usual language within society. So, for example, it is common within a 'care home', that carers are referred to as being 'on shift', or 'on the floor' (Ireland). Those who look after the children could simply be referred to as an adult but are often referred to as 'staff'. Children having a visit from a mum or dad, are often said to be having contact. A home may be called a unit. The very term Corporate Parent, used in the UK, to describe the role of government in looking after children in care, could hardly be more institutionalising. The children in care are called 'Looked After Children', which in the bureaucratic government culture is reduced to LAC. Highlighting the thoughtlessness of this term, one child in foster care, said,

Why do I have to go to a 'LAC' review – what's 'lacking' with me? (Lewis, 2019)

Even the term care can be used institutionally. What message is given to a young person when he or she is told she is leaving care? Unfortunately, as is often the case, it could be taken to mean the young person will have no more care. Nothing could be further removed from what we would ordinarily wish for every child and young person. Mullan et al. (2007), show how the 'artificial environment' of leaving care abruptly at the age of 18 can be a difficult experience for young people. When this policy is imposed upon any setting the impact will be institutionalising on the setting as well as the child.

Lewis (2019) argues how the institutionalised language used is stigmatising for children in foster care. He claims that too often it tells and reminds children of how they are different. As the task of caring for children has much in common, whether in their birth family, foster or residential care he argues that this is mostly unnecessary. It may not always be easy to de-institutionalise language, but it is essential for children in care that we strive to do this. Often, by the time a child arrives in care, especially residential care, he is institutionalised. This may be due to his experiences in his family, through failed interventions, and the social services system. What matters to the child is being placed somewhere that can make him safe, meet his needs, and provide the best recovery possible. Discussing the importance of language, Barton et al. (2012, p. 173) have argued that,

> In some ways, the recovery process for children who are in care is one of de-institutionalisation.

Two of us have had to protest about the way meals are described. Tomlinson has reminded professionals in Ireland that referring to children's 'food and liquid intake' might be appropriate in a hospital but not in a home. And Narey had to ban the use of the term 'feeding' in children's prisons only to later hear the term – more appropriate for a zoo than a place where children live – used in a children's home in England.

The home and size

There is much debate and some very hard held assumptions about the size of children's homes. It is argued there is an inevitable correlation between the size of a home and its likely institutionalisation. Essentially, so the theology goes, the larger the home the more institutionalised it's likely to be.

The evidence doesn't support this, certainly not when we're talking about the difference between, say, a three-bed and a six-bed home. Homes of any size can become institutionalised. Our experience of discussing this both with children living in homes and with staff is that we would have a better-informed discussion if it were informed by a shared understanding of what we mean by institutionalisation. We have been told that the term means things like having house rules – when most families have those – or having locks on bedroom doors (when in reality they are often a necessity to afford individual children privacy and a sense of security about their possessions).

David Berridge's et al. landmark research into life in ten different children's homes threw an important light on what the term means. When comparing homes, they observed (Berridge et al., 2012, p. 40),

> Despite the reasonably comfortable decor, several of the homes seemed to us to retain unnecessarily institutional features. In at least three homes, when the telephone rang a bell sounded loudly through the home; in contrast, in some other units, staff had overcome this by carrying cordless phones to avoid the constant clamour and interruption. In another, certain lights constantly went on and off when they detected movement. Elsewhere, a member of staff chose colour schemes and posters and young people said that they did not have a say in the decisions. A few homes had visible 'health and safety' posters and collections of young people's leaflets on display, on issues such as nutrition and healthy eating or sexual health. While important, these would not usually be displayed in a family home and reinforce an institutional feel ... Many homes managed to avoid these institutional features without adverse consequences. We should attempt to make residential environments as ordinary as possible in order to facilitate everyday, therapeutic relationships and reinforce young people's self-esteem and aspirations.

According to Roger Clough (Clough, 2000, p. 88) what matters in a good home, a non-institutionalised home where,

> The daily life within the home is built from an attempt to produce systems that best match residents' wants and needs.

It's as simple as that. One of the challenges in any home, whether it is a birth family, foster or residential care is how individual needs can be met in a group. Dockar-Drysdale (1961) wrote about this in *'The Problem of Making Adaptation to the Needs of the Individual Child in the Group'*. She showed how with an understanding of each child's needs and careful planning it is possible to get a good balance between individual and group needs. This is much the same as it would be in a large family. There is the need for routines, boundaries, rules, expectations, and order, but at the same time, there is enough attention for each child. While less individual attention may be available in larger families, at the same time other benefits can arise, such as richness of relational opportunities. Children may also be more likely to experience the value of contributing positively to daily life.

