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What Critical Success Factors Are Necessary and Sufficient for Provision of Developmental Care for Each Young Person in Irish Residential Child and Youth Care?

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Submitted in Fulfilment of the Requirements for the Award of PhD

School of Social Sciences and Law, Dublin Institute of Technology

Supervisor: Dr. Kevin Lalor
Advisory Supervisor: Professor Leon Fulcher

January 2011

ABSTRACT

This study seeks to better understand the organisational factors that impact on provision of frontline residential care in Ireland. An historical overview of Irish residential youth care clarifies factors which shaped it by contriving to establish a system of residential youth care which catered for large numbers of children in institutions run by Catholic religious orders. A social risk model of care prevailed in Ireland, focused on the segregation and control of children by enforcement of a regimented, sectarian regime. Despite the fact that the Irish Child Care Act 1991 which currently regulates residential child and youth care mandates youth care services to provide developmental care for residents (s18.3), this study recognises that remnants of a former model can outlive the model itself. Current understanding of developmental child and youth care acknowledges interconnectedness between systems in the ecological environment of the developing child. This study therefore seeks better understanding of how decisions taken at the exo or broader organisational level of residential youth care services impact the lived experience of the young person in residential care. The study is guided by a constructivist perspective. Its relativist ontology, subjectivist epistemology and hermeneutic methodology guided the selection of research respondents from first-line residential care managers and their line managers (referred to in the study as directors of frontline services). Purposive sampling which used a nomination technique yielded 17 respondents from eight different residential services across the four regions of the Health Service Executive (HSE). The narrative accounts of all respondents, gained from use of semi-structured interviews, yielded rich data on their experience of providing care for young residents. HyperResearch (a computer aided software package for qualitative analysis) aided coding and content analysis of all narratives. *Critical success factors*, a 'new managerialist' construct, was used as a framework for organisation and presentation of the data. Five *critical success factors* of Irish residential child and youth care emerged and are presented as being central to the active achievement of developmental care for all young people in Irish residential care. Six out of the eight participating residential services were found to be providing developmental care for their young residents. The two services deemed not to be providing developmental care were structured as rigid bureaucratic organisations which were micro managed by senior administrative managers who prioritised the goals of the service over the needs of individual young people. The six services providing developmental care were structured as either simple structures (Mintzberg 1983) most commonly found in smaller voluntary services, or self-contained task structures (Galbraith 1977) within the broader HSE structure. Both of these organisational design structures provided the necessary protection for the frontline residential service from bureaucratic decisions taken at the broader organisational level. These services succeeded in providing developmental care through their directors who had both authority and domain expertise, effectively monitoring the commitment of frontline staff to on-going prioritisation of needs-led care for young residents.

DECLARATION

I certify that this thesis which I now submit for examination for the award of Doctor of Philosophy, is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

This thesis was prepared according to the regulations for postgraduate study by research of the Dublin Institute of Technology and has not been submitted in whole or in party for an award in any other Institute or University.

The work reported on in this thesis conforms to the principles and requirements of the Institute's guidelines for ethics in research.

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Signature _____ Date _____

Candidate

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I also want to acknowledge the generosity of the seventeen respondents whose narratives formed the database of the study. Their enthusiasm for and interest in the study were a source of inspiration and I sincerely hope that the emergent findings will contribute in some small way to them getting the recognition they deserve for the most important work they do.

The Dublin Institute of Technology deserves great credit for its inspired decision to support staff with postgraduate study by giving a generous time allowance for such research activity. This was a significant incentive and was much appreciated. The library staff in Mountjoy Square, in particular Ann Wrigley and David Forde could not have been more helpful. I also wish to acknowledge the on-going support and encouragement I received from all my colleagues in DIT.

I will always be indebted to my family for their ongoing love, support and encouragement. I look forward now to spending much more time with them all, but particularly with Fintan whose support over the last few years in particular sustained me and greatly helped me to complete this thesis. I owe a special thanks to Ross, whose computer skills helped to retrieve a chapter which was a large part of a summer's work and which somehow vanished from a USB. Erika's patience and help with all sorts of computer-related issues, and insistence that every day's work was backed-up, really did help me through some challenging times. It is a constant joy and privilege to share life with you all.

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CHAPTER ONE:

INTRODUCTION

1.1 Introduction

Residential youth care is provided in organisational settings and organisational factors 'ultimately shape and determine the nature of group [residential] care practice' (Maier 2006: 106). This study examines residential child and youth care in Ireland. It seeks understanding of residential youth care and the organisational factors which shape it, from the narratives of first-line resident managers and their line managers, who were asked to discuss their lived experience of providing care in organisations for young people in Irish residential care. To understand the themes of respondents' narratives in the context of prevailing organisational factors, the study uses *critical success factors* (Rockart 1979) as a conceptual framework for organisation and presentation of the data. *Critical success factors* is a 'new managerialist' concept (Pollitt 1990) drawn from management literature and is discussed more fully in Chapter Three.

The thesis builds on my own knowledge and experience of 25 years of lecturing, researching and writing about Irish residential child and youth care (Graham 1994, 1995, 1996, 1998, 2003, 2005, 2006). Another factor that influenced the focus of this study is my five years' experience as a foster parent of a teenager who joined our family when our own two children were aged five and three years. This fourteen-year-old had spent his entire earlier life in residential care, which gave me a vicarious experience of residential care. Both my career and fostering experiences led to a strengthening of my belief that every young person needs to experience an individualised, growth-promoting

environment in order to achieve a level of happiness in his/her life. This can be particularly challenging to provide for the child in residential care where the tendency is for 'organisational requirements to modify special individual care requirements' (Maier 2006: 95). The beliefs and values of the researcher form essential parts of the context of questioning and analysis in hermeneutic inquiry and are further discussed in Chapter Five.

The study also draws on anecdotal evidence gained from students undertaking professional training in social care work, which indicated that factors remained in frontline practice in the Irish residential youth care sector which tended to marginalise residential youth care work as purely 'childminding' and subjected it to tight controls dictated more by bureaucratic aims than the developmental needs of the young residents. Further anecdotal evidence indicated a level of fear amongst frontline practitioners where the ever-present prospect of allegations being laid by residents or colleagues around inappropriate or unacceptable practice left staff preoccupied with personal protection—a factor likely to block needs-led care of residents.

1.2 Factors that shaped the research question

Current Irish child welfare legislation (Government of Ireland 1991) mandates registered residential child and youth care services to ' *do what is reasonable … for the purpose of safeguarding or promoting the child's health, development or welfare*'(s. 18.3). This is recognised as a mandate to provide developmental care for each young person placed in residential care. The organisation mandated to provide residential youth care in Ireland is the Health Service Executive (HSE), established in 2005 (during the data collection phase of this study). The HSE subsumed the former regional health

boards and remains part of the Irish public service. Public services tend to be structured as bureaucracies and the HSE, like the former health boards, is no exception.

Regulation and control sit comfortably with bureaucratic structures (Mintzberg 1988). Publication of a number of abuse scandals (McGuinness 1993; Moore 1995; Buckley 1996) resulted in an increasing tendency to regulate out-of-home care of children in Ireland. The growth of regulation is particularly evident in Irish residential child and youth care practice (Graham 1996). Attention to regulation may come from a desire to manage the risks inherent in residential care, to raise the quality of services and to make the child welfare system more accountable. However, a strong focus on regulation results in rigid enforcement of policies to secure control and legitimacy for bureaucratic organisational action. This preoccupation with control is more about producing comfort and protection from criticism for government mandated child welfare services and about managing risk, but it can, instead, hide real risk (Tilbury 2007). Bureaucratically structured frontline residential youth care services with an emphasis on control prioritise practice that rigidly adheres to established standards, not needs-led practice deemed essential for the provision of developmental care. Such factors made it increasingly clear that the impact of organisational and/or systemic factors on frontline practice needed better understanding in order to ensure provision of developmental care for young people in residential care.

The investigation of organisational issues that impact on frontline residential child and youth care practice is guided by the theory of organisation design (Barrett 2006; Child 1984; Galbraith 1977; Mintzberg 1983; Pfeffer 1982), but most particularly by the work of Bronfenbrenner (1979) and Senge (1990), both of whom come from an ecological or

systems perspective. This perspective, discussed in Chapter Three, recognises that decisions taken at the broader organisational level of residential youth services impact on the lived experience of young residents at the micro-level, even more than the training or suitability of the frontline social care workers. A major focus of this study is to consider how first-line managers' experiences of residential child and youth care practice are influenced by the organisational context or exosystem in which the experiencing occurs. This balancing of context and experiencing is an important focus of the study.

A major influence on the context of current Irish child welfare practice has been the development of managerialism in public service organisations. Managerialism is reflected in the application of prescriptive management to achieve efficient use of public resources. Its agenda seeks effective control of professionals by managers. Pollitt (when speaking of the British public service) says managerialism claims 'that better management was the key to maximising the effectiveness and efficiency of government delivered services' (1986: 157). Two types of managerialism are presented in Chapter Three: Neo-Taylorism which prioritises efficiency and best value for money, and New Managerialism which stresses the value of motivating people to strive for excellence and recognises the importance of the leader's role in transformation of cultures seen as necessary for lasting change (Pollitt 1990). Adams (1998), referring to the British experience of the Social Services Inspectorate, is referring to New Managerialism when he reports that some versions of managerialism have been found to respond positively to frontline practice issues. In recognition of managerialist pressures in Irish public service bureaucracies, it was considered that use of a *new managerialist* construct in the research question would facilitate both exploration of organisational factors and a

narrowing of the distance between individualised (developmental) care of residents and the bureaucratic performance that group care practice necessarily involves. This led to the selection of the managerialist construct, *critical success factors* (Rockart 1979), as a framework to organise and present the research themes that emerged from the narratives of research respondents. The model developed by Leidecker and Bruno (1984) was chosen as it selects *critical success factors* across three levels of a service organisation and so fits comfortably with Bronfenbrenner's ecological systems model. Use of this model in the presentation of study data resulted in five emergent *critical success factors* from the study. Each *critical success factor* is important and taken together they create a context within which developmental care can be reliably provided for young people in residential care. These factors shaped the research question.

1.3 The research question

What Critical Success Factors are necessary and sufficient for provision of developmental care for each young person in Irish residential child and youth care?

1.4 Structure of the thesis

It is proposed that the research question requires an understanding of Irish residential child and youth care that is informed by the forces which shaped it. An historical overview of Irish residential child and youth care, which explores legislation, prevailing policies and the influence of the Catholic Church on child welfare services, is the focus of Chapter Two. It shows how legislation and the influence of the Catholic Church contrived to support a preference for residential care in Irish child welfare services up until the second half of the twentieth century. Children were cared for in large institutions where strict, controlling regimes prevailed through use of a Social Risk

model of care (O'Sullivan 1979). This model of care was finally replaced through implementation of the Child Care Act (Government of Ireland 1991) which embraced a Developmental Model. Both models of care are also discussed in Chapter Two.

Understanding of forces impacting on the delivery of developmental care in organisational settings draws on the ecological theory of Bronfenbrenner (1979); systems theory of Senge (1990); an exploration of the literature of organisation design (Thompson 1967; Galbraith 1977; Mintzberg 1983; Child 1984); particularly bureaucratic structures (Weber 1947; Blau 1963; Selznick 1943; Argyris and Schon 1978); and the ideology of managerialism (Pollitt 1986; Pollitt 1990; Pollitt and Harrison 1992; Milner and Joyce 2005). These topics, *inter alia*, form the focus of Chapter Three.

A journey through the philosophy of science literature in search of a perspective that would yield a deeper understanding of residential child and youth care is the focus of Chapter Four. Engagement with the Relativism versus Objectivism debate led to a rejection of the view that there exists an *a priori*, universal and necessary structure of human knowledge, in favour of a view that knowledge, truth and reality are relative to a particular conceptual and contextual schema, that knowledge is situation- and time-determined, idiographic, inductive, derived through dialogical, dialectical interpretation and is not value free. Constructivism with its relativist ontology, its subjectivist epistemology and its hermeneutic methodology, focuses on understanding derived from the perspectives of those involved in an activity, practice, text, and thus it emerged as the chosen perspective to guide this study.

The hermeneutic methodology of constructivism, which uses both hermeneutics and dialectics and a reflexive component, is discussed in Chapter Five. Bernstein (1983) acknowledges that all scientific inquiry has a hermeneutical element. Hermeneutics is used to elicit individual constructions and to refine them through interpretation. Dialectics is used to compare and contrast constructions with a view to generating new constructions on which there is substantial consensus. Sampling in this methodology is neither random nor representative, but purposive (Patton 1990). Maximum variation sampling used a nomination method together with both serial and contingent selection of respondents.

The application of Hermeneutics to the research question is the focus of Chapter Six, which presents the decision trail of the research process. Purposive sampling was used to select information-rich respondents for in-depth study. Research respondents were selected from among first-line managers of residential youth services and their line managers. Seventeen respondents participated in the study, drawn from services across the geographic regions of the Health Service Executive (HSE). Serial selection meant that data collection and analysis progressed in tandem during the data collection stage. This facilitated an ongoing opportunity to distil constructions on which there was considerable consensus among respondents. Coding and analysis of data were aided by the use of HyperResearch, a computer-assisted package for analysis of qualitative research. HyperResearch facilitated the management of a large number of codes and the collapsing of them into categories that eventually emerged as themes of the data set.

The Case Report, used to present the findings of constructivist studies, commences with Chapter Seven. The seventeen research respondents represented eight residential

services across the four regions of the Irish Health Service Executive (HSE). The transcribed narrative of each respondent is discussed in the context of the residential youth service to which s/he belongs. Serial selection of respondents facilitated ongoing analysis of narratives which yielded the categories used for discussion of all respondents' transcripts. There is widespread use of quotations from respondents' transcripts that support themes which emerged from each residential service. Service research themes determine the classification of each residential service as representing a *social risk model* or *developmental model* of care.

Chapter Eight focuses on the use of the Leidecker and Bruno *critical success factor* model (1984) for organisation and presentation of the research themes. Initial use of this model yielded seven critical success factors across three levels of the services represented in the study. To ensure the relevance of these *critical success factors* to Irish residential youth care they were presented to a group of key informants who were carefully selected from the Irish child welfare sector. Content analysis of the key informants' transcript (Appendix 3) resulted in the final refinement of five *critical success factors* of Irish residential child and youth care. Discussion of these five *critical success factors* is the focus of Chapter Nine. It is argued that each *critical success factor* is important and, taken together, they are sufficient for provision of developmental care in residential child and youth care.

Chapter Ten concludes the study and provides a summary of the research journey. It describes how the study sought to discover *critical success factors* in order to clarify the practice agenda for Irish residential youth care that strives to ensure provision of developmental care for residents as mandated by the Child Care Act 1991. This study

seeks to narrow the distance between individualised (developmental) care of residents and the bureaucratic performance that care in organisational settings necessarily involves. Suggestions for future research in residential youth care are presented along with recommendations aimed at enhancing the delivery of developmental care.

CHAPTER TWO:

HISTORY OF RESIDENTIAL CHILD AND YOUTH CARE IN IRELAND

2.1 Introduction

> **'***No informed conclusion about the future of residential care can be reached without some understanding and appreciation of those forces which have shaped its history.'* (Parker 1988: 3)

This chapter will discuss the history of child welfare in Ireland, the legislation that regulated practice and the ideologies and policies that influenced it. Public charities played an important part, historically, in the care of destitute children in Ireland. It will be seen that control of these charities was a major factor in determining early policy of child care in this country.

The link between religion and 19th century philanthropy is presented as being central to an understanding of the context within which child care practice evolved in Ireland. In the 17th century—following British rule, the Reformation and the suppression of Catholicism—the public charities which found favour with the British were intent on the proselytising of the Irish masses. Catholic Emancipation (1829) saw the re-emergence of the Catholic Church which was now determined to ensure an end to proselytising and the control of lay charitable endeavours.

The special relationship between the State and the Catholic Church in Ireland following independence from Britain (1922) impacted on charitable societies and ensured that child welfare provision reflected a moralistic and patriarchal perspective which

supported parental responsibility, strict policies on unmarried mothers and their children and on delinquent children.

Legislation which regulated welfare practice in Ireland from the mid 19th century served to consolidate the role of the Catholic Church in the development of child welfare services. Three important pieces of legislation—The Irish Poor Relief Act 1838 (which, in Ireland, provided total institutional care with no provision for outdoor relief), The Industrial Schools Act Ireland 1868, and The Children Act 1908 (which regulated practice in Ireland for welfare children until 1991)—all promoted institutional care for children. These determined the shape of Irish child welfare services into the second half of the twentieth century. Three reports from 1960 onwards (the Tuairim Report 1966, the Kennedy Report 1970, and the Task Force on Child Care Services 1980) are discussed as heralding the need for change in child welfare services. Many of these changes are reflected in the Child Care Act 1991 which will be discussed in some detail. This Act, which prioritises the needs of the child, marks a fundamental change in child welfare services in Ireland.

The politicisation of child welfare services following the publication of reports of child sexual abuse in the 1990s (McGuinness 1993; Moore 1995; Buckley 1996), resulted in the prioritisation of child protection in child welfare services in Ireland. This has led to the more widespread acceptance of a paternalistic perspective (Fox Harding 1991), with its emphasis on parental responsibility. Ideologies underpinning the principal legislation will be discussed with reference to their impact on practice.

2.2 Role of public charities in the historical care of children in Ireland

Throughout the ages, abandoned, unwanted, orphaned children and children born out of wedlock have required the care and protection of public charities. In Christian lands members of the Church accepted the task of the relief of destitution and misfortune. As the Church developed, the monasteries became the main agency through which charity—including the care of homeless children—was made available. This was the case in Ireland until the monasteries were suppressed by the Reformation. The public charity groups that formed to care for pauper children in Ireland following the Reformation had an inflexible principle which was education in the Protestant faith and apprenticeship to Protestant masters exclusively. Education was used as a means of proselytising Catholic children (Robins 1980). The Charter Schools and Bible Societies are examples of such public charities whose proselytising activities resulted in the strengthening of Catholic opposition to them.

Catholic churchmen became focused on protecting poor Catholics from what they described as pecuniary proselytising (Robins 1980). Dr Cullen, the Catholic archbishop of Dublin (1852-1866), addressed a public meeting in Dublin and appealed for funds worldwide to fight proselytising. There were many reported attacks by Catholics on evangelists. Many established Irish Protestants did not support the work of the evangelists. By the end of the 1850s large numbers of Catholic children sought to attend the developing national schools. This, together with an increase in the number of Catholic orphanages and other charities that followed Catholic Emancipation (1829), resulted in the work of the Bible Societies slowing down significantly. The perceived proselytising of public charities galvanised Catholic determination to ensure that the Catholic Church would seek to look after all destitute Catholic children, thereby setting

the stage for the sectarian domination of public charities and child welfare provision in Ireland from the mid nineteenth century up until the late twentieth century (Robins 1980).

2.3 Irish Poor Law

The British government's decision not to fund services for Irish children following the demise of the Charter Schools served to emphasise the urgent need for the introduction of a Poor Law system to Ireland (Burke 1987). The Liberal Party government in Britain at that time subscribed to a laissez-faire and utilitarian ideology (Fox Harding 1991) and found State intervention in the economic and social fields unacceptable. The aim was to deter pauperism, not to reduce poverty. The British government dispatched George Nicholls, a Poor Law Commissioner, to Ireland to investigate which aspects of English Poor Law could be extended there. Nicholls suggested the application of a modified Poor Law system to Ireland, where relief would be available only within the workhouse, with no outdoor relief whatsoever. He recommended that illegitimate children be looked after by their mothers in workhouses (Burke 1987). The government accepted Nicholls' recommendations and introduced legislation which was quickly passed through both Houses of Parliament and became law as the Irish Poor Relief Act 1838.

2.3.1 *Attitude of the people*

The poor were most reluctant to enter the workhouse (Robins 1980). It was not until the great famine of 1845 that increasing numbers sought the shelter of the workhouse. Deserted children and the helpless of all kinds were the first to enter the workhouses in significant numbers (Robins 1980). Destitute children tended to stay longest in the workhouses as boarding out, a form of outdoor relief, was no longer permitted under

Irish Poor Law (Burke 1987). One of the greatest evils associated with the Irish Poor Law system was the accumulation of children in the workhouses. Between 1840 and 1862 the workhouses became the homes of most of the destitute and unwanted children of Ireland. In 1850 there remained over 104,000 children under 15 years in workhouses nationwide (Robins 1980).

2.3.2 *The development of Irish child care services*

Irish Poor Law under Nicholls was guided by principles of non-sectarianism. However, certain events exacerbated sectarian tensions in the workhouses. A decision taken by the Attorney General, Blackburne, in 1842, to have all foundling children brought up in the Protestant faith (the official religion of the State) caused much conflict and confusion (Robins 1980). This decision was overruled by the Poor Law Amendment Act 1862. There were accusations of proselytising from both sides of the religious divide. The fear of proselytising led to the segregation of people on religious grounds. This segregation was approved of by people outside the Poor Law system, most notably Dr Paul Cullen, Catholic Archbishop of Armagh (1849), Archbishop of Dublin (1852) and Ireland's first Cardinal (1866-1878), who sought to establish Catholic institutions for the Catholic poor and became a major player in the development of a sectarian child care system in Ireland (Corish 1984).

Another major influence the Poor Law system had on the development of Irish social services in general, but on child care services, in particular, was that these services were institutionally-based in Ireland because of the workhouse system that prevailed here, while services in Britain were largely community-based because of the outdoor relief system that evolved there (Burke 1987). The Catholic Church, which was set to become

a major player in the child care sector, also preferred the institutional response. These different models were discernable in Ireland and Britain well into the twentieth century (Burke 1987).

Despite the fact that the Poor Law Amendment Act 1862 authorised the boarding out of orphans and deserted children under age eight years; it was not until the 1880s that resistance to boarding out waned and boarding-out was only extended to children under 15 years in 1898. This, together with the advent of the industrial schools, led to a significant decrease in the numbers of children in the workhouses (Burke 1987).

Poor Law relief was a form of charity acceptable only to the shameless, idle and shiftless, so it tended to impose these characteristics on the young reared within its walls (Robins 1980). This legacy impacted on children in residential care in Ireland well into the twentieth century—as residential care, the institutional response initiated by the Poor Law system, was to be consolidated by the involvement of Catholic religious orders in the industrial schools system in Ireland in the twentieth century (Barnes 1989). Boarding-out, which eventually found favour with the Poor Law Commissioners, did not become the preferred option for children in need of alternative care in Ireland until the second half of the twentieth century. This was because, as already stated, fear of proselytising resulted in the segregation of children in need on the basis of religion. While the Protestant Church favoured boarding-out for children in need, the Catholic Church favoured large institutions for such children, run by religious orders (Burke 1987). The Catholic Church, renowned for its hierarchical structure and emphasis on organisation, was expert at exploiting the opportunity to become the dominant provider of services for children in need in the country (Skehill 1999). The Relieving Officers

established by the Poor Law Amendment Act 1862 were eventually given expanded powers under the 1908 Children Act and played a major role in getting young children (whom they perceived to be at risk often on moral grounds) admitted to residential care in the many institutions nationwide run by religious orders (Robins 1980)). The rapid development of children's homes in Ireland by the Catholic Church was greatly helped by the passing of the Industrial Schools Act 1868.

2.4 Industrial schools in Ireland

The Industrial Schools Act Ireland (1868) extended the Industrial Schools Act of England to Ireland. The Act provided that:

> *Certain classes of children under fourteen years of age could be committed to an industrial school, children found begging in public; found wandering without a home or visible means of support; being orphans or whose surviving parent was undergoing imprisonment or being a child that frequents the company of prostitutes. The Act also provided that where a child under twelve years was convicted of an offence that was not a felony, the justices could order it to an industrial school.* (Robins 1980: 302).

The Act broadened the provision of the Reformatory Schools Act Ireland 1858, by providing for the care of children other than those guilty of committing an offence. The 1868 Act reflected the Victorian ideal of institutional care. This was remarkably similar to the outlook of the Irish Catholic Church, which strongly supported the new system of incarceration for destitute children (Barnes 1989). Dr Cullen, the Archbishop of Dublin, renowned for his role in the moulding of the Irish Catholic Church into a highly disciplined organisation in the latter half of the nineteenth century, saw an opportunity to consolidate the role of the Catholic Church by encouraging religious orders of nuns and Christian Brothers to establish orphanages for the care of destitute Catholic children (Barnes 1989). By the year 1864 there were 3,500 children in the care of 24 Catholic lay

bodies or religious orders in Dublin alone (Barnes 1989). With the passing of the Industrial School Act, Dr Cullen actively encouraged existing religious orders to develop orphanages nationwide. The Act enabled voluntary institutions to be certified for state aid, a factor which greatly facilitated the expansion of Dr Cullen's policy. A key concern for advocates of the industrial schools system in Ireland was that religious segregation be maintained. The Catholic Church was keen to exert centralised control over a range of philanthropic activities in order to combat the proselytising efforts of many of the Protestant churches. Sectarianism became a major influence on the thinking of the Catholic Church in Ireland and influenced its practices in the fields of education, health and child welfare well into the twentieth century (Corish 1984).

The schools established under the 1868 Act were to be independently managed, approved by the State and subject to annual inspection. The industrial schools had two functions: the prevention of crime and the provision of State guardianship for children who had no other means of support. Finance for the schools came from three possible sources: the treasury for maintenance and custody, local authorities whose proportion of costs was made optional, and parents if of sufficient ability (Barnes 1989). The management of the schools was delegated to the voluntary/religious body certified to run the school under the Act. Managers were empowered to refuse admission to any child and to have a refractory child removed to a reformatory school. Managers were allowed a free rein in staff selection and firing, in the type and extent of education offered, in the ethos of the school, the discipline code and in the quality of care given. The only control exerted over the managers would be the final one of cutting off finance completely. The punitive nature of the schools was reflected in the facts that children were committed through the courts to the schools, they were brought to the schools by

the police and any attempt to escape was considered an offence punishable by admission to a reformatory school. Religious orders became actively involved in the provision of industrial schools. They had a principle of strict denominational education whereby religious teaching permeated school life (Barnes 1989).

The early years of the schools represented a crucial period in the formation of the system. Precedents were set, patterns of administration were established and most of the physical buildings were placed in position. These were to influence residential child care provision in Ireland until the latter half of the twentieth century. While the Act provided for the establishment of management committees, Protestant schools maintained these, but Catholic schools ceased in their use and this was not considered a reporting matter by the inspectorate (Barnes 1989). The involvement of religious orders in the running of the schools was considered positively by a supportive public and an enthusiastic Administration. The Aberdare Commission (Reformatories and Industrial Schools Commission—Great Britain 1970) reported on the industrial schools in 1884, and was approving of the industrial schools as operated in Ireland. The only reservation of the commissioners arose from the operation of the law and its effects on admissions, rather than from any deficiency in the schools or their management.

After the turn of the century the management of the industrial schools lapsed into a pattern of complacency and resistance to improvements. The policy of separating children from parents was pursued relentlessly throughout the Irish system. Moral regeneration was the goal. A school regime which ensured total obedience and conformity was the method. Religious education formed the bedrock of the schools. (Barnes 1989).

When Ireland gained its independence from Britain in 1922, the Catholic Church consolidated its position in the country, maintaining an active involvement in the care of looked-after children, in education and in health care. The institutional model of child welfare, well established, remained totally intact (Raftery and O'Sullivan 1999). This is in contrast to what was happening in Britain at the time, where there was a sharp decline in the numbers of children being committed to industrial schools. The industrial school system was finally abolished in Britain in 1933 and replaced by Approved Schools which were modelled on more child-centred principles (Raftery and O'Sullivan 1999). As part of this development in Britain, the autonomy of the voluntary bodies (which were largely responsible for the management of the industrial schools) was scrutinised. The Home Office, which was responsible for the funding of the schools, had little control over their management or admission policies. To rectify this situation a Children's Branch was established in the Home Office in 1913. This office exerted considerable central control over industrial schools in Britain, but it had little effect on practice in Ireland (Raftery and O'Sullivan 1999). A key factor in the Home Office Children's Branch gaining control over the industrial schools in that country was the abolition of the per capita system of funding that prevailed at the time. This was replaced by an annual budget in 1919. The per capita funding system remained in force in Ireland until 1984. Its retention in Ireland was a major factor in the large numbers of children who were incarcerated in industrial schools (Raftery and O'Sullivan 1999). The factors that led to the abolition of industrial schools in England (the abolition of the per capita funding system, the development of a comprehensive probation service, voluntary services campaigning for change and the central government control of management and policies) were all notably absent in Ireland (Raftery and O'Sullivan

1999). In Ireland, on the other hand, the management of the industrial schools remained in the hands of the Catholic Church and was operated by a strict Catholic orthodoxy. The State took an active role in the demise of the industrial schools in England, while in Ireland the limited intervention by the government into the welfare of the poor was enabled by the Catholic Church who played a significant role in the provision of welfare services. The public charities were run under the aegis of the Church and they emphatically opposed State intervention on the grounds that

> *'charity could only be administered properly by voluntary charities which had the expertise to decide who was deserving or undeserving of assistance'* (Skehill 1999: 66).

The domination of the Catholic congregations in the industrial schools allowed no alternative system to develop. The religious congregations were suspicious of all non-institutional means of providing services. This reflected their inability to assert total control over anything outside of their own institutions. They succeeded in getting agreement from the State that children would no longer be placed in foster homes from industrial schools. A total of 105,000 children were committed to industrial schools by the courts between 1868 and 1969. For most of the first half of the twentieth century there were fifty-two schools. Up until the 1950s they contained 6,000 children at any one time (Raftery and O'Sullivan 1999). From the mid-fifties the numbers declined, largely because the courts became reluctant to commit children to the schools. The legislation regulating practice in the industrial schools was the Children Act 1908. It required that children enter the schools through the court system. The courts committed the children and informed the Department of Education and the relevant local authority, who between them funded each child by paying a capitation grant to the religious order running the particular school in which the child was placed. Statutory bodies (Gardaí), voluntary societies (NSPCC which became the ISPCC in 1956), and the Catholic clergy

were involved in referring children to the courts for admission (Raftery and O'Sullivan 1999).

Up until the 1950s the Department of Education published in its annual reports a detailed breakdown of the reasons for admission to industrial schools. These reasons reflected the categories stated in the 1908 Act. After the 1950s, all categories were collapsed into three—'*lack of guardianship*', '*non-attendance at school*', and '*indictable offences*'. Approximately eighty per cent of all children were admitted for reasons of '*lack of proper guardianship*'. This category seemed to be a catch-all group and included illegitimate children, orphans, poor children, homeless children, children of separated parents. The State had responsibility for these children, but chose to fund religious orders to incarcerate them in institutions for their entire childhood years. When the courts became less willing to commit children to the industrial schools, the Catholic Church moved to admit the Poor Law children, then in the care of local authorities. There was a statutory obligation on the local authorities to seek foster homes for these children, but they chose instead the institutional option. Approximately 25,000 of these children were sent to industrial schools. By 1969 there were 31 schools caring for 2,000 children (Raftery and O'Sullivan 1999). The last Protestant industrial school closed in 1917. After this date all industrial schools in Ireland were managed by the Catholic Church. The role of a voluntary society, the National Society for the Prevention of Cruelty to Children (NSPCC), was also significant in the consolidation of the role of the Church.

2.5 The National Society for the Prevention of Children (NSPCC)

This charitable society was founded in Liverpool, England, in 1883. The first honorary secretary of the NSPCC was Benjamin Waugh, a Congregational minister. The main aim of the Society was the prevention of juvenile crime by the protection of children. The NSPCC established its first branch in Dublin in 1889. In the same year Queen Victoria of England became a patron of the NSPCC and the British Parliament passed the first Act preventing cruelty to children, which the NSPCC considered largely its own achievement (Allen and Morton 1961). The Society was given a Royal Charter in 1895, which gave it the authority to prevent the public or private wrongs of children and to enforce the law for their protection. The Society appointed inspectors to ensure that the law in relation to children was implemented for their protection. The NSPCC took an active role in the passing of legislation for the protection of children in Britain, including a major role in the drafting of the Children Act 1908 which regulated child care practice in Ireland until the late twentieth century. Involvement of the NSPCC in drafting British legislation empowered the role of the Society in both countries. This power transferred to the Irish Society for the Prevention of Cruelty to Children (ISPCC) when it, as an independent charitable society, took over the assets and responsibilities of the NSPCC in Ireland in 1956. The establishment of the ISPCC consolidated the position of the Catholic Church which sought to influence all charitable societies in the country (Skehill 1999). The Catholic Church moved to consolidate the patriarchal perspective of this newly independent charitable society and to foster its role in the referral of large numbers of children for admission to industrial schools. This is another indication of the importance of the role of charitable societies in the Irish context (Skehill 1999).

2.6 Model of care in Irish industrial schools

There are many documented accounts of the harsh regimes in the industrial schools of this era (Arnold and Laskey 1985; Barnes 1989; Doyle 1988; O'Connor 1963; O'Sullivan 1979; Raftery and O'Sullivan 1999). It is important to note the factors that enabled such a punitive model of care to exist in Ireland for an entire century. Our historical domination by Britain, which resulted in proselytising being supported in an effort to gain the loyalty of the Irish rural masses, set the stage for the people's dedicated support of the Catholic Church. The Catholic Church was determined to consolidate its power base to ensure its influence in the affairs of Ireland, particularly after independence in 1922. The newly independent state was totally willing to delegate full responsibility for the care of the country's disadvantaged children to the Catholic Church. There is evidence of an antagonistic response of the Free State Department of Education in the 1920s to some of the child care ideas (abolition of per capita funding) proclaimed during British rule (O'Sullivan 1979). This could reflect the response of a post-colonial society to the ideas of its former masters. It also enabled the well-organised Catholic Church to consolidate its hold on the child care sector by ensuring that no-one challenged its management of or its admission policies to industrial schools. Each school became a law unto itself; the one thing that they all had in common was the harshness of the care regime for the large numbers of children committed to their care.

However, it is important to note that the 1908 Children Act of Britain regulated child care practice in Ireland until it was replaced, in part, by the Child Care Act 1991, which was the first comprehensive legislation in relation to child welfare enacted by a native administration since the foundation of the Irish Free State. The remaining sections of the 1908 Act were replaced by the Children Act 2001. The 1908 Act, based on

Victorian ideals, promoted an institutional response to child care. While the Catholic Church opposed many things British, this legislation concurred with its thinking and enabled it to gain control of the child care sector, due to its superior understanding of institutions and ability to set them up in a way that enabled it to maintain total control. The Catholic Church was quick to see the opportunity presented in the Industrial Schools Act 1868. Industrial schools were first established when little was known about the psychological/emotional needs of children, but the organisation design and management of the schools resulted in them being strongly resistant to change. The principal aims of Irish industrial schools were the instruction of Irish children in the Catholic Faith and the protection of the power base of the Catholic Church (Barnes 1989). The fact that the influence of the Catholic Church in Ireland became linked to the survival of the industrial schools in this country resulted in the resilience of the system to change. Catholic religious orders were founded for the reason of caring for poor children and these religious orders provided the buildings for the industrial schools. The larger the number of religious orders, the more powerful the position of the Catholic Church in the country (Barnes 1989). This contributed to a mindset that caused religious orders to keep the numbers of children in industrial schools as high as possible in order to perpetuate the system. Evidence of this is seen in how the religious orders took in the local authority children to industrial schools when the courts became less willing to send large numbers of children to these schools. The Catholic Church also opposed the placing of children in foster care, even though the legislation promoted this. The close State/Church relationship which flourished in post-independence Ireland resulted in the State failing to monitor the Church's practice in the residential child care sector. In so doing, the Irish government failed to implement the existing child care legislation (Keogh 1996).

It is reasonable to assume that many of the religious who dedicated their lives to what they believed to be charitable work did not wish to harm the children their religious orders were established to care for (O'Sullivan 1979). It is known that innovations in child care and correction are linked to ideas and fashions of the time concerning the family, to the prevailing social philosophy of the era, or to the interests of social reformers. There is little to indicate an awareness of the social derivation of ideas and practices in child care in Ireland (O'Sullivan 1979). Little attention was paid by society to the plight of its destitute children. This enabled certain factors to flourish.

2.6.1 *Social risk model of care*

The social risk model of child care (O'Sullivan 1979) prevailed in Ireland; it perceived children as a social risk, as a threat to society. It prioritised the perspective of the system over the perspective of the child. This model is reflected in the Industrial Schools Act 1868 and in the Children Act 1908. It also found favour with the patriarchal perspective of the Catholic Church in post-independence Ireland. The determination of the Catholic Church in Ireland to establish an effective power base and the antagonistic response of the Free State Department of Education (who took over responsibility for Industrial Schools from the Department of Justice in 1928) to some of the child care ideas proclaimed during British rule (replacement of per capita funding with an annual budget in 1919) facilitated the unquestioning survival of large institutions in Ireland for the care of children (O'Sullivan 1979). The status of religious orders in post-independence Ireland resulted in an over-riding faith on the part of the State in the efficacy of the industrial school. The characterisation of the child in care as being deprived or injured (a legacy from Irish Poor Law) seemed to attest to the magnanimity of those involved in

child care: the religious orders (O'Sullivan 1979). All of these factors led to the continuance of a model of child care that was never to acknowledge the needs of children and where abuse of children went unnoticed.

The social risk model favoured the use of large institutions to segregate poor, begging, morally-at-risk children, from society. In these large institutions the aim was to provide basic care in a rigidly controlled structure. Goffman shows how the aim of large institutions was to ensure maximum control of inmates by the use of the minimum number of staff (Goffman 1961). Staff were encouraged not to relate on a personal level with inmates; segregation and control were the aims. Instruction in the Catholic religion was also prioritised in the Irish industrial schools (Barnes 1989).

All children were admitted to Irish industrial schools through the courts, regardless of whether they were admitted for reasons of criminal behaviour or poverty (O'Sullivan 1979). The limited information given to the staff who cared for the children permitted greater subjectivity in the categorisation of children and flexibility in goal setting, definition of agency function, and the handling of prescriptive practice from external sources (O'Sullivan 1979). The subjectivity in the categorisation of the children led to staff seeing the children variously as normal but victims of circumstances, or pathological and possessing distinctly deviant traits that must be guarded against and modified. The staff did not differentiate within the client group in these terms. Whatever perspective emerged through interaction with the children was applied to all members of the group, though individual children may have been used to justify particular responses to all the children (O'Sullivan 1979). This describes generalised care of children with no consideration of their individual or developmental needs.

In the Irish context, where all industrial schools remaining after 1917 were run by the Catholic Church and staffed by Catholic religious orders, other factors contributed to a continuation of generalised care of young people in residential institutions operating from a social risk model of care. The religious orders in Irish institutions had a focus on boundary maintenance which enabled the staff to separate the relationship between their religious vocation and the nature of child care in which they were involved (O'Sullivan 1979). Congregational survival became important to the Catholic Church and was linked to the control of the industrial schools. This resulted in the congregations resisting the professionalisation of child care which would necessitate the involvement of specialist staff from outside the congregation in the care of the children. The boundary maintenance problems were part of a wider concern for the identity of the religious congregations at a time of considerable educational change in Ireland in the mid-twentieth century.

While Irish residential child and youth care now subscribes to a developmental model of care which prioritises the needs of the child, we need to constantly ensure that practice reflects individualised, needs-led care. Aspects of former models can outlive the model itself (O'Sullivan 1979). There remains some evidence in today's Irish residential youth care system of generalised, regulation-led care with some residential youth care services operating from a social risk model of care.

2.6.2 *Characteristics of a social risk model of care*

- Primary focus is on system, not the individual resident.
- Organisational factors take precedence over the needs of residents.

- Organisational system influences the norms, pace, limits, and flow of communication of all sub systems, including the micro or frontline system.
- Senior managers with administrative expertise and a major focus on budgets, micro manage frontline practice.
- Frontline practice is tightly controlled and regulation-led.

Regulation-led care inhibits individualised, needs-led care. Evidence that lack of needs-led care historically facilitated abusive practice in Irish residential youth care (O'Connor 1963; Arnold and Laskey 1985; Barnes 1989; Raftery and O'Sullivan 1999); must be used to ensure more child-focused or developmental care in the present residential youth care system. Current Irish legislation (Government of Ireland 1991) mandates provision of developmental care for young residents in State care. Developmental care is very different to care determined by a social risk model of care. It is focused on individualised, needs-led care of each resident. Developmental care in the residential context contributes positively 'to the welfare of personal development of children and young people who cannot live with their own families and who may have been damaged by past experiences' (Whitaker, Archer and Hicks 1998: 154).

2.6.3 *Characteristics of a developmental model of care*

- Focus on prioritisation of individualised, needs-led care
- Protection of each young person from harm
- Exploitation of all opportunities to assist each resident to develop emotionally, interpersonally, educationally and physically
- Use of all life-space opportunities with each young resident to repair the consequences of past trauma

- Commitment to help each young person achieve a level of personal happiness by functioning in line with societal norms.

This study will refer to both models of care when differentiating services in the Irish residential youth care sector, but the focus will now turn to the legislation that regulated residential child care in Ireland since the beginning of the twentieth century.

2.7 Legislation

Welfare legislation is rooted in politics and ideology (Fox Harding 1991). Since we expect to find policy and practice in social welfare broadly determined by the ideological influences of key decision makers an understanding of ideological positions facilitates a more adequate understanding of social welfare policy and legislation (George and Wilding 1994). The major pieces of legislation to be discussed are The Children Act 1908 and The Child Care Act 1991—both of which are explored under: main parts of the Act, prevailing ideologies, and implications for practice. Three reports from the 1960s onwards heralded the need for fundamental changes in Irish child welfare provision and these will also be discussed. These reports are the Tuairim Report 1966, the Kennedy Report 1970 and the Task Force Report on Child Care Services 1980.

2.7.1 *The Children Act 1908*

This Act, referred to as a 'Children's Charter', introduced new provisions and 'repealed or amended 39 existing statutes, ranging from the 1854 Middlesex Industrial Schools Act to the 1907 Probation of Offenders Act' (Stewart 1995: 91).

2.7.1.1 Main parts of the Act

The Act consisted of six parts which ranged from a tightening of fostering and adoption controls to the appointment of infant life inspectors by local authorities. Second, the concept of cruelty was enlarged to include not only physical abuse, but also neglect. It was assumed that parental neglect caused by excessive consumption of alcohol had to be severely dealt with. Third, addressing contemporary concerns about juvenile smoking, the sale of cigarettes to those under sixteen years was prohibited. Fourth, legislation on industrial and reformatory schools was consolidated and amended. The Act was to blur the distinction between the two types of school. Industrial schools were originally intended to deal with the neglected, with the reformatory schools providing for offenders. Under the 1908 Act certain types of offender could be sent to industrial schools; transfers between the two types of school became possible; and it became possible to commit young people to industrial schools should their moral environment be deemed unsuitable. Fifth, a system of juvenile justice was instituted. Penal servitude and imprisonment for children and young people were abolished, save for exceptional cases. This quickly decreased the numbers of children being sent to adult prisons. Juvenile courts were created, whose aim was treatment and rehabilitation rather than punishment. Finally, a miscellaneous and general section dealt with a series of matters not easily included elsewhere, most notably the giving of alcoholic drink to young people and the access of young people to public houses, both of which were banned (Stewart 1995).

2.7.1.2 Prevailing ideologies

The 1908 Act reflects the Liberal Party ideology of laissez-faire. There was a tension between the State in its role as guardian of the nation's capital and the traditional view

of the family as beyond the legitimate range of State interference. While the Liberal Party notions of individualism and personal responsibility influenced the 1908 Act, there is also evidence of 'New Liberalism' which reflected an increased willingness of the State to interfere directly in 'normal family life,' and the interventionists seem to have won the debate (Stewart 1988). The Act was an expression of the Edwardian concern over young people. It is a reminder of the continuing importance of traditional issues such as alcohol consumption in Liberal politics. This in turn was part of a wider fear over the moral environment in which children were raised which explains the provisions on drunken parents and prostitute mothers. The concepts involved were class-specific and intruded on the cultural and social behaviour of the working class. It stressed the responsibility of the individual, particularly the child and the parent. While parental responsibility was to be increased this was done in the context of a more comprehensive supervisory role of the State. The Act gave statutory bodies at local level greater powers to oversee child rearing and maintenance. The Act sought to intervene directly in family life in its attempt to control the child's environment, including more contentious definitions of cruelty and neglect, and in the regulatory and supervisory powers given to statutory bodies. The Act sought to punish offenders against children but also, through monitoring and supervision, to prevent such offences taking place. However, this monitoring was predominantly focused on families. Voluntary bodies such as the NSPCC had a significant role to play in formulating the Act, reflecting the Liberal Party's preference for voluntary action. Powers of visitation of voluntary homes were granted to NSPCC officers and the officials of such organisations would now find it easier to proceed against prostitute mothers or any mothers deemed to place their children at moral risk. The Act inaugurated a system of juvenile courts which dispensed treatment rather than justice and blurred the distinction between young offenders and

the neglected young person. This established important precedents for subsequent social welfare attitudes to those under 16. The young person's moral environment was to be the subject of scrutiny and if this was found to be unsatisfactory the solution lay in the same methods as those used to deal with offenders: admission to an industrial school. The blame was placed on the child or the parent. The Act also contributed to the separating out of children and young persons from the wider population. Different standards of care and behaviour were required of them, restrictions were placed on where they might go and they were given separate status within the legal system. With the passing of the 1908 Act the autonomy of both young people and the family were further eroded, diminishing the number of areas free from some form of regulation by statutory bodies (Stewart 1988).

In Britain in the 1900s two themes emerged that influenced social policy in relation to children. These were, firstly, the mounting fears over the place of Britain in the world and the quality of the town dwelling population, and secondly, that the labour and trades union movement showed a consistent interest in child welfare issues.

The first theme resulted in child health being seen as an indicator of the health of society as a whole; children were the future workers and soldiers of the Empire. Children were morally more impressionable. Children's rights and liberties were more easily interfered with. Children were easy to reach because of their institutionalisation in elementary schools. The second theme acknowledged the importance of the demands of labour. The long-standing association between trade unionism and the Liberal Party resulted in a merging of ideological boundaries. This resulted in 'New Liberalism' seeing measures of welfare reform as steps towards a more just and equal society and

the Labour Party acknowledging the importance of the family and the moral responsibilities of the adult members of it. Both groups acknowledged the importance of children in society. Should children's health be improved, not only would society as a whole be enhanced, but the temptations of socialist agitators would become less inviting. 'Saving' children was not simply a public health matter, it also had significant political overtones (Stewart 1988).

It is also important to note that the perceived need for child welfare policies gathered pace in Britain in the late 1800s. It was an economically unstable period which contributed to imperial expansionism. Countries became concerned about child health and population size. In Britain reform-minded groups became concerned about conditions in working class areas. Voluntary societies became actively involved in local communities. They sometimes co-operated with local statutory bodies such as school boards. Statutory bodies were coming under pressure from labour organisations to increase facilities provided. An increased role for the State in child welfare began to emerge. So too voluntary societies such as the National Society for the Prevention of Cruelty to Children (NSPCC) became well established and had a major influence on the Children Act 1908. Liberal ideology relied heavily on the principles of voluntary action which involved less State expenditure and enabled the government to accept interventions mediated by the NSPCC. Welfare networks set up at this time at a local level were later to be models for the basis of national legislation (Stewart 1988). Child welfare measures of the 1900s in Britain constituted a building on and consolidation of the past rather than any radical departure. However these need to be seen as part of wider ideological struggles and conflicts over the direction of society, and the role of

the State, the family and the individual within it. This is in contrast to the situation in Ireland at that time.

2.7.1.3 Implications for practice in Ireland

The 1908 Act undermined the autonomy of working class families. It was seen as an attempt at a 'national solution' to a 'national problem'—that of the poor condition of working class children, the future soldiers and workers of the Empire. It viewed children as an asset of the State to be invested in. It also expressed concern for the moral environment of children and stated that an unsuitable moral environment warranted admission to an industrial school. While different political circumstances prevailed in Ireland there were remarkable similarities between the Liberal ideology of laissez-faire and the patriarchal ideology of the Catholic Church.

2.7.1.4 State/Church relationship

Catholic Emancipation in 1829 marked a significant change in Irish affairs. By that time there was an increasingly confident Catholic merchant and middle class within most Irish cities (Corish 1984). Following emancipation the Catholic Church became more organised, establishing control over key social services in Ireland, particularly the education system. There was evidence among the Catholic middle class of a conscious commitment to religion which was intrinsically linked to issues of nationalism and resistance to English rule, a feature of Irish politics which persisted into and throughout much of the 20th century. Despite its shared government at the time, British policy manifested itself differently in Ireland, given its differing social, political and cultural context. Industrialisation was not as significant a factor in Ireland as it was in Britain. There were significant numbers of destitute poor in Ireland and, as already discussed,

these were cared for in institutions run under the Poor Law. There was always strong opposition to the form of Poor Law implemented in Ireland. This resulted in the establishment of a number of charities in Ireland for the relief of the destitute and poor. These charities were closely affiliated to the Catholic Church and flourished in 19th century Ireland. Charities distinguished between the deserving and the undeserving poor. While similar practices prevailed in charities in Britain at this time, the context was different in Ireland. Due to the religious basis of most of the charities in Ireland, the decision as to who was deserving or undeserving was made on spiritual rather than liberal values and norms—as was more typical of the situation in Britain. The link between religion and 19th century philanthropy is central to an understanding of the context within which child care practice evolved in Ireland. This remained a feature of social service provision in Ireland up to the 1960s (Skehill 1999). Lay Catholic women who wanted to become involved in charity work in Ireland had to join a religious order or work as a lay person within a religious charitable organisation. This was strongly encouraged by the male clergy of the time. Catholic clerics appeared to exercise considerable control over lay charitable endeavours and were intent on ensuring they came under religious control (Skehill 1999). Both the male clergy and the female religious agreed on their opposition to State intervention into charitable work and relief of the poor. Such intervention was vehemently opposed in relation to both the educational and residential services for children. Such opposition appears to have been based on strong religious commitment to the spiritual well-being of the poor and a strong distrust of State involvement. It was believed that charity was most appropriately provided by voluntary services specialising in distinguishing between the deserving and undeserving poor, largely based on spiritual values. There was a remarkable convergence between the norms of a liberalist view of society and the Catholic Church

which endorsed a familist, patriarchal, individualist ideology. Catholicism became associated in Ireland with nationalism, which was as much tied to the desire to maintain the country's own independent religion as it was with the desire to have independent rule (Keogh 1996 in Skehill 1999). The suspicion and dislike of the English—which remained a strong feature of Irish social, cultural and political life after independence—served to consolidate the relationship between the Catholic Church and the State in Ireland. There is clear evidence of the Irish government in the 1920s and 1930s endorsing the moralistic and patriarchal discourse also supported by the Church. One can also identify a return to an even more archaic position on social policy in relation to children and families following Irish independence (Skehill 1999). The non-interventionist rationalist government structure established following independence resulted in a style of government which regarded poverty with austere detachment and treated social expenditure as a necessary evil that must be cut to the bone (Powell 1992 in Skehill 1999). Church-State relations remained central to the development of child care policy in Ireland up until the 1960s. The closeness of this relationship facilitated the dominance of the Church in child welfare services, in particular in the provision of residential care for children in the industrial schools.

2.8 The beginning of change

Public charities provided all child care services in Ireland up to the 1970s. However, there were signs of change emerging from the mid-1960s. In addition to the cultural and social changes that were sweeping through Irish society at this time, the Catholic Church was undergoing fundamental change, heralded by the Vatican Council Two which saw the need for the Catholic Church to become closer to the people and less reliant on rigidly structured institutions. This resulted in religious orders breaking up

their large schools and providing smaller units for the care of destitute children. Another factor of importance was the publication of three major reports from this period up to the 1980s, all of which strongly criticised the system of residential child care that prevailed in Ireland. These were the Tuairim Report, *Some of our children* (1966), the Kennedy Report, *Reformatory and industrial schools systems report* (1970), and the *Task Force on Child Care Services, Final report* (1980).

2.8.1 *The Tuairim Report: Some of our children (1966)*

Tuairim was a voluntary society which sought to encourage the participation of Irish citizens in public affairs. Their investigation of the Irish child care system resulted in the publication of a report that was strongly critical of the prevailing system that relied on large institutions to house thousands of children. The report recommended that children in need of alternative care be cared for in '*small mixed units of all age groups…and the supervision exercised on the children…. Should be that of a reasonable parent, not a warder'* (Tuairim 1966: 147). The Report suggested that the State grant aid all residential units with sufficient finance to cover all overhead expenses including the wages of subsidiary staff, that local authorities pay maintenance grants for every child in respect of every week or part thereof the child is in residence and that the State pay all salaries of the professional care staff. It went on to recommend that

> *the local health authority, not the manager of certified schools or homes, should act as the legal guardian of the children in its care who are placed in these schools or homes* (p. 46).

and also that local authority Children's Sections

> *should have statutory power to give help and assistance to families or guardians to prevent children coming into care, and should be obliged to work for the rehabilitation of the child's natural home and his subsequent discharge if he is accepted into care* (p. 48).

The Tuairim Report also recommended that training courses be established in Ireland for probation officers, residential child care workers, welfare workers and child care officers (p. 49). It demonstrated an understanding of the necessity to provide a broad conception of care encompassing physical, psychological and emotional needs of children. In response to this report, a committee was established by the Minister for Education in 1967, chaired by District Justice Eileen Kennedy, to make a detailed examination of the industrial and reformatory school system in Ireland.

2.8.2 *The Kennedy Report (1970)*

The Kennedy Report was to exert an enormous influence on the structure of residential child care in Ireland. It suggested the necessity to '*place emphasis on the child's needs to enable him to develop into maturity and to adjust himself satisfactorily to…society'* (p.12). This emphasis on the needs of children resulted in the recommendation that the training of child care staff be an immediate priority: '*The provision of trained staff should take precedence over any other recommendation'* (p.14).

Among the many recommendations of the Kennedy Report was the adoption of the Tuairim recommendation that '*Residential homes should be broken up into self-contained units with groups of 7-9 children in each unit'* (p.16) and that capital funding should be made available by the State to achieve this change. With further regard to funding, the Kennedy Report recommended abandoning payment to the schools on a capitation basis. Instead, a budget should be submitted and approved by the central authority, the Department of Health, Education or Justice. (As already stated, the abandoning of the capitation grants was instrumental in the demise of the Certified Schools in England.) The Kennedy Report also highlighted fundamental issues affecting

the lives of young people in residential homes in Ireland. It recommended that children in residential care must be overcompensated where '*overcompensation means a planned enrichment of the environment'* (p.18). Many of its recommendations were eventually acted upon.

2.8.3 *The Task Force Report on Child Care Services (1980)*

An official committee was established in 1973 to review the implementation of the Kennedy Report recommendations. This committee felt that the question of centralising the responsibility for policy, planning and administration of child care services should be considered, a question that resulted in the establishment of the Task Force on Child Care Services in 1974.

> *The Task Force was asked to make recommendations on the extension of services for deprived children and children at risk, to prepare a Bill up-dating the law in relation to children and to make recommendations on whatever administrative reforms it considered necessary in the child care services* (Task Force Report on Child Care Services 1980: 1).

The committee was expected to report on recommendations for change within six months, but its final report was eventually published in 1980. It did not include a draft Bill but stated that this Bill would now be prepared by the Department of Health. The Report commented that:

> *The most striking feature of the child care scene in Ireland was the alarming complacency and indifference of both the general public and various government departments and statutory bodies responsible for the welfare of children. This state of affairs illustrated clearly the use by a society of residential establishments to divest itself of responsibility for deprived children and delinquent children* (p.182).

The report acknowledged serious gaps in the residential care services which had not been filled in the wake of the Kennedy Report (p.183). It saw the role of the residential service, in co-operation with other elements of the children's services as being:

> *to meet defined deficiencies in the lives of certain children for whom placement in a residential centre, for a given period of time, has been identified as the best means of achieving the planned and agreed objectives for each child'* (p.188).

The report endorsed the decision of government to assign the main responsibility for child care services to the Minister for Health. It recommended the establishment of Child Care Authorities in each health board to be responsible for the child care system at regional level under the Department of Health. The Supplementary Report of the Task Force Report stated that the health boards would need to be substantially reorganised in order to meet their greatly expanded responsibilities, much of which had not been previously carried out in the public service. They argued that the present structure

> '*does not give professional opinion in relation to social work services an effective voice at the higher level of decision making about policies, objectives, the organisation of the services and the allocation of resources'* (p. 393).

The Supplementary Report dedicated a section to the function of the Child Care Authorities. It also referred to the training needs of residential child care workers. It stated that

> '*staff who work with children in residential centres require an expertise and a range of skills equivalent to those of other social workers; they require the same theoretical knowledge of social processes, of personal growth and development, and of family dynamics and of the interaction of all of these'* (p. 402).

They also stated that residential centres should have access to a consultant from outside the establishment who is specially equipped for this role.

> '*Some Child Care experts consider that staff support is the most crucial element in the provision of good residential care, especially for particularly difficult children'* (p. 403).

The main report recommended that child care services (by which they meant residential services) should be provided, as far as is possible, within the broader context of family support services and should be located within the child's own community unless there were good reasons for doing otherwise (p. 268). It made recommendations on the types of residential centres which should be provided and the functions that they should perform. It also stated that the residential placement should

> '*ensure that the care being provided for the child meet his needs and that all necessary measures are being taken to promote his welfare'* (p. 203).

There was an emphasis on preventive services in the Task Force Report and it was the clearest official pronunciation on the dramatic shift that had occurred over the previous 15 years. It reflected the ideals of the reformers of the late sixties and early seventies and gave full expression to the developmental model of child welfare.

2.9 The changing role of the State in child welfare services

In tandem with the shifts in the nature of child welfare provision in Ireland had been a critique of the role of the State in the provision of child welfare services. The State's role in the provision of child welfare services became more central with the passing of the Health Act 1970, which established the health boards. This Act established eight regional health boards. Health boards had responsibility for three main programmes: Community Care Services, General Hospital Services and Special Hospital Services. Community Care Services are further subdivided into three sub-programmes: Community Protection sub-programme, Community Health services sub-programme and Community Welfare sub-programme. Services for children are provided through the Community Welfare sub-programme of Community Care services (NESC 1987 in Buckley, Skehill and O'Sullivan 1997). Prior to the 1970s, virtually all residential

services were managed by voluntary agencies, and the local authorities and the Irish Society for the Prevention of Cruelty to Children (ISPCC) had responsibility for services for children who were not placed in care. The establishment of the health boards with their responsibility for child care services changed this significantly. The ISPCC saw the need to consolidate its position in this new scenario. They selected the issue of child protection and took the opportunity that arose from the emergence of child abuse to try to develop a specialised role in child protection again. The agency used global knowledge and took up the issues of the battered child syndrome and the Maria Colwell case (Colwell Commission of Enquiry 1974). They invited Henry Kempe, an American paediatrician who publicised the battered child syndrome, to address a conference in Dublin in 1976 (Ferguson and McNamara 1996). The ISPCC's efforts to establish a National Advisory Centre on the battered child failed in 1977, when the State, through the Department of Health, decided to take responsibility for child abuse policies and practice. This marked a major turning point in child welfare services provision in Ireland with the State taking ownership of the child abuse problem. This decision resulted in the management of child abuse and the culture of Irish child protection becoming inseparable from the culture of the health boards, the Irish State and the system principles on which policy traditionally developed (Ferguson and McNamara 1996). The role of the State became ever more central in child welfare services with the politicisation of child protection issues in the 1990s. This followed the publication of child abuse inquiries which surrounded every aspect of the child care and protection system, from failures to identify child abuse within the family (McGuinness 1993), to abuse by Catholic priests (Moore 1995) and the abuse of children in care (Buckley 1996). These revelations had a direct impact in the implementation of the Child Care Act 1991, which was finally fully implemented in 1996.

2.9.1 *The Child Care Act 1991*

The Child Care Act 1991 represents the first comprehensive legislation in relation to child welfare enacted by a native administration since the foundation of the State (Gilligan 1992). The full implementation of this legislation signalled an end to the social, political and legislative impasse surrounding child welfare services.

2.9.1.1 Main parts of the Act

In specific terms the Act:

- Extends the legal definition of a 'child' to those under eighteen years;
- Places a positive duty on health boards to promote the welfare of children in their areas, including the identification of children who are not receiving adequate care and protection;
- Places a statutory duty on health boards to provide Family Support Services;
- Extends and refines the powers of health boards and Gardaí in the protection of children in emergencies;
- Clarifies the role of the courts and procedural issues arising from care proceedings and introduces a range of new orders such as the *emergency care order* which replace the safety order of the 1908 Act and authorises the removal of a child or the retention of a child in the custody of the health board for a maximum period of eight days. The *interim care order*, a new short-term provision which may be made where an application for a care order is likely or pending, lasts eight days or a longer period subject to the agreement of the health board and the custodial parent. The *care order* replacing the fit person order of the 1908 Act, commits a child to the care of a health board until his eighteenth birthday or for a shorter

period determined by the court. This order requires evidence of a child having been abused or of being at risk. It gives the health board '*like control over the child as if it were his parent' and the 'obligation to do what is reasonable … for the purpose of safeguarding or promoting the child's health, development or welfare*' (s. 18.3). The *supervision order,* a new measure for the protection of children in their own home, may be made where the court is satisfied that there are reasonable grounds for believing that any of the grounds for a care order are fulfilled. It allows the health board to have the child visited and inspected at home and to give necessary advice to the parents. The order may also require the parents to ensure the child's attendance for medical or psychiatric examination, treatment or assessment at a hospital, clinic or other place stipulated by the court. Parents have the right to appeal where they are dissatisfied with the nature of the board's supervision.

- Sets out clearly the powers and duties of health boards over children who are in their care;
- Enables a health board to provide after-care support for children who were in their care up to the age of 21 or beyond that age until the completion of full-time education;
- Places a duty on health boards to provide voluntary care for appropriate children;
- Creates scope for formal development of pre-school services;
- Requires health boards to 'take such steps as are reasonable to make available suitable accommodation' for a child where the board is satisfied that there is no accommodation available that he can reasonably occupy (s.5);
- Gives to District Justices the power to make access orders;
- Places a duty on health boards to provide an adoption service

- Creates conditions for systematic review of the adequacy of services, and structures of accountability through Child Care Advisory committees (Ferguson and Kenny 1995: 22/23).

2.9.1.2 Ideologies underlying the 1991 Act

Two ideologies apparent in this Act are those of *laissez-faire*, reflected in the support for the family as the primary unit in society and the place where most children are best protected, and *state paternalism* reflected in the prioritisation of the child's welfare and need for protection. Paternalism states that we do not ask children whether they wish to be protected; we make sure they are. The focus is on the child's welfare, not that of the parents. The rights of parents are contingent on the appropriate exercise of duties/responsibilities (Fox Harding 1991). This does not sit comfortably with the provision in the Irish Constitution (1937), which recognises the inalienable and imprescriptible rights of parents. The Constitution recognises the family as the fundamental unit group in society (Article 42). The Catholic Church in Ireland exerted control over State involvement into what it considered the private domain of family life in all issues except the issue of school attendance, where the enforcement of school attendance legislation resulted in a regulation of families that was unprecedented both in its scale of application and in the intrusive, coercive manner in which it affected families (Fahey 1992). While Fox Harding (1991) suggests that particular ideologies point to specific policy consequences, Smith states that the relationship between ideology and practice is bi-directional in that practice influences values as well as the reverse (Smith 1995). The relationship between values and practice in child care must be seen as variable. Dominant perspectives are mediated by a range of factors, including competing values, tradition, cultural variations, organisational ideologies and material

restraints. These issues are important when we reconsider that when the Irish State took ownership of child protection in the late seventies, it resulted in the culture of Irish child protection becoming inseparable from the culture of the health boards, the Irish State and the system principles on which policy traditionally developed (Ferguson 1996). The politicisation of child protection in Ireland resulted in 'child *care* [being] reframed as primarily child *protection'* (Ferguson and Kenny 1995: 27).

2.9.1.3 Implications for practice

The Child Care Act 1991, which was fully implemented by 1996, introduces a number of important clarifications as well as extending the traditional philosophical underpinnings of state-family relations. The Act places positive duties on health boards (now the Health Service Executive or HSE) to act on behalf of the child both in anticipation of and in response to adversity. There are three philosophical principles underlying the Act: (1) the welfare of the child is paramount, (2) due consideration must be given to the wishes of the child, and (3) it is generally in the best interest of the child to be brought up in his own family. The primary emphasis is on the provision of support and assistance by the State so that children can remain at home. The single most important clarification of the Act is that it places a duty on health boards (now the HSE) 'to promote the welfare of children in its area' (Section 3). The Act provides an overall opportunity to develop an integrated child care system that provides a balance of services for all categories of vulnerable children referred to it. Central to this is the full development of the role of the child care advisory committees.

Section Seven (Part Two) of the Act requires the health boards to establish child care advisory committees and the membership of these committees should include

representatives of voluntary bodies providing child care and family support services and external expertise to ensure a multi-disciplinary input into the evaluation of children's services. The functions of these committees as set out in the Act are:

> To advise the health board (now the HSE) of its functions under the Act and the Health Board shall have regard to any advice so tendered to it. Each child care advisory committee shall:
> (a) Have access to non-personal information in relation to child care and family support services in their area.
> (b) Consult with voluntary bodies providing child care and family support services in its area.
> (c) Report on child care and family support services in its area when so requested by the health board.
> (d) Review the needs of children in its area who are not receiving adequate care and protection. The committees' membership must consist of persons with a special interest or expertise in matters affecting the welfare of children (Government of Ireland 1991).

A review of the functioning of the child care advisory committees (O'Doherty 1996) stated that at that early stage these committees were operating as vehicles for the promotion of statutory policies emanating at either health board or Department of Health level. Since, as already stated, the culture of the health boards (now the HSE) and of Irish child protection are closely entwined, it is essential that these committees are seen to operate at the level of policy formation or the HSE is in danger of being seen only as a child protection agency. A review of the operation of the Child Care Act (Ferguson and O'Reilly 2001) mentions the priority given to community care referrals with child protection concerns to the possible detriment of referrals with child welfare concerns. While Ferguson is positive about the workings of the Act, he recognises the fact that there is no child welfare or family support equivalent of the Child Protection Notification system. This has implications for the development of non-protection child welfare services. While the Department of Health records child abuse statistics and the HSE records similar data in reports required under Section 8 of the Child Care Act, there are few other ways of categorising information on child care practice. This

increases the organisational pressure to classify as much intervention as possible as 'abuse', thus distorting the nature of the real work on the ground in the child welfare system.

> *As long as the system only formally recognises abuse there will be little organisational momentum to develop non-protection services*. (Ferguson and O'Reilly 2001: 268).

It is essential that child welfare is recognised as involving family support services as well as child protection. The Department of Health and the HSE need to design information management systems capable of accounting for the range of work being undertaken by community care teams under the Act and measuring outcomes of this work. It is accepted in the commercial sector that what gets measured determines what actually gets done. The Child Care Act 1991 emphasises the importance of preventative work and work with families, as well as child protection. It is known that parenting difficulties, control and behaviour problems in children, neglect and addiction problems, dominate in the referrals to community care social work teams and that these categories, taken together, account for 67% of the referrals which end in children entering care (Ferguson and O'Reilly 2001: 269). A review of the most recently available Section 8 Report (HSE 2009) confirms the findings of Ferguson and O'Reilly (2001), where it states that the total number of reported child abuse cases to social work departments across the four regions of the HSE was 9,461, as opposed to 11,579 cases reported for child welfare purposes (HSE 2009: 8), thus confirming an established trend. This is the first Section 8 Report published by the HSE and it signals a change in the configuration and focus of delivery of child welfare services. This report emphasises the commitment of HSE child welfare staff to the development of preventative, community-based family support services. It mentions a need to shift the focus in child welfare services from child protection to the development of preventative family support services—a need to

shift from a focus on ‘risk’ to a focus on ‘need’. This is a most welcome development and supports this study’s emphasis on the central importance of needs-led practice with young people in residential care if the duty-of-care mandate of the Child Care Act 1991 is to be met.

2.10 Conclusion

This historical overview of child welfare services in Ireland has sought to demonstrate the importance of religion in the development of such services from the 18th century up to the late 20th century in Ireland, when the long awaited Child Care Act 1991 placed responsibility for child welfare services firmly with the State in the name of the HSE. The proselytising campaigns of the British in Ireland following their occupation of this country eventually resulted in the Catholic Church, following Catholic Emancipation (1829), organising to ensure Catholic care for Catholic children by establishing a sectarian child welfare sector. Domination of Irish public charities by the Catholic Church consolidated the central role of that Church in the development of child welfare services in Ireland. This was particularly apparent when the National Society for the Prevention of Cruelty to Children (NSPCC) became independently established as the Irish Society for the Prevention of Cruelty to Children (ISPCC) in 1956 and played a major role in sending large numbers of Catholic children to industrial schools run by Catholic religious orders.

The legislation introduced under British rule in the nineteenth and early twentieth centuries all promoted institutional care for destitute children (Irish Poor Relief Act 1838, The Industrial Schools Act Ireland 1868, and the Children Act 1908). Institutional care for children in need was also supported by the Catholic Church. The natural

alliance between Church and State that developed following Irish independence in 1921 (Breen *et al.* 1990), resulted in the Irish government giving total responsibility for the care of destitute children to the Catholic Church which ran all of the country's industrial schools from 1917 until their demise following the Kennedy Report (1970). Very large numbers of Irish children were incarcerated in these industrial schools for long periods of time, a legacy which impacted significantly on child welfare provision in this country.

Present legislation regulating child welfare practice (Government of Ireland 1991) mandates the provision of developmental care for all children. However, if we are to learn the lessons of history, it is essential that the policies that are necessary for the guidance of best practice in a child welfare system that has a *whole child/whole system* perspective are developed and resourced. A search for achievement of better outcomes for children in Irish residential care prompted this study. The study acknowledges Maier's finding that primary (developmental) care is difficult to provide in secondary (bureaucratic) organisations (Maier 2006). It seeks to establish critical success factors that that are necessary to ensure provision of developmental care in Irish residential youth care services. Chapter Three will focus on the organisational factors that impact provision of developmental care in residential settings.

CHAPTER THREE:

ORGANISATIONAL DYNAMICS OF RESIDENTIAL CHILD AND YOUTH CARE

3.1 Introduction

The purpose of this study is to better understand organisational factors that impact frontline provision of care for young people in Irish residential child and youth care. The study's aim is that understanding of organisational factors will enhance the capacity of residential units caring for children and youth to function more effectively as contexts for development for each young resident. Bronfenbrenner's ecological systems perspective emphasises 'the remarkable potential of human beings to respond constructively to an ecologically compatible milieu once it is made available' (Bronfenbrenner 1979: 7). It is essential that such a milieu is provided in all residential child and youth care settings if the aim is to provide developmental care. Bronfenbrenner views the ecological environment as a set of nested structures which are interconnected. He argues that these interconnections can be as decisive for a person's development as events occurring within the primary frontline microsystem. The developing person is influenced by relations within the immediate frontline setting, but also by linkages between settings, both those s/he actually participates in (such as school or mesosystems in the ecological model), and those s/he may never enter but in which events occur that affect what happens in her/his immediate environment (such as employment opportunities of parents, identified as exosystems in Bronfenbrenner's model (Bronfenbrenner 1979)). An important exosystem for the developing person in residential care is the organisational structure of the service providing agency. Just as Bronfenbrenner stated that the degree of work satisfaction, working hours and pay

conditions more strongly influence a parent's availability and the quality of parent-child interactions than his or his personal qualifications for parenthood, this chapter argues that norms of the service organisation structure, or exosystem of the developing young person in residential care, more strongly influence the carer-child relationship than formal professional training for residential care practice. 'In reality it is the wider context—the organisational factors—that ultimately shapes and determines the nature of group care practice' (Maier 2006: 106). This study, with a focus on organisational factors, seeks to discover *critical success factors* necessary at the exo level of residential child and youth care organisations to ensure the provision of developmental care for residents at the micro or frontline level, as mandated in Irish legislation (Government of Ireland 1991).

This chapter will first define and explore the concept of critical success factors. Critical success factors is a 'new managerialist' construct which can guide residential service aims and agency policies, focus purposeful teamwork practice at service and unit levels, and provide a reliable measure for evaluation of residential child and youth care services. Factors necessary for the selection of critical success factors (creative leadership, shared vision, clarity of purpose) are similar to the factors that Senge (1990) says are essential for learning organisations—the organisational type this study selects as necessary for the provision of effective residential child and youth care. Critical success factors of the total care task will relate to all four systems of Bronfenbrenner's ecological systems model. Environments shape behaviour (Bronfenbrenner 1979) and the environment of residential child and youth care is shaped by the organisational design (or, as Bronfenbrenner defined it, the exosystem) of the service provider which, in the Irish context, is the HSE which is part of the public sector, and by current child

care legislation, the macrosystem in Bronfenbrenner's model. We have already addressed current legislation in Chapter Two. In this chapter organisation design issues related to residential child and youth care will be discussed, describing the bureaucratic mode that prevails in traditional organisations and, in particular, service organisations run by the public sector. The chapter highlights the limitations of bureaucratic structures, particularly in work environments with high levels of complexity and unpredictability, both distinguishing characteristics of residential child and youth care work (Graham 1994).

Managerialism, an ideology that holds that prescriptions of management can cure all economic and social ills (Pollitt 1990) has been widely used by western governments to reform public sectors. Both models of managerialism are discussed with particular emphasis on their impact on residential child and youth care practice. The literature also offers suggestions for changing traditional organisation structures that are failing to achieve the desired outcomes. It is proposed that a combination of organisational redesign of residential child and youth care services, taking account of the totality of the care task and models for organisational learning developed by Argyris and Schon (1978) and Senge (1990), could ensure the cultural change necessary to address the complexities of residential child and youth care work and provide environments for each resident where effective personalised development (Bronfenbrenner 1979) might occur. The chapter concludes with a discussion of the importance of effective leadership in the achievement of sustainable change in learning organisations engaged in complex practices such as residential child and youth care.

3.2 Critical success factors

This is a 'new managerialist' construct first used by Daniel (1961) but popularised by Rockart (1979) whose definition states: '[Critical success factors] are the few areas where "things must go right" for the business [or service] to flourish. If results in these areas are not adequate, the organisation's efforts for the period will be less than defined' (1979: 85). Critical success factors reflect the goals and activities that must be attained in a particular industry/sector in order to claim successful outcomes. They also provide a framework for the measurement of success of a given business/service. Since the Irish public sector, which is underpinned by a managerialist ideology and where measurement of outcomes is widespread, is the major provider of residential youth care, this study seeks to establish critical success factors for the residential child and youth care sector that reflect the essence of the sector's mission (provision of developmental care), to counteract its measurement by solely commercial or bureaucratic success factors.

Critical success factors of a given industry or service require a clearly defined mission statement and a leader whose responsibility it is to get the mission accomplished. (The role of leadership is further developed later in this chapter and is only referred to here as it relates to the refinement of the mission statement and the identification of critical success factors.) Critical success factors relate directly to the mission statement. They are about turning a mission into an agenda. The organisation or service leader involves her/his management team and no-one else in the clarification of the mission statement. A maximum number of twelve members is suggested for this management team, as too large a group can result in loss of focus (Hardakar and Ward 1987). The essential requirement is that this team clarifies the mission statement and commits to the

establishment of critical success factors for the service or organisation. The mission statement should be no more than 3-4 short sentences, addressing three main issues: the boundaries of the service; client/customer population; and description of what must be done and how it will be measured (Hardakar and Ward 1987). Critical success factors must then be identified as what has to be done in order to achieve the mission. There should be no more than 12 factors, with 5-12 being the ideal number suggested by Hardaker and Ward (1987).

3.2.1 *Critical success factors and the learning organisation*

The process involved in clarifying a service mission statement and the selection of critical success factors requires the use of factors which are also listed by Senge as being essential for learning organisations (1990). This study suggests that effective residential child and youth care requires the structure of a learning organisation. Dialogue and discussion (the necessary counterpart of dialogue) constitute one such factor of the learning organisation. Senge notes that dialogue can only occur among colleagues who see themselves in a mutual quest for deeper insight and clarity (1990). Colleagues must function as purposive teams in their selection of critical success factors. Fear and judgement must give way to dialogue. Dialogue is playful, it requires a willingness to play with new ideas, to examine and test them. It requires that individuals suspend assumptions as what is aimed for is that different views are presented as a means of discovering a new view. Dialogues do not seek agreement but a richer grasp of complex issues, with new actions emerging as a result of dialogue. Discussion, as already stated, is the necessary counterpart of dialogue. Here different views are presented and defended as the aim is to reach a decision. The learning team in the learning organisation becomes proficient at movement back and forth between dialogue

and discussion. Productive discussions converge on a course of action (Senge 1990). The learning team, guided by an informed leader, will use dialogue to explore all options related to the possible critical success factors and, through consequent discussion, select those they see as being most critical to the successful achievement of the mission statement.

Fundamental to the selection of relevant critical success factors is a shared vision, another factor highlighted by Senge (1990) who emphasises its importance for all workers and managers in learning organisations. He notes that a shared vision provides the focus and energy for learning. He maintains that generative learning is only possible when people are striving to accomplish something that matters deeply to them. There is an emphasis on the vision being shared by all workers, as otherwise it can be viewed as being imposed by the organisation and is likely to result in compliance, but not commitment, from the workers. Commitment by all to selected critical success factors is essential and this is only likely to occur where all have a shared vision. Senge views the development of the shared vision as one of the key functions of the leader of the learning organisation/service (1990), it is also fundamentally important to the selection of critical success factors.

The leader and management team, through the use of dialogue, discussion and shared vision, clarify the service mission statement and select critical success factors deemed essential to the accomplishment of the mission. Critical success factors are not the ‘how to’ of a service or business and so are not directly manageable (Hardakar and Ward 1987). They are guided by the ‘necessary and sufficient’ rule where each one is necessary to the mission and together they are sufficient to achieve it. Each critical

success factor (CSF) should be devoted to a single issue and should be a mix of tactical and strategic factors related to that issue. Crucially, each CSF must be based on consensus, as every member of the management team must be committed to the accomplishment of each one (Hardakar and Ward 1987). Each CSF may require several processes which must be indicated and together all indicated processes must be sufficient to accomplish a given CSF.

The aim is commitment by all. Critical success factors facilitate proactive relationships as the focus becomes more strategic or long-term. This is particularly important for residential child and youth care where early interventions may not achieve desired outcomes and may need to be revised in the light of new information. Senior management from administrative backgrounds readily see the relevance of critical success factors and view them as a useful way to focus on vital organisational issues (Shank and Boynton 1985). The construct sits comfortably in the learning organisation (Senge 1990), as it is a participative process which helps to bridge the gap between senior management and frontline staff (this gap is a characteristic of the bureaucratic mode as will be discussed later in the chapter). The critical success factors construct suits dynamic environments such as prevail in residential child and youth care services, as critical success factors are time-determined and may vary, even between similar services (Shank and Boynton 1985). The construct helps with the management of uncertainty, which is also a major focus of the learning organisation and a characteristic of residential child and youth care work. It facilitates the alignment of goals across different levels of an organisation and, therefore, can better ensure the provision of a developmental environment for children and youth in residential settings.

3.2.2 *Critical success factors and levels of residential care organisations*

Critical success factors can be applied at three distinct levels of analysis (Leidecker and Bruno 1984):

1. They can be specific to a residential unit where the analysis utilises an internal focus to provide the link to critical factors.
2. At the sector level of analysis use of the construct focuses on certain factors in the organisational structure of the sector that significantly impact any service's performance operating in that sector.
3. At the economic, socio-political, policy level of analysis it focuses on factors that are determinants of sector's and/or service's success (Leidecker and Bruno 1984).

All three levels of analysis have merit as sources for critical success factors. In the residential youth care sector the unit or micro level is the one that attracts most attention and regulation. This is where developmental care is provided for residents and so it is critically important. The study seeks to gain better understanding of what is happening at this level from key players involved in delivery of frontline care. However, Bronfenbrenner has shown how factors at sector (exo) level and socio-political (macro) level fundamentally affect what happens at the unit or micro level. The study will primarily focus on critical success factors of residential child and youth care at sector level. It will also draw on the historical, policy and socio-political factors discussed in Chapter Two as having shaped the sector, with a direct responsibility for legislation that regulates the sector. In this chapter the focus is on sector level analysis that isolates factors that significantly affect the performance of all residential child and youth care services in the sector. We have seen that the public sector, in the name of the health service executive (HSE), is the main provider of residential child and youth care in

Ireland, so the particular focus is on organisational issues prevailing in the Irish public sector. The bureaucratic structure remains much in evidence in the Irish public sector.

3.3 Bureaucratic structure

The bureaucratic form of organisation is designed to induce an impersonal and rational orientation towards tasks which is conducive to efficient administration (Weber 1947). The basic structure of bureaucracies is highly specialised, develops standardised work processes, has 'routine operating tasks, very formalised procedures in the operating core, a proliferation of rules, regulations and formalised communication throughout the organisation' (Mintzberg 1988: 547). While the need to fundamentally change bureaucratic structures became apparent in the private sector during an economic recession in Western economies in the 1970s, many aspects of bureaucracy survive in public sector service organisations (now the major provider of residential services) and are in evidence in the Irish residential child and youth care sector.

The bureaucracy has an obsession with control which pervades the organisation from top to bottom. The overall administrative hierarchy, which tends to have numerous layers, is sharply differentiated from the operating core or frontline practitioners. The role of the manager is seen largely as one of control which is achieved through direct supervision of employees. This reflects two basic factors about bureaucracies: attempts are made to eliminate all kinds of uncertainty, there is widespread use of rules; and there tends to be a lot of conflict which requires control systems to contain it (Mintzberg 1988). Historically, all organisations had bureaucratic structures. The bureaucratic structure was the child of the industrial revolution. Manufacturing bureaucracies owe much of their popularity to Frederick Taylor's scientific management in the early 20th century, where the aim was to remove all discretion from shop floor operators (Taylor

1911). The model treated people as means rather than as individuals. This type of structure suits environments that are simple and stable and predictable, while the environment of residential child and youth care is complex, unanalysable and unpredictable (Graham 1994).

Many service organisations have bureaucratic structures, as do government departments, not only because their operating work is often routine, but because they are accountable to the public for their actions. Everything they do must be seen to be fair—notably their treatment of clients—so they proliferate regulations. Regulatory agencies are drawn to this type of configuration, it is important to remember how regulated Irish child care services are, a factor that is particularly true of residential child and youth care services and has resulted in the widespread use of rules and a tendency to standardise practice in these services. Bureaucracy is a rigid configuration. Like a machine, it is designed for one purpose only. It is efficient in its own limited domain and cannot easily adapt to any other. It cannot operate effectively in an environment that is dynamic or complex (Mintzberg 1988). The work of dynamic environments, which typify residential child and youth care services, cannot be predicted, made repetitive or standardised, and so they need a different configuration if they are to provide a developmental environment for each resident.

Senior administrative managers in bureaucracies, who retain decision-making responsibility, are perpetually searching for more efficient ways to produce outputs or achieve outcomes. They have considerable power at their level and little or no direct contact with the front line. Middle managers, in the bureaucratic mode, are relatively weak and frontline operators have hardly any power at all. This can result in the first-

line manager's job being so circumscribed that s/he can hardly be said to operate as a manager at all; this can impact negatively on managers of residential units.[1] Senior managers of administrative areas of the HSE (Local Health Officers) with responsibility for residential services, who have no contact with frontline practitioners, make decisions regarding resources, aimed primarily at achieving budgetary efficiency, but which can have major negative effects on frontline practice or the care and development of vulnerable children and youth. An example of such a decision is the ban on staff recruitment which, some years later, has left residential units totally dependent on agency staff, with all of the inconsistencies that this inevitably brings. Such inconsistencies can be related to heightened insecurity among young troubled residents in residential care, a factor known to exacerbate challenging behaviour and to militate against the provision of a developmental environment.

3.3.1 *Rigidity in the bureaucratic structure*

Rigidity is the bureaucracy's striking characteristic (Mintzberg 1983). This has major implications for residential child and youth care which requires that each young resident is individualised in order to facilitate her/his development. 'Organisational rigidity negates individuality' (Maier 2006: 94) and so must be mediated in residential child and youth care units. However, in the bureaucratic structure, reliance on tight regulations has been found to cause different forms of goal displacement, which lead to further rigidity. Blau (1963) discusses formalism and legalism as two types of such goal displacement. Formalism refers to when adherence to rules, originally conceived as a means, becomes transformed into an end in itself. This can contribute to an inability to readily adjust to any changing circumstances. Formalism presents as an unchallenged

[1] The research data show that discretion at first-line manager level is essential for provision of developmental care for residents, again suggesting the need for a new configuration or organisational design structure for residential youth care services.

insistence upon punctilious adherence to formalised procedures and can also be seen as a means of eliminating uncertainty, a major goal of the bureaucratic structure. It has resulted in the very elements designed to facilitate efficiency in general, producing inefficiency in specific instances. This factor could seriously undermine profits in a commercial organisation and so is likely to be urgently addressed and eliminated. However, even though it has an equally serious impact on the lived experience of children and young people in residential care causing them to feel misunderstood or rejected, the impact is not as easily quantified and so is allowed to persist. It presents in residential child and youth care as rigid adherence to policies or procedures by staff, even when the presenting needs of a particular child suggest otherwise in specific instances.

Legalism, the second form of displacement highlighted by Blau (1963) also engenders strict conformity with regulations and reduces efficiency in situations not fully covered by regulations. Legalism is a form of displacement of the objectives of a law by the techniques designed to achieve the law. In a tightly regulated child and youth care sector such as prevails in Ireland, legalism can be detected, particularly in the realm of child protection, even when such practice militates against a particular child's best interests. Displacement of goals can result in workers losing sight of the bigger picture and becoming focused on particular issues. Regulations and procedures can take precedence over the individualised care of troubled children, a factor that is detected in residential child and youth care, but which must be changed if the aim is to provide a developmental environment for such children. As an indication of how persistent and prevalent displacement of professed goals can be in the bureaucratic mode it is

interesting to note that it was signalled decades before Blau, by Selznick (1943), who highlighted the importance of informal structures in formal, bureaucratic organisations.

3.3.2 *Informal structures in bureaucratic organisations*

Informal structures were seen to evolve out of the day-to-day practices of workers as they sought ways to meet their own felt needs (not their clients' or residents' needs). The consequence of the informal structure had a deleterious effect on the professed goals of the organisation. Characteristics of informal structures were observed to be the following: they arise spontaneously (among staff), they are based on personal issues such as prestige or friendship ties, and they are power relationships oriented towards control. In a review of numerous studies of formal organisations Selznick concluded that all formal organisations have informal structures whose goals may not bear a constructive relationship with the professed goals of the organisation. These informal structures are centred on specific problems and proximate goals which have primarily internal relevance (to frontline operators or staff in the residential setting). Where professed goals conflict with informal goals there is a tendency to ignore professed goals. An example of a boys' reformatory is used by Selznick to show that the institution subscribed to progressive social work ideals of the day, but the procedural rules were designed to meet day-to-day problems and were substituted for the professed ideals or goals. The workers subscribed to the use of discipline techniques, regimentation and spying on residents as they met daily crises in the institution. They admitted to paying lip service to professed goals and to the use of practices that enabled them to be practical in their challenging environment. Selznick states that there are 'processes inherent in and internal to the organisation as such which tend to frustrate action toward professed goals' (Selznick 1943: 49). To get a true understanding of the

conduct of an organisation the operational or informal goals must be understood. Argyris and Schon (1978) refer to informal goals as theory-in-use and agree with Selznick that it is embedded in the culture of formal organisations and reflects what actually happens. They maintain that the achievement of the cultural change necessary to remedy goal displacement requires purposeful use of the learning circle in the context of a learning organisation and is most difficult to achieve in bureaucratic organisations.

The persistent presence in residential child and youth care of informal structures (for example rosters based on staff needs rather than those of residents), formalism (where rules in relation to double cover at all times, for the protection of children, can be interpreted so rigidly that a child arriving home from school due to being ill is not allowed into the unit until a second staff member arrives for duty), and legalism (where staff are so preoccupied with rules that they cannot function in situations not fully regulated)) suggests that rigid bureaucratic structures are unlikely to provide the environment necessary for the individualised care of troubled children and youth that focuses on their development. It was recognition of the widespread presence of such characteristics in traditional organisations that caused Argyris and Schon (1978) to focus on error detection and correction in bureaucratic organisations and on the learning systems which facilitate or impede the work of dispelling conditions for error in organisations. Their work could guide a search for a more contingent (focused on core work processes) organisation design for residential child and youth care but the research data of this study show that use of a *self-contained task structure* of organisation design (Galbraith 1977) can facilitate provision of developmental care for residents and so is the organising mode proposed by the study, and will be discussed in the context of organisation design and structure, later in this chapter. The focus will first move to

consider the impact on residential youth care of factors affecting public service sectors in changing global economies.

3.4 Managerialism

Management with its ideology of managerialism came to prominence in the private sectors of America and Britain in the 1970s. Western economies were faced with declining profitability and increased global competition in the mid 1970s. These factors forced corporations to recognise that traditional bureaucratic structures were no longer economically competitive and were also resistant to the changes necessary for survival in the emerging global market. Rapid changes in the organisation design of corporations followed, where organisational structure was contingent on the core work processes of particular companies. Bureaucratic structures were viewed as being unnecessarily cumbersome and unresponsive to emerging economic trends. These economic factors also exposed the escalating costs of the ever-expanding public service sectors, particularly in the British economy with its well established welfare state.

In Britain the [Conservative] Thatcher government's mandate was won in 1979 on a promise to reduce income taxes and to get value for money spent on public services. Guided by a managerialist ideology this government sought to transform the British public sector from its staid bureaucratic paternalism which Conservatives saw as a legacy of post-war social democracy. Paternalism had facilitated the social democratic consensus which built the British welfare state based on a combination of the three power modes of bureaucratic, professional and political power (Newman and Clarke 1994). This combination of power modes was seen by the new right government as a major stumbling block to a radical reconstruction of the state and its role in British

society. They set about dismantling the power of the state by attacking all three power modes and replacing them with the power of the market and management (Newman and Clarke 1994). The ideology of managerialism replaced that of paternalism and sought to replace professional power with managerial power. Managerialism, underpinned by the defining principle that progress is the central role of management, views the prescriptions of management as a cure for economic and social ills. The accepted assumption was that 'better management was the key to maximising the effectiveness and efficiency of government-delivered services' (Pollitt 1986: 157). This put management at the centre of the restructuring of the British welfare state during the 1980s, where all new initiatives began to refer to the need for good management to achieve stated objectives. Public sector organisations began to develop a strategy, a vision, a mission statement, devolved budgets, business plans, and responsiveness to customers, who replaced the clients of the public sector. Similar constructs began to emerge in other countries—in particular, in Ireland which also used the ideology of managerialism in an effort to reform the Irish public sector.

3.4.1 *Models of managerialism*

Pollitt (1990: 2-3) says there were two types of managerialism:

1. Neo-Taylorism which had efficiency and increased productivity as its over-riding objectives and so is remarkably similar to the bureaucratic mode. This type of managerialism helped managerial discourse to address the political concerns with the financial burden of public sector spending through its drive to impose the '3Es': economy, efficiency and effectiveness. It prioritised 'value for money' services and achieved 'more for less' by driving down labour costs. In this model the manager is driven by the search for efficiency rather than abstract professional standards.

Efficiency is determined by what is considered best ‘value for money’. Managers exercise their ‘right to manage’ by extending controls, exercising power over hiring and firing of staff, changing working conditions, creating new contractual arrangements and finding new ways to exploit the flexibility of labour. While these measures might enhance efficiency in the private sector they are not going to enhance the provision of a development-promoting environment for troubled youth in residential settings. Residential child and youth care requires a professional staff skilled in the formation of reciprocal relationships with residents within which they (residents) gain a sense of self-worth and are helped to address the issues that led to their placement in residential care. The quality of the caring relationship is of primary importance and central to this is the selection of suitably trained staff who commit to residents, which requires terms of employment with a degree of permanency. ‘Value for money’ can be achieved in residential child and youth care, but only when the developmental needs of the children who require such care are met and the children are prepared for life as productive members of society. Services shaped by short-term cost savings are likely to result in further damage to troubled children with implications for higher levels of dependency or delinquency, both of which will put further financial burdens on public sector services in the longer run.

2. New Managerialism offers a model of the organisation which is people-centred and views bureaucratic control systems as unwieldy, counterproductive and repressive of the enterprising spirit of employees. It stresses the value of motivating people to produce quality and strive for excellence. It recognises the importance of the leader’s role in the transformation of culture which is seen as necessary for lasting change. While this model also subscribes to achieving ‘value for money’ and to

‘getting more for less’, it has some principles in common with Senge’s model of the learning organisation (1990), and is reflected in the critical success factors framework. Thus, New Managerialism is recognised in this study as being better poised to redesign existing residential child and youth care services contingent on the developmental needs of young people.

While Pollitt says the rhetoric of new managerialism is to be heard in the changes to public services in the 1980s, it is the neo-Taylorism version that shaped the practice of public sector management (which explains the remaining presence of bureaucratic practices in the Irish public sector). Both models of management fall within the wider ideology of managerialism which subscribes to a view of management as the solution to social and economic problems, particularly those of the public sector; to a belief that management is the overarching system of authority and a view of management as founded on the inalienable ‘right to manage’.

In both America and Britain the expanded role of the state was seen as an impediment to the free market because it inhibited the exercise of managerial discretion through excessive regulatory activity. This led to state disestablishment in both countries through privatisation and deregulation. Managerialism created an affinity between the free market and the free manager which freed managers from unreasonable restrictions and impediments and strengthened their ‘right to manage’ (Newman and Clarke 1994). The political situation in Britain in the 1980s facilitated these changes in that country. It is interesting to compare this deregulation which occurred in management in the private sector with a noticeable increase in regulation of some services run by the public sector. This was particularly true for residential child and youth care services in Ireland

which are tightly regulated by child protection laws. While new managerialism facilitated de-regulation in the private sector the neo-Taylor model prevailed in the public sector with a preoccupation with control, achieved through rigid regulations. This rigidity does not facilitate needs-led or developmental care which Irish residential child and youth care services have been mandated to provide for young residents.

Perceived failures in public service programmes had altered public confidence in professional competence. The 1970s saw a loss of confidence in professional groups such as doctors, teachers, and the police (Newman and Clarke 1994). This left professional groups vulnerable to externally imposed tests of economy, competence and achievement (Pollitt 1986). The aim was to manage professionals in the public services. However, practice proved much more complex than the rhetoric of new managerialism. Changes easily imposed in the private sector proved more difficult in the public sector as it became evident that the influence of market forces was different in the public sector to that experienced in the private, commercial sector.

3.4.2 *Market forces and the public sector*

Pollitt and Harrison (1992) capture the differentiating factors of public services:

1 **Accountability to political representatives:** Public sector managers are accountable to politicians who differ from boards of directors in that they are answerable to the citizenry. Politicians are obliged to demonstrate that their actions are reasonable, fair and honest. Accountability, for them, usually involves a justification that is couched in the currently espoused ideology (which, as we have seen, is paternalism in Ireland) and often leaves scope for argument as to the justifiability of a particular course of action. ‘Reporting lines and accountability

structures have been blurred or even obliterated' (Milner and Joyce 2005: 85) in the public sector. This is fundamentally different from accountability in the private sector which is committed to the collective entrepreneurialism of the corporate culture as dictated by the free market.

2 **Overall goals and priorities:** Politicians avoid priorities in the interest of not alienating constituents. The absence of clearly defined objectives in the public sector creates problems for managers in that sector. This again differs from the private sector where the idealised model of management views management as the means of achieving the efficient pursuit of limited goals aimed at maximising profitability.

3 **Complexity of organisational networks:** The involvement of public representatives in the public sector adds to the level of complexity and implies that the managerial skills of managing multiple relationships are important in the public sector. While managers in the private sector have specified responsibilities and clear, stable, reporting arrangements, those in the public sector have to be continuously aware of the particular priorities of existing politicians who may be more focused on short-term goals with a view to re-election than on sound business targets or the long term goals for children and youth in residential care.

4 **Absence of competition:** Competition is the fuel of successful business organisations but it does not apply in a normal way to the public service sector. This has led to the widespread use of a performance agenda in the public sector where published league tables of performance can be used competitively to determine which services will get continued or increased funding. Such league tables are often likely to focus on short-term budgets to the detriment of long-term goals, a factor that is not going to facilitate 'best practice' in residential child and youth care services.

5 **Relationship between provision, need, demand and revenue:** This relationship differs in both sectors. Increased demand in the private sector usually results in higher profits. Increased demand in the public sector can present embarrassment or extra demand on public service managers. Excess demand can be endemic in the public sector which may necessitate a form of rationing to substitute for the market's rationing by price. Forms of rationing include social stigma that may attach to some public services or the use of queues. Forms of rationing can involve considerable managerial involvement in the public sector and are likely to fuel informal structures as discussed by Argyris and Schon (1978) and/or formalism and legalism as discussed by Blau (1963).`

6 **Processing people:** Public sector services involve the processing of people. Residential child and youth care involves the remedial care of troubled young people. Such work limits the use of standardisation processes, which is the sole means of coordination in the neo Taylor managerialist or bureaucratic structure. Such work is also highly labour intensive with consequences for costs, which leaves it vulnerable to external forces such as demographic shifts and government pay policies. The outcomes of people-processing organisations are hard to measure. The utility and efficiency of public services are frequently under scrutiny. This study claims that such services can only be appropriately evaluated using critical success factors that emerge from the agreed objectives of managers who are committed to a shared vision of a clearly stated mission of specific services provided by the public sector. Such an evaluation framework would bring public services more in line with private sector activities where critical success factors have been in use since the late 1980s (Hardaker and Ward 1987), and explains the decision to use a critical success factors framework for presentation of research data in this study.

7 **Professionalism and line management:** Professionals delivering services have prominence in the public services. Professionals have allegiance to their professional bodies rather than to their employing agencies and can often complain about system inefficiencies in the public sector. This factor does not occur in the private sector, where managers have a loyalty to the organisation and their general manager. The role of the manager is more predictable in the private sector where s/he sets targets, allocates resources, motivates staff; in the public sector s/he is more focused on diplomatic and administrative functions such as pleading with professionals, attempting to involve them in service planning and the implementation of plans. Managerialism in the public sector has not resolved the issues of the traditional bureaucratic regimes; it has merely re-shaped them. Bureaucratic, professional and political power sources have not been abolished. Managerial power now sits in the middle of a dislocated old regime with the determination to exercise 'the right to manage' in the face of the old power bases. Critics of managerialism claim that managers do not comprehend the rich complexity of how services are provided and fail to appreciate the complex skills, knowledge and judgements which professionals bring to their work (Newman and Clarke 1994). Tension between power bases is likely to result in power games which tend to lead to displacement, as already discussed with reference to the bureaucratic mode. Such political game playing will take the focus off longer-term goals and so could militate against residential child and youth care services mandated to provide developmental care for each resident.

8 **The legal context:** Most public services are regulated by statutory obligations. This is not a factor for managers in the private sector, where management has been given the 'freedom to manage' to facilitate efficiency and profit making. Public services

may be mandatory and may not be economic by accounting criteria—another reason that they need to be evaluated against indigenous critical success factors. The legal context may have consequences for customer relations in the public sector. In the public sector failures to proceed correctly have resulted in policy decisions being overturned by the courts. Such events are most rare in the private sector (Pollit and Harrison 1992).

These discernable differences indicate that excellence in the public sector may not be achieved through the systematic application of the remedies of general management alone, despite its apparent success in the private sector. This has major implications for the ideology of managerialism which has had a significant influence on many public services in both Britain and Ireland and it explains the emergence of 'new managerialism' as an attempt to rationalise public sectors. Clearly there is a need to ensure value for money in the public sector, but this will necessitate the development of performance indicators that relate to agreed and accepted critical success factors of the particular service being measured. This research aims to discover critical success factors for the Irish residential child and youth care sector and suggests that fundamental changes to existing bureaucratic structures of public services will be necessary to deliver on or achieve such critical success factors. The complexity of residential child and youth care work will require a contingent organisation design structure, necessitating high levels of responsiveness to the unpredictable needs of challenging children, and an organisation design capable of organisational learning—issues that will now be explored.

3.5 Organisation design and structure

Organisation design 'is the continuous monitoring and assessing of the fit between goals, structures and rewards; the creation and choice of alternative actions when there is no fit and the implementation of the chosen design' (Galbraith 1977: 7). The structure of an organisation/institution is a means for attaining the objectives and goals of that organisation/institution (Child 1984). Three aspects of organisation structure assist with the attainment of its objectives:

1. The structure contributes to the successful implementation of plans by formally allocating people and resources to tasks and by providing mechanisms for their coordination.
2. The operating mechanisms clarify to members what is expected of them (tasks and how to accomplish them).
3. The structure assists with decision making and information processing requirements. Decision making can be facilitated by programming and specification of stages in the process (Child 1984).

The organisation structure needs to comprise all the tangible and regularly occurring features which help to shape its members' behaviour. It is always challenging for organisations to strike a balance between the need to preserve control and to encourage flexibility. The structure embodies a particular distribution of control, power and rights within the organisation. Selected policies will have direct implications for organisation design. The technology/work practices of an organisation will reflect the kind of environment in which management chooses to operate (Mintzberg 1983). The organisation design provides a framework based on established criteria within which decisions can be taken in an orderly way.

The structure should take into account the characteristics of the staff who undertake the tasks of the organisation/service and the nature of the work that must be performed. Professional staff are more likely to perform better if they feel a sense of ownership over what they are doing, if their work presents a challenge, and they are given recognition for achievement. Professional staff should be involved in discussions which set priorities among the tasks to be done and which set the standards associated with these tasks (Child 1984).

3.5.1 *The content of residential child and youth care work*

The content of residential child and youth care work has been described in a role model that is hierarchical, comprising three categories of role, with three roles in each category (Graham 1994). This model suggests that the residential child and youth care worker, who works in a shared life-space with residents, works in an incremental way with each resident. At the initial stages of the caring relationship the worker focuses on managing the care environment or life-space of the new resident in a way that maximises developmental opportunities for her/him. When there is some evidence of the new resident being more familiar or comfortable with her/his new life-space, the social care worker progresses to the second role category which involves a particular focus on nurturing roles. Here the aim is to exploit all opportunities that present in the shared life-space to form a meaningful, reciprocal relationship with the client. This relationship, which is therapeutic in itself, provides the context for the final category of roles, the therapeutic roles, where the aim now is to address the issues that caused the child or youth to be admitted to residential care. This work is personalised and the pace is determined by the resident. It calls for professional skill, involving sensitive

responsiveness and sound theoretical understanding on the part of the social care worker. The performance of these tasks in this client-focused manner requires flexibility and discretion from the workers in the operating core. This cannot occur in the bureaucratic structure which aims to remove all elements of uncertainty by aiming to standardise all activities and relies on strict adherence to rules to ensure maximum predictability and control. Rigidity, a distinguishing characteristic of the bureaucratic mode, is most likely to result in formalisation, legalism and informal structures in the care setting. All of these factors have already been discussed in the context of the bureaucratic mode and have been seen to militate against personalised, needs-focused care of troubled children and youth.

The distinguishing characteristics of residential child and youth care work show it to be highly complex. The characteristics have been grouped into five sub-sets:

1 **The quantity, variety, brevity and discontinuity of the activities:** These tend to flow into one another.

2 **The contemporaneous nature of the work:** Many different activities occur at the same time.

3 **The unpredictability of the work:** This causes difficulty in terms of being able to plan for events/consequences in advance and in the prioritisation of responses to unexpected events.

4 **Interdependence as a characteristic:** All three types of interdependence (Thompson 1967), were observed in the work, which illustrates the need for particular coordinating mechanisms and has implications for the organising mode of frontline residential youth care services.

5 **The explicit nature of the work:** Most events occur in the company of numerous others, both residents and colleagues (Graham 1994).

These characteristics of residential child and youth care work indicate the presence of both types of complexity: detail and dynamic complexity (Senge 1990). The work is further complicated by the fact that it is a group activity, involving teams of practitioners working with groups of young people. This creates various levels of interdependence, a factor widely recognised as contributing to organisational complexity and requiring expert coordination. Thompson isolated three distinct types of interdependence and proposed that each one requires a particular method of coordination, with implications for organisation design (Thompson 1967). Residential child and youth care work has all three types of interdependence (Graham 1994). There is evidence of *pooled interdependence*. This occurs where the output of tasks contributes to a common pool without any direct interdependence (preparing and maintaining the life-space in residential care). Standardisation is the coordinating mechanism for this type of work. Residential care also has *sequential interdependence*, where each subsequent activity is dependent on its inputs from the preceding activity (the preparation of residents' meals on time to ensure that other planned activities can happen). This type of work is coordinated by planning. Finally, residential child and youth care work has *reciprocal interdependence* where there is two-way dependence between two tasks. (At the beginning of a given shift, essential tasks are distributed among the staff members. An unexpected development with a child may demand an immediate response from a particular staff member which may require their undivided attention and commitment and which will disrupt the planned tasks as originally allocated. A sensitively attuned colleague recognises the relevance of the unexpected

event and ensures that the particular staff member in question is given the opportunity to offer undivided attention to the client, to the exclusion of other planned tasks, which are undertaken by the attuned colleague.) Reciprocal interdependence is coordinated by mutual adjustment (Thompson 1967) and requires high levels of professional skill and flexibility in the operating core.

The neo-Taylor bureaucratic structure coordinates by standardisation only and so can only coordinate activities with pooled interdependence. Since such activities only form a minor part of the overall care task, it is clear that the neo-Taylorist, bureaucratic mode cannot facilitate the total residential child and youth care task. To redesign an organisational structure in a way that facilitates the complexity of residential child and youth care work requires more than mere structural interventions, but an important discovery of this research is that a self-contained task structure can facilitate the total residential youth care task.

3.5.2 *Self-contained task structure*

When a particular task or service within a functional (or bureaucratic) organisation differs significantly from the core tasks of the parent organisation, a reduction of complexity can be achieved by the formation of a self-contained task structure (Galbraith 1977). This structure provides an environment better suited to attainment of the goals of residential youth care. It requires the creation of self-sufficient resource groups focused on a particular task with full authority and responsibility for that task. The self-contained structure is protected from decisions taken in the wider bureaucratic structure, but is accountable to the larger structure for effective delivery of its task. In the residential youth care sector a self-contained task structure requires expert

leadership capable of achieving a balance between the need to preserve control and encourage flexibility at the front line. The leader, who should have full budgetary control, involves key staff in the development of policies that guide processes essential for provision of developmental care. The mode permits greater amounts of local discretion which allows for the design of roles in which 'the occupants can exercise more discretion, participate in decisions affecting their work, and influence the pace of their work' (Galbraith 1977: 87). Such a structure has processes designed to adapt and respond to unpredictable events—a characteristic of residential youth care work (Graham 1994). The self-contained task structure permits a better matching of people, structure, systems and task and is ideally positioned to perform as a learning organisation (Argyris and Schon 1978, Senge 1990). In their theory-of-action perspective, Argyris and Schon developed a body of theory, and a method for inquiry and reflection, on the reasoning that underlies our actions. The tools of their action science are designed to be effective in organisations and especially in dealing with organisational problems caused by high levels of complexity. While an important finding of this study is that the complexity of the residential child and youth care task can be accommodated in a self-contained task structure, provision of developmental care for all residents will also need the perspective of the learning organisation within the self-contained task structure.

3.6 Learning organisations

Argyris and Schon (1978) see organisations as being capable of action for which they are held accountable. They maintain that organisations learn, and that learning occurs through error detection and error correction. They refer to two types of learning: *single-loop learning* which occurs when the error detected and corrected permits the

organisation to carry on its present policies or achieve its present objectives, and *double-loop learning* which occurs when the error is detected and corrected in ways that involve the modification of an organisation's underlying norms, policies and objectives. They suggest the use of maps for detection of errors/problems with clients or customers which could be used in residential youth care services to ensure a maintained focus on developmental care of residents. An underlying purpose of a map is to illustrate to workers the degree to which their organisation is capable of discovering and correcting errors and to illustrate an organisation's capacity to learn how to learn. A map is used firstly to develop a description of any immediate problems troubling particular staff. This should include various views about the problem, the clarity of those views, the accessibility and availability of information needed to understand the problem fully and why it might be considered unsolvable. Another map is used to describe theories-in-use or actual practice in the service. This can be informed by direct observation of actual practice or exercises with staff to gain insight into actual practices in use. Actual practice is then considered in the light of espoused practice (provision of developmental care) as reflected in agency policies. Both practices are then connected to the system of the service. These steps are designed in the Argyris and Schon model to provide the basis for learning experiences that identify for staff factors that inhibit organisational learning. A third purpose of the map(s) is to facilitate clients' internalisation of factors that make sense to them and point a way forward. Fourthly, maps can be used to utilise learning generated by reflecting on the discussion in order to plan the next steps in the learning process. The aim is to break down assumptions and to help practitioners to be more purposeful in their actions/decisions and more focused on desired outcomes for clients.

Such a process could be used in bureaucratically run child and youth care services where layers of camouflage can lead to games of deception, in which everyone knows that realities are being hidden but this is not open for discussion. Correction of such errors would require double-loop learning (Argyris and Schon 1978). Organisational learning occurs when theories-in-use are transformed due to the experience of error, anomaly or inconsistency. This model suggested by Argyris and Schon could have far-reaching results with the potential for enhancing the connection between residential youth centres and their exosystems (Bronfenbrenner 1979), even in bureaucratically structured organisations such as the HSE, where events or practices at the exo level of an organisation will impact the lived experiences of residents and staff in the residential centres (micro level). The public sector, represented by the HSE, is the body responsible for the provision of residential child and youth care in Ireland, and, as already discussed, is part of the child's exosystem. We have noted that a combination of the bureaucratic mode and neo-Taylorist managerialism prevails in the organisational structure of the public sector, part of which is the HSE. We have also noted that rigidity of the bureaucratic mode leads to formalism, legalism and informal structures (similar to Argyris and Schon's inside view of theories-in-use). Bronfenbrenner tells us that exosystem phenomena cross ecological borders, so senior administrative management decisions taken in the interest of efficiency in the HSE can influence the lives of young residents through the effects of these decisions on staff and their interactions with their residents.

An example of such an occurrence is where senior managers, who retain decision making authority in the bureaucratic mode and remain distant from frontline practice, may not understand the rich complexity of the residential task, and may, in the interests

of control and consistency, insist on the use of specified policies by all residential staff with all clients, in particular situations. Such practice is typical of the bureaucratic mode. However, the personalised nature of residential child and youth care work means that the use of policies in such a general manner might not be in the best interest of a particular child at a given time. Adherence to policies in this way robs staff of discretion based on professional judgement. The consequent frustration experienced by staff has been known to result in formalism (a form of displacement already discussed and regularly found in bureaucratic structures). We have seen that formalism results in adherence to rules, originally conceived as a means, as an end in itself. Such practice results in incompatible requirements in organisational theory-in-use in the residential unit. These requirements are usually expressed through a conflict among members and groups in the organisation. Intra-group conflict in a residential setting will militate against developmental work with troubled clients and so it needs to be recognised and urgently addressed. The use of maps, as described by Argyris and Schon (1978), is a method for addressing such conflict and for recognising the complexity of residential child and youth care work. While it is considered that this model would be useful in large bureaucratic organisations, it is recognised that conflict between staff team members could also arise in a self-contained task structure; but it is more likely to be detected in this structure before the levels of camouflage, more typical of large bureaucratic organisations, arise. If such tensions arise in self-contained task structures, it is essential that they are addressed urgently in the interest of developmental care of residents. The Argyris and Schon model could also prove useful in such circumstances. Senge (1990), influenced by the work of Argyris and Schon, proposes that systems thinking is essential for effective organisation learning in those organisations with high levels of complexity, such as residential youth care organisations.

3.7 Systems thinking

Senge shows us how today's problems are often caused by yesterday's solutions. Many so-called solutions merely shift problems from one part of a system to another and can go undetected for years because those who shifted the first problem are different to those who inherit the new one. To minimise such 'solutions', Senge (1990) encourages us to look at underlying structures rather than events, and to think in terms of processes rather than snapshots. All living systems have integrity; their character depends on the whole. This also applies to organisations; to understand the most complex managerial issues requires seeing the whole system that generates the issues. Understanding of issues that impact residential child and youth care requires seeing the whole Health Service Executive system that generates the issues. There are issues where critical systemic forces arise within a given functional area and their solution does not require a broad overview of other functional areas; but there are other issues whose solutions require a consideration of the dynamics of an entire industry (in the private sector) or an entire government department (in the public sector). A key principle of the systems perspective is the 'principle of the system boundary' (Senge 1990: 66). This is that the interactions that must be examined are those that are most important to the issue at hand, regardless of parochial organisational boundaries. This has important implications for effective residential child and youth care work in organisational settings.

Where systemic thinking is not in evidence, there is a tendency to blame outside circumstances for our problems. Systemic thinking shows us that we and the cause of our own problems are part of the one system and that the solution lies in our relationship with our problems. This is particularly important for residential child and

youth care practice where there is strong evidence of the presence of a blame culture which can curtail frontline practitioners and cause them to ignore issues rather than encourage them to solve issues in the interests of their residents.