Relational opportunities

It is argued by Perry and Szalavitz (2006) that one of the difficulties with modern family life is that the size of the typical family group has decreased significantly over the last 100 years. Humans are social creatures, and it is only in recent history that we have begun in some parts of the world to live in small and relatively isolated 'units'. This implies that using the present westernised model of a family may not be the best yardstick to determine what is healthy for children's development. And for children who are in care and who have suffered trauma, *just as in ordinary development 'it takes a village to raise a child'*.

> What maltreated and traumatised children most need is a healthy community to buffer the pain, distress and loss caused by their earlier trauma. What works to heal them is anything that increases the number and quality of a child's relationships.

Perry's research on helping children heal from trauma claimed that what made the biggest difference is the number of significant and positive relationships the child has with adults every day. It can be argued that larger groups and therapeutic community

type settings are more able to provide this. Several homes in the same setting or local area provides closer contact with a wider range of people. As well as their own carers, children regularly see others who work in the organisation. Sometimes a relationship with an adult not directly involved in care work, such as a maintenance person, or receptionist can be immensely valuable for the child. In addition, there are many opportunities for positive peer relationships. The quality of childhood peer relationships has been shown by research to be an important factor in determining outcomes into adulthood (Shonkoff & Phillips, 2000). Department of Communities (Child Safety Services) in Partnership with PeakCare Queensland (2010, p. 73) highlight how important this is for young people,

> Mason (2007) suggests that peer contacts must be prioritised and refer to their research indicating that, often contrary to adult priorities, this is the outstanding priority stated by young people.

One of the authors of this article (Tomlinson) works as a consultant with *Lar de Nossa Senhora do Livramento*, a therapeutic residential service in Porto, Portugal. 45 girls live in groups of up to 9 in one exceptionally large home. Each group has its own living space, so it's like a small home within the large home. Being linked together in the same space has many benefits. The girls who range in age from 6 to 25 see many adults every day. Those who care for them directly, support workers, and senior staff. It is like an extended family. There is the opportunity for many healthy processes within small groups, large groups, and the whole community. The older girls live to varying levels of autonomy according to their needs. And as in Portugal young people can stay in supported care until 25, some of the girls are studying at university and/or working. Therefore, the younger girls can see a model of life from child to adult. There are many different positive relational opportunities between girls as well as adults. Unlike some children's homes situated in relatively isolated locations, Livramento is close to the centre of Porto. It is well-integrated into the local community, with all the services and facilities that help give a sense of 'normality' (Anglin, 2002). Unfortunately, services such as this may be deemed as institutional. One reason is that the large building is not considered to be like a typical family home. This generalising attitude can overlook the positive outcomes which can be achieved in such settings. Maher (2003, p. 280) highlights the possible consequences. Talking about children's residential care in the UK he says,

> Some of them still get referred to therapeutic communities. More of them, however, bypass this sector and are placed in ones or twos in houses over the south of England, maintained through having a staff team, often recruited through agencies, devoted entirely to keeping them 'safe', by virtue of keeping them apart from other young people. They have been deemed impossible to live in a group, and the result is that the powerful forces mobilised by group living and group educating are removed – envy, conflict, sexual attraction, adolescent destructive group processes.

In some countries, regulations dictate small groups of children being looked after by large teams of adults. We now see situations where up to 12–15 staff are needed to work with 2–3 children. As well as the huge cost, one of the problems is that the carers working with the child are continuously changing. Consistency for children and adults is harder to maintain. It can be argued that this is a highly institutionalised form of care. In some countries, even improvements in the quality of housing have been said by

some young people to have a stigmatising effect. This 'posh' way of life is far removed from the reality of their family and friends. One child, Tomlinson experienced, lived as a 'single occupant' in a 3-storey 6 Bedroom children's home. Part of the home had to be sectioned off so that the child did not feel so overwhelmed by 'living in a mansion' as she said.

Length of stay

How long a young person should stay in a residential home has also become a controversial subject. In England, for example, residential care is seen by many Local Governments as mainly a short stay of a few months before moving a child to foster care. So, instead of providing a stable home experience the stay in residential care becomes another transition for the child, another experience of short-term broken relationships. This is a dogmatic approach disconnected from a proper assessment of each child's needs. It can be argued that the reduction of time for children in residential care purely based on a government's preference for foster care is an institutional approach. It is more to do with the needs of the government than the child.

Furnivall (2018, p. 373) highlights the potential for transformation of children's lives in residential care, but also the damage when the service is ill resourced and staff unsupported. She also refers (p. 387) to anxious governmental responses that have driven child protection. When this becomes embodied in rules, systems, structures, and procedures, Hoggett (2013, p. 77) suggests that the real child is then replaced with 'a virtual and electronic child'. We need to be careful that we don't label the setting as institutional when it is really the external context that is the problem. Hannon et al. (2010, p. 132) expand upon this,

> To assume a 'one size fits all' style of placement (foster care) is suitable for all of these children is particularly short sighted, and may mean children for whom foster care is simply not a suitable option will have to endure multiple failed foster placements, and the turmoil this entails, before they are placed in a residential home . . ..In reality, it may be that for children for whom foster care is not suitable nor welcome, residential care placements are a valuable source of stability and opportunity to develop peer relationships. Certainly some of the care leavers we interviewed for this project said they had enjoyed their time in residential care, saying that the other children there had felt like family.

Some children who share a foster family with birth children of the parents can also feel like they are not equal to the birth children. This may be picked up in feelings, conscious and unconscious from the parents to the children. Sometimes it is more basic such as when a foster family takes their children on holiday and the foster child is sent to a 'respite' family (see appendix). An additional difficulty for children who are forced into short placements in residential care only to be moved into foster care is that it can complicate relationships with the birth family. Anglin (2004. p. 184) captures this point succinctly by referring to a comment by one young person living in residential care, 'I don't need a family; I already have a family!'.

Bilson and Barker's (1995) UK based research also found that residential care was more likely than foster care to maintain positive contact with the birth family. They argue,

> Many young people may prefer residential care over foster care, as in residential care they do not have to deal with issues of loyalty and may be afforded more emotional and physical space to grow (Department of Communities (Child Safety Services) in Partnership with PeakCare Queensland, 2010, p. 71).

Hannon et al. (2010, p. 130) explain how this can be especially difficult for adolescents,

> This may particularly be the case for young people entering care in adolescence, who may be experiencing problems with their own family and want to avoid replicating a family environment. For such children, residential care settings may be more suitable.

In Livramento, the Portuguese home referred to above, the length of stay can vary from one year to 5–6 years. This is based on the young people's needs. The girls who stay longer usually achieve a higher level of educational achievement. Relationships with the birth family are fully supported. Some girls who stay up to the age of 25 are assisted to achieve excellent outcomes in work and education. Tomlinson has met young people here, taking a law degree, studying to be a vet and others in similar situations.

Physical affection

This remains an issue not only in children's homes but, alarmingly, in foster care where the vast majority of looked after children live. Fostering regulations require, 'Carers should provide a level of care, including physical affection, which is designed to demonstrate warmth, friendliness and positive regard for children'. But Narey discovered, in successive reviews for the Department of Education that both in children's homes and foster homes, and all too often, staff and foster carers believed that demonstrations of physical affection were frowned upon, or they had been taught to be fearful of potential allegations. As Narey and Owers (2018) wrote,

> In one example, we heard of a foster carer in a room with other carers and changing a baby's nappy. On completion, she raised the child's Babygro and blew a raspberry on his bare tummy. Other foster carers in the room were very concerned that her expression of affection for the baby was inappropriate and could even be seen as a safeguarding issue. These concerns and anxieties can result in some children in care not receiving the physical or emotional affection they need that helps them to thrive. In turn, this will impact on the child's ability to express their need for comfort, reassurance and understanding from an emotionally responsive carer. These are the fundamentals of a healthy childhood.

Of course, it is vital to ensure that physical affection is welcomed. But we have all met staff who have ignored their inclinations to hug a child because they feel such behaviour is no longer acceptable. We are absolutely of the view that physical contact should be encouraged and celebrated in both fostering and residential care. Children, particularly infants, should be held, cuddled, and kissed in the same way parents and carers from all cultures across the world comfort their children. And a growing body of evidence suggests that doing so is demonstrably good for children and can help them to thrive. And, contrary to the beliefs of some practitioners and carers, Ofsted (The Office for Standards in Education, Children's Services and Skills, UK Inspectorate) is not likely to be critical of demonstrations of physical affection. They told Narey's review of fostering that,

> It's important that foster carers are sensitive to the wishes, feelings and experiences of individual children. But we wouldn't want to see an overly cautious, inflexible approach to their role that would mean children wouldn't receive the kind of warm and nurturing care they need and deserve. That includes physical affection.