Systemic thinking is a discipline for seeing wholes. It provides a framework for seeing interrelationships rather than events, for seeing patterns of change rather than incidents. It is reflected in Bronfenbrenner's ecological model where the developing person's environment is viewed as a set of nested structures, all of which are interconnected (interrelated) and so impact the person's development. As a set of general principles, systemic thinking has evolved during the twentieth century and relates to many diverse fields such as the physical sciences, social sciences and management. It helps us to respond to the increasingly complex environment of the 21st century. It is the antidote to the 'sense of helplessness that many people feel as we enter the age of interdependence' (Senge 1990: 69). It facilitates the management of dynamic complexity where cause and effect are not immediately apparent. Dynamic complexity is a feature of residential child and youth care, where outcomes are not readily apparent and often rely on numerous interrelated factors. Features of dynamic complexity are:

1 Effects of interventions over time are not obvious. (It is sometimes only in adult life that a person recognises the positive value of interventions experienced in youth while in residential care.)

2 The same action has dramatically different effects in the short and long term. (Rigid regimes in residential settings achieve control in the short term, but often fail to achieve development of internal control, known to be essential for development of children and youth that leads to them achieving happiness in their lives.)

3 An action may have different consequences in different parts of the system. (Rules-based control can facilitate efficient administration at a level in the system while it can militate against individualised care, so central to development for children and youth in residential centres.)

4 Obvious interventions can have non-obvious consequences. (Interventions based on achievement of compliance can cause serious anger and frustration for troubled youth resulting in a serious deterioration of their circumstances.)

Systemic thinking facilitates the development of a 'rich language for describing a vast array of interrelationships and patterns of change' (Senge 1990: 73). As a way of thinking, it helps to simplify things by throwing light on the deeper patterns lying behind events and details, and as a language it shapes perception—to see system-wide interrelationships requires a language of interrelationships. 'Such a language is important in facing dynamically complex issues and strategic choices, especially when individuals, teams, and organisations need to see beyond events and into the forces that shape change' (Senge 1990: 74). The discourse of managerialism played a significant role in its widespread acceptance as an ideology that could cure both economic and social ills. The discourse of systems thinking highlights the importance of interconnections and the need to understand the whole in order to understand its parts and can guide achievement of environments, within bigger systems or organisations, (such as self-contained task structures) which are suited to development of young people.

The mission statement of managerialism is 'sustainable economic progress' (Newman and Clarke 1994). Residential child and youth care aims to achieve sustainable

development for its young residents. ‘Sustainable’ suggests commitment to long term goals, a central feature of Senge’s systemic model. *New Managerialism* also offers a model of organisation which is people-centred and views bureaucratic control systems as unwieldy, counterproductive and repressive of the enterprising spirit of employees. It favours the loosening of control systems and stresses the value of motivating people to strive for excellence. In this perspective managers become leaders rather than controllers, providing vision and inspiration which generate commitment to ‘being the best’ (Newman and Clarke 1994). Effective leadership is recognised by both the Learning organisation and new managerialism models.

3.8 Leadership

Senge’s model for the learning organisation stresses the importance of effective leadership, a factor now recognised and strongly supported by new managerialism as it seeks to achieve fundamental change in the public sector (Milner and Joyce 2005). We have also seen that leadership is necessary for effective use of the critical success factor framework where there is emphasis on the importance of leaders having a clear strategic vision to act as a target for the involvement of service managers in selection of critical success factors and achievement of strategic change. Studies by Alimo-Metcalfe and Alban-Metcalfe (2001, 2003, cited in Milner and Joyce 2005) stress the importance of leaders being able to articulate and share a strategic vision.

Senge (1990) sees a shared vision as one of the core disciplines of the learning organisation. He describes in detail how a leader must develop the vision collaboratively, and proactively work at embedding the vision across the entire organisation, issues that will enhance the required positive interconnections between the

systems in the ecological environment of the young person in residential care. He talks about the importance of the designer role for learning organisation leaders as they undertake necessary changes. Senge (1990) says the first task of the organisation designer concerns the development of vision, values and purpose or mission. He says the leader, as designer, focuses on making change work in practice. This is essential for growth-promoting practice in residential child and youth care services. The leader designs the organisation's policies, strategies, systems. Policies and strategies reflect underlying assumptions and prevailing norms. We have seen that present structures of residential child and youth care services in the Health Service Executive reflect norms of the bureaucratic mode in its exosystem, where rigidity and control feature strongly. These factors militate against individualised care which is why this study suggests a change of design structure for statutory residential youth care services.

Senge (1990) views leaders as being concerned with integrating the five learning disciplines: vision; values; purpose; systems thinking; and mental models (our internal pictures of how the world works). Senge maintains that the synergy of these disciplines can propel an organisation to major breakthroughs in learning, and believes that all disciplines are critical and must be developed. The first three disciplines regularly appear in studies of leadership in public sector management and are seen as the essential early tasks of the leader. Milner and Joyce refer to a major study by Charlesworth, Cook and Crozier (2003, cited in Milner and Joyce 2005) which found the five top attributes of successful leaders to be: clarity of vision; integrity; sound judgement; commitment to people development; and being strategic. Their study surveyed 1,890 managers for their views on leadership; it listed the following skills as being important for public sector leaders: communicating; engaging employees with the vision; creating an enabling

culture; formulating and implementing strategy; and working effectively with the (local) community. These qualities and skills are very similar to those seen as essential for leaders in learning organisations where leaders must, primarily, help people understand the forces that shape change. The effective leader fosters learning for all employees aimed at helping all people in the organisation to develop systemic understandings. Good leadership is the sharing of one's own personal vision and demonstrating a commitment to the truth. The leader's task is to create a learning environment which requires skills in mentoring, coaching and helping others to learn in a spirit of openness.

The purpose or the 'why' of the organisation plays a key role in leadership, the learning process and in the selection of critical success factors. It is important to know where the organisation has come from and where it hopes to get to. The purpose or mission provides a single integrating set of ideas that give meaning to all aspects of the leader's work. To get the most out of people the leader aims to build a value-based, vision-driven environment. The learning organisation fosters learning how to accept, embrace and seek change, factors essential for survival in the complex world of the 21st century.

Adaptive leadership is required to be effective in this type of context (Milner and Joyce 2005). Bennis (1989), an influential commentator on leadership, provides insight on the roles that effective leaders must adopt and the characteristics they must exemplify. These give us a sense of how adaptive leadership should present in practice:

- The first ingredient of leadership is a *guiding vision.* The leader has a clear idea of what he wants to do-professionally and personally-and the strength to persist in the face of setbacks, even failures. Unless you know where you are going, and why, you cannot possibly get there.
- The second basic ingredient of leadership is *passion* - the underlying passion for the promises of life, combined with a very particular passion for a vocation, a profession, a course of action.
- The next basic ingredient of leadership is *integrity*. There are three essential

parts of integrity: self knowledge, candour, and maturity.

- ‘Know thyself’ was the inscription over the oracle at Delphi. And it is still the most difficult task any of us faces. But until you truly know yourself, strengths and weaknesses, know what you want to do and why you want to do it, you cannot succeed in any but the most superficial sense of the word…
- Candour is the key to self knowledge. Candour is based in honesty of thought and action, a steadfast devotion to principle and a fundamental soundness and wholeness….
- Maturity is important to a leader because leading is not simply showing the way or issuing orders. Every leader needs to have experienced and grown through following - learning to be dedicated, observant, capable of working with and learning from others… Having located these in himself, he can encourage them in others.
- Integrity is the basis of *trust,* which is not as much an ingredient of leadership as it is a product. It is one quality that cannot be acquired, but must be earned. It is given by co-workers and followers, and without it the leader can’t function.
- Two more basic ingredients of leadership are *curiosity* and *daring.* The leader wonders about everything, wants to learn as much as he can, is willing to take risks, experiment, try new things. He does not worry about failure but embraces errors, knowing he will learn from them (Bennis 1989: 39-41).

The challenge of the learning organisation is to lead all in the organisation to master the cycle of thinking, doing, evaluating and reflecting without which there can be no valid learning. This cycle is fuelled by the feedback of a credible leader who reports on reality relative to the widely held vision of the organisation. This process causes a creative tension. Mastering creative tension throughout an organisation leads to a profoundly different view of reality which people see as something they can influence. All aspects of current reality (events, patterns of change, systemic structures) are subject to being influenced by creative tension. Characteristics of persuasive leaders—such as clarity and persuasiveness of their ideas, depth of commitment, openness to continually learning more—instil confidence in those around them that, together, they can learn whatever they need to learn to achieve the results (vision) they truly desire.

Senge says that what matters most is the ‘visible behaviour of people in leadership positions in sharing their own personal visions and demonstrating their commitment to

the truth' (1990: 344). Kotter (1990, cited in Milner and Joyce 2005), stresses the importance of leaders aligning people through communication, emphasising the power of a shared vision and underlining the importance of leadership credibility. To be vision-led means that our reference points are internal; only vision-led organisations can embrace change. Traditional organisations (bureaucratic organisations) change by reacting to events, they subscribe to 'short-termism'. Residential child and youth care requires organisations committed to long-term goals which achieve sustainable development for young residents. Service strategies need to conceptualise such goals so that these can become public knowledge in the organisation, open to challenge and further improvement. A key function of leadership is formulating and implementing strategy.

3.9 Strategic planning and implementation

Residential youth care is provided in organisational settings. To be effective an organisation needs to achieve coherence among strategy, organising mode and integration of individuals (Galbraith 1977). Without the guidance of a clear strategy an organisation cannot be sure that it is allocating resources appropriately, managing critical processes and rewarding positive job performance—factors that are critically important for provision of developmental care in residential settings.

Organisation strategy is made up of strategy planning and strategy implementation. The four elements of strategy planning are: *what* service will we offer; *whom* will we offer it to; *why* will clients come to us; *where* will we place our emphasis. 'The core of strategy implementation is the *how* of the strategy planning, or the systems and structures necessary to achieve the *what, who, why* and *where*' (Rummler and Brache 1995: 81).

Certain questions precede strategy decision making such as:

1. What values are going to guide our service?
2. What do we know or need to know about our target client group?
3. What assumptions about the external environment (legislation, regulation, resource availability) underpin our strategy?

Following clarification of the above lead issues, questions in relation to each of the four elements of strategy planning need to be listed and answered. 'Without strategic definition and goals, which position an organisation in its environment, performance management is a guessing game' (Rummler and Brache 1995: 83). Since the focus of this study is the delivery of developmental care for youth in need of residential care, it emphasises the importance of focused strategic implementation.

3.9.1 *Three levels of strategy implementation*

Organisational level

- Goals: What specific goals and values will underpin our service?
- Design: What internal structure do we need to achieve our goals?
- Management: What resources need to be allocated to the various functions?

Process level

- Goals: What are the goals for the processes that are critical for effective outcomes?
- Design: What are we going to do to ensure that our strategically critical processes are working efficiently and effectively?

- Management: How are we making sure that our critical processes are being managed on an ongoing basis?

Job/performer level

- Goals: What are the goals for the jobs that are most critical for process and strategic success?
- Design: What are we doing to design each key job so that it best contributes to successful outcomes?
- Management: What are we doing (feedback, training and incentives) to create an environment that supports each job's strategic contribution? (Rummler and Brache 1995: 85).

Effective leaders of residential youth care services need to think strategically, to get commitment from all levels of the service to agreed strategies, so that they are common knowledge in the organisation and their implementation is regularly reviewed and evaluated as to their support of all staff in provision of developmental care for young residents.

3.10 Conclusion

This chapter explored the organisational factors that impact provision of care for young people in residential care. It acknowledged that the HSE, currently the major provider of residential child and youth care in Ireland, is part of the Irish public sector and is structured as a traditional bureaucracy. Bureaucratic structures were seen to be rigidly configured and to rely on strict adherence to regulations to achieve control at frontline level. There is a gap in bureaucratic structures between senior administrative management and first-line managers and their frontline staff. The study sought to

narrow this gap and so achieve a more interconnected organisational structure designed to meet the HSE's mandate to provide developmental care for young people in frontline residential care services. Traditional bureaucratic structures subscribed to a neo-Taylor managerialist ideology which is driven by the need for efficiency and achievement of 'more for less' (Pollitt 1990). However, 'new managerialism' (also driven by the need to get 'best value for money') recognised the need for frontline staff to commit to achievement of primary goals that are guided by an agreed mission statement of a given organisation/service (Milner and Clarke 1994).'New managerialism' had more in common with the learning organisation (Argyris and Schon 1978; Senge 1990). This led to the selection of a 'new managerialist' construct, *critical success factors* as a framework for presentation of the research findings. It was thought that use of a *critical success factors* framework would facilitate a 'buy in' from senior administrative management of bureaucratic organisations to organisational factors deemed necessary for provision of developmental care for young people in residential care. A particular critical success factors framework (Leidecker and Bruno 1984) which selects CSFs across three levels of organisations was selected for presentation of the research data. It is hoped that the critical success factors that emerge from the research will facilitate both better understanding of residential youth care work and more relevant measures for constructive evaluation of this practice.

Bronfenbrenner's ecological systems perspective is presented as a paradigm for valid understanding of the interrelated systems that impact the developing person. Factors far beyond the developing person's immediate environment impact his/her development. The organising mode of the service organisation providing residential care is viewed as an exosystem of the developing young person in residential care. Consequently, the

organising mode of the service provider is a significant determining factor in the quality of the caring environment provided for children and youth in residential settings. This view resulted in the prevailing organising mode (bureaucratic mode) of residential child and youth care services being described in some detail.

The bureaucratic mode is explored, listing its characteristics, its preoccupation with efficiency and control and referring to how rigidity, which typifies this organising mode (Mintzberg 1988), can result in displacement of goals through formalism, legalism (Blau 1963) and informal structures (Selznick 1943; Argyris and Schon 1978). Recognition of the need to change the organising mode of residential child and youth care guided a review of the ongoing influence of managerialism in the restructuring of public sectors in Western economies. The ideology of managerialism is discussed with reference to evolving *new managerialism* which acknowledges the need for organisations to manage change in the 21st century. Organisational change also prompted the work of Argyris and Schon (1978), whose theory-of-action model introduces the use of maps in the clarification of issues that cause errors, conflict and anomalies in formal (bureaucratic) organisations, as they seek to facilitate the emergence of learning organisations. Senge (1990) sees learning organisations as the only ones that can embrace change in our increasingly complex world.

Senge claims that effective leadership is centrally important for all learning organisations. Such leadership must reflect an ability to conceptualise strategic insights so that they guide all levels of a given service in the implementation of selected strategies. Strategy planning and implementation are discussed as necessary aids to

residential youth care services committed to provision of developmental care for all young residents.

CHAPTER FOUR:

SEARCHING FOR KNOWLEDGE AND MEANING FOR RESIDENTIAL CHILD AND YOUTH CARE

4.1 Introduction

The purpose of this study is to gain further understanding of the [organisational] forces shaping the care of children and youth in Irish residential child and youth care settings (Bronfenbrenner 1979), in the hope of providing more positive developmental experiences for these young people. There is too little evidence of the residential child and youth care sector being able to satisfactorily meet the many needs of the challenging young people in its care. I believe that these troubled children must be proactively helped to address the issues that led to their admission to residential care and, prepare for engagement with life in a manner that facilitates their becoming productive and happy members of society. This belief prompted my research question and the search for understanding has brought me on a journey through the literature of the philosophy of science.

The literature of the philosophy of science explores, *inter alia*, the considerable debate between rival schools of thought in the field of inquiry in the social sciences. Hermeneutics, and in particular the centrality of the hermeneutic circle, feature prominently in this literature. The hermeneutic circle has been widely accepted by many philosophers as being appropriate not only for understanding science 'but for understanding any form of life' (Bernstein 1983: 130). Hermeneutics is the methodology of the constructivist paradigm which is the selected paradigm for the study.

This chapter will review the theoretical perspectives, or paradigms, of positivism/post-positivism, critical theory and constructivism and indicate the factors that led to the selection of constructivism as the paradigm of choice for this study. A perspective or paradigm is characterised by its ontology, epistemology and methodology, these concepts will shape the discussion of the three paradigms.

4.2 Paradigm

A paradigm can be seen as a perspective that determines how one views the world. 'A paradigm is a set of beliefs, values and techniques which is shared by members of a scientific community and acts as a guide or map, dictating the kinds of problems scientists should address and the types of explanations that are acceptable to them' (Kuhn 1970: 175). Kuhn is credited with bringing the concept of paradigm into our collective awareness. Paradigms put order into an untidy universe, but to demand that all inquiry decisions be in line with the world view embodied in a paradigm is problematic (Lather 1990). Such demands have resulted in much vigorous debate, a considerable amount of which focuses on the acceptance of either objectivism or relativism.

Objectivists are guided by the realist or positivist paradigm, while the relativists are guided by a fundamentally different paradigm, constructivism. Positivists, aided by Descartes, the father of modern philosophers, believe in an epistemological distinction between the subject (researcher) and the object (research question). What constitutes reality (objective) is presumed to be independent of us (subjects). Knowledge is achieved when a subject correctly represents objective reality. Objectivists view science

as an activity which is: based on strict rules and procedures, deductive, nomothetic, reliant on knowledge derived from the senses, and totally value free. They claim there is ‘an a priori universal and necessary structure of human knowledge’ (Bernstein 1983: 10).

Relativists view science differently. They see knowledge, truth, and reality as being relative to a particular conceptual scheme. They seek understanding rather than explanation. Knowledge is seen as situation- and time-determined; it is not easily generalised, it is inductive, ideographic, derived through dialogical, dialectical, interpretation and is not value-neutral. The relativist accuses the objectivist of mistaking what is, at best, historically or culturally stable, for the eternal and permanent (Bernstein 1983).

Many of the debates of objectivism and relativism have been influenced by the Cartesian Anxiety, where Descartes leads us to a grand either/or position: *Either* there is some support for there being a fixed foundation for our knowledge, *Or* we cannot escape the forces of darkness that envelop us with madness, with intellectual and moral chaos. Objectivists believe that there must be some form of fixed, permanent constraints to which one can appeal and which are stable. Relativists believe there are no such basic constraints, except those one invents or temporally accepts. To get beyond the constraints of this dichotomy, Bernstein suggests we look beyond objectivism and relativism by accepting how the discussions converge and illuminate each other from the perspective of hermeneutics.

Hermeneutics was part of the general discussion of the nineteenth century concerning the relation between the natural sciences and the human sciences. The tradition of hermeneutics has been revised in the post-modern re-examination of the social disciplines. It emphasises understanding and interpretation. It is also evident in the post-empiricist philosophy and history of science (Bernstein 1983: 30). Hermeneutics is the perspective underpinning two of the paradigms to be discussed: critical theory and constructivism. Positivism/post-positivism is presented to demonstrate its difference and to illustrate why I believe it would not yield the understanding sought in this study.

The beliefs that define inquiry paradigms can be reflected in the responses given by proponents to three fundamental questions: those of ontology, epistemology and methodology. These questions will be presented and explored from the perspective of the three selected paradigms.

4.3 Ontology

Ontology is a branch of philosophy that is concerned with issues of existence or being. Ontological assumptions concern the very essence of the phenomena under investigation. Ontology seeks to answer the question: What is the nature of reality? Social scientists are faced with the question: is the reality to be investigated external to the individual, thereby imposing itself on the individual's consciousness from without, or is the reality under study the product of individual consciousness? Is reality of an objective nature, a given 'out there' or of a subjective nature, a product of one's mind? The three paradigms presented view differently the question of the essence of reality.

4.3.1 *Positivism/Post-positivism*

The positivist/post-positivist paradigm asserts that there is a world out there which exists independently and that the task of science is to discover nature 'as it really is', 'as it really works'. Particular importance is attached to cause-effect relationships. This is referred to as the realist ontology. It holds that since reality exists independently, our task as scientists is to know and understand it in order to explain and predict it (Greene 1990). Truth is the regulatory ideal of positivism. Things that occur in the real world are determined by certain natural laws. The existence of these laws leads to science's prime directive: to predict and control. If there is no order in nature, mankind will not be able to exploit it in its own interest. Natural laws take the form of cause-effect relationships. Prediction can be accomplished on a statistical basis. Control requires that natural phenomena be managed, be made to act in desired ways. For this to be possible, nature itself must be arranged in cause-effect relationships. The discovery of causal laws becomes the bottom line for scientists who hold realist ontology.

Cause-effect relationships could contribute to a better understanding of residential child and youth care through the use of structured observation of the work which would likely involve control of selected variables, or the use of structured interviews which again would require the use of selected variables/topics. The selection of particular variables will directly influence the data collected. While these methods can yield rich data, the present study seeks to gain an understanding of something that is not fully understood and so the selection of control variables could distort the situation as it really is. It is suggested that the use of unstructured interviews with key players, where they are asked to discuss issues of relevance to them about their work, is more likely to yield data that

will enable the development of constructions which directly reflect critical success factors of residential child and youth care. Such constructions will be both time- and location-specific, not generalisable, so the realist ontology will not guide this enquiry.

4.3.2 *Critical theory*

The critical theory perspective sees the nature of reality as being historically real. It is asserted that reality can be apprehended, that it was once plastic but has been shaped over time by political, cultural, economic, ethnic and gender values and then materialised into a series of structures that are now taken as real. These structures are real insofar as they are a virtual or historical reality. Critical theorists focus on the structures of political and other systems with a view to exposing the forces that shaped them and so help develop recognition that they need not be immutable. They subscribe to a reality that exists objectively and so ontologically are closer to the positivist perspective. However, they focus on meaning as primary and so construe the nature of social reality differently to positivists. They see the empiricist's view of social reality as omitting inter-subjective, common meanings (Taylor 1989). Critical theorists accept the hermeneutical character of existence which assumes that 'the defining characteristic of an ontological hermeneutics is that linguisticality and historicality are constitutive of being human' (Schwandt 1994: 120). There are two schools of hermeneutic interpretation. Firstly, there is philosophical hermeneutics which is concerned with ontology. It holds that the hermeneutic condition is a fact of human experience and philosophical hermeneutics is concerned with a phenomenological explication of condition of existence in the world. It proceeds from a commonality that binds us to tradition in general and to the object of interpretation in particular; it provides the link between finality and universality, between theory and praxis. This transcends the

phenomenologist concern with capturing the actor's point of view, with verification, with discriminating between the *emic* and *etic* perspectives. Secondly there is the objective validation hermeneutics of Dilthey (1961), Betti (1981) and Hirsch (1967) which is an epistemology or methodology with realist pretensions for understanding the objectifications of the human mind. This assumes that meaning is a determinate, object-like entity, waiting to be discovered in a text, a culture, or the mind of the social actor. 'Hermeneutics is a way of interpreting texts to identify objective meanings' (Schwandt 1994: 121). In this way the critical theory paradigm falls into the positivist, objective ontology and the constructivist, relativist, subjective ontology (Schwandt 1994).

The critical theory paradigm could have guided the search for understanding of critical success factors of residential child and youth care through a phenomenological analysis of key players from the selected field of practice. While this study will explore the structures that shape residential child and youth care and will suggest models to facilitate changes to these structures, it seeks only to present constructions based on the interpretation of respondents, with a view to suggesting ways of enhancing existing structures and systems in the provision of effective residential child and youth care. The aim is more to improve practice in residential child and youth care, not the achievement of fundamental societal change to enhance the life experience of selected marginalised or disadvantaged groups.

4.3.3 *Constructivist paradigm*

This paradigm sees the nature of reality as multiple, socially constructed, realities ungoverned by natural laws, causal or otherwise (Guba and Lincoln 1989). It is a relativist ontology. Constructions are dependent for their form and content on the

individual person holding them. Constructions are devised by individuals as they attempt to make sense of their experiences. Experiences are interactive in nature. 'Observed events are defined depending on the kind and amount of prior knowledge and the level of sophistication that the individual brings to the task' (Guba and Lincoln 1989: 86). Constructions can be shared, but this does not make them any more real, merely more consensual. The fundamental difference between positivist ontology and constructivist ontology is that if (as constructivists assert) there is no objective reality, then there are no natural laws and cause-effect attributions are features, not absolute facts. The two ontological positions differ in their understanding of what is truth. For the positivist, truth is any assertion that is isomorphic to objective reality. Truth in the constructivist ontology is the most informed and sophisticated construction on which there is a consensus among individuals most competent to form such a construction. Multiple constructions can exist side by side, all constructions are open to alteration; however, they can be treated as truths at a particular time and in particular contexts. The development of more informed and sophisticated constructions does not mean they are truer, they are simply better informed and harder to challenge, but this can be overthrown should an unforeseen insight come to light. Constructivists resonate with the interpretivists' emphasis on the world of experience as it is lived, felt, undergone by social actors. This is thus the chosen paradigm for this study which seeks to discover critical success factors for residential child and youth care through an understanding of the lived experience of those involved in the provision of such care.

4.4 Epistemology

Epistemology seeks to address the questions: what can be known, what is the relationship between the investigator and what is being investigated? Epistemological

assumptions are about the grounds of knowledge, about how one might begin to understand the world and communicate this understanding as knowledge to others. They entail ideas of what forms of knowledge can be obtained and how one can sort out what is to be regarded as true and what is to be regarded as false. The dichotomy of true and false itself presupposes a certain epistemological stance. It is determined by a view of the nature of knowledge itself, whether it is possible to communicate the nature of knowledge as objective or subjective. Epistemological assumptions determine extreme positions on the issue of whether knowledge is something that can be acquired, on the one hand, or something that has to be personally experienced, on the other (Burrell and Morgan 2001). The epistemological assumptions of the three selected paradigms will now be explored.

4.4.1 *Positivist paradigm*

This paradigm asserts that there exists an objective reality that functions despite any interest that an inquirer may have in it. It is therefore entirely appropriate to require the inquirer to maintain an objective distance while undertaking any research. Objectivity is the regulatory ideal of the epistemology of positivism. Special emphasis is placed on the rigour of the methodology and on the acceptance of one's findings by one's fellow scientists. An inquirer who transparently uses a rigorous methodology aims not to influence the phenomena or vice versa. Findings are discovered through objective observation of how things really are or of how they really work.

Epistemologically, 'realism privileges disengagement and control' (Taylor 1989: 164). Locke, a confirmed positivist, proposed radical disengagement. Taylor discusses how Locke differentiated between knowing and believing. Knowing requires being able to

give an account, to say why it is so; it involves breaking with accepted conventional beliefs of society (Taylor 1989). Positivists believe there is a requirement to work it out oneself and this reflects their notion of reason. Their conception of reason is procedural: the inquirer is called on to construct a picture of things following the canons of rational thinking. 'Rationality is a property of the process of thinking, not of the substantive content of thought' (Taylor 1989: 168). Positivists assert that we are not just independent once we have achieved science; our whole path there must be radically independent, if the result is to be science. This model of reason is radically exclusive of authority. It became established in modernity as the only acceptable means of arriving at the truth. It is central to inquiry in the natural sciences, a product of the enlightened era.

Positivism requires the researcher to disengage from that which is being researched, the path to discovery must be shown to be radically independent, the researcher must remain totally objective. While this method has led to important discoveries in the natural sciences it can be argued that in the social sciences the very presence of a researcher impacts on what is being researched. Rather than aiming to prove through deductive reasoning that particular critical success factors of residential child and youth care exist objectively, this research suggests that a more real and relevant understanding of such critical success factors is likely to be achieved through an informed researcher using prior understanding of the work to explore and interpret the views of key players in the area of child and youth care work. This will yield rich data which are subjective, but which can be shown to emerge inductively from the constructions of those involved in residential child and youth care work. This explains why a realist epistemology could not guide this inquiry.

4.4.2 *Critical theorists*

Epistemologically, critical theorists fall into both domains of objectivity and subjectivity, reflecting their ontological stance. The relationship between inquirer and that inquired into is interactive. The values of both the inquirer and the subjects of the research influence the inquiry which is a subjectivist stance. Findings are value-mediated. This challenges the traditional distinction between ontology and epistemology: what can be known is inextricably intertwined with the interaction between a particular inquirer and a particular research subject (Guba and Lincoln 1994). Critical theory can be characterised by critical consciousness (Schwandt 1990). Researchers in this paradigm systematically investigate the manner in which lived experience may be distorted by false consciousness and ideology. They aim to reduce the illusions of human experience. This theory is grounded in a critique of the dominant ideology of science and technology. The ideology of science produces a technical rationality that distorts the communicative capacity of human beings. Critical theorists claim that under the influence of the predominant ideology the process of inquiry, knowledge, human relations, have undergone a process of reification such that we no longer recognise the distortions of communicative action and language. Epistemologically, this understanding is achieved through a critique of ideology. Within critical theory the researcher and researched engage in a process of dialogue or depth hermeneutics through which the participants achieve self-knowledge which effects a cognitive transformation involving a movement toward autonomy and responsibility. Critical theorists are interpretivists and so celebrate the permanence of the real world of first person, subjective experience, yet in Cartesian style, they seek to disengage from that experience and objectify it. The paradox arises ‘of how to develop an objective interpretive science of subjective human experience’ (Schwandt 1994: 119). Critical

theorists view reality as created not by nature, but by people. It is a state of conflict, not of order. They distinguish between appearance and reality; what appears to be is not reality for it often does not reflect the conflicts that are eminent in society. They believe that subjective meanings are relevant and important, but objective relations cannot be denied. Their interest is to uncover the myths of reality, to expose structures and present reality as it is (Sarantakos 1997). Critical theorists view people as the creators of their own destiny. Critical science employs values and works with values. It uses hermeneutic methodology to gain understanding of the reality as it really is (objectivist), and then gets involved in activism aimed at improving reality. They not only study reality, they act on it. They view in social science the goals of removing false beliefs about society and social reality, they view human beings as creative and compassionate and are critical of the power systems and inequality structures that dominate and oppress people in societies (Sarantakos 1997).

Critical theorists accept subjectivity in that they recognise that the values of the inquirer and the research subject influence the inquiry; they also acknowledge the central importance of hermeneutics and so do not differ fundamentally from constructivists. However, they view understanding as being achieved through a critique of prevailing ideologies, and view reality, which is created by people, as a state of conflict. This research seeks to gain understanding of critical success factors of child and youth care through interpretations of the stated constructions of key actors in the field. This will be achieved through the use of the hermeneutic circle with its forward arc of projection and the return arc of validation in the search for salient success factors. It seeks to understand the reality of critical success factors of residential child and youth care, not to uncover the myths of this reality.

4.4.3 *Constructivism*

The epistemology of critical theorists and constructivists is similar to each other and radically different from that of the positivists. In constructivism the relationship between the inquirer and the object of inquiry is interactive and inter-subjective. Constructions are created as the investigation proceeds, as the inquirer interacts with the phenomena being studied. In constructivism and critical theory the distinction between ontology and epistemology disappears (Guba and Lincoln 1994). In this paradigm it is impossible to separate the inquirer from the inquired into. The answer to the question: 'what is there that can be known?' cannot be considered independently of the question: 'what is the relationship between the knower and the known?' (Guba and Lincoln 1989: 88). Interpretivists, who include constructivists and critical theorists, argue that we understand human behaviour by interpretation. This is fundamentally different from the empiricists who argue that we understand human behaviour by causal explanation. Meaning interpretations themselves are causal for humans; different humans make different sense of, or sense differently and act on, their interpretations. This is not true in nature. Constructivists resonate with the interpretivists' emphasis on the world of experience as it is lived, felt, undergone, by social actors (Schwandt 1994). Knowledge and truth are created and not discovered by mind. The mind is active in the construction of knowledge. Constructivists emphasise the pluralistic, in the sense that reality is expressible in a variety of symbol and language systems; and the plastic, in the sense that reality is stretched and shaped to fit purposeful acts of intentional human agents. This is similar to the emphasis of the critical theorists. Constructivists underline the instrumental and practical function of theory construction and knowing. They accept epistemological fallibilism which states that knowledge is invented and error prone.

Knowledge is not a particular kind of product that exists independent of the knower, but is an activity or process. The validity of a knowledge claim is not to be found in the relationship of reference or correspondence to an independently existing world, but rather 'the relationship between knowledge and reality is instrumental not verifiable' (Von Glassersfeld 1991: 16). To know is to possess ways and means of acting and thinking that allow one to attain the goals one happens to have chosen (Von Glassersfeld 1991). Truth is a matter of the best informed and most sophisticated construction on which there is consensus at a given time. Findings are a literal construction of the inquiry process. The constructions that issue can be evaluated for their 'fit' with the data and information they encompass; the extent to which they work or provide a credible level of understanding; and the extent to which they have relevance and are modifiable (Guba and Lincoln 1989). The Heisenberg Indeterminacy Principle states that questions asked set the stage for certain observations but they may prevent the pursuit of others. The use of an *a priori* theory may lead to interesting results, but they may not necessarily 'fit' or work in the particular situation. Outcomes are not only indeterminate; they are shaped during the course of the inquiry by the interaction of the investigator and the object of inquiry (Guba and Lincoln 1989). Guba and Lincoln acknowledge that constructivist, interpretive, naturalistic and hermeneutical are all similar notions.

Interpretivists, who include critical theorists and constructivists, accept that understanding of human behaviour is achieved by interpretation. Constructivists accept that understanding is to be found by exploration of the world of experience as it is lived, felt, undergone, by those involved in that world. Constructions, which are created realities, are arrived at through the interaction of a constructor with the already known

and the still knowable or to be known (Guba and Lincoln 1989). The subjectivist epistemology of constructivism is presented as the one most likely to yield relevant and reliable critical success factors of residential child and youth care.

4.5 Methodology

Methodology is the doing part of the paradigm. We have tended to derive our understanding of methodology from the conception of scientific method, the principles and procedures that govern investigations of the physical world, and not from the humanistic disciplines (Schwandt 1990). There has been a shift away from this perspective towards an interpretation perspective in the social sciences. It is now recognised that methodology is historically situated and that it evolves. The Aristotelian notion of scientific methodology as grounded in plausible opinion or persuasive speculation was supplanted in the seventeenth century by Renaissance notions of methodology as a combination of mathematical and experimental procedure, bestowing upon results thereby attained a final and assured certainty. This Cartesian notion has given way in the past few decades to 'acceptance of a hermeneutical element in scientific methodology' (Schwandt 1990: 261). It is accepted in the 21st century that there is no such thing as *the* scientific method. Methodology is to study a way of knowing and is linked to epistemology. Our ways of knowing are guided by our assumptions concerning the nature of the phenomenon selected for study. A methodology is the overall strategy for resolving the complete set of choices or options available to the researcher in the undertaking of the research, it examines the principles and procedures by which we formulate inquiry questions, develop answers to these questions and evaluate the correctness and relevance of the answers. In this

understanding of methodology I will now explore how it applies to the three paradigms under discussion.

4.5.1 *Positivism*

The methodology used in the positivist paradigm is experimental and manipulative. Hypotheses are stated and subjected to empirical tests to verify them. The most appropriate methodology is empirical experimentalism, or as close to it as can be managed. Certain conditions must be controlled to prevent the outcomes from being improperly influenced. Positivism overcomes the possibility of inquirer bias and nature's tendency to confound, by the use of a manipulative methodology that controls for both (Guba 1990). The aim is prediction and control. The empirical verification of generalisable laws, which clearly states cause/effect relationships, facilitates both prediction and control. The core tenet of logical positivism is the verifiability criterion of meaning according to which a statement is meaningful only if it is verifiable in terms of sense experience, excepting mathematical propositions. Many theoretical entities cannot be verified in terms of sense experience, subatomic particle physics being one. Recent developments in physics have contributed to the discrediting of logical positivism.

Post-positivists who ontologically subscribe to critical realism modify the methodology of positivism and emphasise critical multiplism or a form of triangulation as a way of falsifying hypotheses. They recognise the problems of positivism and its need to rigidly control conditions, and subscribe to doing research in more natural settings and to collecting more situational information. They re-introduce discovery as an element of inquiry, rather than a heuristic, for properly scientific research. In the social sciences,

post-positivists accept the relevance of *emic* viewpoints to assist in determining the meanings and purposes that people ascribe to their actions, as well as contributing to grounded theory. Post-positivists acknowledge a number of imbalances that have emerged in the search for realism, objectivity. They recognise the imbalance between rigour and relevance. The greater the control required establishing internal validity; the less generalisable are the findings. There is also an imbalance between precision and richness. Precision is critical to prediction and control. Precision emphasises quantitative methods. To redress the imbalance qualitative methods are suggested. There is an imbalance between elegance and applicability. Prediction and control emphasise formal theories, usually reductionist theories which assist generalisability but often do not 'fit' in the real world. 'Locality and specificity are incommensurable with generalisability' (Guba 1990: 22). This is redressed by the use of grounded theory which accepts that theory is the product, rather than the precursor, of the inquiry. The imbalance between discovery and verification, a major tenet of positivism, is redressed by defining a continuum of inquiry which ranges from pure discovery to pure verification. Discovery in positivism is the process by which *a priori* theories and their implied questions and hypotheses emerge. It is not a formal part of the positivist paradigm where the scientific process has as its primary purpose verification. Yet many important advances of science have been made via the creative discovery route, rather than by verification. Both processes are necessary which is why the continuum of inquiry was extended to incorporate both.

A study that seeks understanding of something, heretofore unknown, is unlikely to use a methodology which rigorously seeks verification. How can one verify what is yet unknown? Clearly, positivism, with its emphasis on verification, is not likely to provide

a methodology to gain an understanding of critical success factors of residential child and youth care. Post-positivism, in its acceptance of the limitations of positivism, subscribes to the use of more eclectic methodologies. This emerging paradigm sees the value of triangulation which supports the use of both deductive and inductive methods. This study also recognises the value of triangulation, but proposes to use interpretations based on data from various sources rather than data arrived at through fundamentally differing methods. It does not presume sufficient knowledge of the topic to pursue a respondent's *emic* construction through the use of a set of predetermined questions based solely on the inquirer's *etic* construction. While positivists approach a study confidently knowing what they don't know, constructivists face the possibility of not knowing what they don't know. This requires the use of a highly adaptable research instrument that can enter a context without prior programming, but that can discern what is salient as it emerges, and select to pursue salient factors (Guba and Lincoln 1989).

4.5.2 *Critical theory*

The guiding strategy of the critical theorists is to gain understanding of historical reality as shaped by social, political, cultural, economic, ethnic or gender values, crystallised over time. The transactional nature of inquiry requires a dialogue between the inquirer and the subjects of the inquiry. In this paradigm the dialogue must be dialectical in nature to transform misperception or ignorance into more informed consciousness. The aim is to understand reality in the awareness of the values, perspectives, structures that shaped it—and then to work toward changing these perspectives and structures through selected actions in order to bring about a better reality. Critical theorists link the notion of historical understanding to elements of critique and hope. They see social practices as

containing contradictions in which there are always issues of power domination. Debates on conceptions of power are important to critical theorists. Social values, struggles and interest influence the questions, concepts and strategies of social inquiry. They hold that science needs to be reconstructed with a strong sense of its social epistemology or the interrelation of science with historical conditions in which it works (Popkewitz 1990). History becomes part of the analysis and logic of a science as the researched, research and researchers are interrelated. The critic describes, interprets, appraises the phenomenon and thereby aids in the re-education of the reader's perception. The safeguarding of the subjective point of view ensures 'that the world of social reality will not be replaced by a fictional world constructed by the scientific observer' (Holstein and Gubrium 1994: 164). Subjectivity is not seen as a methodological taboo. The methodological orientation of the critical theorist is hermeneutic. Critical hermeneutics attempts to 'mediate the objectivity of historical processes with the motives of those acting within it' (Bleicher 1980: 152). Hermeneutics merges into a social science in the form of a critique of ideology when traditional meaning is interpreted in reference to given levels of societal labour such as economic development and existing forms of domination (Habermas 1971, cited in Bleicher 1980). On the basis of a theory of societal evolution, especially in terms of emergence of class societies, it should be possible to systematically account for fundamental distortions operative in man's self-understanding. Habermas says that everyday experience of the existence of a false consensus about important issues should sensitise us to the influence of dominant interests active behind the engineering of public opinion (Habermas 1971, cited in Bleicher 1980). The critical theorist uses hermeneutic methodology to understand the false consensus and then acts on this understanding to motivate the holders to action to arrive at a more tolerable position. It

is an interpretative methodology that aims to initiate processes of reflection and to dissolve barriers to communication to deduce explanatory hypotheses. Habermas uses the model of psychoanalysis to show how a critique of distorted self-understanding is combined with knowledge of personality development and individual life histories to bring the individual to more accurate self-understanding. He says that similarly an ideology can prevent certain groups from recognising or pursuing their common interests. This is done through the erection of barriers to communication which block communicative processes directed at the formulation of socio-politically relevant aims and directives. The critical theorist aims to break down or remove distorted understanding to make the life of marginalised groups more acceptable. This methodology is widely used by Marxists and feminists. It aims to study reality from the inside, to capture the meaning of regularities of social action, to understand people. In critical inquiry the process of reality construction and the construction of patterns of meanings and actions are identified. The methodology is 'interpretative (hermeneutic), naturalistic, communicative, reflective and qualitative' (Sarantakos 1997: 52). The purpose of research for the critical theorist is emancipation, empowerment, liberation. The researcher goes below the surface, exposes real relations, discloses myths and illusions, removes false beliefs and ideas and shows how the world should be, how to achieve goals and how to change the world (Sarantakos 1997). The principles and procedures employed by critical theorists resemble positivists and interpretivists, while their epistemology is subjectivist, similar to interpretivists but opposite of positivists. Methods used are directed toward breaking down taken-for-granted concepts and re-building them into new entities. 'Central to this methodology is the dialectic method, the essence of which lies in a process of constantly moving between concepts and data

as well as between society and concrete phenomena, past and present issues, appearance and essence' (Sarantakos 1997: 66).

Critical theorists have much in common with constructivists. They share a subjectivist epistemology and the use of hermeneutic enquiry. Both aim to study reality from the inside, to capture the meaning of human behaviour, to understand people. Both use dialogue and the dialectic method. The purpose of research is different in both perspectives, a factor contributing to the selection of constructivism in this study. Critical theorists are concerned with issues of power domination, so that social values, struggles and ideology influence the questions, concepts and strategies of social inquiry. Critical theorists prioritise emancipation, while constructivists seek knowledge and understanding through the building of constructions by use of the hermeneutic circle. Constructivists seek to contribute to knowledge by achieving new levels of understanding. They bring prior understanding to the inquiry, but focus on uncovering a respondent's *emic* construction through the use of open questions that are not necessarily influenced by issues of power or ideology. Constructivists use unstructured research methods to explore issues and only refine research instruments as salient factors emerge, to facilitate the pursuit of those particular issues. They explore present realities in search of understanding, not merely historical realities, as is more typical of critical theorists.

4.5.3 *Constructivism*

The methodology of constructivism aims to identify the variety of constructions that exist and to bring them into as much consensus as possible. There are two aspects to the methodology: hermeneutics and dialectics. The methodology is hermeneutic in that it is

aimed toward developing improved constructions through interpretation. It is dialectic in that it involves the juxtaposition of conflicting ideas forcing reconsideration of previous positions (Guba and Lincoln 1989). The methodology of constructivism is to aim to expose the constructions of the variety of concerned parties, open each to critique in the terms of other constructions and provide the opportunity for revised or entirely new constructions to emerge. It requires a process that first iterates the variety of constructions that already exist, then analyses those constructions to make their elements plain and communicable to others; solicits critiques for each construction from the holders and others; reiterates the constructions in light of new information or new levels of sophistication that may have been introduced, and finally re-analyses to achieve a consensus. The emphasis is on the world of experience as it is lived, felt, undergone by social actors. 'The process of inquiry is not a matter of somehow getting in touch with the 'ready made' world but rather 'world making' (In child and youth care, Garfat (1998) has called this 'meaning making'), as we know it always starts from worlds already on hand, the making is a remaking' (Goodman 1978: 6). The inquirer as connoisseur turned critic reconstructs or transforms his perceptions into some representational form that illuminates, interprets and appraises the qualities that have been experienced. The representational form is most typically a form of narrative that is presentational rather than representational. The narrative is not an iconic image or mirror of reality but a poetic, expressive form that is a reconstruction of the experience from which it originated. The constructivist describes, interprets, appraises the phenomenon and thereby aids in the re-education of the educator's perception. The narrative accounts can be evaluated for their 'rightness' through the judgement of their coherence, referential adequacy and instrumental utility (Schwandt 1994).

Sampling in the constructivist paradigm is referred to as purposive sampling. Respondents are purposely selected. The aim is not to get a representative sample to which findings are to be generalised. Nor is the sample random. There are six types of purposive sampling: extreme or deviant cases, typical cases, maximum variation sampling, sampling critical cases, sampling politically important or sensitive cases, and convenience sampling. The method of choice should be the maximum variation sampling as it provides the broadest scope of information. The two characteristics of this method of sampling are that the sample is selected serially and that the sample is selected contingently. The issue of sampling and the methodology of constructivism are discussed in further detail in the next chapter which will focus on the methodology used to develop constructions of critical success factors of residential child and youth care.

4.6 Conclusion

This discussion of the nature of social scientific inquiry in positivism/post-positivism, critical theory and constructivism has been minimally comparative and largely descriptive. The aim was to present the arguments of each paradigm with some measure of internal integrity, rather than in reference to selected criteria, and to demonstrate the factors that led to the selection of constructivism as the paradigm for this study. The next chapter will discuss and defend the methodology of constructivism as that most likely to achieve better understanding of critical success factors of child and youth care.

CHAPTER FIVE:

A METHODOLOGY FOR THE STUDY OF RESIDENTIAL YOUTH CARE IN SEARCH OF CRITICAL SUCCESS FACTORS OF IRISH RESIDENTIAL YOUTH CARE

5.1 Introduction

For the past three decades discussions of methodology in both the natural and the social sciences have been dominated by criticisms of positivism and by formulations of alternative views on what constitutes scientific inquiry. Current conceptions of inquiry in the natural and social sciences acknowledge that there is no such thing as a certain foundation for knowledge. Knowledge is recognised in principle to be uncertain, contingent and to have some form of interpretive turn. Social thought is being refigured. As noted in the previous chapter, there is a recognition that methodology is historically situated and that it evolves or changes over time. There is an increasing willingness to accept that there is no such thing as *the* scientific method that is forever fixed and unchanging. However, there still remains a tendency to regard scientific methodology as the one true way of rational argument. Phillips expresses the view that scientific reasoning is epistemologically similar to all forms of human reasoning and that all effective thinkers employ a method of inquiry similar to that of the scientific method (Phillips 1990). Habermas claimed that we have collapsed epistemology into scientific method (Habermas 1971).

‘Methodology is the exploration of a framework for understanding the exercise of method, for examining the principles and procedures by which we formulate inquiry problems, develop answers to those problems and evaluate the correctness and

relevance of those answers' (Schwandt 1990: 262). The previous chapter discussed the selection of constructivism as the paradigm of choice for this inquiry. This chapter will present a detailed discussion of the methodology of constructivism which is both hermeneutic and dialectic.

Residential child and youth care has not been the focus of much research in Ireland. Rather than try to verify the existence or absence of particular variables, this study aims to gain an understanding of residential child and youth care practice from the perspective of key players in the sector. It is hoped this understanding will facilitate development of the sector in a way that benefits both the young residents in the care of the sector and the social care workers whose job it is to meet the total needs of their young residents.

The constructivist paradigm, with its ontological view of relativism which is locally constructed, its epistemology which is transactional subjectivist and its methodological approach of hermeneutics and dialectics, is selected as the paradigm which will facilitate the development of constructions, reflecting the emic views[2] of the research respondents, in an effort to better understand this complex sector. Ethical issues including the presentation of the self of the researcher are included and the chapter concludes with a brief mention of the use of HyperResearch as an aid to data analysis.

5.2 Constructivist methodology

'The paths to inquiry in constructivism share a general rejection of the naturalistic interpretation of the social sciences and seek to inquire into, portray and interpret the

[2] A view that describes a behaviour or a belief in terms meaningful (consciously or unconsciously) to the actor(s) in a context that is culture-specific.

realm of intersubjective meanings as constituted in culture, language, practice' (Schwandt 1990: 264). Two major strands are evident in constructivist inquiry: the ethnographic and the ontological. The methodologies reflect the hermeneutic interpretation of the social sciences and defend their findings as objective—a concept not to be confused with objectivism. Bernstein offers the following explanation of the ethnographic strand:

> *Nineteenth century hermeneutics developed as a reaction against the intellectual imperialism of the growth of positivism, inductivism and the type of scientism that claimed that the natural sciences alone provide the model and the standards for what is to count as genuine knowledge. The character of hermeneutics was shaped by the assault on the integrity and autonomy of the human sciences. The primary task was seen, especially by Dilthey, as that of determining what is distinctive about humanistic and historical knowledge and of revealing its characteristic subject matter, aims, and methods in a manner that would meet and challenge the belief that only the natural sciences can provide us with objective knowledge.* (Bernstein 1983: 112/113).

In the ontological strand, Gadamer contends that interpretation or understanding is not a methodological problem, but an ontological one. He claims that hermeneutics is ontological and universal. Hermeneutics pertains to questions concerning what human beings are; it is a way of being-in-the-world. If we are to understand what it is to be human beings we must seek to understand understanding itself, in its rich, full and complex dimensions. Gadamer maintains that understanding is not an activity of a subject but an event, a happening. Understanding is universal and may properly be said to underlie and pervade all activities (Gadamer 1975). Bernstein goes on to discuss how Gadamer's philosophic hermeneutics involves a fusion of hermeneutics and praxis and claims that understanding itself is a form of practical reasoning and practical knowledge, a form of phronesis or value know-how. Phronesis is introduced by Gadamer to 'clarify the moment of application that is involved in all understanding' (Bernstein 1983: 174). Gadamer contributes to an understanding of our being-in-the-

world as dialogical. He asserts that authentic understanding grounded in tradition and rightful authority yields a distinctive type of practical knowledge and practical truth (Gadamer 1975). Habermas states that there is an essential hermeneutic dimension in all social knowledge (Habermas 1971). Bernstein maintains that hermeneutics is particularly important in the social sciences which are concerned with human beings who are always engaged in the social construction and deconstruction of their world. The task of inquiry is to find the resources within our own horizon, linguistic practices, and experience that can enable us to understand what confronts us as alien. 'Such understanding requires the use of hermeneutics in a dialectical play between our own pre-understandings and the forms of life that we are seeking to understand' (Bernstein 1983: 173). This supports the use of tacit knowledge in data collection and analysis (which is further discussed below) as a necessary specification of the constructivist paradigm.

5.2.1 *Specifications of constructivist methodology*

For a methodology to be meaningful in the constructivist paradigm, the following specifications must be in evidence:

- The methodologies are directly concerned with understanding as nearly as possible some aspect of human experience, activity, as it is lived or felt or undergone by the participants in that experience. To achieve that aim of capturing the qualities of an experience, the methodologies encompass procedures 'for bounding the inquiry within a particular context as it is only within this context that the experience has meaning' (Schwandt 1990: 266). The inquiry must be undertaken in a natural setting. This is demanded due to the relativist ontology of constructivism. The multiple relations that are assumed

ontologically are dependent on the time and context of the constructors who hold them. The inquiry must be undertaken in the same time/context frame that the inquirer seeks to understand (Guba and Lincoln 1989: 175).

- The inquiry is conducted using the investigator as instrument who employs ordinary fieldwork methods. Constructivists do not assume that they know enough about the time/context frame in advance to know what questions to ask. It is unlikely to discover a person's *emic* construction with a set of pre-selected questions based on the inquirer's *etic* understanding. Constructivists enter the field as learners. Lack of prior programming requires that the researcher be highly adaptable so that after a short while in the field s/he begins to discern what is relevant (in the view of the respondent) and to focus on that. The human being has all the adaptable qualities essential to constructivist inquiry (Guba and Lincoln 1989).
- The inquirer disavows a hypothetical/deductive paradigm in favour of forms of inductive analysis. Qualitative methods are essential. Data is collected through the use of human senses: talking to people, observing activities/behaviours, noting the reactions of others, noting non-verbal communication, the use of semi-structured interviews. The constructivist may use quantitative methods once the need for such information is established through the *emic* views of selected respondents.
- Constructivists use tacit knowledge. The fact that they select to investigate a particular topic implies an amount of knowledge by the investigator. These constructions can be clarified at the initial stages. In the case of this inquiry the investigator's prior knowledge of the field (Graham 1994) facilitated the flow of the narrative interview and affected the choice of topics selected for the

interview guide (Appendix 1). The investigator's constructions are further clarified in the investigator's presentation of self, at the end of this chapter. The *emic* material of the research object remains unclear to the inquirer's constructions. The inquirer uses tacit knowledge to explore the *emic* views of the object but the aim is the discovery of the object's *emic* constructions, not verification of the subject's constructions. Tacit information facilitates adaptation and an emergent research design.

5.2.2 *The hermeneutic circle*

The method used in a constructivist inquiry is hermeneutic dialectic. This process is also referred to as the hermeneutic circle. Bernstein's defence of the hermeneutic circle shows how several thinkers working in different contexts discovered for themselves its centrality. He talks of Taylor's references to the criticisms of empiricists who have referred to the hermeneutical circle as a vicious circle by saying that there are good grounds both in epistemological arguments and in their greater fruitfulness for opting for hermeneutical sciences of man (Bernstein 1983). Taylor speaks of the hermeneutical sciences as being moral sciences and that their successful prosecution requires a high degree of self-knowledge, a freedom from illusion in the sense of error which is rooted in our own self-definitions, hence in what we are (Taylor 1979). In the hermeneutical circle the circle of understanding is 'object oriented'. It directs us to the practice, institutions, texts, we are seeking to understand and to the sensitive dialectical play between part and whole in the circle of understanding. The interpreter must have the insight, imagination, openness and patience to acquire this art. There is no determinate method for acquiring this art, some rules, which will be mentioned below, 'are more like heuristic guides that gain their concrete meaning by appealing to exemplars of such

hermeneutical interpretation' (Bernstein 1983: 135). Gadamer's understanding of the hermeneutical circle clarifies the relation between the interpreter and what s/he seeks to understand. He says that interpreters must learn the art of being responsive to their objects of study, they must participate or share in them, listen to them, open themselves to what is being said and to the claims to truth they make (Gadamer 1975). The effort and perceptiveness that is required for understanding is directed to the activity of opening ourselves to what we seek to understand. Gadamer says that the required receptiveness is possible only by virtue of those 'justified prejudices' that open us to experience. The hermeneutical attitude supposes that we purposefully designate our opinions and prejudices and qualify them as such and by doing this we 'grant the object of study the opportunity to appear as an authentically different being and to manifest its own truth, over and above our own preconceived notions' (Bernstein 1983: 138). Beliefs and experience of the researcher are stated at the end of this chapter.

5.2.2.1 Elements of the hermeneutic circle

The hermeneutical circle involves four continuously interacting elements iterating and re-iterating until a consensus emerges:

1. Sampling: Respondents are selected but a representative sample is not selected, as the findings will not be generalised. The sample is selected to serve a different purpose and is referred to as purposive sampling (Patton 1990). Patton describes six types of purposive sampling: sampling extreme or deviant cases, sampling typical cases, maximum variation sampling, sampling critical cases, sampling politically important or sensitive cases and convenience sampling. Constructivists select maximum variation sampling to provide the broadest scope of information. Such samples have two characteristics: they are selected *serially* and *contingently*. Serial

selection: no element is selected until after data collection from the preceding element has been accomplished. Contingent selection: each succeeding element is chosen to be as different as possible from proceeding elements and elements are chosen in ways that best serve the particular needs of the inquiry at that time. Respondents with differing constructions may be needed at the early stages of the research, whereas as issues become identified from the data as being relevant it may be desirable to select respondents who can be particularly informative and articulate about those issues. In this inquiry both maximum variation sampling and convenience sampling were used, as will be discussed in the next chapter which looks at the method used.

2. Interplay of Data Collection and Analysis: Another important element in the hermeneutical circle has to do with the continuous interplay of data collection and analysis that occurs as the study proceeds. A constructivist who interviews a first respondent or makes an observation or reads a document endeavours to uncover items of information that appear to be relevant to the study's focus. The inquirer uses broad ranging questions so that respondents can give information on their own terms. An example could be: tell me the questions I ought to ask and then answer them for me. General responses to questions such as these are analysed as soon as they are obtained so they become part of the agenda in all subsequent data collection. This interplay of data collection and analysis in the present inquiry will be discussed in some detail in the next chapter.
3. Grounding of Findings: Findings that emerge are grounded in the constructions of the respondents themselves. Data collection and analysis proceed at the same pace, generating ever more complex and stable agendas to guide subsequent data collection. As respondents are asked to comment on and critique the constructions

already developed, a joint construction begins to emerge about which consensus can begin to form (or with which selected subgroups can agree or disagree, thus forming a consensus of their own). The joint construction differs from individual constructions originally offered by respondents. It is grounded in all those constructions derived from them via the hermeneutic dialectic process. It is the most informed and sophisticated construction that it is possible to develop in this context, at this time, with these respondents. This grounded construction must meet certain criteria: it is judged to 'fit' when the categories and terms of the construction account for data and information that the construction is based upon; it is judged to 'work' when it informs the understanding of the respondents from whom it emerged and the researcher who was actively involved in the development of the construction. Constructivism prioritises relevance over rigour, so constructions must have relevance, they must address the issues or processes of the situation. Constructivism also subscribes to multiple realities so constructions must have modifiability in that they must be open to continuous change to accommodate new information or new levels of sophistication that may emerge. The grounding of findings in the respondents' constructions will be illustrated in the next chapter and in the case report.

4. Emergence of the research design: The final element of the hermeneutic circle is that the research design emerges as the hermeneutic process progresses. Since the process is inductive, the researcher does not know what is not known but as the process develops and constructions emerge the researcher refines and extends the design.

> *As each sample element is selected, each datum recorded and each element of the joint construction devised, the design itself can become more focused.*
>
> (Guba and Lincoln 1989: 180)

The constructivist paradigm focuses on the criterion of consensus. Overall consensus may not be possible, but it is likely that a small number of constructions will be developed which will concur with the considered views of respondents and seem 'right' to them. If consensus cannot be achieved, the process will clarify the points of difference and signify the need for further negotiation. The emergent research design of this study is discussed in the next chapter.

5.2.3 *The case report*

The findings of a constructivist inquiry are presented as a case report. This report is a joint construction that emerges as a result of the hermeneutic dialectic process. Throughout this process the constructions of a variety of individuals (deliberately chosen so as to uncover widely variable viewpoints) are elicited, challenged, and exposed to new information and new more sophisticated ways of interpretation until some level of consensus is reached. The report helps the reader understand the motives, feelings, and rationales leading to the beliefs held. It provides a thick description that clarifies the context and enables the reader vicariously to experience it. Experience is a basic learning mechanism in humans. The vicarious experience differs from the lived experience, but provides many of the same opportunities to learn.

> *'It is through this process (learning from the vicarious experience) that specific, ideographic knowledge can be applied in a different setting'* (Guba and Lincoln 1989: 189).

The case report must be accompanied by an appendix which describes in detail the methodology followed and facilitates judgement on the validity of the data and the sophistication of the analysis.

The processes and outcomes of constructivist inquiry are continuously shaped and tested through negotiation between inquirer and respondents. The entry conditions must be agreed by each of them. The sampling is carried out with a heavy reliance on a nomination technique in which respondents nominate others who might provide either supportive or divergent constructions. Each new sample element is expected to react to information already gleaned from other sources dialectically. As data are analysed (a process that involves inputs from respondents) the resulting analysis is tested via other yet-to-be tapped sources. The joint construction that emerges must reflect the *emic* view and the *etic* perspective. Judgements of the joint construction's fit, work, relevance and modifiability must be made by the inquirer and respondents jointly. The design, emergent theory and findings will all represent a unique combination of inquirer and respondent values and judgements.

Discovery and verification are tightly interwoven and indistinguishable in the constructivist paradigm. They are both continuously interactive processes. Once an item of information is identified as salient in the local situation it becomes the subject of scrutiny in all subsequent interviews, as well as in connection with all other data sources such as documentary analysis or observations. Reconstruction begins as such scrutinising takes place; the design is aimed in its direction to facilitate additional discoveries.

5.3 Criteria for the defence of findings

Findings of constructivist inquiry, in order to be deemed trustworthy, must satisfy requirements of credibility, transferability, dependability and confirmability. To defend

one's findings certain steps are necessary, both during data collection and analysis (Guba 1981).

- To achieve credibility it is essential to guard against the possible effects of factor patterning which result in noninterpretability, by using, during the study, prolonged engagement, persistent observation and peer debriefing, and doing triangulation, collection of referential adequacy materials and member checks (whereby data and interpretations are continuously tested with the respondents and they are asked to highlight anything that they wish to have removed). The essential tasks at the end of the study are: to establish structural corroboration or coherence, to establish referential adequacy, and to do member checks. It is hoped that these actions will lead to credibility and produce findings that are plausible.
- To achieve transferability, the researcher will do theoretical/purposive/nominal sampling, collect thick descriptive data during the study and after the study the focus will be on the development of thick description.
- Dependability which requires concern with the stability of data can be achieved by establishing an audit trail during the study.
- Confirmability is achieved by triangulation, practising reflexivity and the provision of a confirmability audit which certifies that data exist in support of each interpretation presented (Guba 1981).

5.4 Ethical issues

There is no such thing as value-free inquiry. Every act of science is also a political act as all sets of values cannot be suspended. Ethical issues embodied in the research task fall into moral, legal and social domains. In the moral domain certain criteria must be seen to be met. Important among these are: publicity, which implies that the

methodology must be capable of public scrutiny and defence. Reasonable persons must participate in the public scrutiny and there must be evidence of the use of discretion in discerning what is/is not intrusive. The requirements of this inquiry have ensured the participation of reasonable persons in its public scrutiny. The description in the case report, the use of the member check and the assurance of confidentiality for all respondents are presented as evidence of the discretion used in this study.

In the legal domain, it is essential to show that respondents are not placed at any risk, their legal rights are never compromised, and that deception of any kind is never used. Fully informed consent must be seen to have been secured from all participating respondents. All respondents must be assured of confidentiality and privacy. A copy of the informed consent form used in this study is in Appendix 2.

In the social domain, it is essential that any research inquiry that is undertaken in no way adds to the disenchantment of a cynical public with the arrogance of deceptive researchers. The purpose of this inquiry has been clearly presented and has been undertaken with the hope that the understanding it seeks will benefit the lived experience of children and young people in residential care.

Adherence to a particular paradigm predisposes an inquirer to certain postures in relation to ethical and political questions. ‘The mandate imposed on social scientists to search for a putative truth allows the traditional or conventional scientist to objectify research participants and to deceive respondents in the pursuit of truth’ (Lincoln and Guba 1989: 229). The constructivist does not pursue a single truth or single explanation but seeks to uncover the various constructions held by individuals and often shared

among their professional peers. The constructions created represent the meanings that human beings attach to particular contexts, experiences, in their effort to impose meaning on social interaction. The aim of constructivist inquiry is to interpret *emic* constructions with a view to building re-constructions based on constructions held by a number of key participants of a particular profession/activity. Through the hermeneutic dialectic the inquirer seeks to gain understanding by interpreting the views of the research subjects. Reliability demands accuracy and accuracy demands total honesty on the part of the inquirer, 'deception on the part of the inquirer is absolutely counterproductive to the research purpose' (Lincoln and Guba 1989: 239).

The special, interactive relationship between researcher and respondent in naturalistic research is collaborative, based on mutual exchange, preservation of human dignity, respect and privacy. Respondents are collaboratively involved in data collection, interpretation, and formation of constructions—another factor that demands that no deception is employed in the interest of discovery. The use of narrative interviews in this study facilitated the interactive process in an open, honest way. This is illustrated in the following chapter which will focus on the method used in the inquiry.

The intensity of the researcher/respondent relationship can pose difficulties with maintaining confidentiality and anonymity. In constructivist inquiry the researcher is the instrument of inquiry. The inquiry process can place both the researcher and respondent in jeopardy. Personal relationships develop during the process as each partner gives, takes, shares and teaches the other. Vulnerability can be created as researcher and respondent exchange roles, barter trust and reconstruct identities. The relationship must be appropriately managed by the researcher. In order to prove reliability it may be

useful to present anecdotal data which might also reveal the identity of the respondent to others. The respondents were made aware of these risks in advance and assured that their right to confidentiality would be respected.

The researcher undertook to send each respondent a typed transcript of their interview, and to give each a specified timeframe (two weeks) within which to request that any comments with which they did not want to be associated, be deleted from the transcript. No respondent asked for any deletions. To further protect respondents' confidentiality the male pronoun is used through all respondents' narratives referred to in the case report.

5.5 Reflexivity

It is now accepted in qualitative research that the researcher is a central figure 'who actively constructs the collection, selection and interpretation of data' (Finlay 2003: 5). A reference has already been made to the fact that the researcher in this study has many years experience of lecturing, researching and writing about residential child and youth care and to how this raised her profile in the sector and greatly facilitated access to research respondents. It must also be recognised that such experiences can lead to a researcher having pre-conceived ideas about the topic under investigation. While my experience of teaching critical reflection to final year students would have alerted me to the inherent dangers of such possibilities, it is important here to explore how such issues as my prior knowledge of respondents, gender and power might have influenced both data collection and production of new understandings of residential child and youth care practice.

5.5.1 *Selection of respondents*

17 respondents participated in this study. They comprised of 8 first-line resident managers; 7 directors of residential youth services, all of whom line-managed first-line managers; a senior administrative manager of the HSE who line-managed all directors of residential services in a particular region of the HSE; and a co-ordinator of residential care in a participating service. All interviews were arranged by making direct contact with the nominated respondent. Initial contact with interviewees was by telephone when I introduced myself and the research and mentioned who had nominated them as a potential respondent. When they agreed to participate I made an appointment to interview them in their places of work at a pre-arranged time. All interviews were tape recorded and were based on an initial list of topics which became more focused during the data collection phase, to reflect factors emerging from use of serial selection.

5.5.2 *Respondents known to researcher*

Three of the 17 respondents were known to me prior to this research project. I commenced data collection by asking a resident manager who was known to me as he had also been a tutor in the college where I am lecturing. He then commenced the nomination selection of respondents to achieve maximum variation sampling. Respondent 3, who was known to me, was nominated by a respondent not previously known to me. Nomination selection continued for a considerable period of the data collection phase without me encountering another respondent previously known to me. When transcribing and analysing the transcript of respondent 8, I received a telephone call from a practice placement supervisor for third year students to say that he would be unable to take a student that year due to his residential unit experiencing a level of chaos that caused him to consider it an unsuitable placement for a student at that time. Using

contingent selection I invited this respondent to participate in the study, to which he agreed and he became respondent 9 and was the third respondent of the entire sample who was previously known to me. Nomination and contingent selection of respondents continued until it was considered that sufficient narratives had been collected to address the research question. I did not know any of the other 14 respondents prior to their interview. Knowing respondents prior to being interviewed did impact the researcher/interviewee relationship. While there was appreciable goodwill expressed by all respondents towards the research topic, this was particularly noticeable with those respondents previously known to me. They were strongly committed to sharing their lived experience of providing care for young people in residential care and readily expressed their views on 'what worked' and on barriers to needs-led practice with residents. For purposes of confidentiality these three respondents, in common with discussion of all other respondents, are referred to using the male pronoun, but one was female and two were male. One in particular stated that he found the interview helped him to understand issues more clearly and he vowed to tackle some practice issues in the unit he line-managed. Another one from this category had been having a particularly difficult time in his service, he had thought through the issues and discussing them in the interview confirmed for him how disempowered he had become as a first-line manager and he was reluctantly accepting that he needed to seek employment in a different residential care service. The third member of this category was a director of service and was very satisfied that his service was providing developmental care for its young residents. All three enthusiastically joined in negotiation of meanings in their particular social contexts which facilitated joint production of new understandings. When themes that emerged from these three transcripts were juxtaposed it clarified themes that signified provision of developmental care and those that signalled the

presence of a social risk model of care. However, their openness and enthusiasm for the research topic, coupled with the fact they were already known to me, resulted in them placing significant trust in me which made me more acutely aware of what Finch (1984)[3] refers to as the exploitative potential in the easily established trust between acquaintances and made me more determined to protect all respondents' identities.

5.5.3 *Gender*

While frontline carers are predominantly female workers 'who have traditionally been least valued [in the workplace]' (Munro et al 2004); this factor did not significantly impact the study as respondents were chosen from among first-line managers of residential units and the nomination technique used in the study resulted in an equal representation of both genders. From the total of 17 respondents, 9 were female and 8 were male. Because the focus of the research was on achieving a better understanding of Irish residential youth care practice, there was no exploration of respondents' personal lives or deeply held personal feelings, so there was no discernable difference in how male and female first-line managers engaged with the interview process. Perhaps female managers were even more intent on giving a wholehearted account of their understandings of residential youth care, but this was not noticeable at either data collection or data analysis stages. Both genders participated enthusiastically and use of my tacit understanding provided 'cultural frameworks of meaning in eliciting and interpreting responses', and in forming joint constructions of particular contexts of relevance through which a shared understanding of our discourse was achieved (Mishler 1991: 117). The nomination technique resulted in this even gender mix of respondents. If this method of sampling had yielded a strongly gendered group of respondents, it is

[3] Finch (1984) was referring to the trust that easily develops between female researchers and female interviewees, but I found this also emerged when interviewing acquaintances.

possible that I might have used contingency sampling to check for gender bias—but this did not arise.

The 17 research respondents represented 8 residential services in the Irish residential youth care sector. First-line managers' line managers, referred to in the study as directors of service,[4] were interviewed in 7 of the 8 services in the study. The gender balance here was 3 female directors of service and four male directors of service and, again gender did not present as a factor of significance in these interviews. Because all respondents were managers all had high levels of autonomy over their work and were most willing to engage in exploration of the research topic. Each respondent took a keen interest in the research topic and, once a level of rapport was established, each engaged fully in sharing their accounts of provision of residential youth care in the services to which they belonged, and in clarification of meanings and construction of new understandings.

5.5.4 *Power*

Two factors experienced prior to commencement of this study alerted me to possible abuse of power in residential youth care settings.

1. Anecdotal evidence picked up from students of social care, indicated that they were sometimes encouraged by experienced frontline colleagues to forget their 'college ways' once they had joined the 'real world' of work. This sometimes led to newly qualified residential youth care workers being totally disempowered and being influenced by practitioners whose practice was more focused on control of the care unit to suit staffs' needs, not on meeting the needs of the young residents living in the unit.

[4] Similar to the external line manager referred to by Whittaker, Archer and Hicks (1998).

2. My experience of five years of fostering an adolescent who, at age fourteen years had spent his entire young life in residential care, confirmed my belief that vitally important information is not always reliably shared with primary carers. Serious and unexpected issues arose with our young foster child, which were directly related to his earlier experiences while in residential care. These were known at the management level of the residential service but were not shared with us, his primary carers prior to his placement with our family. While the issues were eventually resolved, their unexpected emergence left us as a family totally unsupported and could have threatened the foster care placement. I saw this as an example of deliberate withholding of very relevant information from primary carers, which could be seen as a power issue.

Power can be exploited at different levels of a service. More experienced practitioners who are intent on maintaining a status quo in a given residential unit may use peer power to indoctrinate newly qualified workers seeking acceptance from established colleagues, by encouraging practice which prioritises staff needs over the needs of residents. Senior administrative managers can exert power by imposing policies at the frontline that prioritise 'best value for money,' not the developmental needs of residents. There is also the possibility of withholding relevant but confidential information from primary carers, who are sometimes regarded by administrative managers as being involved in 'childminding', not the developmental care of residents.

While I was aware of the possible abuse of power in frontline residential youth care services I decided not to specifically frame an introductory question around the issue of power. This was in the belief that issues of power, if perceived by respondents as

relevant, would emerge through my use of broad ranging questions that facilitated respondents giving information on their own terms. This approach to data collection is in keeping with the constructivist methodology and proved effective in eliciting power as a significant factor in residential youth care provision. Since power is an issue commonly found in organisational settings it is reasonable to expect its emergence in the narratives of respondents. I acknowledge that my tacit knowledge resulted in me being particularly alert to power related issues. An example from the data of how a senior manager uses his power to micro manage frontline practice can be seen from the following quote of a director of service: *'The view of child care workers in terms of their status has long been child minders. There is a battle in terms of trying to move yourselves from that position, from not having authority attached to your decision in terms of your decision ... 'It's more that it* [residential youth care] *is driven by the ultimate goal of management, financial control rather than the care aspect of it'* (R12). This traditional view of residential youth care as being merely 'childminding' facilitates an abuse of power at a senior management level by disempowering first-line managers and frontline staff. In residential services where such disempowerment of frontline staff prevails, it results in them being tightly controlled by an array of procedures and standards based on the ideology of quality assurance. This was evidenced by another quote taken from the transcript R12's line manager. When he was asked about what he saw as being most important in frontline residential care practice he responded: '*It does mean that pre-requisites ... care plan, care plan review, all that stuff, your paper work, everything has to be done, it is Quality Assured*' (R16). This reflects a managerial model of accountability which has placed 'the lessening of risk, not the meeting of need' at the centre of social practice (Tilbury 2007). Discussion of such themes with subsequent respondents through use of serial selection clarified their presence in the

Irish residential youth care sector, in that all respondents acknowledged the importance placed on regulation and quality assurance issues in the sector. However, an interesting factor that emerged was that a significant number of directors of service demonstrated an ability to separate an administratively determined accountability model from a child development or needs-focused accountability model. These directors took responsibility within the broader organisational context, for ensuring that all standards of care prescribed by government (Government of Ireland 2004) through established national policy (Government of Ireland 1999) were met within their services; but they also recognised their responsibility to provide developmental care for residents as mandated in Irish legislation (Government of Ireland 1991). They communicated clearly to the first-line managers whom they line-managed that needs-led care of residents must be prioritised at all times. The special leadership skills of these particular directors of service emerged as being central to provision of developmental care for young residents. The following quotes from two directors of service help to illustrate this: '*What we are trying to do is to create a culture, a child friendly culture, a family friendly culture ... Everybody subscribes to that ... this is our function here, this is what we want to create for the child ... they* [resident managers] *go beyond what might normally be expected and that shows commitment ... with some managers I trust them implicitly, I know that no matter what would happen they would always do what was right for the child'* (R12). '*For the HB* [now known as the HSE] *we are very successful, balance the books ... we operate to fairly high standards and occupancy rates ... I think that every manager needs to ensure that whatever happens in a unit that the child is at the centre of that. If the service isn't child centred and becomes the child fitting into the system rather than the system being built around the child you are on a highway to nowhere'* (R3).

These directors of service demonstrated how effective leadership was used to protect the residential services they directly line-managed from the more administrative decisions taken by senior managers in the broader HSE organisation. It is essential that the position of these directors of service is consolidated in order to ensure provision of developmental care in residential youth care services. These directors had some similarities in how they structured the frontline services they line-managed. They delegated responsibility to first-line managers and supported them in provision of developmental care in the units and first-line managers empowered frontline staff to provide value-driven needs-led care (Garfat and Ricks 1995) for each resident. The emergence of these new understandings of residential youth care provision, when considered in the context of the critical success factors framework shaped a number of critical success factors presented as findings of the study.

My focus during data collection and analysis stages remained on trying to determine respondents' emic constructions. Child and youth care practice requires practitioners to attempt to elucidate the re-occurring themes of a youth's living so that patterns that may be hindering his/her development/progress are recognised and available for change (Garfat 1998). This elucidation of themes requires practitioners to use both individual and group reflection in their practice. Through my teaching of critical reflection to students of child and youth care (Graham and Megarry 2005) I am familiar with the process of investigating meaning of students' experiences with clients. This skill helped me to actively remain focused on the emic views of respondents and to collaborate with respondents in the development of emic constructions.

Hermeneutic inquiry requires the balancing of the research context by considering parts and whole (Van Maanen 1988). This requires the researcher to constantly reflect upon the relationship between parts being investigated and the whole to which they contribute. My investigation of organisational issues that impact on child and youth care practice was influenced by the work of both Bronfenbrenner (1979) and Senge (1990), both of whom come from an ecological or systems perspective. The purpose of this research is to consider how managers' experiences of child and youth care practice are influenced by the organisational context or exosystem in which the experiencing occurs.

5.6 HyperResearch

Due to the extent of the data collected in this inquiry and the large number of codes emerging, it was decided to use HyperResearch, a computer aided programme for qualitative data analysis, as a further aid to data analysis. This facilitated a detailed content analysis. It also provided a more effective way of looking at the data as a whole in relation to its salient themes. The programme facilitated detailed coding, through which the codes of each transcript could be analysed separately and each code had a hyperlink to the particular text from which it was generated, which greatly facilitated use of direct quotes from transcripts in defence of each critical success factor. This facilitated ongoing analysis and selection of salient issues for use in subsequent interviews. The *master code list* captured the codes of the entire data set, all seventeen transcripts, which facilitated analysis of the whole in relation to its parts. It was possible to look at consensus across the whole data set which facilitated the emergence of critical success factors of residential child and youth care.

5.7 Conclusion

Constructivism is presented as the paradigm of choice with its methodology of hermeneutic dialectic which involves a continuing dialectic of iteration, analysis, critique, reiteration and re-analysis—leading to a joint construction among *emic* and *etic* views of a practice, case or issue. A defence of the hermeneutical circle as a methodology is given as this has been the principal orientation used in the inquiry. The regulative ideals that give shape to constructivism are examined and criteria for the defence of findings are discussed. The next chapter will focus on the method used in the inquiry and will describe the data collection, coding and analysis. It will present a case report of the overall research process.

CHAPTER SIX:

METHOD OF INQUIRY

6.1 Introduction

'A qualitative approach seeks to capture what people have to say in their own words' (Patton 1990: 22). This chapter will focus on the method used in the search for an understanding of residential child and youth care through the words of key players from the sector, and use of a *critical success factor* model to organise and present the data as *critical success factors* necessary for provision of developmental care for young people in residential care. There will be a discussion of the approach to the research task and how this was guided by the constructivist perspective. Data collection, which was guided by a nomination technique and used open-ended narrative interviews, is discussed to illustrate how such interviews used in serial selection contributed in an ongoing way to the analysis process. Data analysis, through use of the hermeneutic circle, follows a circular, dialectical trail. This trail is presented through discussion of the approach to the research task; data analysis which was aided by use of HyperResearch, a computer aided programme for qualitative data analysis; and organisation of the emergent themes from the data through use of a *critical success factors* model (Leidecker and Bruno 1984), to present critical success factors deemed necessary for provision of developmental care in residential youth care settings. A preliminary list of seven critical success factors emerged from the research trail (Appendix 5). This preliminary list was presented to a group of carefully selected key informants from Irish child welfare services as a means of triangulation. Content and comparative analyses of the transcript of the key informants (Appendix 4) directly

shaped the final set of five critical success factors of Irish residential child and youth care which are presented.

6.2 Approach to the research task

The study sought better understanding of how organisational factors impact frontline residential youth care practice. This focus suggested that the informants best placed to contribute to discovery of themes related to such organisational factors would be first-line managers operating in residential child and youth care units, their line managers and senior managers of the sector in the Health Service Executive (HSE).

At a preliminary stage, possible research respondents were first canvassed at their annual conference, where the president of the Resident Managers' Association (RMA) introduced the research. He asked any interested first-line managers to collect a general information leaflet on the research (Appendix 3) and, if they were willing to participate, they were asked to return the leaflet in the supplied envelope with their name and contact details. The positive endorsement of the RMA resulted in a strong interest among first-line managers in the research. However, selection of research respondents was by use of a nomination technique and only two nominated respondents were from those members of the RMA who expressed an interest in participation. Maximum variation sampling which used serial and contingent selection of respondents resulted in yielded a total of 17 respondents, whose analysed transcripts indicated sufficient data to address the research topic. While only two of the 17 research respondents were present at the RMA conference I believe the interest in the study that emanated from the RMA conference probably contributed to the fact that all nominated managers readily agreed to participate. Before actual participation in the research process all respondents were

given details of the purpose of the research, the intensity of the data collection and analysis processes which necessitated tape recording of all interviews, the member check process which involved follow-up contact with respondents, the collaborative nature of the relationship required for reliable constructivist inquiry, and an undertaking that confidentiality would be protected in all cases (Appendix 2).

Negotiation forms an essential part of constructivist inquiry. The recognition that respondents' constructions are the stuff of research requires that the researcher engage fully in a participative mode. Negotiation for data, for constructions, for interpretations and for respondents' co-operation is the only way to proceed as relationships are re-formed at every stage of the inquiry process and by the need to have respondents be the ultimate arbiters of credibility and plausibility. All respondents were interviewed at their place of work or at a suitable alternative venue of their choice. All respondents received copies of transcriptions of their own interviews and were asked to respond within a given time frame (two weeks) if they noted any content that did not represent their views on the issues explored at the particular time. A number of them responded wishing me success with my study, but none of them queried any content of their transcript.

6.3 Data analysis

The constructivist perspective guided this study in its search for a more detailed understanding of residential child and youth care in Ireland and the organisational factors that impact frontline practice. Semi-structured interviews were used to collect data from purposefully selected respondents. All interviews were tape-recorded, transcribed, coded and analysed by the researcher, which facilitated a high level of

consistency across these tasks. HyperResearch, a computer-aided programme for analysis of qualitative data, was used in the coding of all transcripts. It greatly helped with the management of a large number of codes (1315 codes) which emerged from initial content analysis of the data set, and in the reduction of these codes into salient categories which eventually formed the themes that emerged from the data. HyperResearch also aided serial selection by facilitating ongoing analysis of transcripts and selection of salient issues for use in subsequent interviews. It facilitated detailed coding, through which the codes of each transcript could be analysed separately. Since each code had a hyperlink to the particular text from which it was generated, it greatly facilitated use of direct quotes from transcripts in defence of categories and major themes as these emerged from the data. It also provided an effective way of looking at the data as a whole in relation to its salient themes. The master code list captured the codes of the entire data set, all 17 transcripts. This facilitated ongoing analysis of the whole in relation to its parts and so proved a valuable aid to overall data analysis.

Coding and analysis of early respondents' transcripts indicated that they had particular categories in common. Categories such as 'care related issues', 'staff related issues' and 'support for the first-line manager' began to shape subsequent interviews. Serial selection resulted in continuous comparative analysis of transcripts, and the discussion of issues arising with subsequent respondents, to confirm or dismiss their importance as themes of particular services and emerging constructions or new understandings of residential youth care. Transcripts of respondents from particular services were considered together to further confirm or reject the relevance of particular emergent themes of these services. Findings emerged through an ongoing interplay of data collection and analysis (an element of the hermeneutic circle), presentation of the

content analysis of each respondent's transcript in the context of the particular service to which he belonged, followed by clarification of the themes of each particular service. This is the focus of Chapter Seven. Service themes were then considered in terms of two further factors. Firstly, these themes were considered to determine which model of care service respondents' narratives described (developmental model or social risk model, both discussed in Chapter Two). Secondly, in order to better understand the impact of organisational factors, themes from each service were considered from the perspective of a *critical success factors* model (Leidecker and Bruno 1984). This particular *critical success factor* model was used as a framework for organisation and presentation of the research findings. It shaped a preliminary list of seven critical success factors deemed necessary for provision of developmental care for young residents (Appendix 5). This list was then presented to a group of carefully selected key informants from Irish child welfare services. Content and comparative analyses of key informants' transcripts directly shaped a final list of five critical success factors for Irish residential child and youth care. These findings form the focus of Chapter Eight.

6.4 Hermeneutic circle

We saw in the previous chapter that the hermeneutic dialectic method of constructivism is also known as the hermeneutic circle. The four elements of this circle impacted the study in four ways.

6.4.1 *Sampling*

In preparation for data collection in this study some basic decisions regarding sampling were taken. Sample size in qualitative inquiry is not bound by rules but depends on what one wants to know, the purpose of the study, what will have credibility and what

can be achieved with available time and resources (Patton 1990). Purposive sampling was used. ‘The logic and power of purposive sampling is in selecting information-rich cases for study in depth’ (Patton 1990: 169). Informants were chosen from those whom it was expected to learn a great deal about organisational factors impacting residential child and youth care, namely first-line managers of residential child and youth care units and their line managers. Maximum variation sampling was used to achieve the broadest scope of information; it was coupled with some convenience and deviance sampling. Geographical variation was achieved by selecting respondents from different regional areas of Ireland. When the Health Service Executive (the public service body responsible for provision and delivery of all health and personal social services in Ireland) was established in 2005, during the data collection stage, it was decided to ensure that respondents were sought from all four of its administrative areas, thus getting a small but national sample.

The sample of respondents selected was neither representative nor random. Respondents were selected serially, which meant that no element was selected until after data collection from the preceding element was transcribed and analysed. Respondents were also selected contingently which meant that early respondents were asked to nominate as the next respondent a first-line manager whom they knew to have views which differed significantly from theirs and then, as salient issues emerged, respondents who were expected to be particularly informative and articulate about those salient issues were sought and nominated. (For a general outline of issues explored in the interviews see Appendix 1).

All respondents in the study are given sequential numbers reflecting the order of interview. Respondent 1 (R1) was working as a part-time tutor in the same college as the researcher, as well as being a first-line manager, and was asked to participate as the first respondent, to which he agreed. R1 was then asked to nominate as R2 a manager he knew to have quite different views to him. R1's transcript was analysed for emerging themes which were then raised with R2, together with the outline issues of the inquiry as listed in Appendix 1. R2 nominated R3. I then used convenience sampling and decided to interview the director of R2 who was available at this time, but who was in poor health so might not be able to participate at a later stage. He became R4. R3 was asked to nominate a first-line manager in his service (R5). I then sought a manager from a different geographic area of the Health Service Executive (HSE). R6 satisfied this requirement and was selected from the list of managers who had indicated their willingness to participate in the research at the Resident Managers' Association meeting the previous year. R6 nominated R7, and so on up to R10. R10 presented an opportunity to use deviant or extreme sampling (Patton 1990) as he was experiencing particular difficulties in his residential unit which caused him to contact me regarding his withdrawal from a commitment to take a social care student on practice placement. His difficulty was due to a crisis situation created by an emergency admission to his unit. He agreed to participate in the study, which brought the enquiry into another geographic region of the HSE. R10 nominated R11. At this stage salient issues were emerging (for example staff related issues and how these impacted quality of care: services of Rs1, 10 and 11 were negatively impacted by these issues while the opposite was noted in relation to staffing issues in the services to which Rs 3, 7 and 8 belonged. Another salient issue related to tightly regulated services which were found to disempower first-line managers, a factor which negatively impacted the quality of frontline care (Rs 1, 10

and 11), while child-focused services which empowered first-line managers provided developmental care for residents (Rs 6, 8 and 9). These and related issues highlighted the central importance of organisational factors in residential youth care services; so subsequent respondents were sought from more senior management levels to get a better understanding of forces that shaped such issues. R12 was a director of service of respondents 1, 2 and 4. R13 was director of service of respondents 6 and 7. R14 was nominated by a director of service to whom respondents 8 and 9 belonged, but who thought R14 (also a director) would be more relevant to the study than himself. R14 was a director of large statutory residential and fieldwork services in the HSE area of respondents 8 and 9. R15 was a resident manager in R14's service, selected contingently to explore themes arising from R14's transcript. R16 was a Local Health Officer in the HSE and line manager of R12 (director of respondents 1, 2, and 4); and R17 was the residential coordinator in R14's service.

It was felt that the total of 17 respondents was sufficient to address the research topic in a way that captured sufficient constructions on which there was coalescence from various groups of adherents. It was also becoming apparent that further respondents were likely to add little new information.

6.4.2 *Interplay of data collection and analysis*

An outline of issues was used to guide interviews with all respondents (Appendix 1). Transcription of interviews occurred as soon as possible following the interview and before undertaking the subsequent interview. Each transcript, on completion, was analysed for emergent categories and possible themes. If these related to particular issues in the interview outline they were noted and explored during discussion of this

issue in subsequent interviews. Examples of issues arising from this interplay include implications of selection of unqualified staff for time spent by first-line managers on matters related to staffs' formal training, and also for levels of conflict within staff teams. Discussion of these issues with subsequent respondents resulted in the emergence of an important theme which confirmed the critical importance of staff-related issues for the provision of child centred or developmental care. When this theme was considered in the context of the *critical success factors* model, its importance was further confirmed. It consequently shaped a *critical success factor* of residential child and youth care (CSF 1) which was selected for presentation to the group of key informants. Another issue that emerged in the transcript of R1 and was discussed with subsequent respondents illustrated that provision of double cover in some services was an end in itself, more related to compliance than resident protection and is presented in the research as evidence of goal displacement (Blau 1963), commonly found in rigidly configured bureaucratic structures. Further consideration of this in the context of organisation design theory indicated how a prioritisation of bureaucratic goals in a residential youth care service blocked the provision of developmental care for residents. Other factors deemed to relate to bureaucratic rigidity and a prioritisation of the system over the needs of young residents emerged from various transcripts: R12 from the same service as R1 stated that: '*residential care is more driven by the ultimate goal of management, financial control rather the care aspect of it*' (R12). R10, from a different statutory service, felt totally unsupported by senior management and reported that he was not being listened to in relation to frontline care issues: '*I would have written to [line manager]... and I would have told him very forcibly in writing that I was not doing a satisfactory job in either unit ... the letter was received but wasn't commented on*' R10). R11 was also totally disempowered by the lack of response of senior

management: '*it is just having the support, no I don't get support from them [senior management]'* (R11). These issues were considered to reflect bureaucratic rigidity and their emergence was considered to prohibit developmental care at the front line. They emerged as a major research theme and when considered in the context of the *critical success factors* model this theme eventually shaped CSF 5. Another feature of bureaucratic rigidity facilitated a distancing of senior managers from frontline care issues which seemed to contribute to policies that were more system-focused than resident-focused, which is suggestive of a social risk model of care, a model deemed to block provision of developmental care for residents. The interplay of data collection and analysis resulted in emergent themes being transparently grounded in the transcriptions that formed the data set.

6.4.3 *Grounding of findings*

All findings that emerged from the data are grounded in respondents' transcribed interviews. As respondents were asked to comment on and critique the constructions of former respondents, refinement of themes emerged leading to joint constructions based on a level of consensus. An example of this is the importance of first-line managers feeling supported in their role by their line manager (referred to in the study as a director of service). Where first-line managers felt supported they were more confident and flexible in their care of residents. Their responses to residents were more *child*- than *regulation*-focused. Examples from interviews are given here. When R2 was asked if he felt supported in his job, he referred to having fortnightly supervision (which he found supportive), and when describing practice in the unit he said: '*responsibility [for residents] is shared equally ... we [staff team] are all in tune with all the kids*' (R2). This contrasts with R1, who had supervision twice in the last year and in response to a

question on whether he felt supported he replied: '*Not particularly, at the moment*' (R1). He went on to say: '*It is very rare that I talk to my line manager anyway and that is a difficulty really because he would have very little idea really how I do my job because he hasn't seen me do it*' (R1). Again when this theme (support for first-line managers) was considered in the context of the entire data set, it emerged as a theme impacting the quality of residential child and youth care.

6.4.4 *Emergent design*

As already discussed, purposive sampling with a maximum variation focus resulted in an emerging design as the researcher sought to establish connections between positions. At the outset of making the hermeneutic circle the aim was to uncover as many different constructions as possible; scope was the focus of the research activity. This was achieved by asking R1 to nominate a manager who was known to think very differently about issues. R2's interview resulted in a very different account of practice in a unit in the same service as R1. R3 (who was nominated by R2) described a very different service to that in which the first two respondents worked. He was the director of a major voluntary service.

At this stage, with data analysis occurring between interviews, issues began to emerge that seemed to have particular importance to the topic. Examples of such issues were a tolerance for unqualified staff, especially if these were from the local area in which the residential unit was located, versus an insistence on recruitment of qualified staff only, even for relief panels; a readiness to focus on clients' future placement needs only, in one unit, while needs were individualised and addressed in the other units; rosters were primarily staff focused in one unit, while in the other two units, rosters were structured

to include particular levels of staff on shift at any given time, ensuring that less experienced staff were always on duty with senior and experienced staff. The emergence of these constructions caused the researcher to interview first-line managers' own line managers in a search for more understanding of emerging constructions and any level of consensus that might exist.

The research design emerged in this way. There was almost total reliance on a nomination method of sampling. Only two respondents were chosen through convenience sampling. The first one, as already mentioned, was the director of an earlier respondent and it was thought he could have a significant contribution to make to the research topic. He was available, but in poor health, and he was asked to participate at an early stage in case his health might further deteriorate. He became respondent 4. The second respondent chosen through convenience or deviant sampling was R 10. It was decided to seek constructions from managers across voluntary and statutory services and across the four geographic regions of the Health Service Executive (HSE). At the outset of the data collection phase, the researcher did not know who the respondents were going to be or in what sequence they would be interviewed. The constructions that emerged were based on the lived experiences of the respondents as interpreted by the researcher through the use of narrative interviews and ongoing consideration of reflexivity factors.

6.5 Narrative interviews

This study used an interview outline (Appendix 1) as a prompt for the researcher but, as the transcripts indicate, the flow of interviews was as much determined by the interviewee as by the interviewer. A traditional method of interviewing was deemed to

be inadequate to the study of how individuals 'perceive, organise, give meaning to, and express their understandings of their experiences and their [work] worlds' (Mishler 1991: ix).

My prior understanding of residential child and youth care work made it clear to me that new, salient understanding could only emerge from this inquiry by empowering my respondents to respond to me as someone with personal qualities and views similar to others in their worlds. I tried to be constantly attentive to the fit between my interpretations and my respondents' understanding or constructions. I accepted my interviewees as collaborators or 'participants in the development of the study and in the analysis and interpretation of the data' (Mishler 1991: 126). As respondents engaged in the process of trying to answer questions in a 'coherent, relevant, and meaningful way' (Mishler 1991: 138), their accounts resembled narratives or stories.

6.6 Key Informants

As a further member check, confirmability was sought through presentation of a preliminary list of seven critical success factors (Appendix 5) to a carefully selected group of Key Informants from the Irish child welfare sector. This decision was taken following the first completion of the hermeneutic circle, when all transcripts were analysed individually and then considered as a whole data set. The dialectic process of looking at parts in terms of the whole helped to pull out the particular themes of the research data. When these themes were considered in the context of the *critical success factors* model (discussed in Chapter Three), they shaped a preliminary list of seven critical success factors (Appendix 5), considered necessary for the provision of developmental care for young residents. These critical success factors were prepared

for presentation to a group of carefully selected key informants. Eight key informants were invited to participate and consisted of five senior, experienced practitioners and managers from the Irish child welfare sector, including a senior inspector from the social service inspectorate (SSI); another was a colleague engaged in related research at the University of Edinburgh, and both supervisors who were guiding the research project also attended, with one supervisor taking responsibility for chairing the session.

The list of seven critical success factors directly reflecting the research themes and relating to three levels of service (Leidecker and Bruno 1984) was circulated to the Key Informants (Appendix 5). They were asked to comment on each critical success factor as to its relevance to provision of developmental care in Irish residential youth care. The discussion that ensued was tape recorded, transcribed, coded and analysed, again aided by the use of HyperResearch. This resulted in a second data set. No success factor was dismissed by the group of key informants, but analysis of their comments (Appendix 4), when considered in the context of the original data set further clarified the significance of particular success factors. Consideration of these factors in the context of the literature presented in Chapters One and Two resulted in further distillation of the initial factors, and selection of a final list of five *critical success factors* which are presented in Chapter Eight and are considered necessary for provision of developmental care for young residents in the Irish care system.

6.7 Conclusion

This chapter presents the decision trail of the research process (Whitehead 2004). It describes systematic qualitative analysis which was guided by a constructivist perspective and a hermeneutic methodology and aided by computer analysis through the

use of HyperResearch. Understanding emerged in a circular, dialectical fashion through the use of projection and validation, elements of the hermeneutic circle. The final list of *critical success factors* emerged from the themes of content analysis of the transcripts of research respondents; consideration of these through the lens of a selected *critical success factor* model (Leidecker and Bruno 1984) to elicit a preliminary set of *critical success factors*; presentation of these *success factors* to a group of key informants; and further refinement of the *critical success factors* through content analysis of the transcript of the group of key informants which yielded the final list of *critical success factors* presented in Chapter Eight. The next chapter presents the findings that emerged from all 17 respondents of the study, who represented eight residential youth care services.

CHAPTER SEVEN:

FINDINGS FROM RESEARCH RESPONDENTS' TRANSCRIPTS

7.1 Introduction

The purposive sampling used in this research yielded 17 respondents whose interview transcripts comprise the research data set. The 17 respondents worked in eight discrete residential care services across Ireland. These included five statutory services, directly managed by the Health Service Executive (HSE) and three voluntary services, funded by the HSE but managed by voluntary organisations.

This chapter will describe each respondent's transcribed interview and will group together respondents who belong to particular residential care services. Contingent and serial selection of respondents facilitated the analysis process which was ongoing during the entire data collection phase, continuously moving from discovery to selection of topics from transcriptions for verification by subsequent respondents (Guba 1981). Maximum variation sampling of early respondents quickly led to the emergence of significant categories which were used in the content analysis of all transcripts. Examples of such categories are: 'care-related issues', 'staff-related issues', 'line management support for first-line managers'. All respondents' transcripts are discussed under these headings, with minor adjustment in the final category for transcripts of senior managers whose line managers varied depending on the structure of the service.

The themes that emerged from each service are listed. Each service is summarised and categorised as operating from a developmental model of care (evidenced by a focus on

needs-led care for residents) or a social risk model (evidenced by a prioritisation of the service over the needs of residents).

7.2 Service 1

Respondents 1, 12 and 16 belong to this statutory service, their transcripts are discussed separately and in numerical order. The categories listed above, which emerged from serial selection, are used in the content analysis presentation. Discussion of categories across all three respondents' transcripts illuminated Service 1 themes. All categories and issues are supported by direct quotes from research transcripts. For purposes of confidentiality the male gender is used when discussing all research respondents.

7.2.1 *Respondent 1 (R1)*

R1 managed a short-term statutory residential unit which was part of a large homeless service. He had eight years management experience at time of interview. The unit provided care for 15-17 year old, mixed gender, homeless young people.

7.2.1.1 <u>Care-related issues</u>

R1 stated that the residents of the homeless service were not given access to support services available to young people in mainstream residential care in the same region of the HSE (senior managed by the same Local Health Officer who is R16). This had implications for quality of care for residents: '*the children here mightn't have those services* [which offer one-to-one interventions] ... *because they are not high profile enough or* [considered] *troubled enough*' (R1).

R1 had recently undertaken a major review of unit policies. He operated a democratic style of management and involved the staff team in this policy review. The staff team had an even balance of male and female staff. The unit was located in a large, old building that was formerly two houses, located near the centre of town. The kitchen was isolated '*in a separate house so you could be accused of anything really or you could do anything either*' (R1). R1 felt both the mixed gendered staff team and the isolated kitchen influenced the staff team's insistence on having a double-cover policy which is rigidly adhered to at all times despite the presenting issues. Best practice in Irish residential youth care (Government of Ireland 2004) promotes double cover[5] as a means of protecting children from any possible abuse from staff. Members of R1's staff team were acutely concerned about any possible allegations of abuse being made against them.

While R1 had done his utmost to address daytime staffing numbers to ensure double cover at all times, it had happened that one staff member might call in sick, another might have to make an urgent visit to a school where a resident was facing suspension—factors which could leave only one staff member in the unit for a limited time period. Should a resident arrive back to the unit unexpectedly while there was only one staff present, the policy was that the staff could not let that resident into the unit until another staff arrived. This had resulted in children, who may have returned due to illness, having to wait outside the front door until a second member of staff arrived. The manager found the rigid application of this double cover policy very difficult: '*it is something I have struggled with here because I remember* [the staff] *who pushed and pushed until we rigidly said yes we would rigidly stick to this at all costs ... if it is raining outside and it is winter time and you could have a kid with asthma sitting on the*

[5] Requires having a minimum of two staff present at all times when in the company of residents.

steps' (R1). Such rigid application of this policy could be deemed more abusive in the keeping than in the breaking!

7.2.1.1.1 Lack of practice-led strategic planning at service level

A change of function was introduced in R1's unit two years prior to the interview (2002). This followed the recommendation of an independent review group set up to look at the homeless service in the particular region (still part of the former health board structure at the time). It was promised that the different function would be evaluated within 12 months but this hadn't happened more than two years after what R1 described as '*a complete change'*. The unit closed one morning and opened as a new service catering for 15-17 year old homeless young people that evening and '*nobody ever asked at a senior* [management] *level, there was no discussion* [of] *how do you think you are going to manage the transition, what do you think the issues are ... at a senior level it was never anticipated*' (R1). This manager viewed this as an example of what happens when service strategy is service-led, not practice-led. It results in decisions being taken at a senior management (or exosystem) level that may not enhance the quality of care being provided at the frontline (or microsystem) level.

Such decisions are not rectified in this service as they are neither monitored nor evaluated. '*The lack of strategic management is very common* [in this service] *and if you have the tendency to get on with it you could get away with murder really'* (R1). Units are isolated in this service, there is no development by senior management of a service mentality, of a common ethos or approach to practice: '*that's where it goes back to strategy and somebody driving it ... you need someone at a higher level driving everything forward*' (R1). This highlights implications for frontline practice and relates

to organisational issues in the service which will be discussed when summarising themes that emerged from the three transcripts collected from this service. Here, the focus moves to staff-related issues.

7.2.1.2 Staff-related issues

Initial analysis of R1's transcript had nine codes relating to staffing and recruitment issues in the unit including:

- selection of unqualified candidates, in particular unqualified staff from the local community;
- a probation period that is only used systematically with permanent staff, not with relief staff who may, and often do, become full time employed;
- a major portion of R1's overall time is spent on staff related issues;
- there is a practice in the service whereby staff who have permanent status but are deemed by first-line managers to be unsuited to work with vulnerable children in the residential service, are transferred around various units in the service because human resources (HR) has no procedure for getting rid of permanent staff who are deemed unsuitable.

These issues are discussed in some greater detail below.

7.2.1.2.1 Unqualified staff

'*We have still several untrained staff*' (R1). In common with most of the statutory services in the research sample, this Service had been recruiting temporary, relief staff at a local level. Such staff were recruited typically through word of mouth or through notices placed in other units in the service advertising the need for temporary staff. Those who responded were shortlisted and interviewed by two first-line managers and

occasionally, but not always, by a principal social worker who line-managed first-line residential managers. Candidates selected for relief work in this service were not required to have a professional qualification or equivalent, but were required to submit three references and be garda vetted before being appointed. Satisfactory candidates were then placed on a relief panel and could be called on to work particular shifts, so they worked on quite a casual basis initially. However, '*if a line* [position] *becomes available on the rota, someone resigns or takes a career break then you can slot them* [relief staff] *in and that is how* [unqualified] *people get in*' (R1).

Irish law now gives permanency status to workers who are temporarily employed for a continuous period of three years (Government of Ireland 2003). Most of the services represented in the data set only interviewed qualified staff for temporary positions. Others sometimes selected unqualified staff but used the probationary period to ensure that only those deemed suited to the residential youth care task had their part-time contracts renewed, and ongoing progression to permanency status was conditional on unqualified staff contracting to undertake professional training. In a minority of services in the data set there was no systematic use of the probationary period to ensure suitability for the care task or to gain an undertaking from staff of their commitment to pursue professional training as a condition of appointment to permanent status. R1's service was one of those services, which could also relate to other staff related factors which will be further discussed.

7.2.1.2.2 <u>Staff from the local community</u>

R1 had three staff who came from the community in which the unit was located. All of them were untrained, but R1 considered them a valuable addition to his staff team: '*they*

are natural youth workers as they are, but they can [also] *work in a residential setting ... we did try to target that* [recruitment of local staff]' (R1). Their presence on the team sometimes caused tension... '*because the value of work can be very different ... they can think we are being very soft in our approach ... but their objectivity can be a bit skewed at times ... issues* [of the residents] *may be very personal to their own experience ... kids taking drugs ... people from a marginalised community are exposed to a lot of that within their own family and social circle... because they have real experience of addiction within the family or friends ... so that is a big struggle on our team'* ... (R1). These issues take an inordinate amount of R1's total time in the unit. '*Team dynamics would be something, a huge amount of time trying to empower people to address issues with other people ... every day ... a lot of time ... supervision is a great way of doing that*' (R1).

But R1 saw these staff as positive role models for the residents; they were able to say to residents: "*look at me, I don't have a Leaving Certificate but I've got a good job, I'm a child care worker ... because of the choices I made I've got ... a good standard of living*" (R1). R1 acknowledged that they would need formal professional training if they hoped to advance in their chosen career of social care. R1 spent a lot of his working time on training-related tasks. Because of the local staffs' lack of formal education R1sought out training courses more suited to their level of education. He released some of these staff to pursue literacy studies in preparation for third level training '*it is very hard to match some people's training needs' it's about building up skills really ... if we are encouraging people to go back to college ... unless they have done those pieces* [literacy and computer classes] *they are not going to get through the first year in*

college' (R1). He continued: '*they have great gifts and* [training] *can only enhance their gifts'* (R1).

R1 had responsibility for formal supervision of the entire staff team which also made large demands of his time. He had a team facilitator which helped with the discussion and (sometimes) resolution of practice-related issues, but the major tensions in this staff team had resulted in R1 accepting, in the interests of staff cohesion, a policy whose purpose was more staff protection than child protection—as was discussed above in terms of the double cover policy. '*Most of the* [staff] *issues can be resolved or kept a lid on might be a more appropriate answer to that*' (R1). Another issue in the team related to appropriate physical touch as a means of expressing affection for residents: '*this team would be very torn about ... you know some people would not hug a child ... and other people would be comfortable* ... [some people] *have such issues with* [touch] ... *they are not huggy people, if you put your hand on their shoulder they would nearly flinch so it's maybe their own personal issues as well ... that sort of person may have difficulty discussing issues with young people around sexual health or sexuality ... they are very closed they might be a little judgemental and with teenagers obviously you don't want to condone or promote any particular lifestyle but we have to be open to* [where the residents are at]' (R1).

These are all serious issues that impact the quality of frontline care. They point to the need for development of an ethos and value system that respect residents, and facilitate engagement in work with residents that prepares them for future happy lives. This service was also impacted by another serious staff related issue, that of failure to deal appropriately with unsuitable staff.

7.2.1.2.3 Unsuitable staff

Recruitment of part-time temporary staff in R1's service has already been discussed. All temporary staff were appointed on probation, but how probation was used with temporary staff was not monitored by senior management in R1's Service. R1 was himself focused on the purposive use of probationary periods of newly appointed temporary staff and ensured that any staff who proved unsuited to the care task would have their temporary contracts discontinued '*if there are any difficulties during the probationary period it shouldn't be a shock to anyone at the end of the twelve months that they are not passing their probation*' (R1). However, due to lack of monitoring of the use of probationary periods across this service, other units did not use probationary periods to terminate the temporary contracts of staff not suited to the residential care task. This resulted in some temporary staff getting through the probationary period to permanent status despite being unsuited to the social care task and having made no commitment to pursue professional training.

Once staff achieved permanent status in statutory services they were protected by human resources (HR) policies which supported the rights of permanent staff. Staff that were not suited to residential youth care work often created difficulties within frontline staff teams. When these difficulties proved uncomfortable for such staff they requested a transfer from HR to a different unit and HR: '*say that these people have to go somewhere, they contact our* [senior manager] *and ask if they have any vacancies and then if you do* [these unsuitable staff can be imposed on you] ... *we have inherited* [such staff] *with issues ... that can cause difficulties … there would be people whose practice you would really question and whose style you'd really question and to move them to*

another unit is very damaging to the children and also to the team. It's bad enough to have one team messed up, but to go then and mess up another team and another group of kids' (R1).

7.2.1.3 Absence of line management support for first-line manager

R1 acknowledged that a shortage of staff at his line manager level contributed to his lack of line management support. He saw other units in the service being prioritised by the present line manager. He related this to himself not making demands of the line manager: '*I wouldn't be demanding, I sometimes feel the staff team suffer because of that ... because we don't shout and roar* [like other unit teams] ... *because* [he doesn't shout] *I worry that maybe I don't get as much* [support] *for the team*' He saw his line manager as being mostly focused on beds being full in the unit: '*once the place is running effectively, that he is not hearing much about it, that beds are full and there are no major dramas or crises.*' He referred to residential care as being generalised: '*in residential* [care] *we are inclined to work more with kids, as I say here the herd mentality ... "we can't do that* [with a particular resident] *because the other kids might not like it*"[6] (R 1). Residents in the homeless service had no care plans: '*there are no care plans, statutory reviews are not happening either'* (R1), which contravenes prevailing standards (Government of Ireland 2004), and residents of the service often had no allocated social worker: '*the kids don't have allocated social workers and if you are a sixteen or seventeen year old kid who is homeless you are not going to get a social worker*' (R1).

The homeless service was primarily focused on discharge arrangements (R1's unit was meant to be strictly short-term). The manager was powerless to impact discharge

[6] This refers to comments from the staff team as quoted by R1, and indicates generalised care.

arrangements: '*I mightn't think it is appropriate where they* [residents] *are going to end up but because there is nowhere else ... they are going to have to go into another short term unit which is not in their best interest*'(R1). The quality of care offered at frontline was not monitored by senior management: '*we are not asked about the quality of care really ... the care piece; there wouldn't be major concerns at a senior* [management] *level'* (R1). Communication between units in the service (which could be a source of support for the manager and staff) was not good: '*Communication is a big issue, if there was a proper* [service] *structure ... the units do not have internet which would be an easy way of flashing things around* [between units]'. R1's line manager had no idea how he worked: '*he wouldn't know* [how I work] *because he is never here, he has never been here'* (R1). When asked how often he saw his line manager he replied: '*I have had supervision twice in the last year*' He felt unsupported in decisions he took in relation to the residents '*decisions aren't made easily ... the lack of understanding is difficult, it is not that you would want them* [senior management] *here every day of the week ... it* [the service] *is about efficiency*' (R1). R1 was experiencing very little support from senior line management of the service as he tried to offer effective care to his homeless residents.

7.2.1.4 <u>Discussion</u>

There was a sense of R1 wishing to provide needs-led care, but service-led issues took priority. This assessment was based on his acceptance of issues such as rigid application of a double cover policy that did not protect children in particular situations. Rigid use of double cover on this staff team suggested that the staff felt vulnerable and fearful that they would not be supported by the service in the case of an inaccurate or ungrounded allegation of abuse by a resident. Such a fear could dominate in a service where a blame

culture prevailed. It could cause staff to prioritise their own protection over that of residents.

Other issues that emerged from R1's narrative suggested the presence of a social risk model of care: the absence of a commonly held value system among the staff team to guide needs-led practice; reference to the absence of a practice-led strategy driving child-centred policies in the service; no monitoring of critical processes like the probation period of temporary staff. Many of these issues highlighted that senior management in the statutory service were more focused on value-for-money issues than on the development and support of service processes that ensured delivery of developmental care for residents as mandated by the Child Care Act 1991.

To further confirm the issues that emerged from R1's transcript his line manager was invited to participate in the study. This line manager became R12, whose transcript will now be explored for its key issues.

7.2.2 *Respondent 12 (R12)*

He was acting director of the homeless service, with line management responsibility for an out-of-hours fieldwork service, and for three statutory residential units in the homeless service (referred to as units A, B and C), one of which (unit A) was first line-managed by R1. R12 had responsibility for co-ordination of the entire homeless service across a large geographic area of the HSE which comprised six residential units in all, three statutory and three voluntary. He did not line-manage the voluntary units (one of these voluntary units, Unit D, is represented as Service 2, in the data set and is yet to be discussed).

7.2.2.1 Care-related issues

Since R1 had many difficulties with frontline practice issues in his unit, R12 was asked about his view of such issues in the service. While a tiering model[7] was imposed on the residential units of the homeless service following a review by outside consultants in 2002, R12 believed that the system did not work, but no steps have been taken to adjust the system. '*Part of the tiering is long term* [care] *and we don't do long term, this means the model should be spread across other agencies ... the model itself doesn't really work*' (R12). He went on to say that '*maybe through-put is a measure of success* [of frontline care]' (R12). This suggested system-led rather than needs-led care. Use of this tiering model of care across the homeless service resulted in a well functioning voluntary service which was providing medium term care for young homeless women (Service 2 of the data set) being asked to change its function and become associated with the statutory homeless service which was directed by R12 and senior managed by R16. The change of function for Service 2 is discussed later, but it is mentioned here to show that while R12 accepted that Service 2 was a successful service prior to its change of function ('*they certainly were doing a wonderful job, they were very, very successful in my view'* (R12)); he was caught in the middle between recognising the success of a particular service in provision of needs-led care for residents and acknowledging '*the need to rationalise the use of residential care which is a very expensive resource'* (R12). This suggested the prioritisation of the service over the needs of residents (confirmation of a social risk model of care). R12 referred to the importance of

[7] A model that accepted newly homeless youth into short term, inner city units, so that they could be fully assessed and moved on within six months to a placement more suited to their needs, which could be to return home, medium term residential care placement, supported lodgings, or specialised foster care placement.

providing a homely welcoming unit for children, but while he acknowledged that some first-line managers did not achieve this for residents in the homeless service, he did not see it as his responsibility to ensure that the first-line managers who reported to him provided child-centred care for residents. '*My role is to try to get managers operating ... where we have a situation where children are welcomed, treated like human beings ... it is not going to happen in one day*' (R12). Provision of child-centred care was everybody's responsibility but no-one ensured it happened in this service. There was a sense that this senior manager felt it was impossible to provide needs-led care for the young people in the homeless service whose behaviour was most challenging. He did not empower his first-line managers to provide developmental care but this could be related to his own sense of powerlessness in this service.