This is supported by the views of neuroscientists and trauma experts Van der Kolk et al. (2007) and, Perry and Szalavitz (2006). Touch is vitally important to healthy development but where children have suffered abuse and other adversities there needs to be sensitivity to the child's experience. However, the answer to this is not to do as some organisations have done, which is to ban all physical contact. Not only does this potentially doubly deprive children but also re-enforces the message that adults cannot be trusted. There are many benefits of appropriate physical contact. Such as, non-sexualised hugs, holding hands and pats on the back. Appropriate touch helps create the capacity for attachment, which is partly learnt through touch and proximity maintenance (Barton et al., 2012, p. 101). Affection and physical touch are associated in ordinary family life with love. Steckley (2018, p. 368) highlights how love, which is fundamental in ordinary healthy families has been a taboo subject in residential care. There is now more attention to this, and love has been the subject of a special edition of the Scotland Journal of Residential Care (2016). The taboo on love is another institutionalising factor that has been imposed on residential care.

The benefit of therapeutic residential care – not a last resort

Unfortunately, residential care has sometimes been regarded as a last resort. Children often end up in it following multiple foster placement failures. Price et al. (2018, p. 392) claim that,

> Residential care for children has been subject to controversy with fears that institutionalisation, neglect and abuse are more likely in such care.

The belief that every child needs to be living in a family and this last resort view has seen many children and young people move from foster home to foster home. Anglin (2004, p. 183) states,

> Such a misuse and squandering of both foster family and placement agency time, energy and resources is an unfortunate consequence of faulty thinking about the place and appropriate use of residential group care.

Referring to his research on effective residential homes Anglin (Anglin (2004, p. 188) argues,

> The findings of this study suggest that group homes need to be appreciated for their strengths as extrafamilial developmental and therapeutic environments, and ought not to be denigrated for not being 'natural' or 'real' families.

As Hannon et al. argued, residential homes can feel 'like family' to some children. Although it sits at the more intrusive and support-intensive end of the continuum of care for Looked After children, there are moves to position therapeutic residential care as a mainstay placement option, rather than simply a last resort for the hardest to place children (McLean et al., 2011, p. 5). For some young people, a well-planned residential environment has a unique capacity to deal consistently with intense behaviour. Referring to Anglin's (2002) study, Centre for Excellence in Child and Family Welfare (2006, p. 10) claim,

> Well-functioning family group homes in the study were continually seeking to provide therapeutic care and consistency of structure and expectations with an intensity that is virtually impossible to maintain in a family or foster care setting. Many young people indicated they needed such intensity of interaction with staff for significant periods of time while they struggled with their problems, the pain and the associated anger that interfered with their relationships and at times their own safety.

What is most important to the child is being in a place where his or her needs can be met. Many of the present and historic difficulties in foster and residential care, may not so much be due to the merits of either, but to do with a lack of clear planning and assessment. Whenever it is not possible to meet children's needs, institutionalised practice in any kind of home is more likely to develop as a way of controlling and managing the situation. The special edition of this journal (2018) on psychodynamic issues in residential care, highlights the complexity, powerful dynamics, and emotional pain that is often involved in the work. When this is not acknowledged it can be responded to defensively, leading to a simplistic view that there is something wrong in the setting (Furnivall, 2018).

Conclusion

Providing each child with the right experiences is essential. As Whittaker et al. (2016) from around the world have made clear in their Consensus Statement, there are many types of children's homes. The needs of children also vary widely. So, rather than focus on questions such as, is 'institutional' care or therapeutic care, good or not? or is foster care good or not? we should focus on the needs of each child, and how will they be best met. For some children, supporting their family and kinship carers may be the best option. For others, it may be foster care, and for some, it will be a residential care home (Tomlinson, 2020). In each case, the most important concern is matching the child's needs to the setting. It is how well this is done, rather than the nature of the setting that determines whether the experience is institutionalising or not for the child. It is the quality of the child's experience that is most important not the setting. Most Importantly the appropriate setting will enable a young person to enter society positively as an adult.