7.2.2.2 <u>Staff-related issues</u>

It was already noted that R12 line-managed three statutory residential units which were part of the homeless service, and an out-of-hours social work service also attached to the homeless service. There was a notable difference between how he line-managed the field social work and residential services. In the fieldwork service he delegated responsibility to his team leader (similar level to the first-line manager in the residential service) '*make your decision and we can come to look at it but I will support your best clinical judgement ... they* [team leaders] *get the authority*' (R12). This showed that R12 was comfortable with his authority in the context of the fieldwork service (reflecting his own social work background), but he felt undermined by his line manager (LHO) when it came to practice issues in the residential homeless service. This related to an acceptance of an historical view of residential care: '*the view of* [residential] *child care workers in terms of their status has long been child minders ...* [you have] *a battle to*

move yourselves from that position, from not having authority attached to your decision' (R12). When this comment was considered in the light of other comments "*from a pure management point of view and the implementation of policy ... it has been proven that this is the best way to move forward ... I want you to go and implement that"*(this was how a directive was issued to R12 by R16, his line manager) ... *'I can see it from both sides ... you have individual kids with individual needs, we have a much broader agenda in relation to resource allocation, we spend forty million on residential care ... it is brought down to a numbers issue ... it is a political issue as well ... they* [senior management] *are very closely in touch with what is happening with kids in residential care, with what is being spent and that'* (R12).

These extracts helped us to understand the pressures being experienced by R12 in relation to his line management of the residential homeless service. They showed that he lacked a clear vision of what residential care was about, and that as director of the residential service he felt obliged to be guided by the 'broader agenda' or the management agenda.

7.2.2.3 <u>Disempowerment of director of service</u>

R12 had on occasions tried to support first-line managers on particular issues but he found that his own line manager, the local health officer (LHO) for the geographic area of the HSE and most senior manager in charge of residential services, did not support him. He said the LHO's office co-ordinates the residential service. When R12, guided by his professional judgement, tried to support an alternative care manager who reported to him on an issue of care, he was told by the LHO to abandon his supportive stance and to carry out the directive of his line manager (the LHO). R12 said

professional judgement was not respected in social services in the HSE '*it doesn't work that way in the* [HSE], *it never did'* ... and he had '*questions of suspension raised, so it is a power issue*' (R12). Such treatment totally disempowered a director of service and went some way to explain, though not to justify, how R12 was unable to influence frontline practice in the residential units for which he had line management responsibility. Disempowerment has led R12 to look up the line for his guidance and to be blind to serious practice issues on the front line. This explained R12's inability to support or guide R1 in the provision of needs-led care, since he was guided by his line manager's view which is primarily focused on efficient use of resources. Further evidence of this was reflected in his comments about this service: '*I look at kids and see the continuity is gone, all the focus is the new management approach to it and we follow on ... what is actually missing is the relationship ... nobody is looking at the inner world of the child*' (R12).

7.2.2.4 Discussion

Three important factors that emerged from R12's transcript that negatively impacted provision of developmental care for young residents in his service were recognised as themes that suggested the presence of a social risk model of care:

1. Very senior managers in the HSE (at LHO level) micro managed residential care in this service '[senior management] *are very closely in touch with what is happening with kids in residential care, with what is being spent'* (R12). This is related to its big budget (€40 million as stated by R12) and the desire of senior management to achieve an efficient use of resources.
2. R12 referred specifically to an historical view of residential care in Ireland which was seen as purely childminding. This view dismissed residential youth

care as a discrete area of professional practice and so made it easier for senior managers from administrative backgrounds to undermine the professional judgement of frontline residential care practitioners and first-line management levels. This created a gap between senior and first-line management levels in a residential service,

3. Confusion in relation to the purpose of residential care at director of service level contributed to a prioritisation of the needs of the service over the needs of the residents (social risk model of care).

All three factors have implications for the organisation design of residential youth care services within the HSE. Their emergence in the transcript of R12 led to a decision to interview the LHO of this service who became R16.

7.2.3 *Respondent 16 (R16)*

This respondent was appointed as assistant chief executive (ACE) in the former health board structure and held the position of local health officer (LHO) in the recently established HSE structure. He had full operational responsibility for all social services in a particular geographic region of the HSE. The HSE followed '*an existing level of service'* [approach] (R16) so its establishment in 2005 did not result in any major changes to established services at that time.

7.2.3.1 <u>Care-related issues</u>

When R16 originally took up office as ACE he inherited a major residential service in disarray '*it wasn't very efficient, it certainly wasn't very effective ... like everything else it has to be managed'* (R16). He worked quickly to improve levels of compliance in the service: '*issues around lack of care plans ... basic guidelines that must be adhered to ...*

that quality assurance piece' (R16). He set up a residential placement committee to oversee all admissions to and discharges from the residential service. This committee which was comprised of senior professionals from both field and residential services was chaired by a senior administrator who reported directly to R16. This consolidated authority at senior administrative management level. The residential placement committee: '*is rocky but as I said it does bring order to* [the residential service], *it does mean the prerequisites, the care plan, reviews, all that stuff, your paper work, everything has to be done, it is quality assured ... we can't be all things to all people, kids coming into care, a few basics, the regulations*' (R16).

When asked for his view on the critical success factors necessary for provision of effective care for young residents, R16 had many interesting views. He mentioned the need for a '*policy around residential child and youth work, having some plan ... you need a workforce ... people who are skilled and we continue to up-skill them to do the job that is required of them ... to be flexible ... it is not just one size fits all ... having a continuum where you can move someone in and out ... managers to manage that ... a whole range of behaviour management supports, other experts that might be needed to help* [staff] *do that ... they are the few key things ... it is as you would want yourself for your own kids, that's the approach that I would be seeking*' (R16). When asked about success indicators he went on to say '*there is the general governance issues, the Standards ... that piece has to be done ... if you are up to the mark on them you are doing fairly well ... you want good outcomes, kids who are happy ... to achieve whatever their potential might be ... staff happy enough and comfortable that they can do the job that is asked of them ... if kids could be happy in themselves, just as normal as can be and that we support them on that'* (R16).

When further asked about the processes necessary to meet the indicators, he expressed some concern about measurement of outcomes: '*we are not great on outcomes and measuring them ... we don't systematically collect data, measure data ... the care plan that we have at the moment could be changed, maybe there is another piece that is needed to do some assessment as to what we are achieving ... we need to adapt our approach depending on how the kid might be presenting. It is an area we are not great on I feel ... but we* [must consider] *what is possible to achieve ... it mightn't be a lot when measured against what we want for our own kids but it might be as much as can possibly be achieved ... we have to do what we have to do and the Standards are great, if we comply with them we are doing well*' (R16).

7.2.3.2 <u>Staff-related issues</u>

R16 was primarily focused on the system and made some significant changes: '*we looked at how we might manage the residential care sector ... it was so big ... there were hundreds of issues ... we weren't meeting any sort of standard with it ... it was all over the place in the extreme ... we decided to take that piece* [residential care] *away from the principal social workers and bring in a manager* [an alternative care manager] *who would support the system'* (R16). The alternative care manager was at the same level as a principal social worker. This decision separated residential care from the fieldwork service and was also seen as providing a better career path for first-line residential managers '*now you have someone in residential care who can actually support unit managers, support the practice in what we are trying to do*' (R16). There was no doubt that R16 improved the shape of the large residential care service that he senior

managed, there was a sense of him wanting to do things right but to achieve this in a complex residential service it is essential to do the right things right (Galbraith 1977).

7.2.3.2.1 Emergence of the above factors suggested:

1. R16 was focused on developing a system that provided care that complied with the Standards (Government of Ireland 2004) but not one that was sufficiently flexible to provide personalised, needs-led care for young residents.
2. There was confirmation that the traditional view of residential care mentioned by R12 prevailed in this service, and created a gap between first-line and senior management levels.
3. R16 micro managed the residential service, so his prioritisation of the system was most likely to filter down through the levels of management in this service and it was one explanation for why frontline practitioners were focused on compliant care, on sticking rigidly to a double cover policy which was more about their own protection in a strongly compliant service than protection of vulnerable residents.

7.2.3.3 The homeless service

R16 had full operational responsibility for the homeless service to which Rs 1 and 12 belonged. '[Homelessness] *is still a huge issue ... there are a huge lot of interests in that service, it is a hugely political type of service'* (R16). He was not fully convinced that the recommendations of the review body to establish a tiering model with short term residential units in the city centre, was the best way to go but he agreed to give it a try. He was then: '*working up a piece based on the experience of what has happened how we might provide a service and it is certainly within a view that it will be more localised*

... when kids get into the homeless service, the emergency central service ... there can be huge difficulties in getting them back to their local areas ... so if we have to set something up out in the areas, in the periphery let's do that' (R16). He said managers at his level [of the HSE] '*are on a like mind in relation to this ... what we are doing cannot be supported* [the new model] *will be under local management as opposed to a separate management in the centre ... there were huge IR issues and I think now over time they sort of go away and there might be more interest now in addressing the issue'* (R16). There was no sense here of R16 involving existing first-line managers of the homeless service in this planning process, which suggested a top/down management style (typical of bureaucratic structures) with little consideration for issues being encountered at the front line. It was as if R16 believed the *system* could solve all frontline issues provided the staff complied with its directives. This did not suggest a system that prioritised staffs' commitment to needs-led care.

When asked about responsibility for ensuring the quality of care in the existing short term units of the residential homeless service, especially in units where the first-line manager might be struggling, R16 replied that this was the responsibility of the alternative care manager. When asked who monitored the alternative care manager (ACM) he replied that the ACM reports to the general manager and the general manager reports to R16, but: '*as regards detail in relation to that it needs to be a bit more systematic, a bit more formalised ... now you are the ACM and this is what you are responsible for, I don't ask you is this what you actually did ... the answer to your question is I'd say we are weak on that, it is missing, you expect people to do what they are supposed to do ... the practice end should be* [measured]... *we are woefully poor around measuring managers'* (R16). This explained how frontline practice was more

system-focused that resident-focused in this homeless service. If ACMs were appointed to keep the *system* moving, to ensure the placement of new admissions and timely discharges of residents in keeping with the aims of the *system*; it was not likely that they would prioritise needs-led practice issues of residents with unit managers. As the old maxim attributed to Drucker (1968) goes 'what gets measured gets done;' if direct needs-led care issues were not being measured at first-line, middle or senior management levels in this service, it is reasonable to assume that needs-led care was not prioritised at the front line in any reliable, predictable way. There was evidence of this service being rigidly monitored at the front line, particularly around discharge issues '*it's mad having to say* [to residents] *at admission where are you going to from here'* (R1); while monitoring of senior management in the system was non-existent. This confirmed the presence of a gap between first-line and senior management with all authority vested at senior management level. This feature is commonly found in rigidly structured bureaucratic structures (Mintzberg 1988) and was seen here to inhibit practice-led policy development in the service.

7.2.4 *Summary of issues emerging from Service 1*

Issues that emerged from first-line manager R1's transcript, including: (a) manager feeling unsupported; (b) unit policies focused on compliance; (c) no practice-led strategic planning at service level; and (d) major staff-related issues, were more clearly understood following analysis of the transcripts of Rs 12 (director of homeless service) and 16 (LHO).

The categories highlighted in R1's transcript captured an informed account of practice in his unit, highlighting factors that impeded him in provision of developmental care for

residents. Failure of the HR department to develop a strategy to get rid of frontline residential staff found to be unsuited to the work was seriously disrupting practice in some residential youth care units of the service. These factors inhibited provision of developmental care and certainly blocked any generative learning (Senge 1990) necessary for managing the complexity of needs-led residential youth care work.

It became clear from the analysis of R12's transcript that he was not focused on his responsibility to support the first-line managers reporting to him, in the provision of developmental care for residents. He was disempowered in his middle management position by his own line manager (R16) and so focused on making the *system* work; on the broader agenda of efficient use of resources.

R16 confirmed that middle and senior managers were not supervised in this service and that 'quality of care' issues were not monitored. R16 (with administrative expertise) took his guidance from other LHOs in the health service executive (HSE) and micro managed the residential service in an effort to achieve best value for money. The evidence that emerged across the levels of this service indicated a rigidly bureaucratic structure with a gap between senior and first-line managers, with all authority located at senior management level. There was no sense of this service being shaped by practice-led issues. By prioritising the system over the developmental care of residents this service was categorised as belonging to a social risk model of care.

7.3 Service 2

This voluntary service was represented by Respondents 2 and 4. Due to its voluntary status, R2, a first-line manager reported to R4 who was the founder-director of the

service. The service was established over thirty years ago to care for homeless young women and evolved into a highly regarded residential service providing medium term placements for troubled girls in the 12-18 year age group. It was located in the same geographic region of the HSE as Service 1. R16, as LHO had responsibility for a major part of Service 2's funding and imposed a change of function on Service 2 to comply with the tiering model of the homeless service which was discussed in the context of Service 1. Rs 2 and 4 from Service 2 were strongly opposed to the tiering model but felt obliged to implement it for a trial period: '*we were told we were slotting in so we said we would try it ... we were told it was a scientific experiment, it was scientifically proven it* [new model] *would work ... it was meant to be reviewed after a year but it hasn't happened yet* [eighteen months later]' (R2).

The imposed change of function had a major impact on the service '*the whole ethos of the house changed, the mindset of the kids changed and the staff ... our staff stay a long time ... you can lose* [stability] *very quickly ... our twelve beds ... have become six month beds at the request of the clearing system of the homeless service ... but we are still striving to do the work we were doing ... we are saying to social workers that it is a 6 month placement but we are also saying that we are not putting* [residents] *out after 6 months*' (R2). Given that R12 was quoted in the context of Service 1 as saying of Service 2 '*they were very, very successful in my view*' (R12), imposition of the change of function suggested that R16 did not recognise the important work being done with residents in Service 2.

However, the voluntary status which gave this service a level of independence, enabled Rs 2 and 4 to ensure that Service 2 remained focused on the needs-led care of residents.

R2's transcript will be presented under the same headings used for presentation of the transcript of R1.

7.3.1 *Respondent 2 (R2)*

R2 was nominated by R1and was the first-line manager of Service 2.

7.3.1.1 Care-related issues

R2 said that respect must prevail in residential child and youth care practice: '*You have to have respect in the house to make it work and that means we respect the kids and they respect us ... we base ourselves on what a good parent would do ... a good parent wants to know where their kids are all the time ... they would demand respect and show them respect*' (R2). This reflected a whole-child approach and there were signs that it worked '*the staff are not assaulted here ... very, very rarely anybody lays a hand on us ... kids do not assault each other either and yet they come from places where it is going on, where kids are restrained ... we had one child who came to us and she was restrained every day of the week* [prior to admission] ... *our policy is not to restrain children here ... we took a chance* [with that child] *and she settled*' (R2). When asked if past residents keep in touch, the response was: '*they come and sleep over and come back for meals and to raid the fridge and that kind of thing*' (R2).

R2 was clear about the residential care task and saw it as his responsibility to lead and support his staff team in delivery of this task. '*We do a lot of work on safe care, on* [residents] *keeping themselves safe ...on relationship building and drugs issues ... and we do a lot of work on bullying*' (R2). All children in this service had a social worker and all had care plans, which was different to R1's unit in the same service. R2 ensured

that he spent time with residents every day he was on duty: '*it depends on what kind of manager you want to be* ... [time] *with the kids or ... doing administrative work ... and I prefer to be with the kids*' (R2).

The director (R4) has taught the staff to share everything: [responsibility for a child] '*is shared equally ... we are all in tune with all the kids*' (R2). There was open communication between all staff '*you're constantly discussing here, it's constant, ongoing ... staff can ring* [R2] *at home at any time ... I always say to people that this is what I'd do if I was there but ... you have to decide now what is going to happen*' (R2). This indicated how staff were supported in their care of residents and they were also empowered to take informed decisions in their provision of child-centred care.

7.3.1.1.1 Double-cover policy

There was a strong commitment to having double cover in this service; it was a factor that shaped the staff roster, so every effort was taken to ensure that it was provided in a reliable, dependable way. In the case of an emergency where a staff had to go to an urgent, unexpected meeting then [as staff]: '*you do what a mother would do, you just take part, take the chance*' (R2). This suggested child-centred care driven by informed decision making, not care that was totally compliance-led.

7.3.1.2 Staff-related issues

R2 spoke most positively about the entire staff team: '*we have lovely staff really ... all decisions* [regarding residents] *are made as a group and* [residents] *are constantly told that* [staff team] *decide together'* (R2). All staff at time of interview had been in post for a minimum of three years so it was a stable staff team.

7.3.1.2.1 Staff supervision

Staff supervision was prioritised in this service '*we might do* [supervision] *formally once a month but we do a lot ... of informal supervision ... lots of discussion ... making sure someone feels ok ... we very much support each other ... especially with new people coming in*' (R2). This service strongly supported new staff when first appointed and ensured that the roster was shaped by having a senior staff on duty at all times. There was a staff team of 11 caring for 12 residents. There were four senior staff on this team: the manager (R2), a deputy manager and two team leaders. This senior team shared staff supervision and met formally every fortnight to '*discuss how supervision is going, anything new we can bring to supervision, if we have a worry about* [a staff] *who mightn't be coping or if somebody needs extra support*' (R2).

7.3.1.2.2 Staff recruitment

All staff appointed to this service were professionally qualified either in child and youth care or in social work; this also applied to all relief staff: '*it just happens that they all have them* [qualifications]' (R2). Selected staff were Garda vetted and obliged to submit three references; they joined as probationary members of the staff team only following satisfactory completion of an induction period, where '*they shadow* [an experienced] *staff for two weeks ... we go through files and policies ... getting to know the place ... they wouldn't have access to kids' files ... they'd have access to daily records but not to social work reports ... they are then rostered always with experienced staff'* (R2). The staff team, therefore, did not have to facilitate colleagues pursuing their professional training and R2's time with staff was focused on their support in their challenging work, not on matching training to staff with various educational backgrounds, as was the case

with R1. Recruitment related issues in the service will be further discussed in the presentation of R4's transcript (R2's line manager).

7.3.1.3 Line management support for first-line manager

R2 was supervised by his line manager, R4. Formal supervision occurred every fortnight but, informal supervision happened '*every day, twice a day*' (R2). R4 was in frail health at time of this interview but he still managed to keep in daily telephone contact with R2. The director (R4) was a constant support to R2 and to the management team of the unit. He took a keen interest in the placement plans of all residents and helped maintain a focus on child-centred care in the unit.

There was a strong sense from this transcript that needs-led care was being provided to residents of the service. This was very different to R1's transcript. While use of maximum variation sampling was expected to throw up differences between units, the difference between the first two transcripts of the data set was striking. Since R2 was line-managed by a different senior manager to R1, I decided to interview R2's line manager to gain better understanding of the factors which shaped this notable difference between two units in the same homeless service. R2's line manager became R4, whose transcript will now be explored.

7.3.2 *Respondent 4 (R4)*

R4 was the founder director of the service in which R2 was unit manager. The aim of the service was reflected in the following statement: '*you cannot put any other criteria before the concrete needs of an individual here and now, if you can meet it*' (R4).

Discussion of R4's transcript is discussed using the same headings as those used with previous respondents.

7.3.2.1 <u>Care-related issues</u>

R4 said that residential care in the particular region of the HSE had become more bureaucratic. He said the bureaucrat's reality was regulations '*if it is not written down it doesn't happen*' (R4). When asked about the key tasks of residential child and youth care, he saw the task as moral formation of residents: '*we are beings who have emotions, feelings, reason, desires, capacity for love ... and these are totally uncharted by nature ... we must all put a shape on them ... if we want* [residents] *to be kind they have to learn kindness, if we want them* [residents] *to care they have to learn care and it has all to be individual*' (R4). This reflected a whole-child approach to care. He went on to say the task was '*to persuade A or B or C to move towards being good in her own way, and in her own way, cope with her specific difficulties; she has a bad temper, we'll say, show her how to integrate that into a creative pattern of life*' (R4). He said '*the tendency is for all* [residential child and youth care staff] *to follow processes, procedures, practices ... which are little more than general rules ... I want staff to make moral judgements; ... rules, regulations are just stop signs but they don't tell you what is the good thing to do here ... the answer to that is partly what is good for the child, what is good for the hostel, and what is good for yourself ... if you ignore those* [three dimensions] *and just apply abstract procedures you are dumping the child into a moral vacuum'* (R4). He continued with further statements that captured his understanding of the residential child and youth care task: '[it] *is to enable* [the child] *to grow, develop and thereby become a happy child because it will be fulfilling its essential needs and will not be chasing phoney needs*' (R4). He said that '*your vision determines your*

behaviour ... if you keep clearly that you are trying to get this child to be a happy child, start off with that and work back from that' (R4). Here we saw reference to how a vision of care facilitated clarity of purpose. These extracts were quite the opposite to those statements about the residential care task quoted from the transcript of R12 above. The difference between the two units was more sharply reflected in the differences between the two senior managers or directors of service. It had to be acknowledged that R4 did not have to formally report to a more senior manager as was the case with R12 (who reported to R16), but R4's clarity of purpose contrasted strongly with R12's apparent confusion in relation to the residential child and youth care task. We saw in discussion of Service 1 that R12's confusion and disempowerment seemed to result in him aligning himself with his own line manager (R16, from an administrative management background), and in him prioritising bureaucratic goals for the residential care service. This was reflected in his lack of support for first-line managers who reported to him and his lack of engagement with frontline practice issues. We will now explore staff related issues in R4's service.

7.3.2.2 <u>Staff-related issues</u>

R4 used to attend all staff meetings for years. When health difficulties prohibited this the staff team visited his house weekly as part of their staff meetings. There was no compulsion on staff to attend the meetings in R4's house but all staff chose to attend. He availed of such opportunities to have a serious, care focused discussion with staff to explore their knowledge base: '*what knowledge claims can you make for working with those kids*' (R4). He saw his role with the staff as being primarily educational: '*you are in fact educating people to think, to judge, to act ... giving them enough understanding of the nature of the knowledge they have ... its limitations ... its total difference from*

rules and regulations, its insight into human nature ... the imaginative capacity to express that yourself and then to others ... your emotions are as important in your cognitive growth as your intellect is ... if we could just remember that we are agents who have capacities but we have to develop those capacities and if we don't we wont have them ... we can be assisted [in these tasks] *by dialogue, by discussion, by argument by reading ... any source of thought*' (R4). R4 used this educational approach with staff to build their confidence and to help them to be needs-focused in their work with residents. He emphasised the '*the diagnostic side of the work. This is the continual, recurring, judgement ... making judgements is a terribly important part* [of the work] ... *knowledge grows only through judgement ... I tell the staff you must pass judgement on those kids every day, you have to have a framework for judgement* ... [staff] *have to be making assessments all the time without allowing* [assessments] *to interfere in any way with* [their] *relationship with* [the resident] ... *then* [staff] *share that* [judgement] *with colleagues at the general meeting when that* [resident] *comes up* [for discussion]. These extracts showed how R4, as director of this service, worked to keep all professional staff focused on child-centred care.

7.3.2.2.1 <u>Ethos of the service</u>

R4 emphasised the importance of ethos: '*it is a community-based activity ... where there is knowledge that has to be acquired from the experienced to the inexperienced ... it is something ... like a set of beliefs that are formed and shaped by a particular community to which that community gives allegiance in a very strong sense and the younger generation are inducted into it in a spontaneous sort of way and it becomes a living, vital, embedded system of beliefs out of which they act'* (R4). Such an understanding of ethos was a strong guiding force in a system. It indicated how important it was that

senior management of a residential child and youth care service aimed to develop and embed an ethos that reflected the mandate of care stated in Irish legislation which is the provision of developmental care for all residents.

7.3.2.2.2 Staff recruitment and selection

Only qualified staff were called for interview '*we are bound to that now*' (R4). He left responsibility for all the statutory requirements to the management team. The interview panel would always consist of the director (R4), the first-line manager (R2) and the director of the statutory homeless service (R12). R4 looked for personal qualities in candidates '*child care demands personal qualities far more than arid intellectual ones* ... [I look for] *a person who is a happy spirit, brings joy into the house ... staff have to have that sensitivity to ideas* [about caring] *whereby they become realities for them* ... [I look for] *staff that have a very clear focus of what they are aiming to do with or about the* [resident]' (R4).

7.3.3 *Summary of issues emerging from Service 2*

Content analysis of the transcripts of the two respondents from Service 2 indicated a service operating from a developmental model of care. This was evidenced by the service ethos which had been embedded by R4 and prioritised respect for residents and for staff. Themes that emerged from the transcripts showed a united, stable staff team fully committed to provision of needs-led care of residents. Recruitment and staff selection practices were directly managed by R4 who had domain expertise and was committed to appointment of qualified staff only. Strong supervision policies supported staff in their challenging work; R4 as service director took an educational role with staff which challenged them to think and empowered them to take informed decisions in the

interests of needs-led care. R4's clarity of the purpose of residential youth care as being the provision of developmental care and his support for staff that used informed decision making resulted in a staff team with no sense of fear or presence of a blame culture.

7.3.4 Factors that differentiated Services 1 and 2:

- R16's satisfaction with a service that complied with existing regulations and standards and his total lack of direct contact with frontline practice in his service versus the clear commitment of R4 to needs-led care and his commitment to embedding this in the service ethos through his regular contact with frontline staff.
- The first-line manager in Service 1 expressed a total lack of support, while the first-line manager in Service 2 reported positive, ongoing support.
- Recruitment of permanent staff was removed from the first-line manager in Service 1 and there was widespread use of taking unqualified relief workers onto the staff rota in preference to having permanent but unsuitable staff imposed from the HR staff panel, whereas in Service 2 there was commitment to the appointment of qualified staff only.
- A disempowered director of service (R12) in Service 1 reported to a senior line manager (R16) who micro managed the residential service due to its major budget and his prioritisation of value-for-money policies. This contrasted with Service 2 which empowered the first-line manager and frontline staff to make informed decisions in relation to residents that prioritised needs-led care.
- The disconnect between senior management and first-line management in Service 1 fed a climate of fear which saw a staff team using compliance with

Standards (Government of Ireland 2004) as a means of prioritising its own protection over that of residents. This compared with an integrated approach in Service 2 where a clearly stated service ethos fostered a commitment at frontline level to needs-led care of residents.

7.4 Service 3

Service 3 was represented by Respondents 3 and 5. It was a voluntary service which belonged to a religious order and was funded by the HSE: '*the responsibility for the centre ultimately rests with the trustees who are four elected sisters of the* [religious] *order ... they appoint a board of management with representatives from the HSE, the local community, the local school, a member of staff ... I am there as secretary ... I also have responsibility to share a vision, dream, expectation of where the organisation is going, how it is to be developed, that as well*' (R3).

7.4.1 *Respondent 3 (R3)*

R3 who was nominated by R2, was the director of this voluntary service which was situated on a campus comprising four residential youth care units. The service was organised as a therapeutic community with commitment to needs-led care of residents.

7.4.1.1 <u>Structure of service</u>

R2 described an integrated service structure: '*The trustees meet with the board of management three times a year, the board of management meets with the director of service* (R3) *a minimum of ten times a year, the managers of the four residential units* [of the service] *meet with the deputy director and myself ... weekly, the child care leaders with responsibility meet the management team on a monthly basis and meet with*

me separately also on a monthly basis and they meet themselves so they get three meetings a month to feed into the management system. Each [residential unit] ... *has a weekly staff team meeting; the high support unit*[8] [of the service] *meets to look at their practice with the child care consultant on a weekly basis and some of the management team sit in on that and we explore how staff practice, good, bad, or indifferent is impacting on what is going on in the unit and that* [now] *happens in all units, they have a session with the child care consultant on a weekly basis* ... [first-line managers] *need to ensure that there is a real relationship, an appropriate relationship between child and staff, between staff and management, between management and the HSE or here with the office*' (R3). This was taken as a description of an integrated service structure. R3 saw his role as '*trying to manage the resources around meeting* [residents'] *needs*' (R3), which was taken as a commitment to needs-led or developmental care of residents.

7.4.1.2 <u>Care-related issues</u>

Every first-line manager in this service was expected '*to ensure that whatever happens in a unit that the child is at the centre of that; if the service isn't child-centred and becomes the child fitting into the system rather that the system being built around the child you are on a highway to nowhere* ... In this service, '*we aim to force the kids into relationships so that they can process them, learn safe models and move on safely into an adult world with the experience of a positive adult/child relationship*' (R3). He went on to say '*the relationship and safety* [of residents] *are the two* [most important] *things for me*' (R3).

[8] High Support is a residential placement which provides an opportunity for additional support via higher staff ratios and higher levels of therapeutic input.

Every resident in this service had a social worker, a care plan and an essential placement plan. '*Every social worker signs up to a contract on* [a resident's] *admission that they will visit on a fortnightly basis, that they* [or a colleague] *will return a phone call* [from the residential service] *within a working day*'. (R3). He said: '*If you want a service which is very expensive, it is no good us doing the work here and you not doing your bit and the child not benefiting because we believe there should be continuity, the social worker should follow the child from high support to state run fostering and should have brought* [the resident] *in ... the child should have some view that social work support is consistent*' (R3).

When it came to frontline staff he encouraged them '*to be looking out for the kids ninety percent of* [their] *time. I would hope* [residents] *are at the centre of absolutely everything that is going on* [in the service]' (R3). This director believed in partnership care to achieve best outcomes for young people '*partnership is around equals ... we can't do the social worker task, we can't do the psychology task, no more than we can expect them to do our task but if we put all the pieces together then there is less chance of failure* [for residents]'. (R3)

7.4.1.2.1 <u>Double cover</u>

There was a minimum of three staff on duty at a given time. Occasionally an emergency could result in one staff only being in the unit; if such a situation arose a staff from one of the other units on campus came over to ensure double cover at all times '*it is about planning that rather than wringing your hands and* [wondering what to do]' (R3).

7.4.1.3 Staff-related issues

The service had no difficulty attracting suitable staff. It had a full staff quota at time of interview '*since 1996 you cannot apply here for a job without the degree or diploma*' (R3) so only qualified staff were appointed to this service.

7.4.1.3.1 Staff recruitment

The service had an annual recruitment drive which involved advertising in the national press, advertising on the FÁS (government re-training and job creation agency) website and R3 did a tour of numerous institutes of technology to place advertisements on college notice boards. They interviewed approximately 60 candidates in all. In the year of interview they selected 20 suitable candidates.

7.4.1.3.2 Selection

Eligible candidates were put through a robust interview process. '*We invite [candidates] to a pre interview day to explain the interview process, what we are looking for, how the service operates. The interview is a three part process: there is a group exercise ... around some aspect of care work ... that they are asked to* [discuss]; *that is followed by writing a reflective piece on the contributions of others in the group* [and] *your own perception of your contribution and how that impacted the group and that is written up immediately afterwards ... so* [those three parts] *and the 300 words you have to write on your application form, form the basis of your interview ... we have agreed five competencies that we want to explore ... we have a therapist or psychologist ... and a four person panel interprets your account'* (R3). The panel took as given the professional qualifications of all candidates and looked specifically for '*a sense of self awareness, openness to personal development and an openness to change'* (R3).

7.4.1.3.3 Induction

Before new staff came on site they had an induction week. This week was the responsibility of a designated senior staff person. The focus of the first two days included an introduction to all service policies, the pay system in use, and the remainder of the induction week involved visiting all the residential units of the service, attendance at a community meeting and observation of practice in the units. When they eventually came on duty, the staff responsible for induction ensured that a particular member of the staff team receiving a new member of staff was designated as the new recruit's ongoing support person in the unit. New staff were appointed to particular units, but it was clearly stated that '*they are employed by the centre not by a particular* [residential unit]' (R3) so they could be moved to different units as staffing levels required.

7.4.1.3.4 Probation period

All staff had a six month probation '*we do the six months probation which we can extend for another six months ... they* [staff] *can fail probation ... one of the biggest issues is resistance to our model* [of care] ... *therapeutic care is the goal* [of the Service] ... *it is psychodynamically based ... if someone comes in and sees the therapeutic model as being soft, that it doesn't make sense, people are undermined or colluding with kids or trying to avoid work, that is not acceptable*' (R3).

7.4.1.3.5 Staff supervision

The service had a supervision hierarchy. '*The deputy director supervises the four unit managers and the therapeutic care manager; the therapeutic care manager also*

receives clinical supervision from the child care consultant ... there is a piece of work done there on supervision as well; the four unit managers supervise their child care leaders ... and the two weakest members of the team; the child care leaders supervise their child care staff' (R3). Supervision '*is not an option'* (R3) it was expected to happen every three weeks, it occasionally slipped to four weeks but '*it is a disciplinary issue if you miss three supervision sessions*' (R3). An outside consultant took a three hour session weekly with every staff team in the service, two hours of which focused on therapeutic work with the residents and the remaining hour focused on staff related issues.

7.4.1.3.6 Rosters

Rosters were structured to facilitate the weekly team sessions with the child care consultant, as well as weekly staff meetings with their first-line managers. These meetings were not optional. Another factor taken into account in rosters was '*that you have a senior staff, experienced staff on* [duty] *with someone learning their trade, you don't end up with three junior staff or three senior staff, one is dangerous and the other is a waste of resources*' (R3).

7.4.1.3.7 Staff supports

Staff were offered individual sessions with an outside counsellor following critical incidents or if they had difficulty understanding what the child care consultant was asking of them in their practice. The service also paid for any medical attention required by staff following a critical incident with a resident; doctor and physiotherapist fees were covered in such rare occasions. '*If you don't look after staff you are on a highway to nowhere*' (R3). All staff were trained in the use of therapeutic crisis intervention

(TCI). Restraints were used with residents when deemed necessary: '*you can't let* [residents] *cut their wrists*' (R3). He saw his job as containing all the anxiety of the centre: '*the ripple effect, the child in the middle; their* [anxieties] *have to be contained by the* [frontline] *staff who need to be contained by the child care leaders, who need to be contained by the* [first-line] *managers who need to be contained by the office here ... I am fairly comfortable with that'* (R3).

7.4.1.3.8 Structural factors

This service was configured as a self contained task structure (Galbraith 1977). R3 was given total autonomy by the trustees and board of management of a voluntary service to co-ordinate the four residential units of the service and to ensure provision of child-centred care for young residents in accordance with the duty of care mandate in the legislation that regulates Irish residential child and youth care. The service was guided by a therapeutic model of care based on a psychodynamic approach which was totally child-centred. R3 had domain expertise and a vision of residential care that enabled him to direct the service with commitment and clarity of purpose. He recognised the importance of committed, skilled and well supported staff teams. He demanded commitment to child-centred care and provided supports that kept staff focused on their young residents' needs.

He protected the service from interference from senior management of the HSE who provided funding for the service. He assured the HSE senior management that he was running a first class, child-centred service. '*For the HSE we are very successful, balance the books ... we rarely have an empty bed ... we operate to fairly high standards and occupancy rates ... we are never in court ... or on the front page of a newspaper ...*

there are never issues going up to the [LHO] for assaulting each other, we get to manage what is here fairly adequately' (R3). He protected the service from a directive from the HSE aimed at cost cutting '*The HSE would like us to close down units when the kids are in school because it would be a saving, but we are not going there*' (R3). It seemed that R3's credibility as a respected director of service helped him to avoid implementation of this decision that could have had a major negative impact on the quality of care being offered in the service.

R3 was critical of the role of the Social Services Inspectorate (SSI), in that he felt the inspectorate has not addressed issues in Ireland that negatively impact the residential child and youth care sector. He said the inspectorate was not using its powers to improve practice in residential care. He saw it as being satisfied with shabby practice, continuing '*I think it hasn't looked at the measurability of* [outcomes], *it has gone for the easy bits* [administrative bits], *it is not good for practice, it is not good for models of care ... they are still letting unqualified staff into the system*' (R3).

There was strong evidence in this transcript of a director of service who knew the right thing to do and had the leadership qualities necessary to ensure provision of developmental care in the service for which he had senior management responsibility. To confirm reliability of R3's account of practice in the service a first-line manager from the service was also interviewed; he was nominated by R3 and became R5.

7.4.2 *Respondent 5 (R5)*

R5 was the first-line manager of the high support unit in R3's service. This unit cared for children in the 6 to 12 year age group who presented with severe attachment related

issues which had caused their parents to feel incapable of providing effective parental care for them. R5 referred to the residents being classified as un-integrated so they clearly needed much focused, therapeutic care. The staff team was strongly supported in the care of these residents by a specialised consultant who helped the staff use Winnicott's model of intervention with these young residents. R5's transcript is presented under the same headings used for other first-line managers.

7.4.2.1 Care-related issues

Every child in the unit had a key worker and '*because the work we do* [with residents] *is within the relationship ... the aim as part of the healing process is that they make a relationship ... with one person and begin to trust that one person and through that relationship we can meet* [residents'] *primary needs*' (R5). He went on to say '*I see that we* [staff of the entire service] *are all on this therapeutic journey ... we use a psychodynamic approach rather than mainly behaviour modification*' (R5) This manager saw his working time broken down roughly as him spending '*20%* [of time] *with children, 10-20%* [of time on] *admin stuff and the rest* [60-70% of time] *would be with staff' (R5).* Residents' needs were prioritised *'the child, always the child* [takes priority]; R5 saw himself *'as* [being] *the middle of the wheel and the communication ... if anything happens and* [staff] *are not there ... I can say this is the way so-and-so is working with the child ... so a lot of my time* [with staff] *is listening'* (R5). The care model in use in this unit (similar to the overall service) was yielding positive outcomes '*we had one child ... she was the third child into the unit, she stayed for five years ... she went to foster parents and she phoned me* [recently] *to say she had had a review and she was going home for good so I think we are doing something right*' (R5). Content

analysis of R5's transcript confirms that the service directed by R3 provides child-centred care for young residents.

7.4.2.2 Staff-related issues

These were discussed in some detail in the analysis of R3's transcript above, from the same service.

7.4.2.3 Line management support for first-line manager

When asked about his supports as a manager in this service R5 expressed feeling very supported. He reported to the therapeutic care manager (who is in charge of clinical supervision in the service), and he also got support from the deputy director and the director (R3); '*I tend to go into the* [director's] *office ... the three desks are in the one office so when I go in I'm supported by the three of them ... I see it as an open door policy ... I feel the relationship that I have* [with all three staff in the head office] *I would see as being very supportive*' (R5).

7.4.3 *Discussion*

Content analysis of the transcripts of respondents 3 and 5 confirms an emerging theme from this study that the organisation design of a residential child and youth care service has major implications for its ability to provide developmental or child-centred care for residents. This service is structured differently to both previous services, where Service 1 was configured as a bureaucratic structure with a LHO who tightly controlled the residential service in his region of the HSE, but was guided by bureaucratic aims which sought regulation-led care of residents and best value for money; Service 2 was configured as a simple structure (Mintzberg 1988) with a director who prioritised needs-

led care and succeeded in embedding this ethos in the service and protecting his voluntary service from some of the bureaucratic goals of the LHO which directly impacted Service 1; and Service 3 which is now seen as configured as a self-contained task structure (Galbraith 1977) with a director who has both domain expertise and authority and whose vision of residential care is one based on partnership to achieve needs-led care for young residents. The simple structure and the self-contained task structure have characteristics in common; one is more commonly found in a smaller service, while the other is suited to larger more complex organisations. Both authorise a selected senior manager (at director of service level) to take responsibility for all operational decisions of the service. Clearly the success of the service depends on the calibre of that senior manager. Provision of developmental care in a service configured as either a simple structure (Mintzberg 1988) or a self-contained task structure (Galbraith 1977) requires a senior manager with authority and domain expertise (Drucker 1968). He must be a competent manager/director who has a vision for the service and leadership skills to motivate, support and lead staff teams in the provision of developmental care. The data suggest that either structure of organisation design can ensure the provision of developmental care, but the self-contained task structure is one that could ensure the provision of developmental care in statutory services provided by the HSE, which is a large organisation. Respondents 3 and 4, who had full authority, have shown evidence of domain expertise which gave them a clear understanding of developmental care and an ability to lead residential services in provision of developmental care in the two services they line-managed.

7.4.4 *Summary of issues emerging from Service 3*

Content analysis of the transcripts of Rs 3 and 5 from this service locates the service in a developmental model of care. R3 leads a service about which he states '*I would hope* [residents] *are at the centre of absolutely everything that is going on* [in the service]' (R3). His transcript refers to factors that are now emerging as being essential for provision of developmental care such as:

1. strong recognition of the mandate of care enshrined in Irish legislation and leadership ability which provided protection of the service from bureaucratic decisions taken at senior management level of the HSE;
2. a strongly supported, respected and integrated staff team from frontline to first-line and senior management levels;
3. robust staff recruitment, selection, induction and probation processes managed by staff with domain expertise and authority;
4. mandatory supervision for staff,
5. ongoing support of staff in their focused use of a child-centred model of care.

7.5 Service 4

This service was represented by respondents 6, 7 and 13. All three respondents were attached to a statutory residential service directly managed by the HSE. Rs 6 and 7 were first-line managers of high support units in the service but R7's unit had only recently been re-designated a short-term high support unit and was the only short term high support unit in the data set. R13 was a director of service who line-managed both Rs 6 and 7. All three respondents worked together as managers when the same service had a voluntary status under the management of a religious order. The religious order decided to discontinue involvement in residential youth care provision and R13 was appointed

to oversee the transition of the service into the statutory sector and was then given responsibility in the statutory sector as director of the residential service in the particular region of the HSE. Both Rs 6 and 7 maintained their management positions in the newly established statutory service. There was evidence in all three transcripts that, while the transition went smoothly, they were still consolidating their new situation and striving to continue the best practice and systems that were considered to work when in the voluntary sector. Content analyses of the transcriptions of Rs 6 and 7 will be presented together and R13 will be presented separately.

7.5.1 *Respondents 6 and 7 (R6 and (R7)*

R6 was invited to participate in the study to ensure a geographic spread of respondents. When he was asked to nominate a first-line manager whose role differed from his, he selected R7 as the manager of the only short-term high-support unit in this region of the HSE.

7.5.1.1 <u>Care-related issues</u>

R6 described care in his unit through the following extracts taken directly from the data '*We are using the model* [of care] *"<u>Relating and Caring"</u> there is a lot of focus on the relationship with the young person and then the development of caring obviously comes from the effective relationship that is formed ... one of the significant changes ... has been the development of the complexity of need that you find with a particular child* [in high support care] *... we always try to put in place the plans that will best meet the needs of the young people at that given time ... we don't accept a young person unless s/he has a care plan ... every* [resident] *has a social worker and is reviewed fortnightly ... care is repeatedly assessed ... the care plan is statutory ... from that we develop our*

individual placement plan for the young person ... we also develop what we call significant pieces of work ... it could be a piece on emotional development ... it could be a simple thing around [a child's] *routine ... we set a time limit for achievable goals ... for the time the child is with us* ... (R6). He went on to say: '*my main task is to ensure that* [residents] *get the best quality care that is available to them* ... [I] *have to ensure that the resources are there to allow that to happen ... that the staff are there, the best staff that are available ... staff that are able and empowered to look after the* [residents] *... it is ensuring that they know what their task is ... I very much invoke getting people to take responsibility, giving people the opportunity to make decisions, empowering people to do that'* (R6).These extracts were taken as indicating provision of child-centred care in R6's unit.

R7's transcript also indicated the provision of needs-led or developmental care in his short-term high-support unit. When asked about his main responsibilities as first-line manager he said: '*it is about safe care of the young people and the safe care and support of staff within the work because* [residents] *can be so challenging ... that we are working under the regulations that are there'* (R7). He went on to say: '*it is working with the models* [of care] *... working with the psychologist to see what we can use of the models in the other houses* [of the service] *... which would best suit particular children ... he* [psychologist] *is flexible if we identify needs he aims to meet them ... a lot of the needs* [of residents] *we can meet ourselves, I prefer to do it as it is much more challenging for the staff team to tackle difficulties themselves ... I think that once young people feel they are being heard and that there is respect for them ... that is the big thing ...* [residents] *may feel "he wont give what I want but I know he will listen to me" ... for me every day coming to work I always need to spend ten minutes with the kids ...*

it is giving them that time if they want a chat or are hurt ... I have 3 or 4 teenage girls that will ring me even though they are gone, for a chat, that says a lot ... they [residents] *wouldn't be here if they didn't have problems, sometimes people forget that*' (R7).

7.5.1.2 <u>Staff-related issues</u>

Staff were supported through regular staff meetings, '*we have staff meetings once a fortnight and everybody attends, it is built into the schedule; child care workers have a group meeting outside of the centre ... facilitated by an outside facilitator ... to discuss practice issues and their own development; the child care leaders are part of a regional group which has its own regular meetings'* (R6). '*Every* [staff member] *receives* [monthly] *supervision, it is compulsory, it is operational and developmental ... there is a communication book within the centre ... to allow people to communicate issues, concerns, points for development or whatever*' (R6). He went on to say: '*the present roster is working very effectively ... and meets the needs of the centre, the staff are well aware that if the needs of the centre change then the* [roster] *could change*' (R6).

R7 also had clarity around his role and the importance of collaboration with social workers in the interest of residents '*we have a very good working relationship with* [social workers] ... *people know* [my] *expectations here as a manager and it works'* (R7). When asked about his most important tasks as first-line manager, he replied: '*my development of myself and the staff team together as a group ... getting the staff team on board and buying into the care we are offering for the* [residents] ... *being available as well ... I try ... to see each staff member for supervision every 3/4 weeks ... the staff here are very protective of the unit and of the young people and getting involved and wanting to be involved so we give them the responsibility* ... '*we review* [the roster] *every couple*

of months and see [if] *it is working, is it meeting the needs of the young people ... I am fairly flexible and I love being on the floor with the young people ... I think it is important as a manager to be on the floor*' (R7).

Both managers also referred to monthly meetings with all first-line managers in the service which were chaired by their line manager, R13. Service strategy '*is discussed within my line supervision ... [and] in a bigger forum like management meetings ... I would localise it as well through my own local management within the centre ... which would be the initial opening for discussing strategies ... and what is not working*' (R6). (This indicated use of practice-led strategic planning and development in the service.) R7 also referred to these meetings '[first-line managers] *of the 8 units we have in residential services ... meet with* [R13] *... once a month ... we look at the issues coming up and discus them ... it is using peer support ... we find that good ... we do an on-call system as well ... 24 hour cover ... so* [all first-line managers] *are tuned into* [all units] *... staff would move to other centres and cover shifts and support each other*' (R7). (This reflected a service mentality among first-line managers which was also emerging as a feature of those services providing developmental care for residents).

7.5.1.2.1 <u>Staff recruitment</u>

R6 referred to the corporate function of recruiting which prevailed in the HSE. He had more direct involvement in recruitment when the service was part of the voluntary sector: '*we had more of a close hand with recruitment ... now we are with the HSE it is a lot different ... there is a personnel and HR department who look after all of that ... we are finding there is a time gap that is a problem ... and there is serious confusion in regards to what* [qualification] *is recognised and what is not recognised ... my*

responsibilities [in the statutory service] *are more tied to where I work ... in some ways we have lost a bit of personal touch in our work ... the process of interviewing is ... focused on practice, legislation ... it has become so rigid in relation to who is actually being called for interview ... there is an initial probation period of twelve months in the* [HSE] ... *what should happen is that an assessment* [occur] *at the end of the twelve months where you would review the person's progress ... there is no system for doing it* [in the HSE] ... *I've come from a system* [in the voluntary sector] *where we would weed* [staff] *out and we would have assessed them ... in saying that ... because everyone* [in my unit] *receives supervision monthly* [unsuitability] *would be well notified ... I am very comfortable with that*' (R6).

R7 also referred to changes in recruitment since joining the HSE: '*we have* [now] *fallen in under their HR and their recruitment methods ... we had much more say in the voluntary sector ... a recruitment drive has just happened in* [the statutory service] ... *the interviewers were identified by the HSE* ...[but] *the director* [R13] *has said he needs to have* [particular people] *on the panel because they are the people who know what we are looking for ... the panel hasn't been reconvened yet ... I suppose it is being dealt with through HR ... I interviewed last week for relief staff ... we got 8 CVs and interviewed 8 people ... they are being processed ... Garda clearance has gone out, reference checks ... HSE regulations require that all* staff [including relief staff] *have a qualification ...* [relief staff] *are nearly all working full time at this stage because of vacancies within the service ... temporary contracts can be offered to a relief person if they have the required qualification ... if there is a panel* [for permanent staff] *a person from that panel would join my staff* [if I had a vacancy]' (R7). Both respondents felt

able to express their preferences in relation to replacements on their staff teams: '*I definitely feel heard*' (R7).

7.5.1.3 Line management support for first-line managers

Both managers had regular supervision: '*I have supervision which is fortnightly ... it is* [mostly] *operational ... we review what we are doing well* [with residents] *and what we are not doing well and looking at the areas of development ... I am very happy with that ... good systems, accountable systems with good feedback when needed*' (R6).

R7 feels equally supported: '*I would have supervision every 3 or 4 weeks ...I find it more operational ... the young people, the placements, the staff, the unit itself, the HSE, the paperwork side of it ... I've been having* [developmental] *supervision myself for the last 10 years, I find it good and useful ... I'd be very conscious that I need to be getting feedback ... unless* [my line manager, (R13)] *comes out here he is not going to get the sense that I am doing my job'* (R7).

R13 as director of service supervised all first-line managers and expected them to monitor and ensure that the quality of care being given to young residents was to the standard or above standard; that frontline staff were supported and '*that they are constantly looking at and reviewing how we are working with the kids*' (R13). This indicated that this integrated service was focused on the developmental care of residents.

Open communication between levels of staff was in evidence. First-line managers were also involved in monthly mapping meetings: '*with the child care manager and the*

principal social workers of the different areas [of the HSE region] ... *we go through all young people in the centres, are they due to move on or not ... we look at the referrals for the month, can we take them or not and the reasons why*' (R7). There was a major review of residential care provision underway in the region of the HSE at the time of both interviews: '*frontline people* [are involved in the review], *managers* [first-line], *principal social workers, child care manager, psychologist ... we* [looked at] *services we are providing and what we should be providing* ... [we recognised] *we need a short term emergency unit*' (R7). This short term unit has been set up and was being managed by R7. Since frontline people had an input into this decision, there was full support for it from staff across the service and R7 was committed to making the unit a success. This was a good example of practice-led service development (the opposite of what occurred in Service 2 when a change of function was imposed against the first-line manager and directors' judgement).

7.5.2 *Respondent 13 (R13)*

R13 was the regional manager for the statutory residential child and youth care service in a particular region of the HSE. He previously directed the same service when it was in the voluntary sector.

7.5.2.1 <u>Previous responsibilities</u>

While in charge of the voluntary service R13 had clarity around his role: '*I provided the professional supervision to the [first-line] managers, I looked at policies and procedures, the strategy around how we were going to develop the service that was, I dealt with human resource* (HR) *issues*' (R13). While employed by the voluntary

service, R13 was involved in setting up one of the first high-support units[9] in the country. '*There was no model to follow ... one of the biggest difficulties about high support was that they had to be so rushed, there was so much pressure to open ... there wasn't enough thought put into the profile of the type of staff we needed in terms of their qualifications, their experience ... one of the high support units we opened ... most of the staff were unqualified or had Montessori training which wasn't adequate to the work ... they became very overwhelmed by the task and things quite rapidly broke down ... a theme for us throughout the development of high support units to date is that we have never been able to maintain enough staff to manage existing services ... we haven't been able to attract the numbers we need or the type of expertise we need in the staff as well*' (R13).

7.5.2.2 Present role in the statutory service

'[The move] *changed my role enormously* (R13)*'. 'There were five services I was responsible for* [in the voluntary service] ... *I came into the HSE to be informed that I was taking on* [in addition] *a special care*[10] *service and two youth homeless services ... there is not the infrastructure in place* [in the HSE] *to support my role in order to be able to do that*' (R13).

7.5.2.3 Alternative care review

This review which was underway at time of interview covered residential child and youth care, foster care, child psychiatry, disability services, after care. The review group highlighted '*that the different areas that have responsibilities for children's services don't work together*' (R13). A report has been submitted to the LHO recommending '*an*

[9]High support units provide an opportunity for additional support to young people in residential care through use of higher staff ratios and higher therapeutic input.
[10] 'Where children can be detained or retained for the purposes of treatment' (Durcan 1997: 9)

alternative care service under one line management structure' (R13) but there had been no response to this at the time of interview.

7.5.2.4 Staff-related issues

7.5.2.4.1 Recruitment process

R13 had experience of recruiting frontline staff across both the voluntary and statutory sectors. He recognised the importance of the quality of the staff who directly worked with young people in residential care. Both Rs 6 and 7 referred in their transcripts to them having difficulties with delays caused by HR in recruitment of staff. R13 had seen the need to oversee the recruitment of staff for the residential service more closely: '*the recruitment dept of the HSE doesn't meet the needs of what residential services need ...* [HR department] *just cannot meet the demand ... we have tried that route several times, in one campaign they had fifty applicants, twenty five were eligible, we interviewed seventeen who turned up for interview and three were appointed ... over the years we have brought in a lot of staff who were not suitable so I am not bringing anyone in now unless I am absolutely confident that they can do the most difficult job in our services ... we have changed the whole way we interview ... we are now looking for emotional intelligence in staff ... interviews are not so much task oriented but more getting* [applicants] *to reflect on their experiences ... we have spent a lot of time around the specific questions, around how the panel is formed, around panels working together ... we have now interviewed 120 candidates ... we have also introduced a written exercise* [which] *gives another dimension to quality of staff; it is something I want to pursue more ... the feedback we have from people coming on board through the new process is that we have set the bar higher ... they certainly seem more reflective, more energetic,*

much clearer about what they are coming into ... we expect them to come in and to work with difficult kids ... so we are raising the bar that way' (R13).

7.5.2.5 <u>Structural issues of the HSE</u>

R 13 reported: '*There are three child care managers* [in the HSE structure in this area], *I report to one. Each of the three roles has a regional responsibility for a particular* [service] ... *one has regional responsibility for child protection ... another for foster care ... another for residential care, which is enormous ...* [my boss] *reports to the local health officer* [LHO], [my boss] *should be reporting to the general manager but the general manager* [in this HSE area] *hasn't taken on the residential service. There is some dispute around that so we have been brought in under the LHO ... some of the key decisions have to go through my boss to put to the LHO'* (R13). This reporting system had not given R13 any clarity as to how his job was viewed within the HSE structure: '*I am not terribly sure how anybody above me sees my job ... I make it up as I go along ... I haven't come with a clear brief ... the understanding of residential care is not* [in the HSE], *nor the expertise ... how I see my job is to develop some sort of vision as to what the post should be about ... special care is quite new to the HSE ... residential care is very new to the HSE ... a lot of my role is at the moment providing information and looking at what systems and structures we need in place ... to look at what the needs are in the region for young people in residential care'* (R13).

Developments of service that R13 had been involved in since becoming part of this statutory service had '*come in an ad hoc way ... there is no-one to tell us we have to* [develop services], *there is no structure* [within the HSE] *that supports that ... if I didn't want to work with anyone else and wanted to mind my own patch I could do that and it*

wouldn't help with the development of services ... professional supervision is something I don't receive ... I have regular operational meetings with my manager ... but he doesn't have authority to make decisions ... he sees me as the expert in the residential area and would go with the decisions I make ... this is not the safest way ... I need to be able to report to someone who can make key and critical decisions that effect residential care ... the residential care budget is something like €12.5-13million ... I can't even get clarity on how much money I am allowed to sign off on ... I am not sure if I can sign off on €500 or €5000 ... I need to report to someone who has the authority' (R13).

7.5.2.6 <u>Discussion</u>

This situation, as described by R13, suggests a disconnect between the frontline residential service and senior HSE management in this region of the HSE. No-one in the senior management structure ensures that R13 monitors that the quality of care being provided for young residents is adequate, not to mention developmental, as mandated in Irish legislation. R13 himself, because of his domain expertise, sees this task as a centrally important responsibility of his role as regional manager of residential care.

There is no reference to senior HSE management interfering with the developments that R13 has proposed, so there is no evidence of this statutory residential service being micro managed by senior HSE management (as was the case with Service 1). However a change of person at either R13's level or at LHO level of the structure could totally alter the present fragile situation. It is clear that consolidation of provision of developmental care for troubled residents in statutory HSE services requires a more

robust organisational design structure within the HSE structure, which provides for a manager at director of service level with both domain expertise and authority, who is held accountable for provision of needs-led care as mandated in Irish legislation.

7.5.3 *Summary of issues emerging from Service 4*

Service 4, which was represented by three respondents, presented evidence of operating from a developmental model of care. There was a robust staff recruitment process, staff were supported through focused, mandatory supervision; open communication across the levels of the frontline service indicated an integrated frontline service. While the director of service (R13) was focused on providing the necessary support for first-line managers to ensure their empowerment to provide developmental care for residents and their involvement in practice-led service development, there was also evidence in R13's transcript of him not getting the necessary authority in the existing HSE organisational structure to ensure protection of the frontline service, or its consolidation within the existing HSE structure.

7.6 Service 5

The service was represented by one respondent: R8. This was a statutory homeless service for young adolescent males in the 15-17 year age group. It was open for only 3.5 years at time of interview. It was the residential part of an overall homeless service in a different region of the HSE to Service 1. It was linked to a social work team which worked exclusively with homeless youth in the region. This comprised 8/9 social workers, 2 team leaders, 2 public health nurses, 1 sexual health person and 2 community social care workers. Both the residential and fieldwork services were directed by a child care manager with domain expertise. Since opening, the residential

service had accommodated approximately 100 young people in the service residential unit for periods varying from a few nights to six months. The service as developed by R8 also offered accommodation to its homeless youth in selected supported lodgings and two small hostels which had a skeleton staff to support those young people who were not ready for full independent living following a six month placement in the residential unit. The service also catered for unaccompanied minors who comprised 20% of total residents over the three year period and who were offered the same service as Irish homeless youth in this region.

7.6.1 *Respondent 8 (R8)*

R8 was nominated by R7 from a different region of the HSE. He was the first-line manager of this residential service for homeless youth.

7.6.1.1 <u>Care-related issues</u>

R 8 described care in the residential service through the following comments: '*for the first week or two we have ... an intake interview, very detailed, it looks at* [residents'] *family history, history of alcohol/drug abuse, family history of employment, supports, educational history ... young people are more responsive at giving information in the first week or two ... in the next phase we do a general assessment ... the purpose of the place is preparation for independent living or* [return] *home ...* [assessment] *is based on a child perspective, based on emotional, social, family ... then you are able to shape a care plan ... the provisional care plan* [is] *to be accommodated ... after the assessment we have an independent living programme where each young person has a folder ... we could be looking at self esteem, education, family, budgeting, cooking, hygiene, whatever area they need ... the folder becomes their resource pack ... every resident gets*

a social worker from the [homeless] *service*' (R8). The service had also developed 8/9 supported lodgings '*people who have been trained, who are willing to take a young person in supported lodgings ... where lads can go to their training and come back to a meal in the evening time ... we also have two centres with one staff on from 9pm until 9am where youth who are able to live a modicum of independent living* [can go] ... *they move* [from there] *into flats or houses*' (R8). This integrated service offered ongoing help to homeless youth '*that support is there, they* [residents] *know that*' (R8). There was also clarity of purpose '*the function here is that it is a homeless hostel to help them move on to independent living*' (R8).

7.6.1.2 <u>Staff-related issues</u>

R8 was given a lot of responsibility for the development of the residential part of the homeless service. He had clarity about his role '*to manage the staff complement but also to manage the reason you are opened up for ... I am the emergency unit response ... I do not get a chance to cherry pick who comes to the service ... I teach the* [staff] *team collective responsibility, my role is actually facilitating, enabling staff to do this here ... the culture of the place is very important, I want to have a welcoming culture and one that reflects that I am available to staff ...the culture where staff feel empowered to make decisions ... you* [manager] *are a role model, if your staff do not feel empowered it cant work ... I have three highly emphasised principles: the basic principle of the best interest of the child, the principle of consultation and the* [principle of] *general welfare of the local community ... we might review* [decisions taken by staff] *afterwards but I will defend* [a staff's] *right to* [make that decision] *and that is important ... if you have made the consultations and then make the decision it will be a stronger decision rather than blindly following policy or procedure*' (R8).

7.6.1.2.1 Recruitment of staff

R8 was centrally involved in staff recruitment, selection, induction and probation processes for the residential staff team. The number of staff deemed necessary by the HSE for the homeless residential unit was 8. The jobs were advertised in national newspapers, which ultimately resulted in the selection of 22 candidates for interview. Interviews yielded 8 suitable candidates who were placed on a panel and offered jobs; all 8 accepted the job offers and commenced work at the residential unit. All 8 staff remained in post at the time of interview (3.5 years later).

7.6.1.2.2 Staff selection, induction, probation and development

R8 had clarity about the staff he wanted for this service: '*You want people with some experience of homelessness, you want people with an educational background that would be open to social care, that would be aware of some of the issues ... preferably third level, second level with good experience ... a number of years experience in the area was also acceptable ... we went through the normal criteria or general job specification ... working rosters, working unsocial hours, that it would be a homeless hostel ... expected to work days and nights, then the sorts of duties that might be expected, working with young people one-to-one, group work, working on a team, small household general duties ... I had the total say ... when I was processing applications I sent my decisions down to the child care manager, this is what I am looking for ... of the 8 successful applicants I ended up with 2 child care leaders and 6 child care workers ... my approach is not a hierarchical approach ... to me it is more about collective leadership and shared responsibility according to ability ... once my line manager and HR knew that I was happy they agreed it*' (R8). All successful applicants had a two

week induction programme which would have been '*a look at their own experience, looking at the type of culture/approach we have, look at policies, training in therapeutic crisis intervention (TCI), have things like child protection ... I set the programme but invited people to take particular parts of it*' (R8). All staff were put on a year's probation. '*I have done a performance appraisal* [for all staff] ... *based on understanding across six different areas ... for example attachment theory, issues regarding homelessness, the Child Care Act (1991), working as part of a team, using ecological models, family support systems ... I supervise all staff at the beginning*' (R8).

R8 was also clear about what he expected from staff: '*I have dealt with issues of practice that have resulted in verbal warnings to staff ... behaviour that was not acceptable and if it continued then there was going to be serious consequences ... there would have been one staff who ... would have had a tendency to shout ... it was brought to her attention ... it got so serious that I had to put it in writing to her and to tell my line manager that this is what I was doing ... it is not acceptable for staff* [to shout] ... *it took a few sessions to help her realise how important an issue this was* ... [she was told] *if this continues the next step for me is to initiate dismissal proceedings ... she is now an acting child care leader so it worked but it was a very tense time for both of us*' (R8). He also put an emphasis on whistle-blowing and safeguarding in the staff appraisal form '*Loyalty to colleagues is not greater than needs of clients*' (R8).

7.6.1.3 <u>Line management support for first-line manager</u>

R8 felt '*very much supported by*' [his line manager]. '*My line manager has changed* [recently], *she meets with me regularly, maybe once a month formally but usually 2/3 times a month either in her office or up here ... she has come to staff meetings, she has*

come on outings with us ... she has a good sense of what is going on ... she is not really interested in the detail ... she would have a bigger role in the difficulties we might be experiencing [with] *social workers, other professionals* [or with] *difficult behaviour* [of residents] .... R8's line manager was a child care manager and director of the homeless service in this region of the HSE (similar position to R12 in Service 1 but she was totally focused on frontline practice issues and on provision of needs-led care for the homeless residents).

7.6.2 *Main themes emerging from Service 5*

1. Frontline care is child-focused and needs-led.
2. Respect for staff includes their empowerment to undertake the care task and to make informed decisions in their needs-led care of residents.
3. R8 has full responsibility for staff recruitment, selection, induction, probation and development (indicating the importance of domain expertise and authority for the manager with responsibility for workforce issues in residential youth care services).
4. R8 as first-line manager is supported and empowered by a line manager with domain expertise.
5. Leadership with clarity of vision, responsibility, accountability and commitment of staff to a welcoming culture in the service.
6. Strategic development of service is practice-led.

7.6.3 *Summary*

Service 5 operated from a developmental model of care. When compared to Service 1 it was clear that homelessness was not such a political issue in this region of the HSE.

Despite being a statutory service, Service 5 was not micro managed by senior HSE management, as was the case with Service 1. The short-term length of residential placement in this homeless service was similar to that which prevailed in Service 1. There was no mention of discharge arrangements being such a major focus in Service 5, where the focus was firmly on individualised, needs-led care of residents. This showed that short term placements which are focused on needs-led care can be effective.

7.7 Service 6

This was a voluntary service which provided aftercare for girls in the same regional area of the HSE as R8's service. It catered for young women in the 16-23 age group, had eight residential aftercare places and supported a further 60 clients through its outreach service. Its structure resembled that of Service 3, where the centre was owned by a religious order, the trustees of the order appointed a board of directors which delegated responsibility for management of the service to a first-line manager.

7.7.1 *Respondent 9 (R9)*

R9 was nominated by R8. He had been first-line manager of Service 6 for five years at time of interview. He had twelve years of social care management experience prior to this appointment. He had a strong commitment to use of a therapeutic approach underpinned by a psychodynamic model similar to that used in Service 3. He appointed the same child care consultant as Service 3, who supported frontline staff with care related issues.

7.7.1.1 Care-related issues

7.7.1.1.1 Individualised programmes

'When a girl comes in here we aim to design an individual programme around her ... a condition of admission is that a person is willing to undertake a structured programme as part of their every day ... [we look] *at the girl while living here as a member of a group and all that that means; we train for independence and adulthood ... each girl has a key worker and we have a checklist in terms of independent living skills and the girl would work with the key worker on that ... we have monthly reviews on each girl ... all girls under 18 have a social worker ... there is a plan around each girl and there is a whole language around that plan ... that is my vision ... I think being creative and having an individualised approach to each girl is very important in terms of success; the relationship* [with each resident] *is critical'*(R9).

7.7.1.1.2 Client-focused policies guide collaborative practice

'We have a 'no sanctions' policy ... we sit down with the girl and ask why is [coming in late] *happening ... coming in late is hampering* [getting her life back on track] *... some of those discussions would typically happen with me ...* [but] *any staff member could intervene ... the whole staff team would be united around the goals of the girls, that is the type of thing we discuss at staff meetings; it is around the girl taking control .... I would try to hold all the pieces in my head in terms of each girl, I am here every day while the care workers may be off* [duty]. These extracts were taken to indicate provision of developmental care.

7.7.1.2 **Staff-related issues**

7.7.1.2.1 Staff supervision

R9 and the deputy manager divided the staff team for supervision. They aimed to have supervision for staff every month. Supervision '*can be supportive, there is the accountability aspect and there is the developmental aspect ... it depends where the individual is at ... I expect staff to work as part of a team ... to use supervision and staff meetings in a way that progresses the work in an open way* ... [I want staff] *to be able to say "I am really having difficulty here" ... to have openness and honesty about themselves'*(R9). This approach was aimed at empowering staff to facilitate focused collaborative work with residents.

7.7.1.2.2 Support for staff

'I carry a phone with me all the time and I am available for consultation with all the staff, I have no difficulty with that because they are a good staff team, they don't ring unless they have to' (R9). There is an outside consultant who does staff development three times a year *'he looks at the clients and the work around them and advises on that*' (R9).

7.7.1.2.3 Recruitment, selection and staff probation

R9 was totally involved in all recruitment related issues. They recruited annually through use of advertisements in national newspapers. Only qualified staff were selected for interview *'that is now the expectation from the HSE but it is also what we would wish ourselves'* (R9). This also applied to relief staff in this service ... *'we have two relief staff ... they are qualified social workers who are doing their Masters'* (R9). The interview panel used was similar each year: *'we have an interview panel of four ...*

myself and the deputy manager, a member of the board of directors and a manager from an outside organisation ... our staff turnover is not high .. the only problem [with recruitment] *is with Garda clearance which can take a long time to get and can catch you for a few weeks ... all staff* [are on probation] *for eleven months ... I would work with people through a probation process and* [use] *an evaluation sheet* (R9). This suggested a recruitment process that was fit for purpose. R9 had clarity around the type of staff the service needed and was prepared to use the probationary period to weed out staff that might not have been suited to work in the particular service. There was no problem attracting staff to work in this service which was a positive indicator.

7.7.2 *Line management support for first-line manager*

R9 had outside professional supervision which was paid for by Service 6, and which he found satisfactory. He was also supported by the board of management '*I manage the service, I report to* [the board of management]... *they are there as a support ... there are two inspectors in the HSE who inspect the voluntary agencies and monitor all residential units as well ... within the last five months I have seen* [the monitor] *three times ... she would look at a few different Standards each time ... I filled out* [a form] *in terms of notifying the monitor of any* [critical] *incidents that took place ... I find* [the service supportive] *it is a good way of maintaining a focus on these issues ... there are so many things happening it is a good way of keeping up to speed ...* [the monitor] *sends me a report after each visit and a copy is sent to the child care manager* [representing the statutory service] ... *I would* [meet the child care manager] *through other things ... she is quite involved ... we communicate regularly, mostly by email ... in terms of funding I would have contact with her*' (R9). This manager was supported and empowered to manage the service in a client-centred manner. As a voluntary service

there were positive connections with the statutory monitoring service and with the area child care manager; this interconnectedness provided positive support for the service.

7.7.3 *Main themes emerging from Service 6*

- R9 ensures a service focus on needs-led, individualised care of residents.
- There is satisfactory management of workforce factors by a leader with domain expertise and authority.
- Staff team are supported through regular supervision, outside consultation on practice-related issues and open communication systems in the service.
- Manager prefers '*very expert and well-qualified team who deliver very effective interventions*' (R9). Only qualified staff are selected for interview for both permanent and relief positions.
- R9 is supported and empowered by: (1) the management committee, (2) outside professional supervision paid for by the service, (3) support from statutory monitor who sends copies of reports to the statutory child care manager.
- Integrated service is focused on the preparation of very troubled young women for independent living; strategic development of the service is shaped by practice-led issues.

7.7.4 *Summary*

Service 6 showed evidence of providing developmental care for residents. The service had many self referrals from clients over eighteen years of age which suggested that the clients found the service helpful as they prepared for more independent living.

7.8 Service 7

This was a mainstream statutory service and was represented by respondents 10 and 11, both first-line managers from two separate units of the same service. R10 was selected through contingent sampling. He had been a supervisor of third year social care students pursuing their professional training but was obliged to contact me to withdraw from a commitment to take a student on practice placement because of major difficulties in the residential unit he line-managed. While discussing these difficulties with R10 I referred to my research topic and invited him to participate in the study, to which he agreed and became R10. The service was experiencing major changes at the time which will be discussed under 'Restructuring Issues'. R10 nominated R11 (first-line manager of another mainstream unit in the same service). Issues in relation to this service were discussed from both transcriptions together as both were first-line managers in the service and were being impacted by similar factors at the times of their interviews.

7.8.1 *Respondents 10 and 11 (R10 and R11)*

7.8.1.1 <u>Care-related issues</u>

R10 had major concerns about the care of residents during this period of change. '*The answer to you question* [who is overseeing the welfare of the children] *is no-one*' (R10). When R10 discussed with senior HSE management, his concerns about the quality of care being provided for residents in the units he line-managed the answer [he] got back was: '*we hear your problems, there is no money, you have to manage ... you are paid to manage, manage*' (R10). This response disempowered R10. He was particularly concerned about staffing issues in his service which will be discussed in the section addressing that topic. In R11's transcript there was evidence of a first-line manager being overwhelmed by care related issues. There was '*chaos in the house, just complete*

chaos, the 13 year old was quite physical, he kicked in the office door ... he would be highly aggressive; then you would have the other 14 year old ... who needed constant supervision, because [of his sexualised behaviour and] *there was another 9 year old and a 11 year old in the house ... you can't divide yourself in two*' (R11). When asked about being able to discuss such issues with his line manager (a principal social worker (PSW), the response was: '*we talked and talked and talked, it is crisis management in the HSE ... there was no action; nobody goes out looking for that kid* [who was staying out overnight] ... *we dot the 'i's and cross the't's, write our letters but who actually goes out to look for that child?*' (R11). The chaos in this unit caused it to close for three weeks due to large numbers of staff taking sick leave. The four residents were moved to other residential units and to an emergency foster care placement. The fourteen year old with the sexualised behaviour settled in his new placement and opted to stay in that unit. This was a great relief to R11 't*hat was a huge piece, it allows me to deal with the 13 year old because his behaviour still hasn't come back to an even keel; he is still in a lot of difficulties even though he is sleeping in the unit every night which is a huge thing for him ... we have* [a behaviour assessment report for him] ... *it recommends a different type of residential unit ... so it is up to the social worker now to follow through on that*' (R11). There was no mention of needs-led care in R11's transcript. R11 says he gets no support with residents' care: '*there is nothing out there for children* [in residential care] *who need urgent help, it takes months to get a child assessed in any sense of the word ... it is only after a child has been in horrendous difficulties with the guards, with themselves, with the community, it is only then that something might get done ... it took me three years to get* [a resident] *moved on ... I don't know* [what residents need] ... *we seem to be always going down the road of high support, secure care, they seem to be the only answer*' (R11). R11 gave his line manager, the PSW, monthly feedback on the

residents, but the PSW never asked about care programmes in use with the individual residents. Residents' social workers (who also reported to the same PSW) called to the unit to visit the young people on their case loads; they did not do any work with the children '*they would be a visitor*' (R11). They did not discuss children's day-to-day care issues, '*not that specific, they do not get into that detail ... may-be they should be*' (R11). There was no evidence in R11's transcript of concern at any level of this service with meeting the prevailing mandate of care.

7.8.1.2 <u>Staff-related issues</u>

Both respondents discussed serious staff-related issues in this service. R10 said '*the most urgent issue for the service is recruitment of full-time staff and to decrease dependency on agency staff*' (R10). R10 was attending college to get his professional social care qualification during the year of the interview. This required his attendance in college for two days weekly during the academic year, leaving him with only three days to manage his residential unit. Following the resignation of another first-line manager from the service, R10 was asked by senior HSE management to take first-line management responsibility for a second residential unit in Service 7. He initially refused on the basis that he was attending college and if he had responsibility for two units he would only have 1.5 days weekly in each unit. Pressure was brought to bear and R10 felt obliged to agree to take the added responsibility, to help the HSE during an emergency period for three months only. That period had just elapsed at the time of interview and R10 had written to his line manager the PSW, asking to be removed from his dual first-line manager roles. He received no response and within two weeks he sent a second letter stating: '*I will only manage one house and I have stated a particular preference as to which house I manage ... there will be a meeting very shortly ... I am in*

a very, very awkward situation' (R10). This was complicated by the fact that R10's original unit had to take an emergency admission following the closure of another residential unit in Service 7. This put additional pressure on a previously well functioning staff team. R10 believed the unit's closure was caused by an over reliance of that unit on agency staff. He mentioned his understanding of first principles in child care: '*the first principle has to be building up a relationship* [with residents], *the second one probably has to be some degree of consistency ... and you have to have staff who are fairly comfortable and at ease in themselves and their work. When you are using agency staff you may be missing all those components'* (R10). The HSE had an embargo on the recruitment of staff at the time of interviews with both respondents 10 and 11. '*I am in the position where the second house I am managing as of a weeks time will be minus three staff ... despite the fact that I flagged this a number of weeks ago when people told me they were resigning ... I spend an awful lot of my time, even when I am in college, on to the agency looking for staff; huge amounts of time ... as I speak to you I have no-one at the moment doing an overnight on Monday or next Friday, I have only mid-shift staff up to Sunday ... I have no mid shift staff to-day, Thursday, for next Monday, Wednesday Thursday, Friday, Saturday, Sunday, yet ... I have no overnight staff and they are my critical staff, they are the backbone of it, I have no-one either for next Monday or Friday due to a bereavement* [of a member of staff] ... *it is a worry, concern and anxiety to me personally'* (R10). He had also repeatedly told the PSW and the general manager of the HSE that he could not do any staff supervision due to his severe time constraints caused by him having management responsibility for two units and attending college for his professional qualification, but no action was taken.

R11 also reported major issues around staffing, largely caused by a rigid enforcement of an employment embargo in the Department of Health. '*The reality now is you have* [the staff] *who you have and you work with what you have*' (R11). This manager was prepared to overlook staffing issues (such as non-commitment of staff or refusal of temporary staff to pursue professional training prior to achieving permanent status) as '*if I challenge that person they might leave and I am left with agency staff working with the children and that creates more problems ... I can have any amount of agency staff here where I cannot recruit ... it is just them* [unsatisfactory members of the staff team] *or agency staff and agency staff are just, you know* [very disruptive] ... [staffing] *is a huge issue ... sick leave and all sorts happening*' (R11). He described the main challenges of his job as relationships with staff and supervision of staff for which he had sole responsibility.

7.8.1.2.1 Staff recruitment, selection, induction and probation

R10 described how staff recruitment operated prior to head office in the particular region of the HSE taking a more direct interest in the residential service: '*there was recruitment at local level ... a* [first-line] *manager would* [report a staff vacancy] *to the principal social worker ... the residential units of the area would be contacted* [to enquire about any staff vacancies] ... *we would all come together and recruit for* [the required number] *of relief staff ... at a local level ... we were recruiting temporary staff*' (R10). He then discussed recruitment of permanent full time staff in the service. '*Formal advertisements were placed in national newspapers ... these would be formal interviews for outsiders but there would also be formal interviews when it was agreed that temporary staff* [from existing residential units] *should be upgraded to permanent*

status ... there was a big move on from the unions and the social services inspectorate (SSI) that there were too many temporary staff [in the system] *and they should be made permanent ... I would have sat on those panels, they would be quite formal ...* [they had] *panels of three ... always a first-line manager, a retired person as an independent auditor and there might be a social worker*' (R10). The local interviews had ceased and first-line managers had less input into the formal interviews which had also ceased at the time of both interviews.

R11 had been involved in the same local recruitment drives described by R10. He confirmed that unqualified staff were selected through this method. Temporary staff were recruited by placement of '*a very loose type of advertisement that is put up around the* [local residential units] *... it is word-of-mouth really ... two first-line managers would go through the application forms, CVs, and select candidates for interview ... the procedure is ... there are other people involved in the selection, we all make a decision and we are accountable for that ... it works fairly well ... there are three different grades of staff, there is a trainee worker ... they do not have* [a professional qualification]. Relief or temporary staff were appointed on a probationary basis for six months. There was no formal monitoring of these probationary periods. '*Training would be discussed with* [trainee staff] *in supervision but it is difficult to keep after that one ... very often you're coping with other crises in residential care and training is the least of your concerns* ... [their six month contract] *is renewed for another six months.* When asked whose decision it was to renew the probationary contract R11 confirmed this responsibility was left with the first-line manager in this service, *'it would really be me at this stage unless there is an industrial relations issue'* (R11). R11 thought it was very rare to use the probationary period in this service to get rid of unsuitable probationary

staff and he felt reluctant to take such action as he suspected he would not be supported by his line manager. '*No I don't get support from them* [principal social worker or senior management] *on issues like that ... very often you are fire fighting on issues around children and other issues like staff issues get left'* (R11). Both respondents expressed total dissatisfaction with recruitment of staff in this service, the recruitment embargo was creating difficulties, but recruitment practices prior to the embargo were not satisfactory either, with no proper use of the probation period and a willingness to let untrained temporary staff progress to permanency without any undertaking on their part to pursue professional training.

7.8.1.2.2 Staff being imposed on units

Two residential units of this service had been selected for closure as part of a restructuring process recently initiated by senior HSE management. Closure of these units would necessitate re-deployment of existing permanent frontline staff. This is a major concern for R10. '*I would be very strong on the view that I don't want staff thrown on to my shift, I want flexible staff*'' (R10) R11 also found his present staff team difficult to manage, he only selected three out of the eleven staff on his team, '*I inherited them, when I took over the management of this unit some of them would have been in post; some* [others] *were allocated* [by HR] *to my unit'* (R11). Imposing staff (who were sometimes deemed unsuited to residential youth care work) on first-line managers was found to be disruptive for residential units in Service 1. R10 clearly believed there were unsuitable staff in this service and he was concerned about them being imposed on him. This issue of imposing unsuitable staff on frontline residential youth teams did not emerge in any of the other services in the data set.

7.8.2 *Absence of line management support for first-line managers*

Both respondents have the same line manager who is a principal social worker (PSW). The PSW post was recently vacant for six months during which time neither respondent had formal supervision. Prior to the PSW position being vacant the previous principal '*might have come out to my* [unit] *two/three times at my request because staff would not be happy over something ... you would go for supervision, which ... was not supervision, because ... you discuss the kids, now that is not professional supervision*' (R10). When asked if he felt supported in his job R10 replied: '*in recent times totally unsupported, no I don't feel supported*' (R10). R11 reported feeling supported in the job sometimes, but not at other times. When asked to elaborate, he stated: '*when things are going well you always feel a lot less stressed, you are fine, you are coping ... but when things get out of control ... if chaos prevails ... or if I am involved in an incident with a kid, that's when I feel I am not getting support* ... [the lack of decisions] *leaves me in a very vulnerable situation, getting phone calls at home, a child sleeping out rough and I am thinking what if he is the next kid involved in a joy riding incident on the dual carriageway*' (R11). R11 paid for his own external supervision as he did not receive professional supervision in the service and he had been refused financial support for external supervision. Neither first-line manager in this service felt supported at a particularly difficult time in their HSE region.

7.8.3 *Re-structuring issues*

There had been '*massive changes'* (R10) in this service in the last year. '*The residential homes are run by the local community care area* [in our region] ... *I am responsible directly to the principal social worker (PSW) who is my line manager and has overall responsibility for five residential units in this area*'. This worked satisfactorily before

head office took a direct interest in the residential service. '*At a local level we had our policies and procedures, our meetings with our PSW ... we didn't have a PSW for a huge period of time* ... [this happened when] *the purpose and functions of residential units were being re-designated in our service ... we would have been going to* [head office] *to meetings with our assistant chief executive (ACE) who took a huge interest in residential units and visited every unit ... over a summer period*' (R10). Previous to these developments, local residential units had no direct contact with head office. When head office got involved they set existing policies and procedures off to one side. A decision was taken at head office to carry out a major review of the residential service in the region in preparation for the setting up of the HSE the following year. During that period '*we have gone through four ACEs in a twelve month period*' (R10). A residential change committee was set up and R10 was a member of that committee. This change committee was asked to look at the needs of the area and consider how existing residential services could best meet current needs and to consider these issues in the context of best value for money. The cost of the service was recognised as an issue and the low number of residents in some units became apparent, but the brief of the change committee was to report on the type of units required to meet present need, not to consider the viability or otherwise of existing units. There was a series of 4/5 meetings at head office to which first-line managers were directed to attend. The meetings were chaired by the ACE and at one meeting the group was given a report which included many of the recommendations of the residential change committee, but also recommended that two particular units in the service be closed. This decision had not been mentioned prior to the particular meeting and the first-line managers present felt the decisions had been taken without any consultation with them. This caused a lot of bad will in the service. First-line managers recognised that bed occupancy levels had to

improve across the service and that this would involve changes in the purpose and function of exiting units. They recognised the need for this, but found the suggestion to close units without any consultation was not appropriate and alienated those staff at the frontline. These issues reflected a disconnected service which could be one explanation for the chaos that prevailed in some of its frontline residential units.

7.8.4 *Themes emerging from Service 7*

- There is no mention of needs-led care in the transcripts of Rs 10 or 11 and there is no sense of such care being provided for the residents of their units at the time of interviews.
- Both respondents feel totally unsupported by their line manager and more senior HSE management.
- Workforce difficulties comprise the single biggest issue for both managers.
- Staff are imposed on first-line managers in this service against their wishes.
- The chaos that R11 described in his unit suggested that the unit is not meeting residents' basic right to safe care which is in total breech of the existing duty-of-care mandate.
- This is a disconnected service with little meaningful communication between first-line and senior management levels.

7.8.5 *Summary*

This was a statutory residential service represented by two first-line managers, Rs 10 and 11. The factors that emerged indicated a model of care that prioritised the system over the needs of residents, which is taken as evidence that it operated from a social risk model of care.

7.9 Service 8

This was a large statutory service. It was represented by three respondents: R14, R15 and R17. While R14 line-managed both Rs 15 and 17, each transcript was discussed separately as the respondents were from different levels within the residential service.

7.9.1 *Respondent 14 (R14)*

R14 was a child care manager (CCM) who was appointed to director of services level and line-managed both the residential and fieldwork services in a particular region of the HSE. He differed from other service directors by virtue of being the budget holder for the two frontline services he senior managed. He had responsibility for '*all the HSE's residential children's services of which there are 11 units, which includes two high support* [units], *one special care* [unit] *and the rest are mainstream units. I also have responsibility for one of the largest social work teams in the country and responsibility for Springboard*[11] *projects, NYP*[12] *projects and a variety of other national and local projects in the area ... we* [CCMs] *each have a strategic responsibility, a regional responsibility and our community care service area responsibility ... and direct line management responsibility'* (R14). He was nominated by another CCM from the same HSE region who I invited to participate as the line manager of respondents 8 and 9. That CCM, when hearing the focus of my study, thought it would be more appropriate for me to interview R14 since he line-managed the major statutory residential service in the region. He discussed this with R14 who agreed to participate in the study.

[11] Springboard is a programme of family support for vulnerable families initiated by the Department of Health and Children and targeting early intervention to children and families at risk.
[12] NYP is a community based youth development and family support service which is a joint venture between Foroige and the HSE and run on a joint management basis. It works with young people aged 10-18 and their families.

7.9.1.2 Care-related issues

The focus of this discussion was on the residential service senior managed by R14, but it was interesting to note that when asked about possible conflict of interest arising from management of both residential and fieldwork services, R14's response was: '[services] *dovetail as* [a lot of the time] *the issues are about children ... having responsibility I can get both to come to an arrangement and that is how it usually functions*' (R14). R14 aimed to run a child-focused service: '*if a child comes into care the last thing a child needs is further uncertainty and adults at odds with each other; they need to know ... that adults are taking responsibility to ensure that their stay will be a consistent experience ... so* [the service ensures] *there is no drift ... what we re trying to do is to create a ... child-friendly culture, a family-friendly culture*' (R14). He had clarity of purpose for the service. They used a therapeutic crisis intervention care model (TCI) and R14 wanted to be able to say to any referral agency: '*this is the model, this is the milieu, this is the ethos of our service, this is what a child can expect*' (R14). He recognised the HSE's mandate of care, that this involved a corporate responsibility to care for children in need of residential care: '*we have a child, we have the capacity, we need to pool our resources* [within the service] *as best we can, we need to support each other and we need to make the necessary provision to take this child in ... part of the ethos is getting* [frontline] *workers to see it that way, they are working to a service as opposed to a specific unit'* (R14). He emphasised the importance of a safe environment for a resident particularly at the time of admission to a residential placement, and saw that this was related to support for staff: '*if a child comes into a unit and the staff ... have the confidence to set the necessary boundaries and enforce them in an appropriate way ... the child settles very quickly ... they feel the adults really are in charge ... if the*

adults cannot sustain [boundaries] *and* [boundaries] *keep getting pushed out ...* [residents] *quickly feel out of control, frightened ... you need to be able to do that in an appropriate and caring manner ... if a staff is subject to assaults the child easily picks up on feelings of rejection, of dislike, which actually exacerbate the situation; if staff feel ... they will have support, that gives them confidence to say they will not be abandoned with a difficult child, the supports are there ... I have two principal psychologist posts dedicated to residential care only ... they work not only with the children within the service but also work very closely with the staff, supporting and exploring issues and assisting staff in their dealing with the kinds of behaviour that present*' (R14). This service was prepared to make very special arrangements for particular children: '*we had a particular child who went for assessment and the collective view was that the child needed to be on his own for a period of two months in a specialised unit as it wouldn't work to put him in with other children ... much needed to be done with the child to prepare him for being with others ... we did up an old house ... because of our ethos I spoke with the unit managers and we put together a very good team of workers ... the child is going into that unit to-day and will be there for two months ... we will* [then] *transfer the child to a nearby unit so hopefully the staff from that unit will also be involved and will know the child when he moves on to them*' (R14). The child-centred focus of this service was further seen in their refusal to summarily discharge residents: '*we have a policy in the service that no child will be summarily discharged ... no child leaves our service in that way ... if there is a problem we try to work on it, if there is time needed we will do whatever it takes to try to secure a child's placement so whatever transition takes place is a smooth one ... the vast bulk of the managers I have I would be happy that they do things in a child friendly way ... our service will offer a quality service to the best of our ability'* (R14).

7.9.1.3 Staff-related issues

There was strong evidence of R14 recognising the fundamental importance of quality staff to an effective residential youth care service and he saw provision and support of such staff as a major part of his responsibility as senior manager of the service. He said that '*training of staff is pivotal ... relationship building is key ... key working is that place where the work is done because that is where the relationship is built and if you don't get a staff group that understand that and can work on building a relationship you can forget it*' (R14). R14 had appointed a co-ordinator (R17), to ensure agreement on a service value system underpinned by a child-friendly culture that guided needs-led practice across the service.

7.9.1.3.1 Recruitment of relief staff

'*We advertise, a lot of the time we bring in staff on a temporary basis, on a relief basis so we are constantly interviewing staff on that basis ... when we are notified that staff are needed we talk to unit managers and we make sure* [relief staff] *are Garda cleared and all the requisite details* [are addressed] ... [relief] *staff are interviewed by the manager ... once we get the profile of somebody ... then we get a sense of the person ...* [that happens] *just for covering certain shifts ... each unit has its own relief panel ...* [staff] *have built up their own relationship with* [relief staff] *and observed their work in practice ... part of our ethos says we need to pool that ... it is building up the recognition that we are working within a service, not within a unit*.

7.9.1.3.2 Recruitment of mainstream staff

'*We advertise through the HSE and we interview ... we have open days in a hotel, we invite people in and give them all the information, show pictures of the units, we have managers and children from the units there so they can talk to them ... if* [they remain] *interested they can apply, then people have a sense of what they are applying for. Staff levels are satisfactory at the minute ... I have got over* [the recruitment embargo] *by use of* [creative accounting]' (R14).

7.9.1.2.2 Staff qualifications

'*The basic requirement is the diploma but the advertisement says diploma or equivalent ... we named* [the equivalent] *youth and community degree, social work, psychology, nursing degree, teaching ... with* [social work] *we look for a placement in a residential setting ... people from equivalent backgrounds provide a good mix and they bring a different perspective which I think is helpful ... we do* [not have] *a plethora of social workers or teachers scattered about the units ... we have people with psychology degrees, our unit manager for our special care unit has a teaching background ... we are saying to people who are in service, however you came in in the past, you need this* [social care] *qualification and we will support you in doing that ... we have spoken to unit managers about how many staff they can release* [for training] *and we will cover and pay for the cost of the courses ... we need as many as possible to get into that and to come the other end with a* [social care] *qualification ... we are in negotiation with* [local IT] *... we have the first group finishing in September ... we say to our staff on study relief that they are on contract to us and we ask them to sign an undertaking that they will stay with us for two years following qualification*' (R14).

7.9.2 *Line management support for first-line managers*

R14 line-manages all first-line managers in this service. (Supervision of frontline staff will be discussed in the context of R17's transcript.) '*I give direct supervision to all principal social workers, project leaders and unit managers ... I do my supervision in the units ...when I go out on supervision I get a complete run down on each child in the unit ... I know all the children in the units, I have personally met them, I get all their details, I know all their names ... I'd know how their reviews are going ... I am very conscious of each child ... we are here to look after these children if I don't know their names ... that doesn't reflect well on leadership in terms of promoting an ethos that focuses on individual child needs; then I go through all staff related issues, resource related issues and any strategic issues around how the unit is developing, health and safety ... there is a format to the supervision ... I then meet with the residential co-ordinator* (R17 whose transcript has yet to be discussed), *there might be an issue around lack of staff confidence around a certain issue ... so I would ask him to go down and work closely with them for a few weeks ... when I return for supervision, progress has been made in relation to that issue ... we have found in areas where we have met certain difficulties we turn the spotlight on that, we concentrate all our efforts, we go in, roll up our sleeves and get stuck in for a couple of months or in one case for nine months; that has worked to turn things around; it has made a huge difference in one unit'* (R14).

R14's clarity of purpose was reflected in how he assessed his first-line managers: *'(1) in their openness, that I am aware of everything I need to be aware of, (2) their confidence in the sense that the difficulties that arise in talking to them ... in terms of how they set about problem solving the situation rather than problem focusing ... most*

of the [managers] *I have in place show great initiative and commitment and innovation in trying to resolve issues ... they go beyond what might normally be expected and that shows commitment ... so their commitment, their competence, their maturity ... some of the managers I trust them implicitly ... no matter what would happen they would always do what was right for the child ... so* [I judge managers] *in terms of how they give affect to the child-friendly/family-friendly ethos that I am trying to engender within the service*' (R14).

7.9.2.1 <u>Team mentality and empowerment of first-line managers</u>

'*It depends on how good your* [first-line] *managers and principal social workers are and we have put an awful lot of time into building up a team mentality ... I hope a lot of the team building we do with unit managers is to say that if they buy into the vision or ethos they should actually be able to make the necessary decisions among themselves because the resources are there ... I know* [first-line] *managers will ring me if there is a difficulty but also that they have autonomy to deal with issues themselves ... I have monthly meetings with the group of unit managers ... the thing was to create this notion that we are one service and that we should all be facing in the same direction ... the aim was to get a much more flexible movement within the service ... leadership in the units is* [very important] *... we trained people from the ground staff* [in TCI] *where it didn't work, we were trying it for ages so we came back and said the only way this can happen is if the unit managers and their deputies are trained as trainers* [in TCI] *and lead out by example in the units, we did that and it made a huge difference ... everybody does their refreshers ... there is no slippage, this is a minimum requirement that has to be done during the year ... we are concentrating on the whole de-escalatory issue ... we are finding* [that] *where you can find the staff to buy into that, their confidence levels go up*

and the children sense that and their fear levels go down ... it is when the children sense fear that the whole thing goes out of control' (R14).

7.9.3 *Organisation design issues*

R14 was originally given additional responsibility for a small statutory, mainstream residential service in his region of the HSE with particular responsibility for development of two high support units and one special care unit. On completion of these new units he senior managed four residential units and his fieldwork service. When a major voluntary residential service transferred to the statutory sector in his region, R14 was eventually given senior management responsibility for the now enlarged residential service together with the fieldwork service. He set about amalgamating the two residential services. '*One of the big things that I had to overcome was the 'them' and 'us' mentality*' (R14). He had monthly meetings with his group of first-line managers. His focus with this group was to agree a mission statement: '*getting people to buy into it and then to work on the relationships between the resident managers ... to get a much more flexible movement within the service*' (R14). He focused on core processes in the residential service: he set up an admissions committee co-ordinated by an admissions officer; he set up of an assessment process involving a multidisciplinary team, which has a seven-week cycle broken into three phases[13]. He appointed co-ordinators: a residential services co-ordinator (R17) whose responsibility was to '*develop the ethos, the culture of the units and looking at the oil that makes the machine work'* (R14), a therapeutic crisis intervention (TCI) co-ordinator to ensure that *'all staff were trained in TCI and that all refreshers were adhered to'* (R14), a critical

[13] This assessment process is for children referred to the residential service by community social workers. Phase 1 involves a residential care worker working with the child in his own home for two weeks; phase 2 is a three week residential placement; phase 3 is writing reports, doing follow-up work with child and family, culminating in a final report for the referring social worker.

incident review group chaired by R17 '*to revisit the* [serious] *incident with the staff and see what learning can come out of that*' (R14). R14 line-managed all co-ordinators, principal social workers, project leaders, child care monitors and first-line managers. This kept him in touch with all major processes of the service. His domain expertise came from his fieldwork experience as a social worker and from his residential experience as a first-line manager and his direct involvement in setting up and managing both high support and special care units. His authority came from being the budget holder for the two frontline services he line-managed.

He managed a budget of €12 million. He reported to the general manager '*who would also have an eye on the budget book*' (R14). He negotiated assurance of support from the general manager that any budget surplus that might accumulate remained ring fenced for his service. '*I have the discretion in relation to that ... the admissions officer post is one I came up with and one that I am instigating but I have total control over that*' (R14). He negotiated these terms when he was asked to take up his present post '*in fairness I have had a free hand in large measure*' (R14). R14 had full authority over both the residential and field services that he senior-managed. The organisation design structure of R14's service resembled that of a self-contained task structure (Galbraith 1977). He had the confidence of senior HSE management and they gave him full responsibility for the two major services he senior managed. This structure enabled R14 to protect his services from any direct interference from senior HSE management, he was held accountable for delivery of services as mandated by the Child Care Act 1991. His domain expertise enabled him to develop a child-friendly, family-friendly service which was focused on provision of developmental care for young residents.

R14 also showed evidence of leadership reflected in his ability to get commitment from first-line managers, principal social workers and project co-ordinators to a service mentality where they were all focused on provision of developmental care for residents. He involved his first-line managers in the formation of a mission statement for the residential service and through a shared vision got their commitment to this statement. This shared vision and clarity of purpose (Senge 1990) informed strategic development of this service, all of which was practice-led. Examples of strategic development were the development of the assessment programme, the admissions committee, the critical incident review group, development of an aftercare service; the appointment of co-ordinators. This service was committed to needs-led care of residents and was sufficiently flexible and empowered to achieve its mission which was provision of a child-friendly/family-friendly service. This service could be a blueprint for statutory residential youth care services elsewhere in Ireland.

7.9.4 *Respondent 15 (R15)*

R15 was a deputy manager in R14's service and was invited to participate to explore how he finds first-line management in R14's service. He was nominated by R14 and managed a mixed gender mainstream unit. His transcript was briefly discussed to confirm the effectiveness of R14's service model.

7.9.4.1 <u>Care-related issues</u>

Staff meetings occurred weekly and were attended by all staff and by the unit psychologist. The psychologist was focused mostly on care-related issues for the residents: '*we review an individual child at each meeting using the individual crisis management plan*' (R15). The deputy manager takes responsibility for '*staff training,*

staff supervision, staff support, staff debriefing, very much working with the staff in supporting them in direct work with the children ... highlighting any gaps in the rota or in the team either in communication or consistency ... looking at issues and exploring who we need to bring in to help with particular issues ... any issues that I need to address they are discussed with the manager and if they needed to go up to the child care manager they would have ... the support is very much there' (R15).

7.9.4.2 <u>Staff-related issues</u>

R15 had responsibility for the relief panel for his unit. He described the recruitment of relief staff exactly as described by R14. When asked about qualifications of relief staff, the reply was interesting: '*that is a hard one in the sense that in a crisis it is not that you would take anybody but someone who may not have the full child care qualifications is not excluded, we would look at them all and interview to see their suitability and look at the various criteria then ... we wouldn't exclude somebody if they only had a psychology or teaching background* [they would all have some qualification] ... *the majority have a social studies qualification ... we would have full say in the appointment of temporary staff and relief staff ... but permanent staff ... we are not involved in the interview ...* [that panel consists of] *people from personnel, the child care manager and someone from administration side*' (R15).

7.9.4.2.1 <u>Probation</u>

Probation is used with all newly appointed staff and only those found to be suitable are offered permanency: '*we have regular weekly supervision with staff who are temporary and we would have progress reports on them ... they would be aware of issues and would be expected to address them ... issues have to be highlighted because staff are*

told about their entitlement to permanency ... if they refuse to address issues or cannot improve in designated areas they will not be offered permanency'

7.9.4.2.2 Staff supervision

(R15). R15 said the service had '*what I would consider a superb supervision policy ... all staff have supervision, the child care leaders supervise some of the child care workers, myself and the manager supervise the child care leaders between us and whatever child care workers are remaining, my supervisor is the unit manager and her line manager in the child care manager*' (R15). These factors indicated the supports derived from a positively interconnected system. R15's transcript confirmed that Service 8 was focused on provision of developmental care for residents.

7.9.5 ***Line management support for first-line managers***

R15 reported that there was support within this service for first-line managers. Social workers, a principal social worker, and the unit psychologist regularly attended staff meetings to participate in discussion of particular residents (this suggested a integrated structure). '*In some cases we feel very supported because it would be very obvious that the young person is wrongly placed and needs to move to alternative accommodation ... we feel listened to and we would be supported in getting extra resources ... the child care manager would assess the situation and say we need extra staffing ... it is up to us to find* [those staff]' (R15). Line management support for first-line managers in this Service is further discussed in the context of R17 below.

7.9.6 Respondent 17 (R17)

R17 was the residential co-ordinator in R14's service. His primary role was to develop the child-friendly/family-friendly culture of the residential service. He reported to R14 but had no line management responsibilities. He was a qualified social worker who previously worked in frontline residential care and in first-line residential management across mainstream, special care and high support units; he also worked for a year as an inspector/monitor, so had strong domain expertise in residential care work.

7.9.6.1 <u>Care-related issues</u>

He saw his present role as largely developmental. '*What we want is a service that bends around the children as opposed to having children bend around a service ... that will be our core ... what we are striving for is that everything we do would be looked at through that lens ... how we do our meetings, how we do the work with the children, supervision, everything'* (R17). He developed policies that facilitated a child-friendly culture across the service. An example was a sexual health policy: '*I wanted to influence more directly how* [frontline staff] *interact with the children in relation to* [sexual health issues] ... *I feel that ... as an organisation we need to have a value system ... we shouldn't be afraid of that ... the research says that children leaving residential care get pregnant very quickly after leaving care ... we are working with very troubled children ... if there is something we can do to stabilise their lives then we need to do it ... it is the people who are with the children 24/7 who can have the most influence on their lives because they can use everyday experiences to work on issues ... children are watching lots of television programmes ... who is balancing issues? ... who takes the opportunity to introduce discussion around everyday sexual issues? ... staff don't know how to take a stance ... what I mean by a policy is one that clearly sets out our value system ... I have*

seen policies that avoid the issue really ... I envisage the situation that this will be seen as the service value system in relation to these important issues and it may require staff to put their own personal values aside and to acknowledge that this is our position' (R17).

Another example of such policy development was around clarity in relation to violent behaviour: '*it is about the* [first-line] *manager being clear about violence. If you are not clear about that, if you can't create a secure base for the children all the rest is useless ... if the children aren't held safely, and* [if] *their strong feelings aren't contained, it becomes unsafe for everybody and then the whole thing begins to fall apart ... I expect staff to be clear with the children and say "you are not going to hit me, we are not having that here and if you do* [hit me] *we will safely hold you" ... I don't really expect sanctions, I expect* [staff] *to talk to the children afterwards, to help them understand what is going on, to help them develop the skills necessary to express their feelings appropriately ... there is this little 12 year old boy who has had the experience of being totally in control for 51 hours when he took charge, did whatever he wanted to basically ... he feels so scared and so powerful... his life experience has been that the adults around him are frightened of him so I find myself repeating* [to him] *"don't worry about that we'll keep you safe here, we'll manage that, it will be ok" ... he is only 12 and he is feeling so unsafe ... you are doing nothing if there is no containment there, how can you do anything if there is no secure base'*(R17). He went on to discuss the support offered: *'following critical incidents ... we set up a group of people together, myself, a couple of psychologists, TCI co-ordinator, to look at how we support people during those* [critical] *periods ... it is supporting the* [care] *team and* [meeting] *Quality Assurance ... if a staff has been assaulted or there is serious damage to property the first-line*

manager is expected to send a written report to the TCI co-ordinator who reviews it to see if there is a pattern to it [that is the quality assurance piece] *the other part is that the group is available to the manager and staff to meet following an incident ... our focus is support and learning ... I think it is good for people ... I think it is empowering because sometimes in this work people can feel very dis-empowered ... we are saying "lets take charge of this again, what can we learn, how can we do it differently" ... it turns something very hard into something positive ... they feel in charge again ... it is about having a vision for the service, about saying we are trying to create a learning organisation*' (R17). He referred to the culture of the service as meaning that children are treated as individuals '*we are involved in a therapeutic process with the children ... bringing about change and helping children develop skills that they need to live happy, more meaningful lives ... it is about working with children's families as well ... we need to believe in what we are doing, just take the risk sometimes ... I can think of a number of incidents where the Standard (Government of Ireland 2004) was met but it hasn't enhanced the care of the children ... it is about the containment of children's anxieties ... if this is done it can be a good system*' (R17).

7.9.6.2 <u>Staff-related issues</u>

7.9.6.2.1 <u>Supervision</u>

R15 referred to the service having a superb supervision policy. R17 developed this policy. '*We have developed a generic supervision policy ... we have common standards throughout the units, everybody will have a supervision contract, will have regular supervision ...* [it is] *part of developing a common standard ... one way to ensure quality is that someone along the line is in a position to ensure that quality supervision is happening and that we are sure about what we mean by supervision as well'* (R17).

There was further evidence of an interconnected front line service: '*the monitors see the supervision records ... not the intimate details* ...[but] *how the agenda was drawn up, care plans, was the care of the children considered or was it just all supportive supervision ... in view of the standard it will reassure us anyway*' (R17). R17 worked closely with the child care monitors and they reported to R14 which illustrated how an interconnected structure facilitated frontline practice that was child-centred.

7.9.6.2.2 Recruitment

We saw that R14 took charge of recruitment and selection of permanent staff, but that relief staff were recruited and selected by unit staff. R17 had been on interview panels for permanent frontline staff and for first-line managers. He had recently been reviewing recruitment procedures for relief staff. '*With the new rules in relation to part-time staff and their rights of tenure after a certain number of years service (Government of Ireland 2003), we needed the same procedures as were in place for permanent staff ... we have* [decided] *that all applications for relief staff go to the same person and we have developed an interview process for all relief staff ... it is the same as if they were going for permanent posts really ...* [if unqualified] *to get permanency under the Act* [staff] *are required to enter into a contract to undertake that they will commence formal training within two years ... we will stick to that and it will be enforced*' (R17).

7.9.6.2.3 Training

There were 40 staff (out of 250 in the service) who did not have professional qualifications in social care. R17 had been liaising with a local Institute of Technology and had some input into a degree programme for unqualified frontline staff. 20 unqualified staff were currently pursuing their professional training. R17 considered

that this was working well: '[training] *impacts discussions and conversations within units ... they are influencing practice*' (R17). R17 was making staff aware of the Act (Government of Ireland 2005) '*and the fact that people will be expected to register in the future and that the qualification will be a condition of registration ... if* [they] *don't have* [qualifications], *regardless of* [their] *professional competence, they will not be able to progress in the care profession ... I encourage them to consider training ... but the permanent staff that don't have qualifications we can only put it out there and hope they will take it up ... we only want people who are committed to take up training as it is demanding to work and train at the same time*' (R17).

7.9.6.3 *Line management support for first-line managers*

'*For me residential units need* [managers] *who are leaders, people who are enthusiastic about their work, who have a vision of what they want their residential unit to be about, who are child-centred, keen to learn ... they* [first-line managers] *are key to effective care*' (R17). He went on to discuss the regular meetings that R17 and R14 had with all first-line managers to involve them in the strategic development of the service. '*We have regular meetings with the managers ... unit managers meet as a group every three months for a day ... that includes high support, special care and mainstream managers; the high support and special care managers meet together every three months as well, and the mainstream managers also have their own meeting every three months; so all managers are meeting twice as a group every three months ... they get an opportunity to set the agenda, to get support around the areas they see the need for support ... they are networking'* (R17). Respondents 14 and 17 *have been trying to develop a vision for the service ... it is really important to explore where we see ourselves going ... we are getting every manager to consider [the vision] and to carry out selected exercises with*

their staff teams so that everybody has an input into the vision because it must be shared by everybody in the service to be effective ... I believe if a first-line manager doesn't know what their vision of care is ... no matter how good or experienced the care team are that doesn't really matter ... I have seen this, it doesn't matter how good each individual care worker is if there is no one person [manager] *uniting them ... we are all here to support one another*' (R17). The role of the first-line manager was highly valued in this service.

7.9.7 *Themes emerging from Service 8*

- References to 'needs-led', 'child-centred', 'child-friendly' culture in all three transcripts from this service indicate a firm focus on the provision of developmental care for residents.
- There is recognition of the importance of mandated child and youth residential care services having a clearly stated value system to guide frontline practice in needs-led care.
- This is a positively interconnected service with evidence of open communication between the levels of service and clarity around people's responsibilities for provision of developmental care.
- Engagement across all levels of the frontline service with the formation of a mission statement led to a shared vision and stated clarity of purpose.
- The shared vision also facilitates generative learning in the meeting of children's needs in the service as evidenced by development of a sexual health policy and by supporting staff teams following critical incidents with residents.
- First-line managers are highly respected, supported and empowered

- Commitment from first-line managers indicates a prioritisation of needs-led care over regulation-led care.
- Strategic development is practice-led.
- Senior manager with authority and domain expertise has responsibility for staff workforce factors.
- A service designed as a self-contained task structure facilitates and supports provision of developmental care in statutory residential services.

7.9.8 *Summary*

There is strong evidence of this service operating from a developmental model of care. R14's vision of a cohesive, interconnected residential service with clear aims, a stated ethos which strives for a child-friendly/family friendly culture; and his strong leadership ability have resulted in the development of a service, structured as a self-contained task, which shows that developmental care can be reliably provided for residents in a statutory residential care service.

7.10 Conclusion

This concludes discussion of the findings of the study that emerged from the content analysis of the transcripts of the 17 research respondents. The respondents represented eight residential child and youth care services across the geographic regions of the health service executive (HSE) and transcripts were discussed in the context of the particular service to which respondents belonged. Each frontline residential youth care service was summarised as belonging to either a developmental care model or a social risk model of care.

The categories which shaped discussion of the respondents' transcripts resulted in the emergence of core themes of their particular residential child and youth care services. Chapter Eight will discuss the presentation of these themes through the perspective of a critical success factor model.

CHAPTER EIGHT:

EMERGENCE OF CRITICAL SUCCESS FACTORS OF IRISH RESIDENTIAL CHILD AND YOUTH CARE

8.1 Introduction

The aim of the study is to discover how organisational factors impact provision of care for young people in residential care. It sought better understanding of organisational factors of residential youth care from the narratives of first-line managers and their line managers. Particular attention was paid to how decisions taken at the Exo level of service organisations impacted the lived experience of residents at the Micro level. The study selected a 'new managerialist' construct *critical success factors* as a framework for presentation of the themes of respondents' narratives in the context of prevailing organisation factors. It was felt that this construct would be familiar to senior administrative managers of the HSE, the main provider of Irish residential youth care, and that location of frontline care factors in an organisational context could help to narrow the gap between frontline factors and those organisational factors with which senior managers were primarily concerned. This chapter will clarify how the themes that emerged in Chapter Seven are organised for presentation through use of a particular critical success factor model (Leidecker and Bruno 1984). This particular model addresses critical success factors across three levels of a service, and so sits comfortably with Bronfenbrenner's ecological systems model (1979).[14]

[14] Initial use of the critical success factor model yielded seven factors which were presented to a group of key informants. It is discussed in Chapter 6 how analysis of the key informants' transcript resulted in a refinement of the seven factors to shape five final critical success factors.

8.2 Themes found to differentiate residential youth care services

Table 1 is presented in this chapter to illustrate how a simple comparison of all services of the study across common variables illustrates how certain core themes of the data emerged as significant factors in determining whether services operated from a developmental or a social risk model of care. Since the study seeks clarification of critical success factors of residential care necessary for provision of developmental care those themes associated with developmental care shape selected critical success factors which were then finalised following consideration of the contribution of key informants from the Irish child welfare sector.

TABLE 1

Service	Homeless	Short term	Mainstream	Ages (12-17)	1st line manager supported	Domain Expertise (1st line manager)	Empowered Director level	Domain expertise (Director level)	Micro managed senior management
1	✓	✓	X	✓	X	✓	X	✓	✓
2	✓	✓	X	✓	✓	✓	✓	✓	n/a**
3	X	X	✓	✓	✓	✓	✓	✓	n/a**
4	X	✓*	✓	✓	✓	✓	✓	✓	X
5	✓	✓	X	✓	✓	✓	✓	✓	X
6	✓	X	X	X	✓	✓	✓	✓	n/a**
7	X	X	✓	✓	X	✓	X	✓	✓
8	X	X	✓	✓	✓	✓	✓	✓	X

* A short-term high-support unit
** Voluntary services

Table 1 Illustrates that all 8 services had many variables in common indicating that all provided needs-led care for residents some of the time, however all six services that were categorised in Chapter 7 as operating purposefully from a developmental model of care had directors of service with domain expertise who were empowered by their line managers to provide developmental care. The two services categorised in Chapter 7 as operating from a social risk model had one variable that was not present in the other services: front-line care was micro managed by senior administrative management. These senior administrative managers had full authority, but no domain expertise and prioritised service needs of efficiency over the developmental needs of young residents. Decisions of senior administrative managers in these services reflected use of a Neo-Taylor managerialism (Pollitt 1990), as they prioritised efficiency and value-for-money without an understanding of how their decisions, taken at an exo level of the service, might affect the lives of young residents at the micro level of the residential services they line-managed. There was evidence of a disconnect in both these services where senior administrative managers had no direct contact with first-line managers and sought to disempower managers at director of frontline service level. Isolation of these factors helped to clarify those factors needed for prioritisation of developmental care in residential youth care settings.

8.3 Themes of services operating from a developmental care model

The six services of the data set deemed to be delivering developmental care varied across variables such as type of service, length of placements, age group of residents; but all had a supported first-line manager with domain expertise, and a senior manager at director of service level with authority and domain expertise. The presence of these two factors protected services from being micro managed by senior administrative

managers. This was particularly important for large statutory services, which was where the only evidence of micro management of frontline residential services was evidenced in the data. Empowerment of both levels of manager in frontline services ensured positive interconnectedness across levels of frontline services, a factor which facilitated prioritisation of the caring relationship at the micro level in these services, essential for the provision of developmental care for residents. These services which were deemed to be providing developmental care also had developed value systems which guided needs-led care of residents. All six services providing developmental care had the following themes in common:

- First-line managers with domain expertise who were supported by managers at director of service level who had both domain expertise and authority—factors which also created an interconnected service
- Regulated by the mandate-of-care in Irish legislation which prioritises developmental care for residents
- Clearly stated value systems which guided informed decision making in the provision of needs-led care
- Workforce factors managed by directors of the frontline service
- Directors of service with leadership skills that ensured commitment by all frontline staff to provision of needs-led care by clarifying the purpose of residential youth care as provision of developmental care for residents
- Strategic planning and development of the frontline service that was practice-led.