Appendix by John Whitwell

John Whitwell must be one of the few people who has led separate residential and foster care services for long periods. He spent 15 years leading a Residential Therapeutic Community and then another 15 leading a large Specialist Foster Care Service. Therefore, his opinion on this subject offers a well-placed and interesting perspective.

Institutionalisation in Foster Families

When I changed jobs in 1999, moving from leading a well-established therapeutic community for boys to a pioneering independent fostering organisation, some of my basic assumptions were challenged.

I was surprised to encounter some foster families who were successfully looking after children who would not have been able to cope with group living. This overturned my assumption that children who couldn't cope in foster families were referred to specialist

residential homes, that it was one-way traffic. I had not expected to see the reverse of this. These foster carers were resilient, empathetic, courageous, imaginative, very child-centred and had a highly effective support network.

I was also surprised to encounter a few foster families that ran their homes like institutions. The foster children were not made to feel truly part of the family. This might show itself by, for example, a living room that the foster children were not allowed to use or by holidays taken without the foster children. The phrase 'going on respite' was one of those institutional phrases which could make foster children feel like second class citizens. We are so awful our carers need respite from us. It's a fine line between carers who need to look after themselves, to ensure their long-term commitment to their foster children, but not at the expense of the children's trust.

The fostering organisation I worked for challenged such institutional practices and would ultimately be prepared to deregister the carers. Unfortunately, this sometimes led to the carers changing agency and continuing as before despite the new agency being made aware of our concerns. Occasionally the foster children's care authority colluded with this, not wanting to rock the boat of what appeared on the surface to be a stable 'placement'.

Another example of adult-centred rather than child-centred practice was linked to finance. If, for example, a foster family was approved for three foster children to live with them it didn't necessarily mean that this approval should be fully utilised. The more child-centred foster families would carefully judge when a new child should join their family based on the needs of the children or the child they were already looking after. Adult centred families would cram in as many children as they could to maintain the maximum income without sufficient consideration that this would have on the dynamic of their family. Therapeutic fostering organisations would not collude with this, and the foster family would be likely to seek an agency that would not challenge this practice.

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No potential conflict of interest was reported by the author(s).

Notes on contributors

Three of the authors of this article connected at Innovate Services where Emma Blakemore is CEO, Sir Martin Narey is a Non-Executive Director, and Patrick Tomlinson is a consultant. Patrick Tomlinson worked for fifteen years with John Whitwell who was Principal at the Cotswold Community from 1985-1999.

Emma Blakemoore With over 20 years of experience in children's social work and residential care, her expertise spans social work change-management, safeguarding board development, MASH management, frontline social work delivery, therapeutic life story, and residential work. About her current role, Emma says, 'It enables me to affect change by placing the child at the centre of our

work. By doing this, we creatively support local authorities to secure better outcomes for children and young people. We aim to co-produce more innovative and effective ways of working. This is where real sustainable change happens'.

Martin Narey DL The eighth of nine children and from Middlesbrough, Sir Martin Narey was the head of the Prison and Probation Services in England and Wales as part of a twenty-three-year career working with offenders. He later ran Barnardo's the UK's biggest children's charity before advising Number 10 and the Department of Education about issues relating to child neglect. He has written and published five reports for the UK government and now holds several non-executive appointments most of which are pro-bono. In 2013 he was knighted for services to vulnerable people.

Patrick Tomlinson Patrick's experience spans from 1985. Beginning as a residential care worker at the Cotswold Community, he has held positions at all organisational levels, to CEO. He is a qualified clinician, strategic leader, manager, and author of numerous papers and books. Patrick Tomlinson Associates (PTA) was founded in 2008 to support the development of people and organisations. Therapeutic models that Patrick has worked on in several countries have gained widespread recognition. www.patricktomlinson.com

John Whitwell Was the Principal at the Cotswold Community for fifteen years. He worked there for twenty-seven years. Following that he was Managing Director at Integrated Services Programme (ISP), a specialist foster care service, for fifteen years. John has also been Chair of Trustees of the Gloucestershire Counselling Service, Trustee of the Planned Environment Therapy Trust, and Trustee of the Mulberry Bush Organisation. He has been a UKCP registered Psychotherapist and a full member of the British Psychotherapy Foundation (BPF). John is also a qualified Group-analytic Psychotherapist. He has published numerous articles and papers on his experience in therapeutic residential and foster care services. www.johnwhitwell.co.uk

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