8.4 Themes of services operating from a social risk model

- Disconnected services with no ongoing direct communication between senior and frontline managers where senior managers prioritised value-for-money over provision of developmental care
- No delegated authority at director of service level which led to micro management by senior managers of the frontline service
- Prioritisation of compliance in frontline practice, not needs-led care as mandated in Irish legislation
- Presence of a traditional view of residential care as being merely childminding
- Strategic planning and development of frontline services seen as the exclusive responsibility of senior management
- Workforce factors exclusively managed by human resources departments.

8.5 Themes and critical success factors

Discovery of critical success factors necessary for provision of developmental care in Irish residential youth care is a stated aim of the study. The themes that emerged from the data were organised through use of the Leidecker and Bruno (1984) model of critical success factors. This model selects critical success factors across three levels of a given organisation or service and so sits comfortably with Bronfenbrenner's ecological systems model (1979). Seven critical success factors emerged from use of the Leidecker and Bruno model (Appendix 5). These were presented to a group of Key Informants.

8.6 Critical success factors relating to three levels of service

8.6.1 *Level 1*

Level 1 equates with Bronfenbrenner's micro level (1979). Since the lived experience of young residents is directly impacted by the ability of frontline staff to care for them in an individualised and needs-led manner, workforce issues must impact critical success factors at that micro level. Staff need evidence of domain expertise and so require a basic level of training in order to undertake this challenging work. The data also showed that a residential service needs to have a stated value system that guides practice. This value system should shape service policies and directly impact practice by providing guidance on how to make informed judgements necessary for needs-led care of young residents. In order to provide a sense of safety for residents, staff must feel respected, supported and safe. Creative responses to troubled youth require a working environment which facilitates generative learning, and so the absence of a blame culture in a residential service is essential.

Factors relating to Level 1 that were presented to Key Informants included:

- Robust workforce policies
- Need for support from manager at director of service level with authority and domain expertise for core care activities (development of ethos reflecting core importance of the caring relationship).

8.6.2 *Level 2*

This level equates with Bronfenbrenner's exo level (1979). The focus is on factors at the organisational level that significantly impact any service's performance. Themes that emerged from data relating to this level of analysis were the importance of

interconnected systems with open communication and accountability at all levels for provision of developmental care. It was found that managers at director-of-service level need to have both domain expertise and authority to manage, in order to ensure provision of developmental care. Directors of service need leadership skills that use a clear understanding of the purpose of residential youth care in order to get commitment from staff to a service value system that continuously strives to provide developmental care. Directors of service must also empower both first-line managers and frontline staff in provision of developmental care for residents. Factors reflecting these research themes that were presented to the Key Informant group included:

- The residential child and youth care sector needs an expressed clarity of purpose underpinned by core values to which all residential services subscribe and are measured against
- Strategic planning and service development require as much attention as frontline care
- Service development, responsiveness to presenting issues, monitoring and control at all levels of service.

8.6.3 *Level 3*

This is similar to Bronfenbrenner's macro level. At this macro level of analysis the Leidecker and Bruno (1984) model focuses on legislation and national policies that regulate and guide practice in a given sector. The macro level factors related to this study are Irish legislation, Child Care Act 1991, and its mandate to provide developmental care for young people in need of residential care. The major provider of residential youth care in Ireland is the Health Service Executive (HSE). Historically most Irish residential youth care services were provided by religious orders, but the last

decade saw the majority of these religious orders moving away from provision of residential care and the transfer of their services to the HSE. Two services of the data set (Services 4 and 8) referred to their recent move from the voluntary to the statutory sector. R13, director of Service 4 highlighted the lack of understanding of residential youth care in the HSE. This lack of understanding could have been instrumental in senior HSE managers' tendency to micro manage residential services which had large budgets, in their effort to achieve 'best value for money'. The presence of an historical understanding among senior HSE management of residential care as being merely 'childminding' (referred to by Respondent 12 from Service 1) could also be related to their failure to fully understand their mandated responsibility under Irish legislation to provide developmental care for troubled young people in state run residential youth care services. The factors reflecting Level 3 issues presented to the Key Informants included:

- Need to prioritise responsibilities of corporate parenthood and to ensure that bureaucratic inputs are transparently instrumental in supporting a client centred culture
- Ability to meet government standards.

Content analysis of the recorded discussion of the Key Informants confirmed the trustworthiness of the research themes and contributed to the final refinement of critical success factors across three levels of residential youth care services.

8.7 Emergence of five critical success factors

8.7.1 *Critical Success Factor 1*:

The senior manager tasked with responsibility for the workforce in the residential youth care sector must have authority and proven domain expertise.[15]

The importance of a manager with domain expertise having responsibility for workforce issues in the residential youth care sector emerged from the research data and was totally supported by the group of Key Informants from the Irish child welfare sector. The research data found that there were examples of robust workforce processes in the six services that provided developmental care and there were major problems with workforce processes in the two services deemed to be operating from a social risk model of care, where workforce issues were managed exclusively by human resource (HR) departments in the HSE. HR departments were reported by research respondents as lacking in understanding of the purpose and function of residential youth care services. Respondents 3, 13 and 14 described their role in the development of robust recruitment and staff probation processes in their services. These managers all had domain expertise and their robust processes resulted in their services having less difficulty attracting and retaining suitable, professionally qualified staff. Key Informants saw HR control of workforce processes for the residential youth service as reflecting the bureaucratic disconnect that prevails in residential services that are directly senior managed by bureaucratic managers. They stated that HR departments did not prioritise frontline needs, did not have clarification of the residential care task, of required qualifications, of the particular relevance of probation, or of the training and support needs of frontline staff. Key Informants reported that the time lags between selection

[15] This relates to point 1 of Level 1 issues as presented to the group of Key Informants.

and appointment of staff (which can result in very good candidates taking up alternative employment) were regularly caused by bureaucratic factors such as annual budgeting. These factors influenced the shape of the final critical success factor concerned with workforce issues.

8.7.2 Critical Success Factor 2:

Provision of developmental care in Irish residential child and youth care practice requires reciprocal relationships which are needs-led, not regulation-led.[16]

The Key Informants mentioned the presence of confusion in the sector about the substance of the caring relationship, which resulted in the formation of a CSF at the micro-level, more directly related to frontline practice as being needs-led, not regulation-led. This also more accurately reflected a theme that emerged from narratives of research respondents that needs-led care is essential for provision of developmental care. Key Informants referred to some senior managers of residential youth services wanting to reduce the caring relationship to a series of instrumental tasks and to deny the emotional content of such relationships. Caring expertise (Maier 2006; Fulcher and Ainsworth 2006; Garfat 1998; Fish, Munro and Bairstow 2008) recognises that caring relationships must be reciprocal; caring relationships represent the positive risk of social care work and must be supported in the interests of needs-led practice. These issues contributed to the final shape of CSF 2.

[16] This CSF combines comments of Key Informants in relation to discussion of point 2 of Level 1 issues and point 2 of Level 3 issues which were incorporated in the shape of this Level 1 critical success factor.

8.7.3 *Critical Success Factor 3*:

It is necessary to have accountable leadership with authority and developmental care expertise which is committed to a shared vision about the purpose of residential youth care and the provision of developmental care.[17]

The Key Informants repeatedly referred to the importance of leadership at first-line level for the provision of developmental care for young people in residential care. However, they also referred to the fact that social service inspection (SSI) reports regularly reported that the views of first-line managers are not being heard by senior HSE management. Leadership in residential services must be at a sufficiently senior level (director of service level) to give a voice to the first-line manager and to protect the frontline residential service from bureaucratic directives. Leadership is also mentioned by respondents 14 and 17 from Service 8 as essential for provision of developmental care for residents. The person occupying the important post of director of service must have authority and domain expertise, and have the ability to get commitment across the frontline service to a shared vision which clarifies the purpose of residential youth care as provision of developmental care for residents. Within a major bureaucratic structure such as the HSE, a manager at the level of director of the residential service can report to senior HSE management and be held accountable for the provision of developmental care. While this has significance for the calibre of person in the director of service position, it would not require a major reorganisation of existing HSE regional management structures. These factors shaped CSF 3.

[17] This CSF relates to issue 1 of Level 2 presented to Key Informants, placing more emphasis on the importance of accountable leadership to provision of developmental care in residential settings.

8.7.4 *Critical Success Factor 4*:

Strategic planning and service development in residential youth care need to be practice-led, guided by a shared vision of developmental care and ongoing evaluation.[18]

There is an obvious link between strategic planning and service development which is reflected in one critical success factor in the final list. Key Informants referred to strategic planning in the residential sector being negatively impacted by prioritisation of child protection policies in Irish child welfare services. They also referred to senior HSE management seeing strategic planning as their sole responsibility (which resulted in strategic planning of residential youth care services being service-led, not practice-led in the Irish context). Key Informants agreed that service development in the Irish residential youth care sector should be practice-led. They saw that accountability for practice-led service development needs to be linked to vision and ongoing evaluation. These issues contributed to the final distillation of CSF 4.

8.7.5 *Critical Success Factor 5*:

Responsibilities of a duty of care mandated by the Child Care Act (1991) must be prioritised to ensure that bureaucratic inputs do not undermine developmental care in Irish residential youth care services.[19]

Provision of needs-led, developmental care for young residents in organisational settings is a complex task (Maier 2006). Irish legislation (Government of Ireland 1991)

[18] This CSF combines issues 2 and 3 of Level 2 presented to Key Informants.
[19] This CSF relates to issue 6 at Level 3 as discussed with Key Informants.

clearly mandates the Irish public service in the name of the HSE to provide developmental care for those young people whose parents are unable or unwilling to provide such care. The challenge is to prevent the government's mandate from becoming bureaucratised. Bureaucratic care is generalised care, care that can be reduced to a series of instrumental tasks, care that can be controlled through insistence on rigid compliance. These factors are the direct opposite to care that is developmental, individualised and needs-led. Clarification and provision of developmental care require accountability at senior management level and the delegation of authority to a manager at service director level with expertise in developmental care, for development of an interconnected service focused on provision of developmental care. Recognition of these issues shaped CSF 5.

8.8 Conclusion

This presentation of research results emerged from the content analysis of 17 respondents representing eight residential child and youth care services in Ireland as presented in Chapter Seven, and the presentation of the emergent themes through a selected critical success factor model (Leidecker and Bruno 1984). Six of the eight residential services were categorised as providing developmental care and had the following themes in common: an interconnected service focused on provision of developmental care; a senior manager at director of service level, with domain expertise and authority to senior manage the service; support for first-line managers and frontline staff in the provision of developmental care; robust recruitment processes, commitment to a shared vision of care that clarified the task as provision of developmental or needs-led care. The two services categorised as operating from a social risk model of care had a major theme in common which seriously impeded provision of developmental care for

residents. They were both micro managed by senior bureaucratic managers. While both these services had directors of service in post with domain expertise, in neither case were these directors of service empowered by their line managers or held accountable for provision of developmental care for young residents at the frontline. Both directors of service in these services were principal social workers, one was seriously disempowered by his line manager and the other paid very little attention to the residential service he line-managed which may be because of a prioritisation of child protection issues in the fieldwork services for which he also had line management responsibility (a factor mentioned by the group of Key Informants as negatively impacting strategic planning and development of Irish residential youth services). These factors indicate the importance of residential youth care services being senior managed by directors of service with authority and domain expertise. These directors of service should be tasked with development of interconnected frontline services with accountability across all levels of service for provision of developmental care. The services deemed to be operating from a social risk model of care were structured as bureaucratic organisations where there was a disconnect between senior and first-line management, there was no supervision or accountability of senior managers, HR departments took charge of workforce issues and the stated goal for frontline services was full compliance with government standards (Government of Ireland 2004). One of these services in the data (Service 1) might have been achieving compliance with government standards, but lack of evidence of safe care in the second service (Service 7) raised serious questions of it even meeting existing standards of care. Neither of these two services provided developmental care for their young residents.

Use of the Leidecker and Bruno model of critical success factors for the organisation of the research themes yielded seven critical success factors across three levels of frontline residential care services. To test the trustworthiness of these results (Guba 1981), these critical success factors were presented to a group of Key Informants from the Irish child welfare sector as being necessary for provision of developmental care for young people in residential care. This confirmed the trustworthiness of the research findings as all factors were considered by the Key Informants to be relevant and necessary for provision of developmental care for residents**.** Content analysis of the transcript of the discussion of the group of key informants in relation of the seven success factors guided the shape of a final list of five critical success factors (CSFs) which are presented as the results of this study. These five CSFs are interrelated, each one is necessary to achievement of developmental care and together they are sufficient to achieve the provision of developmental care in Irish residential child and youth care.

CHAPTER NINE:

DISCUSSION OF CRITICAL SUCCESS FACTORS NECESSARY FOR PROVISION OF DEVELOPMENTAL CARE IN IRISH RESIDENTIAL CHILD AND YOUTH CARE

9.1 Introduction

This chapter discusses each of the critical success factors that emerged from application of the Leidecker and Bruno (1984) model, in the context of related research and theory. It illustrates each factor's importance to the provision of developmental care for young people in residential care. The research themes that yielded the five critical success factors indicate that, taken together, all are important in the provision of developmental care. These critical success factors (CSFs) relate to the mission of Irish residential child and youth care as identified in the 1991 Act (Government of Ireland 1991) and reinforced in the National Children's Strategy (Government of Ireland 2000). This set of factors identifies what has to prevail in the Irish residential youth care sector in order to facilitate reliable provision of developmental care for young residents. The Leidecker and Bruno model of critical success factors was selected for presentation of the research findings because it facilitated clarification of critical factors across three levels of Irish residential child and youth care services and so sits comfortably with Bronfenbrenner's ecological systems model (1979) which developed a model of levels of factors necessary for the developmental care of all children and young people. Critical Success Factors 1 and 2 refer more directly to Level 1, or Bronfenbrenner's micro level, and so relate more directly to frontline care. Critical Success Factors 3 and 4 refer to Level 2 or Bronfenbrenner's exo level, and so relate to those organisational issues that must prevail to facilitate developmental care for young residents. The final factor, Critical

Success Factor 5, refers to Level 3 or the macro level and refers to the mandate-of-care established in Irish legislation. This interrelated set of critical success factors highlights the need for a whole system approach to facilitate provision of developmental care for young residents and acknowledges that organisational factors are likely to impact frontline care even more than the quality of frontline staff, reflecting Bronfenbrenner's comments in relation to the importance of exo level factors in the emotional development of children and young people (Bronfenbrenner 1970). There is much reference in this chapter to the contribution of Key Informants from the Irish child welfare sector, to whom a preliminary list of critical success factors was presented and who had comments to the refinement of all five factors based on their long experience of working at senior levels across the child welfare sector in Ireland.

9.2 Critical Success Factor 1 (CSF 1):

The senior manager tasked with responsibility for the workforce in the residential child and youth care sector must have authority and proven domain expertise.

Workforce issues such as staff recruitment, probation, development, retention and support form a core process in the provision of developmental care in all child welfare services, including residential care for troubled young people. No sector can seriously aspire to improve outcomes for children and young people without a respected, valued, and professional workforce. The core importance of a robust workforce is reflected in the Children's and Young People's Workforce Strategy (Department for Children, Schools and Families (DCSF) 2008) which outlines Britain's strategy for workforce development for 2020 as part of the *Every Child Matters* initiative (Department for Education and Skills 2004). Retention of competent frontline staff in residential youth

care services has been a problem in Britain. There is some evidence there to suggest that residential youth care workers believe that their work is not valued at an organisational level. There are references to them experiencing lack of support with provision of developmental care for residents and to the residential youth care service being impacted by the presence of a blaming culture (Colton and Roberts 2007). It is hoped that the Children and Young People's Workforce Strategy (DCSF 2008) will succeed in addressing these issues.

Child welfare services on the other side of the Atlantic have also been blighted by high levels of staff turnover. This has prompted nationwide concern in North America where the Government Accountability Office (GAO) reported that a federal Child and Family Service Review (CFSR) found that problems with staff retention negatively impacted outcomes for children and families (Government Accountability Office 2003). Staff turnover was found by the GAO to be most detrimental in residential care, where staff changes intensify residents' feelings of neglect and can lead to their resistance to therapeutic interventions. These factors have led to a growing recognition in North America that a competent, committed workforce is critical to effective child welfare services which include residential youth services. This calibre of workforce requires residential youth care services to have robust staff recruitment and retention processes.

Similar factors to those mentioned in England and North America impact workforce issues in Irish child welfare services. Key Informants from the sector who participated in this study referred to the presence of a blame culture in the residential youth care sector which is similar to that reported by Colton and Roberts (2007). A blanket ban on recruitment in the sector reflects a lack of understanding at the broader organisational

level of how central a competent, committed, professional workforce is to the provision of developmental care for young people in residential care.

Staff recruitment, selection, probation, development and support issues were explored with each respondent in the research sample. Voluntary residential services of the sample (Services 2, 3, 6) expressed satisfaction with their recruitment procedures and all had total confidence in their frontline staff teams, reporting no problems with retention of committed professionally qualified staff. The remaining five services—all statutory—reported varying levels of satisfaction with their recruitment procedures. Services 4, 5, and 8 acknowledged the central importance of recruitment and had managers (Rs 13, 8, and 14) with sufficient leadership ability to ensure the development of robust recruitment processes. These yielded competent, qualified staff, with induction and probation processes which ensured that only staff suited to the care task advanced to permanent posts. The remaining statutory services (1 and 7) continued to rely on the human resource (HR) departments in their regions of the HSE for the management of workforce issues in their frontline services.

Both Services 1 and 7 reported staff-related issues which negatively impacted frontline care of residents. The senior HR managers who controlled workforce factors had administrative expertise and little or no understanding of the residential care task. This seemed to feed a negative culture in these frontline services. A practice which prevailed in both residential services and negatively impacted frontline practice was that of moving some members of permanent staff (who were mostly unqualified and deemed by first-line managers to be unsuited to caring for troubled young residents), around residential units and imposing them on any first-line manager who had a staff vacancy.

Respondents stated that these staff had been found to be disruptive of both staff teams and resident groups. Respondents reported that, as first-line managers, they were prepared to put up with unsatisfactory practice from temporary staff on their teams rather than loose them and be exposed to the imposition by HR of one of these less suitable staff with permanency status who were almost impossible to get rid of. There were no policies in the HSE for removing unsuitable permanent staff from frontline practice. This issue was mentioned by respondents from both Services 1 and 7 only and not by any respondents from the other services that participated in the study. This is a safeguarding issue and needs to be urgently addressed by the HSE, as it directly impedes provision of developmental care for residents.

Other workforce factors which prevailed in Services 1 and 7 that negatively impacted care of residents were found to include:

- no proper use of a probation period for newly appointed staff to ensure that only those suited to residential care work progressed to permanent positions;
- widespread use of agency staff;
- inadequate staff supervision policies; and
- first-line managers were not being empowered to lead their staff teams.

Negative workforce practices were also seen to exacerbate difficulties with the retention of good, well performing staff who most probably found such practices intolerable. High staff turnover in frontline practice directly feeds into a negative culture, which in turn negatively impacts the care of troubled residents.

Studies aimed at understanding factors contributing to recruitment and retention of child welfare staff have highlighted some factors impacting staff retention. Important among these are job clarity, intrinsic job value, work-life balance and perceived organisational support (Smith 2005). Low co-worker support was also found to be linked to staff turnover (De Panfilis and Zlotnik 2008). When these factors are considered in the context of how workplace social interactions shape employees' notions of what to expect from a job and how to respond to job conditions (Pfeffer 1982; Argyris 1982), one finds support for Smith's findings that organisational level characteristics substantially affected the likelihood of staff retention in child welfare services (Smith 2005).

Services 1 and 7 had negative workforce factors and both had human resource (HR) departments of the HSE which directly managed all workforce processes. The managers of these HR departments, although with administrative expertise, had no understanding of frontline residential care work, and so were not suited to directly managing workforce processes for frontline residential care services.

The presence of negative workforce factors in these residential services could cause the HSE to be found in breach of its mandate-of-care in current Irish legislation (Government of Ireland 1991). Fulcher (2002) refers to a judgement of the Law Lords in England which found that the principle of vicarious liability imposes legal responsibility for the actions of others which have been shown to cause injury. Vicarious liability, often applied in the employer/employee relationship, commonly occurs when there is a superior (a senior HR manager) who is legally responsible for the

acts of his/her subordinate staff.[20] If an employee is negligent on the job (by failing to provide developmental care for residents) the employer is legally responsible for any neglect or damage the employee might cause. The principle of vicarious liability needs to be seriously considered by HR departments of the HSE which exercise full control of workforce processes for frontline residential care services where negative factors impede provision of developmental care for residents.

These factors shaped Critical Success Factor 1. This CSF emphasises the importance of the manager with responsibility for workforce issues having domain expertise and authority to ensure continuous availability of a workforce capable of providing developmental care—168 hours per week—for young residents.

9.3 Critical Success Factor 2 (CSF 2):

Provision of developmental care in Irish residential child and youth care practice requires reciprocal relationships committed to needs-led, not regulation-led care

Those services included in the sample population deemed to be providing developmental care for their young residents recognised the central importance of the caring relationship between frontline practitioners and residents. These services designed care processes to maximise the effective use of such relationships in the needs-led care of residents. The services were sufficiently interconnected and led by managers with both the authority and expertise in therapeutic care to ensure the provision of an environment in which reciprocal relationships emerged. The services deemed to be

[20] Recorded in a unanimous judgement by British Law Lords in 2001: Lister and others v. Hesley Hall Ltd (2001) 2 All ER 769.

operating from a *social risk model* were seen to have a disconnect between frontline and senior management levels. They were micro managed by senior managers with full authority but no expertise in the provision of developmental care. The outcome that guided social risk services was compliance with national standards (Government of Ireland 2004), not commitment to needs-led care of residents.

Reciprocal relationships are essential to needs-led practice with troubled children and young people (Garfat 1998; Graham 1994; Graham 2006; Maier 2006; Smith 2009). Such relationships represent the context in which people-changing activity takes place, and as such, demand professional understanding and skill. Positive exploitation of reciprocal relationships between frontline practitioners and troubled residents requires an environment within which carers are encouraged and supported to engage with intentional, needs-led work with residents. Such work requires that carers are capable of making informed judgements in relation to presenting issues with residents (Garfat and Ricks 1995), and that they are empowered to take whatever action is considered to be in the resident's best interest at a given time. While all actions with residents must be guided by prevailing standards of practice, intentional actions are determined by informed ethical decisions at a given moment in time and must always reflect needs-led care (Fish, Munro and Bairstow 2008).

It is argued that compliance with regulations alone, without evidence of commitment to needs-led care, will not achieve developmental care for young people in Ireland. Needs-led care requires practitioners capable of self-driven ethical decision-making (Garfat and Ricks 1995). Such decision-making presumes a problem-solving approach to practice and not merely an approach reliant solely on external guidelines or codes of

practice. At its worst, compliance can result in the prioritisation of an agency interpretation of practice guidelines where the staff focus involves ‘dotting i’s and crossing t’s’, instead of responding respectfully to an individual child or young person’s needs. At best, it results in a commitment to regulation-led care, not needs-led care.

Provision of residential child and youth care that is developmental requires skilled practice. It is work which is characterised by dynamic complexity, particularly in organisational settings (Graham 1994). An ecological systems perspective (Bronfenbrenner 1979) holds that effective work in dynamically complex domains requires that we change from seeing people as ‘helpless reactors to seeing them as active participants in shaping their reality, from reacting to the present to creating the future’ (Senge 1990: 69). This challenges us to change how we view our work with young people in residential care. A systems approach to multi-agency safeguarding and child protection work has recently been presented in Britain by Fish, Munro and Bairstow (2008). Such adaptation of the systemic approach offers the potential to radically change residential youth care work.

Safeguarding has become a major preoccupation in child welfare services. The sector has been damaged by the plethora of enquiries into the abuse of children, culminating in numerous enquiries in the 1990s into the abuse of young people in residential care, in Britain and Ireland (Levy and Kahan 1991; Kirkwood 1993; Kent 1997; Warner 1997; Department of Health 1996; Government of Ireland 2002). Everyone committed to effective outcomes in child welfare services recognises the importance of protecting children and youth. However, reviews of reports of enquiries in Britain show that, while these have had a major influence on how services have been developed and regulated

(Parton 2004; Stanley and Manthorpe 2004), their value is now being questioned, as they regularly identify similar problems in frontline practice and make similar recommendations with little evidence of fundamental improvement of outcomes for young people (Rose and Barnes 2008, cited in Fish, Munro and Bairstow 2008).

It is also generally accepted in the child welfare sector—the residential youth care sector in particular—that the introduction of clearly stated standards of practice and regulations that require compliance have led to improvement of overall practice. What is being said here is that compliance to established standards is an important guide to informed decision making. However, compliance is not sufficient on its own to achieve developmental care for all young people in residential care. Developmental care requires a fundamental change to practice which could be achieved through wider use of a systemic approach.

A systemic approach focuses on patterns and is constantly guided by the feedback loop which recognises interconnectedness within a system. Such an approach recognises the need for informed decisions at the frontline, not simply compliance, focusing attention on the presenting need in a particular context. Reliance solely on compliance in social care practice assumes that precise application of selected standards or regulations to complex issues of practice will lead to best outcomes for all residents in all circumstances. Such an assumption has led to preoccupations in the sector with getting structures and policies in place to ensure that national standards of care (Government of Ireland 2004) are implemented at all times.

A standard of care has been accepted legally as the degree of prudence and caution required of an individual who is under a duty to care (Stanton and Dugdale 1996). The duty of care mandated by Irish legislation (Government of Ireland 1991) clearly subscribes to provision of developmental care for young residents. This mandate-of-care is discussed more specifically in the context of CSF 5, but it is mentioned here to highlight the responsibilities of child welfare agents of the state to whom the duty of care mandate is handed over in the case of young people admitted into state care (Fulcher 2002). This mandate in Irish law is to provide developmental care for each young resident in state care. Provision of developmental care requires genuine support from employers for needs-led practice at the frontline level. Such practice can only occur when frontline practitioners are empowered to make informed decisions based on their best understanding of a client's needs at a particular time. Regulation-led practice, on the other hand, focuses on control of practitioners at the frontline and a distancing of senior managers from frontline practice issues. A major emphasis on regulations disempowers frontline practitioners and tends to feed a 'blame' culture. This can cause practitioners to be defensive, to prioritise their own safety—not the needs of a particular young person at a given time. A systems approach, on the other hand, sees blame as not contributing to problem solution or service enhancement.

Instead of focusing on regulations, the systems approach proposed by Fish, Munro and Bairstow (2008) emphasises the importance of learning from practice. It uses a case or incident as a window on the system and focuses on what is working well and also learning about possible flaws. It recognises that a frontline practitioner is not totally free to choose between good and problematic practice, but is influenced by the tasks s/he performs, what supports are available, and the environment within which s/he operates.

The systems approach places the focus of any enquiry or evaluation on the system itself—not the individual frontline practitioner. Such an approach seeks to promote a culture of learning, not of blame.

The systemic perspective acknowledges that child welfare work is marked by significant uncertainty. A 'one size fits all' approach cannot work in the dynamically complex world of residential child and youth care practice. If safeguarding is everybody's business, learning must be too, and this includes people at all levels in the system, from top-level management to frontline practitioners. A systems approach recognises that senior managers at local and regional levels, as well as national policy makers, need opportunities to learn from frontline workers and first-line managers. A practice-led view is necessary for senior managers to understand how policies, guidance and operational decisions impact direct work with youth and their families.

The systems approach is underpinned by an assumption that human behaviour is fundamentally understandable (Fish, Munro and Bairstow 2008). Decisions that turned out to be mistaken seemed sensible at the time they were taken. It suggests that hindsight needs to be avoided when evaluating professional practice. Instead, the aim should be to reconstruct how the situation looked to those involved at a particular time and then consider all factors influencing decisions taken at a given time. Such a perspective is not about apportioning blame, but about learning from practice in order to be better able to provide developmental care for residents.

Regulation-led care in its most extreme can be seen to remove judgement or discretionary decision-making from frontline child welfare practitioners. Needs-led

developmental care of young people cannot be provided by frontline practitioners who are not given authority to make informed decisions based on their understanding of presenting factors at a given time. The findings from this research on Irish residential child and youth care clearly indicate that services which encouraged informed decision making at frontline level, reinforced by a strong commitment to needs-led care from staff, achieved developmental care. Services micro-managed by senior administrators, who focused on compliance and removed all authority from frontline practitioners and first-line managers, were deemed to have failed to deliver developmental care and could be seen as being in breach of the duty of care mandated in Irish legislation.

9.4 Critical Success Factor 3 (CSF 3):

It is necessary to have accountable leadership with authority and developmental care expertise which is committed to a shared vision about the purpose of residential youth care and the provision of developmental care.

Leadership with domain expertise emerged from the research data as being critically important to the provision of developmental care for young residents. This was confirmed by the Key Informants who viewed leadership as being essential at first-line management level. The understanding of organisational factors necessary for developmental care that emerged from this study shows that effective leadership can only prevail at first-line level when it is facilitated and supported by the first-line manager's line manager. This occurred in the narratives of all three voluntary services in the data set and three of the five narratives collected from statutory services, all of which were deemed to be providing developmental care for residents.

Milner and Joyce (2005) argued that effective leadership is essential for successful outcomes in contexts that are characterised by high levels of complexity. Needs-led residential care is a highly complex undertaking (Graham 1994) and effective leadership (Bennis 1989) is essential for provision of developmental care in residential youth care settings. Leadership in residential youth care services needs to have sufficient authority to develop a shared vision and to get commitment from all frontline staff to needs-led care. Leaders' authority also enables them to protect the residential service from bureaucratic decisions taken at a senior management level of the HSE. It was seen that the two services categorised as operating from a social risk model of care had managers at director of service level who might have been expected to have domain expertise (both were principal social workers with line management responsibility for field social work and residential youth care services), but neither had the delegated authority to ensure provision of developmental care for the young people in the residential services they line-managed. It emerged from Service 1 that there was acceptance of an historical view of residential care as being merely childminding, not provision of developmental care for troubled young people. This view seemed to be reflected in the ability of both directors of service to manage their field social work teams—apparently more satisfactorily—where child protection regulations guided fieldwork practice. However, lack of delegated authority left them seemingly helpless to confront practice challenges in the residential youth care services that were failing to provide needs-led care for residents.

Leaders at director of service level need expertise in the provision of developmental care, authority to ensure that it is provided, and accountability for its quality. A self-contained task structure (Galbraith 1977) might better ensure the provision of

developmental care in statutory residential services that form part of the HSE. Thus, accountability for developmental care should be a guiding principle for all who practise in HSE structures, with the director of service being accountable to senior management of the HSE—in keeping with the HSE's duty-of-care mandate—for provision of developmental care for children and young people placed in residential care.

The leader's task is to create a value-based, vision-led environment (Senge 1990). The challenge for a leader of a residential service committed to developmental care is to lead a workforce of carers to master a cycle of thinking, doing, evaluating and reflecting. In this way, leaders facilitate the generative learning often required to meet the complex needs of young residents. Persuasive leaders instil confidence and empower carers to provide effective, needs-led frontline care.

The Health Service Executive (HSE), the principal provider of residential child and youth care services in Ireland, is part of the Irish public service. Present day public services find themselves in 'an environment where in many instances new rules of engagement are evolving all the time' (Milner and Joyce 2005: 84). In organisations where personnel are experiencing ongoing, changing demands, there is a tendency for staff to resort to what they do best. Such is the bureaucratic structure of the Irish public service that controls become ever more regulated, predictable and allegedly efficient. Due to the unpredictable nature of residential child and youth care work (Graham 1994) a more controlling environment cannot be relied upon to achieve policy agendas advocating developmental outcomes for children and young people in residential care.

The findings from this study show that services which satisfactorily provided

developmental care for their residents had leaders at director of service level in the system who shielded first-line managers and frontline practitioners from the possible negative effects of bureaucratic decisions taken at the exo or organisational level. These service managers often had to lead in environments where reporting lines and accountability structures had been blurred or were sometimes non-existent (as reported by R13 from Service 4) and so they needed very particular skills to ensure provision of developmental care at the frontline.

In those two services which did not provide developmental care the following extract from R16 highlights blurred reporting lines: '*What do we do to prepare you for this [senior management position] and on an ongoing basis to support you with this? We are weak in that area, very weak in that area'* (R16). This weakness, described by the most senior manager from a residential youth service operating from a social risk model, confirmed how the leadership/management that prevailed in traditional or bureaucratic structures was centralised at a very senior level and was more focused on control aimed at getting best value for money, not on ensuring environments capable of providing developmental care for each young resident.

It was argued in Chapter Three that the skilled leadership necessary for the provision of developmental care for all young people in residential care is *adaptive leadership*. The roles of effective leaders as developed by Bennis (1989), and presented in Chapter Three, clarify how adaptive leadership can be recognised in practice. There is evidence of many of the characteristics of adaptive leadership in the transcripts of the Irish respondents who directed services delivering developmental care for the young

residents in their units. A fundamental requirement for adaptive leadership is the generation of a shared vision—a concept that was prominent in a number of transcripts.

9.4.1 *Shared vision*

'[Shared vision] is a familiar concept in corporate leadership but on close examination visions tend to be one person's or a small group's which are imposed on organisations. Such a vision, at best, commands compliance, while a genuinely shared vision is one that many people in an organisation are truly committed to because it reflects their own personal vision. It is not what the vision is it is what it does' (Senge 1990: 207).

A shared vision helps build a common identity. An organisation's shared sense of vision, purpose, and operating values establish the most basic level of commonality. Vision establishes an overarching goal and clarity of purpose. A shared vision fosters intelligent risk-taking and experimentation. In residential child and youth care work it is known what has to be provided (developmental care), but how to provide this for particular residents can be a challenging task. Achievement of developmental care requires commitment to a shared vision of needs-led care. Residential child and youth care work is about trying to lay a foundation of values and attitudes that will help a young person ten years hence. It requires a vision that can be realised only in the longer term. Traditional, hierarchical organisations demand compliance which can be effective in the short-term, but developmental care of young residents requires commitment to the longer term and acceptance of a shared vision (Senge 1990).

9.4.2 *Clarity of purpose*

A vision facilitates clarity of purpose—as reported by R14 who required commitment from all frontline staff to '*a child-friendly/family-friendly culture*' (R14). R4 required commitment to needs-led care: '*We never refuse anybody in need*' (R4). Content analysis of the narratives showed clarity of purpose in the transcripts of all respondents from those services providing developmental care (Rs 2, 3, 4, 5, 6, 7, 8, 9, 13, 14, 15 and 17). The transcripts of respondents from services categorised as operating from a social risk model (Rs 1, 10, 11, 12 and 16) highlighted confusion with respect to their stated purpose. Clarity of purpose emerged through the leadership of senior staff whose direct line responsibility was for frontline services. These leaders were committed to the development of a shared vision or 'the art of visionary leadership' (Senge 1990: 212). They had the integrity that gained the trust of their first-line managers and frontline staff, factors which clarified the purpose of their services around the provision of developmental care. A group of carers truly committed to a common vision and clarity of purpose can accomplish the seemingly impossible. A shared vision and clarity of purpose help generate energy and focus for both adaptive and generative learning. Generative learning can only occur when people have clarity of purpose and are striving to achieve something that matters deeply to them. Generative learning involves the expansion of people's ability to create (Senge 1990); it is considered necessary for effective engagement in residential youth care work which is characterised by unpredictability and the need to respond to complex social and emotional needs of residents (Graham 1994).

Frontline developmental care needs to be protected by a senior manager (service director/manager) who is committed to the provision of developmental care. The

findings from this study show that managers whose leadership facilitated the development of a shared vision and a commitment to needs-led care were indeed providing developmental care for residents. While leadership is also a necessary quality for unit managers, the findings from this study suggested unit managers are not at sufficiently senior a level in the system to protect frontline care from bureaucratic decisions that can undermine the provision of developmental care. These factors influenced final refinements to Critical Success Factor 3.

9.5 Critical Success Factor 4 (CSF 4):

Strategic planning and service development in residential youth care need to be practice-led, guided by a shared vision of developmental care and ongoing evaluation.

CSF 4 is a combination of preliminary Critical Success Factors 4 and 5 as presented to Key Informants. Following analysis of key informant feedback, both strategic planning and service development were combined into a single critical success factor. The Key Informants viewed strategic planning and service development as key elements that are centrally important to residential youth services, but they stated that these elements were not happening in any reliable way in current Irish residential services. Key Informants referred to a tolerance by senior management of the HSE for lack of resources at frontline level of residential youth services. Key Informants considered that first-line managers were pulled in so many directions that there was no time to plan strategically. Principal social workers at director level of statutory residential services were said by Key Informants to be so busy with child protection work and court appearances that little attention was paid to the residential services they line-managed. Key Informants found that child protection issues thwarted strategic planning in the

residential youth care sector as these issues forced the sector into knee-jerk responses and legitimised micro-management responses in some residential youth services. The result was a focus on doing things right, not necessarily on doing the right things right for young residents. Key Informants also said that strategic management in the statutory residential sector had been captured by senior HSE management, many of whom did not recognise the central importance of practice-led strategic development. It was unanimously agreed by the Key Informants that service development was essential in the residential sector which was caring for young people with multiple interconnected needs that demanded that service providers be flexible and creative in their responses. It is essential that practice-led issues inform strategic planning and service development in the residential youth sector, a factor in tune with the aspirations of the *Agenda for Children's Services* which serves '*as a broad statement of principles for all services concerned with children*' (Office of the Minister for Children (OMC) 2007: v). At the heart of this agenda is a whole child/whole system approach and it refers to the need for policy makers and service providers to work strategically together to enable all involved in children's services to take personal responsibility for advancing the national goal of needs-led, evidence-based services that promote good outcomes for children. The agenda emphasises an interconnected approach to achieving desirable outcomes for children and young people, stating that better outcomes should drive formulation of policy and the expression of policy in services, ensuring that desired outcomes are achieved.

Understanding 'the whole person' must be embedded in every stage of service delivery. If the system cannot help children, we need to change the system (Langford 2008); this

requires a shift from service-led to practice-led residential youth services, and policies that take cognisance of practice issues with young residents.

The research data presented a model for practice-led residential youth care focused on provision of developmental care for residents. This model was satisfactorily developed by R14 from Service 8. The organisation design of Service 8 resembled a self-contained task structure (Galbraith 1977). This structure allowed R14 to take a leadership role in collaboratively developing a vision for the service and in getting commitment to provision of developmental (or needs-led) care across levels of the service, by the establishment of a child-friendly/family-friendly culture. This structure, which gave R14 full budgetary control for the residential service he line-managed, facilitated R14, at the process level, to appoint co-ordinators to oversee core care processes in that service. These processes were being continuously evaluated by practice-led issues and their ongoing support of frontline practice aimed at the provision of developmental care for residents. Management of strategy implementation in Service 8 facilitated the interconnectivity essential for generative learning in the service, which in turn shaped strategic planning and guided creative responses to presenting problems of the young residents. All strategy in Service 8 is guided by its commitment to its shared vision which is provision of a child-friendly/family-friendly culture. This service, through its robust supervision policy, is constantly evaluating outcomes of strategy implementation in the service. The service's commitment to provision of needs-led care is evident from the transcripts or respondents 14, 15 and 17. This service illustrates the importance of CSF 4 for provision of developmental care for young residents across the residential youth care sector.

9.6 Critical Success Factor 5 (CSF 5):

Responsibilities associated with a duty of care mandated by the Child Care Act (1991) must be prioritised to ensure that bureaucratic inputs do not undermine developmental care in Irish residential youth care services.

> *An Ireland where children are respected as young citizens with a valued contribution to make and a voice of their own; where all children are cherished and supported by family and the wider society; where they enjoy a fulfilling childhood and realise their potential.*
>
> *(Government of Ireland 2000: 4)*

This vision of the National Children's Strategy reflects a commitment to ensuring that the young people of Ireland will experience an environment which respects their particular needs and promotes their welfare as they journey through the developmental stages of childhood and adolescence towards a responsible adulthood. To turn this vision into a reality for young people who need state residential care will require a broad acceptance of this mission for residential child and youth care in Ireland. Any such mission would have to include a stated intention to ensure the provision of *developmental care* for every child in receipt of residential care. Provision of developmental care in organisation settings requires that organisational structures and cultures prioritise developmental or individualised care. Residential youth care organisations must demonstrate a culture which guides priority setting that demonstrates a respectful attitude toward practice and acknowledges its inherent uncertainty as it seeks to provide developmental care for young residents.

This study sought to achieve a more detailed understanding of Irish residential child and youth care, in particular the organisational factors impacting residential youth care. The

study was guided by the existing vision in Ireland of a developmental model for residential care (Chapter Two). It was found that certain critical factors must be in evidence at the organisational level to ensure that organisational structures[21] do not impede the delivery of developmental care in residential units. It is hoped that better understanding of each critical success factor will enhance the capacity of services delivering residential care for children and young people to function more effectively to meet personalised developmental needs for each young resident.

9.7 Duty-of-care mandate

The duty-of-care mandate comes directly from legislation, which in the case of mainstream and high support residential child and youth care in Ireland is contained in the Child Care Act 1991. The 1991 Act gives the Health Service Executive (HSE) clear responsibilities in relation to

- the protection of children at risk of homelessness, abuse and neglect;
- the support of families where children are at risk; and
- the regulation of provision for young people in State care (Gilligan 1992).

The focus of this study is young people in state care for welfare reasons, which is regulated by the 1991 Act. Under section 3.1 of the 1991 Act, each administrative area of the HSE is required to '*promote the welfare of children in its area who are not receiving adequate care and protection*'. Provisions of the Act show how legislators intended this duty to be discharged. For children deemed to require alternative care—such as residential care under a care order—the Act gives the HSE '*like control over the*

[21] An organisational structure embodies a particular distribution of control, power and rights within the organisation. (Galbraith 1977)

child as if it were his parent' and the '*obligation to do what is reasonable… for the purpose of safeguarding or promoting the child's health, development or welfare*' (s18.3). This section is taken by the study to reflect an obligation on the HSE to ensure that all young people in its care experience developmental care. Developmental care thus features as a core element in the duty-of-care mandate. We have seen (Chapter Two) how a succession of Irish governments throughout the 20th century failed in their duty to monitor children's residential services (Keogh 1996). It is thus important to ensure that the Irish Government now fully delivers on these responsibilities in the present, and provides developmental care for each young person in residential care. The central importance of this duty-of-care mandate was endorsed and supported by the Key Informants who helped shape the wording of this critical success factor.

9.7.1 *Duty-of-care mandate and Key Informants*

Key Informants had much to say about both the central role of the duty of care mandate and bureaucratic inputs in the Irish residential youth care system (Appendix 4). They acknowledged that the mandate goes through all levels of the system and requires that all levels work together to support activities at the micro or frontline level. The duty-of-care mandate was seen to go back to Common Law, to a case in England in 1530 which referred to not taking sufficient care (Fulcher 2002). This suggests that the organisation level is governed by Common Law and that a duty of care can be seen as the standard below which a determination is made about not caring enough.

Key Informants also discussed how responsibility for care can be interpreted as resting only with frontline practitioners. They stated that it was most important that the sector and all service levels be open to investigation as to how they are exercising this

responsibility. It was stated that this requirement is often missing (a factor also noted by Fish *et al.* (2008) to relate to British child welfare services). Key Informants saw the organisation level as being focused on the political agenda, reactive to the political flavour of the month. There was a suggestion that the level of fear experienced at the organisation level influenced its tendency to be more focused on control factors than on their duty of care mandate. This tension between a frontline level seeking to be client focused and the organisation level that is more focused on '*structures, strictures and available resources*' (Appendix 4: 2), causes ongoing tension at frontline level, and inhibits support for frontline issues by dragging first-line managers into corporate risk management. This reinforces a major finding from this study that provision of developmental care in organisational settings prevailed only in frontline services that resembled either self-contained task structures[22] (Galbraith 1977) or simple structures[23] (Mintzberg 1983) with a senior manager who led an interconnected service focused across all levels on provision of developmental care. Both of these structures were also seen to provide protection for the frontline residential youth care service from bureaucratic decisions and corporate risk management factors.

9.7.2 *Duty-of-care mandate and the Social Service Inspectorate (SSI)*

There was acknowledgement amongst Key Informants of the positive contribution made by the Social Service Inspectorate (SSI) to practice in statutory residential units for youth, since its establishment in 1999. The SSI focus to date has been largely at the micro-level, where it has positively impacted policies and practice. However, it is known that competing values, organisational ideologies, cultural variations and

[22] Structures that require the creation of self-sufficient resource groups, within large diversified organisations, focused on a particular task with full authority and responsibility for that task.
[23] Single unit with a strongly committed leader co-ordinating all processes necessary for achievement of a clearly stated task.

economic constraints can influence the daily lives of young people in residential units at least as much as frontline care policies and practices (Bronfenbrenner 1979). This research is concerned with scrutiny of residential services across all levels of the child welfare system as to how they meet their duty of care mandate.

9.8 Bureaucratic factors in residential youth care services

The findings show that bureaucratic factors played a significant role in differentiating residential services providing developmental care from those failing to deliver developmental care. Key Informants mentioned evidence that bureaucratic aims did not support agency best practice—that what was considered best practice by the first-line manager was not always considered best practice by bureaucratic human resources (HR) systems. It was considered important for managers to be strong enough to withstand such anomalies, an issue found only in those services where first-line managers were supported in their role by line managers (at director of service level) with both domain expertise and authority. There was an acknowledgement by Key Informants of the presence of fear in frontline practice.[24] This was compounded by staffs' perceptions that any mistakes made by them were noticed much more than any good, effective work they were known to do with clients.[25] Bureaucratic systems can be antithetical to client-centred practice, a point made by Menzies in 1979, which suggests their influence in child welfare services over a protracted period of time. Key Informants mentioned experiencing at first hand the disconnect between frontline staff and more senior managers at the organisation level. They referred to the fact that supervision exists only at frontline level, that senior managers have no supervision—a factor which also

[24] Anecdotal evidence of this factor was instrumental is shaping the research question of the study.
[25] Mistakes draw attention from the organisational level while good practice goes unnoticed by this level

emerged from the research respondents and one that is characteristic of bureaucratic structures (Mintzberg 1983). Key Informants saw this as a key factor in explaining why senior managers of the HSE were not in touch with frontline practice issues and so did not consider how policies imposed by them could impact provision of developmental care for residents. The disconnect was also seen by Key Informants to be related to conflicting expectations of frontline staff, where they were expected to act from a rights and justice perspective with clients, but they themselves were often treated badly by the organisation level.

There was strong conformity between respondents' views reported in this research and the views of the Key Informants, five of whom had domain expertise and held senior management positions in the Irish child welfare system. Both groups referred to how organisational factors impacted residential youth care. Provision of developmental care in organisational settings has been shown to be highly complex (Maier 2006). As stated in the *Agenda for Children's Services* (OMC 2007), provision of developmental care requires a '*whole system approach*' (Barrett 2006), an approach which can only prevail in particular organisation structures.

9.9 Organisational factors

Organisational factors that Key Informants saw impeding the provision of developmental care for young residents were already discussed in Chapter Three in the context of bureaucratic structures. The concept of the *Learning Organisation* (Argyris and Schon 1978) was also explored in Chapter Three for its significant contribution to our understanding of how organisations function and to the fact that organisations need to be held accountable for their actions. Building on the work of Argyris and Schon,

Senge (1990) established the idea that solutions for organisational problems require a systems perspective which guides exploration of underlying structures rather than events, and to think in terms of processes rather than snapshots. As public sectors grapple with ever expanding costs there is increasing evidence of them adopting a whole system approach to problem-solving and improvement of services (Milner and Joyce 2005; NHS Executive 1996; OMC 2007). Senge indicated that issues can arise in a given sector whose solutions require a reappraisal of dynamics across an entire public service. The findings of this study signal a need to look at the dynamics of the whole Health Service Executive in order to facilitate its capacity to reliably meet its mandate to provide developmental care for young people in residential care. This is what is meant by a whole system approach. If the residential youth care sector remains under the direct control of senior HSE management, provision of developmental care will require a review of the sector to ensure an alignment of the vision, mission and values across all levels of the sector. Irish legislation has established the vision for residential youth care (provision of developmental care for each young resident), the HSE now needs to implement its mission statement to focus on what the organisation needs to do in order to realise this vision. The vision and mission can galvanise workers in an organisation around the same purpose (Senge 1990; Barrett 2006). This requires that leaders and managers have a clear line of sight between their sense of personal mission and the overall mission of the organisation. Every employee in the organisation needs to know how s/he makes a difference to the ability to deliver the primary service. This alignment of purpose creates the necessary commitment across all levels of the organisation to shared outcomes. The emphasis that the whole system approach places on the values of the organisation is important. Values should direct decision making which, in child welfare organisations, is often moral and contestable. Values should also

support frontline practice that is uncertain and requires informed decisions by professional practitioners. The values of the residential youth care sector need to reflect provision of developmental care as its primary purpose.

To achieve whole system change and achieve cultural transformation, the most senior leaders and management must have compelling reasons for making changes in the first place (Barrett 2006). In the strongly bureaucratised Irish public service system such change may be difficult to achieve. An alternative solution may be re-organisation of all statutory residential youth care services into self-contained task structures within the HSE. Such structures (an example of which is functioning successfully in Service 8) need to be mandated to establish the required alignment of vision, mission and values aimed at achieving developmental care for each young resident.

9.10 Conclusion

Provision of developmental care for young residents requires the creation of environments which facilitate *needs-led care*. Such environments require a whole system approach where there is alignment between the vision, mission and values of a service committed to provision of developmental care. Such alignments can only occur in a positively interconnected system. The five critical success factors that emerged from this study draw attention to factors essential to the achievement of a service mission aimed at providing developmental care for young residents. These five critical success factors span the three levels identified in that conceptual framework (Leidecker and Bruno 1984) used to organise and present findings from 17 respondents' narratives collected in this study. The critical success factors are interrelated but each addresses particular processes. Each is considered essential, and together they are presented as

sufficient to guide the provision of developmental care in Irish residential child and youth care services.

CHAPTER 10:

CONCLUSION AND RECOMMENDATIONS

10.1 Introduction

The study set out to identify critical success factors essential for the provision of developmental care for residents within Irish residential child and youth care services. It sought to build on a previous study which clarified the purpose and content of residential youth care work in Ireland (Graham 1994). The research data confirmed that a majority of the services which participated in the study provided developmental care. A minority of services demonstrated remnants of a social risk model that was prevalent during the industrial schools era—a model of practice which prioritised the system over the needs of the child (O'Sullivan 1979) and failed to provide developmental care. Five critical success factors were highlighted which differentiated the two categories of services. In six services all five Critical Success Factors were evidenced, indicating provision of developmental care, whilst all factors were absent in the remaining two services judged as failing to provide developmental care for their young residents.

Use of a constructivist paradigm which employed purposive sampling achieved dialogue through serial selection and discussion through contingent selection of respondents from first-line managers through to their line managers in the residential youth care sector. Senge (1990) argued that discussion and dialogue are essential for clarification of a shared vision or mission. The mission of Irish residential child and youth care is mandated in the Child Care Act 1991 as involving the provision of developmental care. This mission presents a practice agenda for Irish residential child and youth care. The study sought clarification of the practice agenda to guide provision

of developmental care in the Irish residential child and youth care sector. An enhanced understanding of the sector gained from narrative accounts of the lived experience of first-line managers and their line managers was reconstructed to generate the five critical success factors deemed essential for the provision of developmental care for children and youth in residential care. Critical success factors are not the 'how to' of service delivery; they are the agenda. Each involves a combination of tactical and strategic factors that when taken together are sufficient to achieve the mission of developmental care within the Irish residential youth care sector. Each critical success factor is discussed below as a product of the research journey. While each success factor is considered necessary for provision of developmental care, taken together they contribute towards the active achievement of developmental care for all young residents in care.

10.2 Critical Success Factor 1:

The senior manager tasked with responsibility for the workforce in the residential child and youth care sector must have authority and proven domain expertise.

An Audit Commission Report in Britain (2002) recognised a major difficulty with public sector workforce factors, in particular staff recruitment and retention. This report mentioned the importance of maintaining a working environment that engages, enables and supports staff, and that people delivering public services should feel valued, respected and rewarded. However, a study in 2007 stated that retention of staff in residential care in Britain remains an issue. This study noted that [residential care] workers may still believe their work is not valued at an organisational level and refers to them experiencing lack of support to provide an effective service (Colton and Roberts

2007). There is no recent research on recruitment or other workforce factors for Irish residential youth care, but the data from this study confirm the central importance of workforce issues in a residential youth care sector mandated to provide developmental care for residents.

Research that could lead to residential youth care staff feeling more valued in the Irish context could focus on the clarification of the core care processes essential for the achievement of the critical success factor model presented in this study. Such research could shape the development of a model for evaluation of residential youth services charged with provision of developmental care for all residents. It is suggested that such developments could enhance the perceived value of residential child and youth care work across both statutory and voluntary services.

In the three voluntary residential youth services featured in the study, control of workforce factors rested with senior management who had authority and domain expertise. They directly managed first-line managers and also had involvement with frontline care issues. These services, represented by Respondents 2 and 4; 3 and 5; and Respondent 9, had robust recruitment policies and no problems with staff recruitment, development or retention. All three voluntary services valued, respected and rewarded their staff. Importantly in each of these services, there was no reference in any interview transcript to first-line managers being seriously engaged in resolving staff-related conflicts. Staff-related conflict featured in the transcripts of first-line managers in those services where the recruitment of permanent frontline residential staff was directly managed by administrative managers who had limited or no understanding of frontline residential youth care services.

In all statutory services contained in the data set, responsibility for workforce factors, including recruitment of permanent residential youth care staff, rested with human resources (HR) departments. In some statutory services, recruitment was directly shaped by senior managers responsible for delivery of frontline care, while in the remaining statutory residential youth care services, HR departments took direction on recruitment from senior administrative managers who were distant from delivery of frontline care. This proved to be an important factor in relation to recruitment of frontline staff. First-line managers of services who reported to senior managers who lacked authority, had less input into recruitment procedures for permanent staff and spent more time on staff-related problems (R1 is a good example of this.), than those in services where recruitment procedures were shaped by senior managers from professional care backgrounds and authority over frontline practice. Respondents 13 and 14 both directed large statutory residential services; both were from social care backgrounds and both took an active role in strategically developing staff recruitment and retention processes in their respective services. They were both focused on provision of needs-led care and their narrative accounts of the recruitment process reflected ways in which staff recruitment and retention are central to the provision of developmental care for residents. Those statutory services which succeeded in providing developmental care for residents had senior managers at director-of-service level with both domain expertise and authority. These directors of service line-managed first-line managers and had an input into frontline recruitment and retention policies. The two statutory services where managers at director-of-service level had limited authority had first-line managers who had no input into recruitment policies. These two services also highlighted other practices which seriously undermined provision of developmental care for young

residents. Such practices involved a failure in those statutory services to address the issue of some permanent staff in the residential youth service who proved to be unsuited to direct work with vulnerable young people. Such staff remained in the residential care system where they tended to be moved around various residential units, often disrupting staff teams and resident groups and sometimes becoming surplus to need. This resulted in them being placed on panels from which they were imposed on residential managers as vacancies occurred in units across the service. There was no system for getting rid of these permanent staff as the industrial relations (IR) departments of the HSE were most reluctant to take the necessary legal action to remove such permanent staff from the residential youth care service. This is a safeguarding issue that needs to be urgently addressed by the HSE. Discovery of these realities shaped Critical Success Factor 1.

Closely related to staff retention policies in a frontline residential youth care service is provision of meaningful supervision for frontline staff and first-line managers. There was considerable variation across services when it came to staff supervision. In two services supervision was stated by directors (R3 and R14) to be mandatory. Both these services had robust supervision practices and both were focused on provision of high-quality developmental care for residents. There were occasions in R13's service (another large statutory service), when supervision might have been postponed, but there was also strong evidence in the transcripts of respondents from this service (Rs 6 and 7) which recognised the central importance of supervision. Supervision of first-line managers was recognised as an important part of R13's responsibilities. Supervision was prioritised in all three voluntary services included in the data set. The major exception when it came to supervision was, again, noted in the two services that were deemed to have failed to deliver developmental care for residents. R1, from one of these

services, was focused on supervising frontline staff, but he only received supervision from his line manager once in the 12 months prior to the interview. R1's supervision never took place in this manager's own unit, which left him believing that senior management of the service had no knowledge of the quality of care being provided for residents in that unit. In the remaining service, that to which Respondents 10 and 11 belonged, both managers had major difficulties with their own supervision and both also had difficulty providing supervision for their frontline staff—particularly R10 who failed to supervise any staff due to impossible pressures of work imposed by senior administrative management in that service.

The data suggest that the quality of frontline supervision is a good indicator of the quality of frontline care being offered. But an important factor that also emerged was that only those services where first-line managers felt supported in their role were judged to provide developmental care for residents. Many factors contribute to feeling supported, but important among these is the empowerment of the first-line manager to make decisions in relation to frontline issues that are primarily child-centred and needs-led, not just based on compliance. This factor is presented as having major implications for practice, and it shapes Critical Success Factor 2.

10.2.1 *Recommendation 1*:

Ensure the development of systems in HSE industrial relations departments capable of speedily responding to carefully documented reports from resident managers of a permanent staff member's unsuitability for provision of developmental care in residential units.

10.2.2 *Recommendation 2:*

Explore ways in which partnerships between social care training colleges and statutory residential child and youth care services might provide better support for practice teachers with their on-the-job training of new staff.

10.2.3 *Recommendation 3:*

First-line managers of residential youth care services need to be better supported by line managers who have both domain expertise and authority to ensure robust workforce policies necessary for provision of developmental care in frontline services.

10.3 Critical Success Factor 2 (CSF 2):

Provision of developmental care in Irish residential child and youth care practice requires reciprocal relationships committed to needs-led, not regulation-led care.

A factor mentioned above as being important for developmental residential youth care practice was empowerment of first-line managers. Empowerment was related to decision-making in relation to presenting frontline issues. The services committed to needs-led care empowered first-line managers to take practice decisions based on the best interests of the resident, the staff and the unit at a given time, and not just on routine application of prevailing regulations. While these services acknowledged the importance of standards, they saw them as 'stop' signs, not necessarily as providing guidance on the most informed decision to take at a specific time and in particular circumstances. Such practice requires an ability amongst first-line managers and frontline staff to make self-driven ethical decisions as described by Garfat and Ricks (1995). Developmental care of residents requires skilled practitioners capable of such

decision-making. Practice that merely rewards compliance to standards of care at all times results in generalised care, not individualised care; it is totally prescriptive, not needs-led; it is standardised, not personalised; and it will not guarantee developmental care for children and young people in residential care.

Two statutory services in the data set which subscribed to compliance with existing regulations as an acceptable level of practice did not succeed in providing developmental care. While it has to be acknowledged that R16, a senior HSE manager, had managed to achieve a more co-ordinated structure in that large residential service, there was no evidence of this service providing developmental care for residents. This manager is committed to the development of a good residential youth care service, but developmental care requires more than a senior administrative manager who seeks to do things right. It requires that the *right things* are done right! There was no manager at director-of-service level in R16's service with responsibility for ensuring provision of needs-led care for residents. R16, the most senior manager in that particular region of the HSE, was intent on meeting existing standards (Government of Ireland, 2004) and was concerned to know that the service was quality assured.

The second statutory service deemed to fail in provision of developmental care was not even achieving compliance with existing government standards at the times of interviews with Respondents 10 and 11. This particular service was in some chaos at the time of data collection, with management decisions coming from head office which totally disempowered first-line managers. R11 referred to ensuring that all 'i's were dotted and t's crossed', which suggested compliance at a micro level and resulted in feelings of disempowerment. When protesting about not being able to manage two

residential units at a time (while attending college two days a week), R10 from the same service as R11 was told by senior management that he was paid to manage and to get on with it. It was as though senior administrative management of this service felt they were meeting standards by ensuring that residential units had a nominated manager.

The remaining six services in the data set prioritised needs-led care over regulation-led care. R17 spoke of being confident of meeting the standards of care in the service but this co-ordinator recognised that this in itself was not sufficient; and spoke about the need for staff to be prepared to take a chance for residents: '*I can think of a number of incidents where the standard was met but it hasn't enhanced the care of the children'* (R17). Needs-led care requires use of reciprocal relationships within which frontline staff enhance residents' sense of well-being by making them feel valued, respected and cared for.

Residential youth care practice has been described by Garfat (1998) as 'hanging out' and 'hanging in' with youth in residence. While such work might confuse a bureaucratic manager bent on measurement of performance, it is also challenging for the recently qualified child and youth care worker. This type of practice requires an ethic of care concerned with responsibilities and relationships, rather than regulations and standards (Sevenhuijsen 1998 cited in Smith 2009). 'Hanging out' in a clinical sense, demands skill at being 'fully present' to both residents and situational factors at the point in time, and using presenting opportunities to enhance residents' sense of well being. 'Hanging in' requires the residential child and youth care worker to respond sensitively to a given resident's presenting problem(s). To achieve this within an ethic of care requires use of self-driven ethical decision-making (Garfat and Ricks 1995). Such decision-making

requires a child and youth care worker to be capable of filtering an issue through her/his personal framework, codes of ethics and standards of practice and to apply these to the presenting situation and to the process of problem-solving. Actions resulting from such decisions must be 'evaluated to provide feedback to the problem-solving process as necessary and to the worker's framework which is validated or modified to respond to future situations' (Garfat and Ricks 1995: 395). Such decision-making in residential child and youth care practice can enhance developmental care, but it needs a well-developed and carefully-protected child-centred culture to flourish. It will not flourish in an environment where compliance is prioritised over the needs of residents, an issue which shapes Critical Success Factor 2 (CSF 2). Use of a self-centred rather, than rule-centred, problem-solving approach in residential youth care could be enhanced by research that is guided by practice knowledge. Practice knowledge needs to shape policies that guide developmental care of young residents. First-line managers in Services 2, 3, 4, 5, 6 and 8 were all empowered by their line managers to prioritise residents' needs in the residential units they managed. In Aervices 1 and 7 first-line managers were not empowered to prioritise residents' needs, but felt obliged to prioritise the system in keeping with expectations of senior administrative managers who micro-managed both these frontline services.

10.3.1 *Recommendation 4:*

It is recommended that mentoring programmes be established to train supervisors/practice teachers in how to work with team members on relational support, life space and ethical decision-making skills.

10.3.2 *Recommendation 5*

It is suggested that regulation in child welfare services be required to accommodate self-driven ethical decision-making by informed practitioners aimed at achieving developmental care of children and youth, particularly those in residential care.

10.3.3 *Recommendation 6*

It is recommended that practice knowledge should inform research in residential child and youth care.

10.4 Critical Success Factor 3 (CSF 3):

It is necessary to have accountable leadership with authority and developmental care expertise which is committed to a shared vision about the purpose of residential youth care and the provision of developmental care.

The importance of leadership emerged early in the data collection stage. Analysis of the first interview (R1) confirmed the persistent prioritisation of bureaucratic goals in a statutory residential service. R1 nominated R2 who was a manager in a nearby voluntary service which had had a change of function imposed on it by senior management of the statutory service to which R1 belonged. At the time of interview, R2 was required to take all referrals from the homeless service to which R1 was also attached. While both respondents managed units which formed part of the same service for homeless young people, the care being provided for residents, as described by both respondents, was strikingly different. R2's unit was firmly committed to the developmental care of residents. There were recurring references in R2's transcript to

the importance of the director's role in this service. He was described as a hands-on director who inspired the entire staff team and kept them focused on needs-led care of residents. R2's director was selected for interview through use of contingent selection. He became R4 and presented as an inspired leader who was centrally involved in the provision of developmental care for residents in the service. Serial sampling yielded this discovery at an early stage in the data collection process. Leadership thus became a focus of subsequent interviews and was found to be a critical factor in all services that provided developmental care.

Senge's model for the learning organisation (1990) stresses the importance of effective leadership. This factor is now recognised and strongly supported by *New Managerialism* as it seeks to achieve fundamental change in the public sector (Milner and Joyce 2005). We also saw (in Chapter Three) how leadership is necessary in facilitating the selection of *critical success factors*. Senge (1990) sees a shared vision as one of the core disciplines of the learning organisation and describes in detail how a leader must develop that vision collaboratively and proactively work at embedding such a vision across the whole organisation/service.

It is contended in this study that such leadership will enhance the positive interconnections required between systems in the ecological environment of the young person in residential care. The study suggests that future research of residential youth care should be cognisant of nested environmental factors. Research in this area must aim to gain understanding of underlying factors across ecological levels that facilitate developmental care, and of those factors that militate against provision of developmental care.

The prevailing mandate of care enshrined in the Child Care Act 1991 places responsibility on the HSE to provide developmental care for the young person in residential care (s. 18.3). Provision of developmental care is the mandate and the research data showed that this only prevailed in residential services managed by leaders (at director-of-service level) who got commitment from all staff to a shared vision, a common service identity and a central ethos which clarified the function of a service as being the provision of developmental care for its residents. The data set confirmed that all services which had such leadership provided developmental care, while those services which failed to provide developmental care had leadership focused on bureaucratic goals (in the case of one service) and a lack of leadership (in the other, where there was evidence of chaos). Both realities blocked all possibility for the provision of developmental care. This confirmed the selection of a particular type of leadership being central to provision of developmental care and shaped Critical Success Factor 3. Leaders of frontline residential services also have responsibility for strategic development and implementation, factors which shape Critical Success Factor 4.

10.4.1 *Recommendation 7*:

It is recommended that a systems model of organisation learning be considered as the model most likely to ensure provision of developmental care for young people in residential care.

10.4.2 *Recommendations 8:*

It is recommended that all research in residential youth care be cognisant of nested environmental factors.

10.5 Critical Success Factor 4 (CSF 4):

Strategic planning and service development in residential youth care need to be practice-led, guided by a shared vision of developmental care and ongoing evaluation.

It was shown in Chapter Two that the newly independent Irish state delegated total responsibility for the care of disadvantaged children and young people to the Catholic Church. This resulted in many residential youth services remaining part of the voluntary sector until after the commencement of the new millennium, when the public sector took over responsibility for direct provision of these services. This reality left some regions of the Irish public sector with virtually no experience of direct provision of residential youth services. An added difficulty was that the senior managers from religious orders involved in direct provision did not move across to the public sector, thus stripping residential services in these regions of experienced senior managers. This, coupled with a prevailing belief in the public sector that residential care simply involved childminding and so was not a discrete area of professional practice (as it is throughout Scandinavia for example), left the sector in some regions exposed to the traditional, neo-Taylor managerialist model of management structures that prevailed in the Irish public sector at the time. Managerialism in the public sector has not resolved issues surrounding the traditional bureaucratic regimes. It has merely re-shaped them. Managerial power now sits in the middle of a dislocated old regime where there is a new-found determination to exercise 'the right to manage' (Pollitt and Harrison 1992). These factors, combined with the high cost of residential youth care, resulted in senior administrative management in some regions of the HSE taking over direct authority for the micro-management of residential youth services. This disempowered both directors

of service and first-line managers, a factor emergent from the data as being strongly associated with failure to deliver developmental care for residents. The focus of Irish statutory residential services directly controlled by administrative managers set the agenda to comply with care standards and to achieve apparent value for money. There was no evidence of strategic development of residential youth care in these services at the time of data collection.

In other regions of the public sector, however, there was some reluctance among administrative managers to take direct responsibility for a sector about which they had little understanding and where negative public attention followed on from a plethora of abuse scandals. Senior managers were appointed in some of these regions from social work or social care backgrounds and were given authority and responsibility for directing frontline residential youth care services. Since these managers at director-of-service level were able to satisfy senior HSE management in their areas that they could stick to agreed budgets and run services efficiently, they were given space to consolidate and develop services to meet presenting needs of residents. In one HSE region a senior manager (R14) was given full budgetary responsibility and authority to develop a robust residential youth service. As a child care manager, R14 already had managerial responsibility for a large community care social work service and proceeded to absorb the residential service into an existing *self-contained task* structure. This enabled that manager to ring fence both services within the bureaucratic structure of the HSE. R14 had direct experience of setting up both high support and special care residential units prior to his appointment as overall service manager. He was an inspirational leader determined to develop a child-friendly service with a family-friendly culture. An embedded vision shaped strategies aimed at empowering first-line

managers and gaining commitment to a developmental care ethos across the service. These strategies were implemented through appointment of coordinators who were given responsibility for the development and support of core care processes.

There were other statutory residential services that also developed under senior managers (at director-of-service level) who strategically developed services aimed at delivery of needs-led care. At the time of interview, a number of such services were thriving and providing developmental care, but some were not structured as self-contained tasks and were therefore vulnerable to senior administrative decisions that could alter their existing situation. R13 is such a director of service who had been actively involved in strategic development of the residential youth service in that region of the HSE to ensure provision of developmental care and was hopeful and capable of consolidating the structure, even though this had not been fully achieved at the time of interview.

In services with leaders who gained commitment of staff to a shared vision of developmental care, there was also evidence of strategic development and policy implementation linked to needs-led care and developmental outcomes for residents. Services which lacked leadership, or where leadership prioritised bureaucratic goals, there was no evidence of strategic development linked to developmental outcomes for residents. This was considered a critically important factor for ongoing provision of developmental care which shaped Critical Success Factor 4.

10.5.1. Recommendation 9:

It is recommended that frontline residential youth care services not be micro-managed by senior administrative managers of the HSE.

10.5.2 *Recommendation 10:*

It is recommended that responsibility for strategic development and implementation in residential youth care services be the sole responsibility of directors of frontline residential services who have both domain expertise and authority.

10.5.3 *Recommendation 11:*

It is recommended that strategic development in residential youth care service be practice-led.

10.6 Critical Success Factor 5 (CSF 5):

Responsibilities associated with a duty of care mandated by the Child Care Act (1991) must be prioritised to ensure that bureaucratic inputs do not undermine developmental care in Irish residential youth care services.

In common with all five critical success factors, Critical Success Factor 5 was informed through an historical overview of Irish residential child and youth care and the review of organisational issues the impact provision of primary care in organisational settings. However, it emerged from the emic constructions (a description of behaviour or a belief in terms meaningful—consciously or unconsciously—to the actor(s) in a context that is culture-specific) of key players from the sector on which there was a level of consensus. An historical overview highlighted how British proselytising activities in early

nineteenth century Ireland set the stage for the consolidation of power within the Catholic Church following Irish independence. The closeness of church/state relationships in the newly independent Ireland resulted in the newly established state being ready to delegate full responsibility for the care of the country's disadvantaged children to the Catholic Church. This resulted in the state failing to monitor the church's practice in the residential child care sector and in so doing, the Irish government failed to implement its duty of care under the child care legislation of the day (Keogh 1996). Widespread use of industrial schools in Ireland (105,000 children were admitted between the years 1868 and 1969.) set precedents for administrative practices and the harshness of care regimes for children which influenced residential child care provision in Ireland until the latter half of the 20th century (Barnes 1989). A social risk model of child care prevailed in these schools (O'Sullivan 1979)—a model which perceived children as a social risk or threat to society. It gave priority to a system perspective as compared with the perspective of the child. While Ireland now subscribes explicitly to a developmental model of child care, this research acknowledges O'Sullivan's statement (1979) that aspects of former models frequently outlive the model itself.

Delegated responsibility for the care of children to the Catholic Church also highlighted organisational issues with serious implications for the residential care of Irish young people. It is only since 2005, with the establishment of the Health Service Executive (HSE), that the state has become the major provider of residential youth care in Ireland. In the research data (collected between 2004 and 2006) there was reference in two separate regions of the HSE to recent administrative changes resulting in the HSE taking full responsibility for provision of two major residential services previously operated by a Catholic religious order. Non-involvement of the statutory sector in the

direct provision of residential child and youth care resulted in a lack of experience in or understanding of direct residential youth care provision in the statutory sector. The timing of recent changes in direct statutory provision of residential youth services coincided with a general acceptance of the ideology of managerialism by public services seeking to achieve increased efficiency in the use of resources. Managerialism gave management new-found confidence in their right to manage. Public sector managerialism adapted to factors that differentiated it from that operating in private sector enterprises (Pollitt and Harrison 1992). Milner and Joyce argued that 'reporting lines and accountability structures have been blurred or even obliterated' in the public sector (2005: 85). There was also a lack of clearly defined objectives in the public sector which is said to create problems for managers. However, this also gave managers the freedom to pursue objectives for a given service that differed substantially from those contained in an existing service mandate.

Residential youth care services became particularly vulnerable to two underlying principles of managerialism: 'value for money' and 'more for less' (Pollitt 1990). Within a managerialist model, a manager can be driven by the search for efficiency rather than by abstract professional standards. There is evidence of this perspective in a quote from the transcript of a research respondent R16, a senior manager in the HSE, as he spoke of his appointment as Assistant Chief Executive in 2000: '*There were three of us [Assistant Chief Executives] recruited in 2000 ... We looked at how we might best manage the residential care sector'* (R16). Administrative managers are expected to prioritise efficiency and, where they take a direct role in the provision of residential youth services, their tendency to regulate and control often took priority over the developmental needs of young people. This is an example of how system priorities can

take precedence over the needs of individual children. It offers but one reason why this study recommends that all residential youth care services should be managed by managers at director-of-service level whose professional backgrounds require an understanding of developmental care, and that they are given authority and responsibility for ensuring delivery of developmental care for residents. The challenge is to ensure that the former close church/state relationship which prevailed following Irish independence—and was instrumental in the failure of the Irish government of that time to ensure implementation of existing child care legislation in relation to children in residential care (Keogh 1996)—is not replaced by a present-day government's acceptance of a managerialist ideology which prioritises bureaucratic goals over the needs of children in residential care. A prioritisation of bureaucratic goals in frontline residential youth care services will never ensure the provision of developmental care as mandated in current Irish legislation.

Dialectical data analysis in this study showed that developmental care for residents was not evidenced in those services which prioritised bureaucratic goals over residents' needs-led goals. This became a differentiating factor between services providing developmental care and those failing to do so. It underpinned the delineation of Critical Success Factor 5. The care mandate identified in the Child Care Act 1991 explicitly embraces a duty to provide developmental care. Developmental care is personalised care, an organic activity which does not sit comfortably in bureaucratic structures which seek prescriptive activity based on control and predictability. Discussion of the findings of this study (Chapter Nine) refers to how services which provided developmental care prioritised child-centred, personalised care of residents, while services that failed to provide developmental care prioritised bureaucratic goals at the frontline. As the major

provider of residential youth care in Ireland, the HSE is mandated by Irish legislation (Government of Ireland 1991) to provide developmental care for young residents. It is thus essential that no bureaucratic inputs deter the provision of developmental care for children and young people in Irish residential care. Developmental care was achieved in a HSE region which placed the residential service within what resembled a *self-contained task* structure (Galbraith 1977) in the wider bureaucratic HSE structure. This ring-fenced the residential service and provided it with protection from bureaucratic decisions that did not prioritise developmental needs of young residents. The manager of this *self-contained task* structure was given both the authority and responsibility necessary to ensure provision of developmental care for residents. He reported to a general manager in the HSE on operational issues and was held accountable for efficient use of the residential service budget and for delivery of developmental care for all residents. It is a major finding of this study that such an organisational structure facilitated delivery of developmental residential care within the broader bureaucratic structure of the HSE. Effective management of such *self-contained task* structures requires a manager at director-of-service level with domain expertise and full authority to ensure provision of developmental care.

10.6.1 *Recommendation 12*:

It is recommended that statutory bodies responsible for direct provision of residential child and youth care services structure frontline residential services as self-contained tasks (Galbraith 1977) under the direction of a senior manager (at director-of-service level), who has domain expertise together with authority and responsibility for delivery of developmental care for all residents.

10.7 Summary

Thus concludes a long journey, one that has been both challenging and exciting. Rigour is always challenging but can also be rewarding when it yields results that were partially unexpected, even when all the more welcome. This study shows that a majority of the participating Irish residential youth services were providing needs-led, developmental care for their residents. It establishes beyond doubt that residential care can be a positive choice for challenged and challenging young people. It also clearly shows that certain factors in the organising mode of residential services will undermine the provision of developmental care.

The bureaucratic structure is designed to induce an impersonal and rational orientation towards tasks which is conducive to efficient administration (Weber 1947). Residential youth care practice is fundamentally relational, and reciprocal relationships must acknowledge and express feelings. The bureaucracy develops standardised work processes and has 'routine operating tasks, very formalised procedures in the operating core, a proliferation of rules, regulations and formalised communication throughout the organisation' (Mintzberg 1988: 547). Developmental residential care requires an individualised, needs-led response to young residents which seldom flourishes in a formalised, tightly-regulated environment or operating core. Senior administrative management in bureaucratic structures hold authority and control and are sharply differentiated from the operating core of frontline practice. This disempowers managers of the frontline service at both director-of-service and first-line levels. The research data showed this to be directly implicated in the failure to deliver developmental care. The bureaucratic organising mode suits environments which are simple, stable and predictable, while residential child and youth care has been shown to be unpredictable

and to be shaped by factors of dynamic complexity (Graham 1994). Provision of developmental care in Irish statutory residential child and youth care services will require development of *self-contained task* structures within the HSE. These need to be co-ordinated by senior managers with an understanding of developmental care who are given full authority and responsibility for delivery of needs-led care for residents. The senior managers of *self-contained task* structures such as these require strong leadership skills. The research data show that throughout the country, there are people in post with the necessary skills for the task. It is my hope that the Critical success factors that emerged from this study will provide them with reassurance as well as helpful guidance as they undertake their important work.

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Appendix 1:

Introductory Questions

Description of Unit, Numbers of Staff, Children

How did you first get into residential youth care work? Training?

When did you become a manager?

How have things changed during your time as a manager?

How might you describe a normal working day?

What might you describe as the most important tasks for you as a resident manager?

What takes up most of your time? What Works?

Whose views impact most on the children?

What communication systems do you use? In House? With other agencies?

How were you trained for the tasks of management in residential youth care work?

What supports do you have available to you? Who do you report to?

What do you consider to be the most important issues or challenges for young people in residential care?

What would you like to be asked about the work you do?

How would you like to answer those questions?

Suggested themes:

Clinical V Bureaucratic tasks
Facilitation of primary care tasks
Child Protection and day to day supervision of residents
Ecological perspective, whose decisions impact mostly on residents?
Teamwork, staff selection, support and development
Employment policy/stability. Efficiency V Effectiveness

Prompts (Tolich and Davidson 1999)

Can you give me another example of that?
Does that happen all the time?
How does this compare with your experience elsewhere?
Really?
Please tell me more
I never knew that
Could you elaborate or be more specific?

Appendix 2:

Informed Consent Form

Title of Study:

What Critical Success Factors are necessary and sufficient for provision of developmental care for each young person in Irish residential child and youth care?

Statement:
This PhD study is being undertaken at Dublin Institute of Technology (DIT) under the supervision of Dr. Kevin Lalor, Head of Dept. of Social Sciences, DIT and Professor Leon Fulcher, Professor of Family Science, Zayed University, Abu Dhabi, UAE.
I have been a lecturer in the School of Social and Legal Studies at DIT for twenty years, where my discipline is Professional Practice in Social Care and my area of particular interest is residential youth care.

For this study I am building on a Masters thesis completed at Trinity College, Dublin (1994), which looked at the *nature* and *content* of residential youth care work. I am using a different methodology on this occasion where I am seeking to gain a deeper understanding of the critical success factors of residential youth care from the perspective of key players in the field. I hope to interview a number of *residential managers*, *alternative care managers* and *assistant chief executive officers in health boards* who manage resources for the residential youth care sector. The results of the research will be submitted for assessment as a doctoral thesis and it is hoped the publications that ensue will inform developing policies in the residential youth care sector.

Ethical Undertaking:

I undertake to protect the identity of all research respondents. Should there be a particular contribution that I wish to use in the final report I will first check with the respondent concerned for specific permission about how that contribution might be presented. For the purposes of confidentiality the names of respondents and agencies will not be disclosed. All interviews will be tape recorded, transcribed, coded and analysed by me under the guidance of my two supervisors.

Thank you for agreeing to participate in this research.

Signature of Participant:

_____

Date: _____

Signature of Researcher:

_____

Date: _____

Appendix 3:

Information Leaflet

Research Invitation To Residential Managers

Would you be interested in contributing to a major Irish study into Residential Child and Youth Care?

Title of the Study:

What Critical Success Factors are necessary and sufficient for provision of developmental care for each young person in Irish residential child and youth care?

This PhD study is being undertaken by Gay Graham, lecturer, DIT. Supervisors to the study are: Dr. Kevin Lalor, Head, Dept of Social Sciences, DIT, and Professor Leon Fulcher, MSW, PhD, Asst Dean, College of Family Sciences, Zayed University, Abu Dhabi,United Arab Emirates.

The study seeks to identify what resident managers consider to be the key success factors of Residential Child and Youth Care practice in Ireland. Responses obtained from resident managers will be examined with a view to identifying what factors they see as being critical to successful work with young people and how these might shape caring processes in their centres. The study will then explore ways in which service delivery and responsive practices might be enhanced through a focus on core work processes and evaluation practices.

Central to the satisfactory outcome of this study is a nationally representative sample of the views of resident managers, who are recognised as pivotal in the delivery of residential Child and Youth Care services. The views of middle managers and senior health board personnel will also be sought and analysed.

If you are willing to participate in this study please complete the detachable section below, place it in the envelope provided and drop envelope into the box located at the DIT stall.

Thank You

Gay Graham, M.Litt CQSW

Name:	
Address:	
Telephone:	
Email:	

Appendix 4:

Content Analysis of Key Informants' Transcript

<u>Analysis of Critical Success Factor A</u>

Need to prioritise responsibilities of corporate parenthood and ensure that bureaucratic inputs are transparently instrumental in supporting a client centred culture

Code Analyses

Code: 'Corporate Parenting': referred to twice in case.

1. Reference to a website of a care agency in England where it was considered important to have corporate parenting because it helped clients to know that some-one 'out there' cared.
2. Referred to C P suggesting that the organisation cares. The critical success factor is broader than that. It is about everyone who encounters a child in a care capacity needing to recognise the child's right to care.

Code: 'Duty of Care Mandate': 8 references

1. It is the law that decides the duty of care and hands it over to designated personnel, the law is quite precise.
2. The duty is handed from someone who has authority to someone who takes it
3. Every person who encounters the child would have to have a caring culture and own responsibility for the care of the child, in style/spirit and not just in function
4. The duty of care goes right through the system from front-line practice right up through the organisation, throughout the sector. Everything is working together to support what is happening at the front line.

5. Duty of Care has a slightly medical feel to it.
6. Term could be problematic as it conceptualises care as a duty, it is legalistic, reductionist, minimalist whereas care should be seen as part of the human condition, it is about nurturing, the human call to care which connects in with 'Vision' and takes 'care' beyond dotting 'I's and crossing 'T's
7. Term goes back to common law, to a case in England in 1530 about the breaking of a beer bottle. It refers to not taking sufficient care. It also refers to vicarious liability where the House of Lords found that an organisation breached its duty of care by not supervising a manager sufficiently. This suggests that the organisation piece is governed by common law as well. It could be taken in a legalistic way or it could be taken as the standard below which a determination is made about not caring enough. There is concern about getting too tied up in the lawyer piece.
8. Duty of Care can become bureaucratised where the system gets complicated and looses sight of why it was set up in the first place. The example given is the use of an invoice system for the purchase of clothes for children in care. The system takes so long that the child may no longer need the item of clothing when it eventually comes through. Staff involved in this work are often under great stress. The Duty of Care mandate can only work if it extends to the support of all those involved in the child's care

Code: 'Responsibility for Care' Two references:

1. This can be an issue as to whether or not this is taken individually by the people who provide care
2. The agency or the sector must also take ownership of this responsibility. They must also be open to investigation as to how they are exercising this responsibility. This is the piece that is often missing.

Code: 'Child-Centred Culture': One reference

This describes a culture that we are trying to create.

Code: ‘Need for common understanding of key terms’: One reference
Terms are regularly used but there is no evidence of them being commonly understand, terms such as ‘child-centred’ or ‘children’s rights’

Code: ‘Need for debate for compelling vision for kids’: One reference
A reference to the need for this debate as vision has not been unanimously agreed

Code: ‘Need to operationalise existing national policy’: One reference
The national children’s strategy strongly emphasises the voice of the child so the challenge to the sector is to operationalise this policy.

Code: ‘ Need to address the children’s rights agenda’: One reference.
This agenda is still new to the sector.

Code: ‘Lip service to existing policies’: One reference.
There is evidence that policies are stated but there is no real commitment to implement them.

Code: ‘Agenda of the Organisation’: Three references.

1. The organisation is focused on covering its back and on anticipating what is coming down the tracks in the media. It is focused on the political piece.
2. There was agreement that there is a huge element of that, there is evidence of political re-activeness to the political flavour of the month.
3. Further agreement by referring to the present focus on services for the elderly, on the nursing home issue. Organisations seem to be weary from such events and they cause them to not be totally child-focused.

Code: ‘Tension between duty of care and organisational goals’: One reference

This tension is present on a daily basis. Front line practice is focused on children's rights and child-centred practice while the organisation is focused on structures, strictures and available resources.

Code: 'Navigation of tension between differing goals': One reference
The tension between front-line practice and the organisation's goals is being navigated on a continuous basis, particularly by more senior front-line managers. The focus should be on circles of support for front-line practice and on being able to avoid being dragged into corporate risk management.

Code: 'Duty of care and need for supervision at all levels in the organisation': One reference.
Frontline staff get supervision but this ceases at the level of the resident manager with more senior managers not getting any supervision. This is still the situation despite the fact that there is lip service to the idea of supervision and supervision is mentioned in SSI reports but senior managers are exempted.

Code: 'Lack of supervision and Bureaucratisation': One reference.
This is seen as a key factor in management/admin staff not being in touch with what is happening at the front line, they are not connected to the key function.

Code: 'Default power in bureaucracy positions': One reference
Refers to situation encountered when managers in senior operational positions in organisations can be beholden to clerks in the finance dept. or the HR dept. The service is not driven by the manager but there is evidence of the bureaucracy taking over.

Code: 'Conflicting expectations of front line staff': One reference
Staff on the front line are expected to operate from a rights and justice model and yet they can be treated very badly by the organisation where their own rights are not respected.

Code: ‘Contradictory expectations of front line staff’ paired with: ‘Schizoid personality of bureaucracies’: One reference
Refers to situations where staff can be expected to carry out contradictory roles such as a social worker going to court to get custody of children and then the same social worker follows up with the family to advise them on the aftermath. This can present great difficulties for the practitioner.

Code: ‘Recruitment and Permanency’ (related to factor F): One reference
Relates to the widespread use of temporary appointments in the residential care sector and refers to its implications for standards.

Code: ‘Disconnect between bureaucratic level and front line’: One reference
Key informant is confirming the presence of this disconnect.

Code: ‘Example of Bureaucratic rigidity’: One reference.
DIT is used to illustrate how bureaucratic systems dictate how processes occur often at major time cost to people concerned.

Code: ‘Similarity of bureaucratic behaviour’: One reference
A member states how her move from one organisation to DIT was easy because of the bureaucratic similarities.

Code: ‘How resident managers spend their time’ (duplicated with preceding code); One reference.
Refers to reality that resident managers spend considerable time addressing bureaucratic procedures, time that could be more gainfully spent interacting with the clients.

Code: ‘Need for Bureaucrats to prioritise main function of the organisation’: One reference.
Bureaucratic systems should not become ends in themselves but means to ends. While administrative systems aid efficiency they should always be linked to the main function of the organisation and only used when they further this function.

Code: Bureaucracy arms are not supportive of agency best practice': One reference

Arms of bureaucracy see themselves as service supports while the opposite is often the case. The example given was the HR dept which berated a manager for not following established procedures while all he did was to bypass them in order to ensure he had sufficient staff on the next shift. What was best practice for the manager was not considered best practice by HR. Managers need to be confident enough to bypass systems in the interests of clients.

Code: 'Source of front line fear': Two references.

1. Practice seems to be that even if your best works for 99% of incidents and fails on the 1% occasion, it is the 1% that is remembered, that the practitioner gets berated for.
2. Recent developments in the sector seem to have compounded this fear. There are also some services where there is a culture of fear and distrust and blame that compounds the negative dynamic and suggests that the trenches of bureaucracy pervert best practice.

Code: 'Recommended reading': Two references

1. Work of Isobel Menges who referred to social systems being a defence against anxiety. She also referred to 'task' and 'anti-task' Bureaucratic systems can be antithetical to child centred practice. This reference shows that this type of thinking has been around for a long time but has not been addressed.
2. Tony Morrison also talks about anxiety but says that the organisation tends to deny the presence of anxiety and to pretend it does not exist.

Code: 'Example of anti-task' One reference

Refers to Isobel Menges again when she found that staff in residential contexts were more likely to identify with the helplessness of the client than with the power of the management system so staff tended to get more

delinquent and not feeling empowered to carry out the care task, another example of anti-task

Analysis of Critical Success Factors Factor B:

Residential Child and Youth Care Sector needs an Expressed Clarity of Purpose underpinned by Core Values to which All Residential Services Subscribe and Against Which They are Measured

Code : ‘Need for common understanding of key terms’ One reference
Need to clarify what we mean and ensure that we don’t have different constructions of what terms mean.

Code: ‘Conflicting values between national policies and front line practice’: One reference
In Scotland at the political level there are very non child centred policies emerging in a very punitive view of young people and yet front line staff are expected to adopt a child-centred approach with these kids. Unless we have congruence in the system we are going to have conflicting values.

Code: ‘Problems arising from lack of clarity of purpose’: One reference
Services can develop organically but then if a difficulty arises senior management can insist on the service addressing the functions it was set up to address even though the service could have changed in the meantime and there can be conflicting expectations about what exactly a service is supposed to do. Such issues can impact on staff development and on opportunity to specialise in particular areas. A service can’t be all things to all people all of the time, ten times a day. This seems to suggest that a service purpose should be re-established as changes emerge.

Code: ‘Problems arising from over rigidity’: One reference
Over rigidity of purpose can be used as an excuse for not accepting a child. It can cause a service to expect a child to fit in with them rather than consider how the service can meet the individual child’s needs.

Code: ‘Positives of a service response’: Three references

1. Refers to evidence in Study 1 of a service believing that they have a responsibility to address the needs of all children who present in their area. The challenge is to explore how the existing service can meet the needs of a particular child. Extra resources are put around particularly challenging children, possibly 3/4 senior staff at a given time focus on the child in a unit to address the presenting needs and to support the existing staff with the particular child.
2. Refers to a high support unit changing from a unit to a service and how this changed the view of the staff. They now look at the child in terms of his needs as a member of a family or member of a community. They now focus on helping the child and his family. The change brought the staff away from being much focused on their own care to being more focused on the kids and the manager sees the importance of caring for the staff in order to enable them to care for the challenging children. This change which came from the bottom had major effect on senior management as they appreciated that more positive work was being done and they were less inclined to want to interrupt the positive work.
3. In the sector at present what differentiates services is where front line staff are totally client focused, operate effectively and communicate this up to senior management who tend to be receptive if they recognise that service is actually more effective. There is no evidence to indicate that real client-focused work is being demanded by top management, they seem to be more committed to bureaucratic goals.

Code: ‘Need for Alternative Care Perspective’ : One reference

In the new HSE structure new Local Health Officers (LHO) are competing for more responsibility for residential care while what the sector needs is a more joined up approach to children’s services. Future planning for children will need an alternative care perspective, to be effective. We have made progress in our area where all residential services for children (voluntary and statutory) have been brought together in an effort to meet children’s needs.

All admissions come through the Placement Committee and the best placement is selected for the particular child. Resident managers are represented on this committee and are bound by the committee's decisions. However further progress will require that all children's services be amalgamated under 'Alternative Care'.

Code: 'New Structure Militating Against Alternative Care Perspective': One Reference

The new HSE structure is regionalised but the power is vested in the LHO so we are back to a situation where the power is still vested in an individual.

Code: 'Service Delivery Culture': One Reference

Refers to how Kibble in Scotland lost all its central funding in 1996 and were faced with the decision to close or become a social enterprise which involved re-inventing itself as a service that marketed good services and best practices to local authorities in northern England and all of Scotland. This changed people's view from 'this is what we do' to 'this is what we can offer'. Kibble adopted a service delivery culture which has transformed the place. This can be done in various ways, even at a regional level but it requires a lot of commitment from managers at a very senior level to the development of a strategy that embraces a service culture.

Code: 'Bureaucratic Culture of Fear and the importance of Leadership': One reference

A service delivery culture requires senior managers with a vision and autonomy and this is something the sector does not offer to resident managers because of the bureaucratic culture. Because of the culture of fear we do not let resident managers manage. We need to let leadership flourish at resident manager level.

Code: 'Leadership from managers must be developed and supported': One Reference

The present sector depends too much on random forces. We have some exceptional managers like JN who has described a most interesting, effective

service but the sector cannot depend on resident managers, who are not at a level to significantly impact the system, to ensure the necessary changes or introduce the necessary strategies. LHOs need to be monitored on how they support positive front line practice by developing leadership at resident manager level.

Code: 'Lack of Clarity facilitated use of trade union tactics': One reference
The SSI explored a theme in a particular area and found that units were saying that they could not operate the new residential care plan until residential co-ordinators were in post. There was no sense of the units being primarily concerned about the needs of the children in their care [an example of goal displacement].

Code: 'Low status of residential care leads to managers not being heard': One reference
The present state of the sector could be suffering from a residue from the past when residential care was seen as a last resort. Only 500 children out of a total of 5000 children in care are in residential care, the remainder are in foster care. The residential sector suffers from the bureaucracy in the system. Another factor is that some resident managers do not have first hand experience of front line residential care practice. Another factor that the SSI encounters is that residential staff often feel that they are not heard, managers are included in this. Managers are not being heard. When this is mentioned in Reports senior management do not like it. Senior managers do not like to see this fact put in print.

Code: 'Lack of Accountability at senior level': One reference
This was evident in the data from study 1 and was accepted by group of key informants.

<u>Analysis of Critical Success Factor C</u>

Strategic Planning and Service Development Require as much Attention as Front Line Care

Code: ‘Strategic Planning is Negatively Impacted by Existing Culture’: Two references

1. Many existing staff are committed and want to do a good job but often their responsibility is too great (lots of responsibility without corresponding authority). Lack of resources at the front line is tolerated. Overloaded managers can be pulled in so many different directions that while they may want to plan strategically they do not have the time.
2. This was supported by the SSI findings where principle social workers were so busy with child protection work and court appearances that they paid little attention to the residential units in their area. Clearly they were not able to manage all the responsibilities they had.

Code: ‘Co-Ordination Role Essential for Strategic Management’: One reference.

Management of both residential and field services is being satisfactorily done in an area where the budget holder appointed co-ordinators to take charge of each sector and he (budget holder) had both these people reporting to him and was able to keep both services sufficiently resourced and supported. This is a differently structured service, properly co-ordinated and more affective. It supports the need for proper structures, leadership, and independence with appropriate accountability.

Code: ‘Strategic Development is Stymied by Child Protection’: One reference.

Child protection forces the sector into a reactive, knee-jerk response and so stymies strategic development. The focus on child protection is isolated from the sector’s hopes for children. Child protection legitimises the minute managerial response. At a strategic level we need to take the heat out of child protection to allow us to look at service development.

Code: ‘Child Protection Service has a Long Waiting List’: One reference

There are 400 cases in the Dublin area waiting for evaluation.

Code: ‘Child Protection Service has Many Problems: One reference
There are children in the community who have been reported but where no-one yet knows what is going on and there are children in care who have no social worker so the system is too stretched.

Code: ‘Child Protection is Prescriptive’: Two references

1. Child protection is all about doing things right it is not about doing the right thing. It is about following procedure and making sure you are not the next guy in the newspaper. It is not about doing the right thing for children.
2. There is evidence to support this in study 1 where a service realised that following procedures in a given case was not in the child’s best interest. This service was exploring ways of taking certain risks in the interests of children.

Code: ‘Child Protection Practice should not Excuse Poor Residential Practice’ One Reference
While the system may not be able to assess all referred children it is essential that children already in care have their needs addressed, they are in the system and need to be prioritised. This may not be strategic but it should be happening.

Code: ‘Strategic Management seen Solely as Senior Management Activity’: One reference
Strategic management may have been captured by senior management while often very strategic decisions are taken at front line level. A change in mind-set requires strategic thinking and while this happens in some of our best services it is not called strategic planning. This term seems to have been hijacked by senior management.

Code: ‘Strategic Planning from Bottom Up needs Recognition’: Two references

1. It might be absent because we do not validate inductive strategic planning which comes from the bottom.
2. The quality in care practice should actually influence changes in care policy instead of it always being the other way around where policy influences change in practice.

Code: ‘Strategic Planning Negatively Impacted by Cost Factor’ Two references

1. Residential care is probably the most expensive service that a senior manager has. Residential care needs to recognise this and be seen to want to share out their slice of the cake more (e.g. get involved in shared care situations and take a more community perspective).
2. The cost of residential care is unsustainable especially when the cost of double cover at all times is strictly adhered to (refer to example from MR in study). Double cover taken to extremes can empower kids in a negative way while dis-empowering staff and making residential care more of a negative thing in the eyes of senior managers.

Code: ‘Strategic Planning and Historical Context’ One reference
Historically the residential solution was the preferred one in Ireland and there is still evidence of social workers wanting full residential care in many instances. We now offer a high support service which may involve a shared care component but not full residential care. Social workers are beginning to see that this can have much more satisfactory outcomes, which has led to us being able to have much more productive meetings and being able to make more effective plans. This also enables us to offer a broader service with the same slice of the cake which is in everybody’s best interest and is undoubtedly strategic.

Code: ‘Strategic Planning not Impacting Practice’: One reference
When you are at the front line and feel unheard strategic planning does not impact your work. Also as a manager who is over stretched strategic planning is something you only pay lip service to. You put it in your annual

report but you know it will never happen. The challenge is to create the virtual circle to minimise this happening.

Code: 'Strategic Planning and Networking Among Managers': One reference
Managers of a certain level should be encouraged to network to focus on practice issues. Too much discussion about management results in less discussion about practice and practice development. In Scotland there has been a review of social work in the 21st century and it refers to the important role of networks of practitioners and about the importance of a bottom up approach to practice development. This is now happening among high support managers in Ireland.

Analysis of Critical Success Factor D

Staff Recruitment, Development and Retention

Code: Staff selection and recruitment are critically important: One reference
It was generally agreed that without good staff a service is doomed to failure.

Code: Recruitment should involve Operational Managers: One reference.
If we aim to have functional teams then we must give operations managers a role in staff recruitment and selection.

Code: Present system of Recruitment by HR seems to reflect bureaucratic disconnect: One reference
If one looks at the Sunday ads of the HSE it can be seen that a senior post in the residential sector got only five word description while other less senior posts in other sectors got substantially more words. Clearly HR has their own priorities and they do not include the needs of the child in care.

Code: 'Recruitment by HR does not prioritise practice team needs': One reference.
Posts can take a very long period to fill. There is no process for prioritising certain posts.

Code: Recruitment should not be sole responsibility of HR: One reference.
Recruitment should also involve managers from the particular sector.

Code: Recruitment is impacted by factors: One reference.
Geographic factors influence recruitment as it depends on how many people are available in the area. The quality of the senior manager and his/her influence in the area and his/her priorities are other factors. The core issue is culture and there is not a culture of recruitment being easy or straightforward.

Code: Present Recruitment Practice seems to influence negative culture: One reference
Recruitment seems to be culturally anti-task. Even after posts are advertised the goal posts can change. HR decides who to shortlist but then at interview it can emerge that those called are not suitable because, while they have care experience it could be with the elderly or with mentally ill so much time can be wasted. This could be avoided by involving resident managers in the entire process.

Code: Recruitment and Policy of Temporary Posts: One reference
All care staff are appointed temporarily which militates against commitment form newly appointed staff. Qualifications are no guarantee of permanency.

Code: ‘Promotion of Temporary Staff to Acting Positions’: One reference
Qualified temporary staff can be quickly promoted to more senior positions in an acting capacity but they remain temporary. It is not unusual to have an acting manager and a number of acting staff in a unit at a given time.

Code: ‘Recruitment delays have resource implications’: One reference.
The gap between advertising and appointment means that the best staff have moved elsewhere.

Code: ‘Recruitment Policy and Staff Ceilings’: One reference

Lots of posts have been bled out of the system because a line was drawn under them on the last day of December. There is a policy of ‘what you have you hold’, it is government policy but it bureaucracy at its worst.

Code: ‘Staff Retention and Development’: One reference
Staff development is a necessary part of retention. While regulations have dragged standards up they need to be balanced by development to ensure staff continue to use their professional judgement because fear of being blamed has resulted in staff not using their judgement. Development should be aimed at giving staff back their professional judgement and so let common sense prevail.

Code: ‘Staff Development Negated by Culture of Fear’: Two references

1. No training or development can be effective if there is a culture of fear. There was total acceptance of this fact.
2. Staff must feel that they will be supported by their service even when they make a genuine mistake. Fear of being unsupported inhibits staff from using their professional judgement. The presence of fear can have a very negative influence. Fear can be based on a false perception.

Code: ‘Staff Retention Requires Supportive Working Environment’: One reference
A number of factors influence staff retention such as the location of the service, number of options staff have locally, but most importantly staff must feel supported and they need to experience that they are doing the job they applied to do, caring for children and not just minding themselves in case of assault or abuse. Care of the carers is important. The manager must focus on keeping the system safe for those working in it.

Code: ‘Staff Development Requires Positive Feedback’: One reference
Many services now review negative incidents or incidents that required the use of physical restraint. This should be used as an opportunity to give

positive feedback as well as negative as the aim is to empower staff to aid their development.

Code: ‘Staff Retention Endorsed by Senior Management’: One reference
It is endorsed but there are no processes in place to enhance it, that is left to the individual manager.

Code: ‘Staff Retention Related to Two Factors’ : One reference.
First factor is that ambitious staff tend to move on quickly if they feel they are not likely to progress much further in their present job.
Secondly there is the staff who settle in the area, buy a house, set up a family, they want to stay and don’t want too much hassle. It may not be development but the want to stay and don’t want the system to hassle them or to ask too many questions.

Code: ‘Staff Development Reflects Organisational Investment’: One reference
Staff are released from work to pursue professional development which is a positive thing and reflects the organisation’s investment in training. SSI are finding levels of qualified staff improving which is seen as a most positive development.

Analysis of Critical Success Factor E

‘Support from top management for core care activities and development of ethos reflecting core importance of the caring relationship’

Code: ‘Support from top management to take risks to maintain kids’: one reference
Refers to the need for top management to recognise that front line staff must, occasionally, take risks with kids to work effectively with them. Recognition of this might help staff to be less defensive about their work with kids.

Code: ‘Caring relationships viewed with suspicion’: One reference

This is a view widely held in practice. It possibly comes from an era when caring relationships were exploited negatively. Caring relationships are often reduced to a series of instrumental tasks and there is sometimes suspicion if such a relationship encompasses an emotional element and yet care by its nature is reciprocal, it involves an emotional give-and-take between carer and cared for. It was thought that this was part of the debate of the tension between the professionalisation of care work and the actual doing of it.

Code: ‘Caring relationships are reciprocal’: One reference
There is a need to manage these boundaries satisfactorily. If we want young people to share their lives with us we must be prepared to share, appropriately, with them also. There was very strong support for the fact that the care relationship must be reciprocal, that this is a difficult thing to manage, it can be a bit dodgy but it must be managed for effective outcomes to be reached. This represents the positive risk of care work and must be supported but this support is certainly not always evident.

Code: ‘Caring relationships require staff to feel safe’: One reference
The boundary of the caring relationship can only be appropriately managed when the practitioner feels safe and supported.

Code: ‘Caring relationships and spiritual needs of kids’: One reference
The spiritual needs of children seem to be overlooked in the more sanitised, bureaucratic model of the modern day, this in contrast to how the system aims to meet the spiritual needs of non-national kids who are in our system.

Code: ‘Caring relationships and being professional V professionalisation’: One reference.
There is a danger that professional training can make people more inclined to intellectualise what they do rather than be more responsive to our clients, the emphasis can be wrong. By not differentiating these two concepts we can loose track of what it means to be truly professional which is doing the right things right and getting sufficiently close to kids to make the difference but then being able to manage the boundaries of that. That boundary can lie in

different places with different relationships which is why bureaucracy has such difficulties with professional caring.

Code: ‘Caring relationships have implications for the length of placement’: One reference
This is a debate currently underway in the high support sector. There is a tendency to prescribe the length of placement but this should be impacted by the quality of relationship that must be formed to address the child’s issues.

Code: ‘Caring relationships require joined-up care’: One reference
There was general agreement with a statement sent in writing to the group by an invited participant who couldn’t make it. His point was that all children should know the whole plan at the earliest possible time. They should know if high support is being offered where the step down care will be provided. The absence of the information can cause children to be preoccupied with fears about the future and so not be able to address the issues of the present.

Code: ‘Importance of shared values across the organisation’: One reference.
It is important to involve top management in the practice of the unit directly if only on an annual basis. There should be a formal think-tank so that the managers encounter the values of the front line team. It is important that both levels meet in a formal way.

Code: ‘Caring relationship is valued by clients’: One reference
The SSI has found that there is strong evidence to support that children really do value relationships with key staff, that real trust develops. Some children disclose abuse for the first time to care staff. However many children come into residential care following many placement breakdowns and have great difficulty with being able to trust. These children can be very challenging for staff but when they succeed with these children there is evidence that the children really appreciate the relationships formed.

Code: ‘Caring relationship and attachment’: One reference.

Attachment theory must be kept centre stage when it comes to meaningful relationships with kids. Sadly we can see when we meet ex residents that the damage of not having normative attachments in childhood has lasting effects.

Code: ‘Caring relationships and positive containment’: One reference
Containment can be both negative and positive in the care context. If all that happens for a kid is that he is contained in a holding fashion then this is totally negative. But if a child is contained in a holding fashion this can really facilitate relationship building. Then the effective resident manager aims to contain the team to provide the care through reciprocal relationships. Containment is a term that needs to be explored in the context of residential care.

Analysis of Critical Success Factor F

Service Development, Responsiveness to Presenting Issues, Accountability at All Levels of Service

Code: ‘Service Development and Responsiveness are Important’: One reference
Significant changes in the client population in the last decade have highlighted the need to keep an eye on both these issues. Children coming into residential care are among the most challenging. They present with very challenging behaviour or they are continuously absconding. Both groups need much specialised responses and, to be effective, the service must be able to supply these. The other issue mentioned in terms of service development is the whole area of non Irish-national children and their needs. There is the issue of multi-cultural training which is emerging.

Code: ‘Accountability is preferable to Control’: One reference
‘Monitoring’ and ‘Control’ were the terms first used in this critical success factor but the unanimous view of the key informant group was that these terms suggest an ‘audit’ and monitory control. The term ‘Accountability’ was selected instead. While it is essential that a service knows where it is

going and how it hopes to get there the process cannot be monitored solely by ticking boxes, it requires vision and ongoing evaluation. Organisations probably feel we are good at monitoring and control because the systems are in place to do it but this type of monitoring often does not favour the client or the service aims. 'Control' was considered to be a term with a lot of extra baggage.

Code: 'PMDS' is being introduced at service delivery level only': One reference
This new system is only being introduced at team level in the statutory social care sector. While it is being introduced at the individual level in the university and IT sector it is going to be at team level in the HSE. The trade unions seem to have had an input into this decision in the different sectors. In the 'Sustaining Progress' programme there is some focus on personal development and there might be an occasional monitoring of practice but this is only happening at service delivery level, not at senior management level.

Code: 'Culture of self monitoring might be preferable': One reference
The systems in place at the lower level could be counter development as development requires professional discourse and not abstract monitoring. It requires a culture which is self monitoring ('Single-loop learning' Argyris and Schon 1978 Pp 18).

Code: 'Team based performance management is self monitoring': One reference
The team based monitoring in the HSE is about the team setting its own goals and its own standards and monitoring them themselves.

Analysis of Key Success Factor G

'Ability to Meet Government Standards'

Code: 'Standards belong to the people': Two references

1. Standards were selected following widespread consultation so they belong to the Irish people.
2. Everybody is consulted and ultimately subscribe to the standards. The SSI are the guardians of the standards

Code: ‘Residential Standards limited to 10’: One reference
Good number of standards as it is most problematic inspecting more than 10

Code: ‘Fostering standards number 25’: One reference.
There are too many fostering standards for thorough inspection, further work will have to be done to rationalise these standards but the residential standards are appropriate and workable.

Code: ‘Standards help with Accountability’: One reference
The standards have dragged the sector into compliance and have facilitated accountability. Prior to having the standards in place it was possible to writing to senior management continuously regarding certain issues without any results but as soon as the SSI highlight an issues there is a response.

Code: ‘Standards more readily applied at front line level’: One reference
It was felt, and managers actually experienced this, if there was a standard they were failing to meet there could be an urgent consequence while other standards were allowed to drift, these are the ones the SSI is helping to get movement on. This reflects the same issue that all regulation seems to be seen as a front line issue.

Code: ‘Resources are important for best practice’: One reference
There needs to be greater emphasis on available resources. Responsiveness to presenting issues can sometimes call for extra resources and this needs to be recognised. It might be a positive thing in a particular service to refuse emergency admissions but some children may need an emergency admission and this can call on extra resources. How can a service meet needs indefinitely when there is an embargo on recruitment? These are serious issues that need to be mentioned.

Code: ‘Recruitment delays have resource implications’: One reference
If HR departments are asked to delay appointments to keep the financial pot workable this is a resource issue. It may play out as a bureaucracy issue but it is a resource issue.

Code: ‘Resources needed to meet needs of ‘new Irish’’: One reference.
Unaccompanied minors need resources as do the children coming to the country with parents who are asylum seekers. Social care workers need extra training to work effectively with these children as do social workers and foster parents. These extras have to be bought in. resources are important.

Code: ‘Critical success factor is involvement with families’: One reference
A factor being isolated as a key success factor for residential care by the SSI is collaborative involvement of residents’ families in the work of the unit. The concept of shared care is seen as increasingly important. One unit recently inspected had shared care down to a fine tee, the parents couldn’t speak too highly of the unit and the children were relaxed about their parents coming to the unit and sitting down to talk about issues. All these children were due to be discharged to their parents which is another important factor as we know that by far the majority of children return home on discharge from residential care. The good services visited in the research were all recognising the importance of the involvement of families they were looking outward and involved in responsive practice but there were other services where this was not happening at all.

Code: ‘Family Group Conferences are not widely used’: One reference
FGC was not in use in the units involved in the shared care project. FGC is not in widespread use, it could be because of difficulty with the idea of sharing power rather than administering it.

Code: ‘Family Group Conference used under different guise’: One reference
FGC might be being used more with children prior to placement in residential care. While sometimes in residential care FGC may not be

referred to officially its principles are in use. An example was given of a support worker facilitating a meeting of all parties involved in a particular case that was causing great difficulties for a service. The outcome was that the child was moved into a shared care arrangement which worked really well for the particular child. The person offering this shared care was a member of the extended family. A recent research project showed that use of the FGC depended largely on the views of particular team leaders. It can be a good way of getting resources.

Code: 'Family Group Conference seen as needing extra resources': One reference
Recent research in the juvenile justice area showed the FGC as needing significant resources, anything from one hour to fifty per conference so it was scary in terms of resources, perhaps the process needs to be looked at again as this should not be the case.

Code: 'Critical Success Factor is having a continuum of care view': One reference
Residential care should be seen as part of a continuum from community based care through residential, high support, secure care. When it is viewed as part of a continuum it has better outcomes for kids.

Code: 'Critical Success Factor is a collaborative approach': One reference
There is much evidence to indicate that professionals do not collaborate in the best interests of the child. There is often much infighting reflecting professionals' preoccupation with their own power and the child can get lost.

Code: 'Critical Success Factor is Care for the Carers' One reference
This looks at parallel responsibility to self within the system. There is reference to times when in residential care, workers can resemble the injured partner in a domestic violence situation. Care workers can facilitate violence rather than calling halt. Some care workers consider assaults as part of the job. If front line workers call a halt to this tolerance of violence senior management will eventually listen and they will have to collaborate in the

development of a service that prioritises the child but expects safety for staff also. Care for the care givers is essential to effective care. There is some evidence that this has been lost sight of by organisations.

Appendix 5:

List of Seven (Preliminary) Critical Success Factors

(Presented to Key Informants)

1. Need to prioritise responsibilities of corporate parenthood and to ensure that bureaucratic inputs are transparently instrumental in supporting a client centred culture.

2. The residential child and youth sector needs an expressed clarity of purpose underpinned by core values to which all residential services subscribe and are measured against

3. Strategic Planning and service development require as much attention as front line care

4. Staff Recruitment, Development and Retention

5. Support from top management for core care activities (development of ethos reflecting core importance of caring relationship

6. Service development, responsiveness to presenting issues, monitoring and control at all levels of service.

7. Ability to meet government standards