An Historical Perspective on Residential Services for Troubled and Troubling Youth in Canada

Grant Charles and Peter Gabor

There can be no doubt of the impact of residential care in the history of children*s services. To many it is the most intrusive and, consequently, most unwanted form of state-sponsored intervention. To others, it is the most effective form of intensive treatment for troubled and troubling young people. Thus, a debate is raging; few remain neutral in their opinion of residential care. However, this has not always been the case. In its inception, residential care was almost universally considered to be a benevolent intervention.

The beginnings of residential care in this country can be traced back to the 18th and 19th centuries; its development can be traced through five eras or stages. As with all developmental processes, the eras overlap and interact. The evolution of new philosophies have not always meant the disappearance of old philosophies. The philosophies of the early eras still affect programs today. The result is that there is no single driving philosophy behind residential care in our country.

Early Sources

The time period from the 18th century to the mid-l9th century can be labelled the "Moralistic-Saviour Era." Service provision during this period focused upon providing basic care to children who were orphaned, abandoned, or who had physical or cognitive characteristics which made them different from mainstream society. These children were mixed together without consideration for special needs or circumstances. Often there was a blending together of child and adult populations.

The majority of these residential programs were established by religious organizations who provided basic care from a sense of community duty, and also as a means of saving the souls of the young people in their care. A parallel movement involved the setting up of mission schools on many reserves and isolated native communities (Daily, 1988). While somewhat different in focus and application, these two residential streams both served to correct the perceived inferiority of the young people in their care. The duty of these programs was to overcome the inherent moral, genetic and/or cultural weaknesses that children in need were assumed to suffer (Meen and Chubb, 1981). The interventions were very paternalistic/maternalistic and moralistic in nature.

The second stage, which may be called the "Reformation-Rescue Era," started in approximately the mid- 1800s and lasted into the first part of this century. It involved the evolution of special programs for children which focused upon the concept of protection as well as the provision of basic care. It was during this period that services began to be provided by secular organizations. While still paternalistic/maternalistic and moralistic in nature, the focus began to shift from saving the souls of wayward youth to the early stage of attempting to protect young people from the abuses of the adult dominated world. It was during this period that the early Children's Aid Societies were established and rudimentary child welfare legislation was enacted (Jones and Rutman, 1981).

Intervention focus during this era was upon reformation and education (Schnell and Taylor, 1988). Programs sought to train young people on how to "fit" into society. It was believed that given a correct and proper environment, these young people could be steered towards assimilation into the value system of the dominant, white anglophone/francophone Christian community.

These programs were often family replacement rather than family enhancing and, as such, were long-term and usually permanent in nature. There can also be no argument that organizations operating under this era's philosophy promoted change. However, it was generally not a positive experience. The psychological and physical separation that young people in these facilities experienced from their families served to destroy and sever the sense of parent-child cohesiveness and connectedness. The result for most young persons was the development of overdependence upon the facility and a sense of low self-worth. These youngsters' bonds with their families were severed and replaced with what must have seemed to them to be an alien set of beliefs. Indeed, it was during this era that the notion of institutionalization emerged.

The third stage, the "Protection-Segregation Era," which began in the late 1800s and lasted until the 1940s, brought about the beginnings of specialization in the provision of residential services. Distinctions were made between the "mad" or disturbed, the "bad" or the criminal offenders, the morally week or the unemployed and/or poor, and the unprotected or the orphans and homeless (Ainsworth and Fulcher, 1981). These special populations were segregated from each other. Of course, they also remained segregated from the general population.

The third era marked a significant change in how children and young people were perceived. There was a shift from seeing special needs children as morally inferior to a new emphasis on recognizing the impact of the environment in which the young person was raised (Schnell and Taylor, 1988). While this change was an improvement, this was still very much a model of "Blame" in which society accepted no responsibility for the conditions in which children were raised. Instead, the fault was shifted from the shortcomings of the young person to the weaknesses of the family.

It was during this period that the beginnings of the treatment movement occurred. While most of the services were still of a basic care or a child protection nature, this era also saw the beginning establishment of child psychiatric services (Crespi, 1989). Although these services were often just adjuncts to adult programs, there was now a growing awareness that the special needs of young people were somewhat different than the needs of adults. There was as yet no distinction made between the symptomatology of young people and adults. However, there was a recognition that somehow the interventions may have to be different or somewhat modified to address the specific needs of young people.

This time period also saw the establishment of facilities for juvenile delinquents or young offenders. These programs, often called training schools or reformatories, were set up as a means of "correcting" the negative or criminal behaviours of youth. In many ways these programs borrowed values from previous areas in that the focus of intervention was on reformation of character and re-education of values and attitudes. However, these facilities were different in that they attempted to respond to the specific needs of young people. Some facilities had a blended reformation and treatment approach where services by social workers and psychologists were also offered. The trend in corrections, too, was towards specialization and away from harmonization of services. Young people were seen as unique

and separate from the adult population. Young people needed to be saved (Meen and Chubb, 1981).

A third stream of services during this same era was represented by residential schools for native youth. Replacing the earlier mission schools whose purpose, in part, was to save the "souls" of aboriginal children, these new schools focused upon integrating youth into the mainstream European culture (Daily 1988; Johnston, 1983; Collins and Colorado, 1988). As white people came into greater contact with native peoples, residential programs proliferated. In some ways, these schools were the true forerunners of the later concept of milieu intervention. The schools, through the psychological and geographical isolation of the youth, sought to completely control every aspect of their lives. This was perhaps the child saving movement at its worst. Humiliation, gross abuse and total cultural deprivation were the norm (Collins and Colorado, 1988). It is no exaggeration to state that the purpose of the programs was to eradicate native culture, which was deemed to be deviant, and to integrate native youth into the predominant white culture.

It is important to note that the three eras described above were not static or mutually exclusive. Each stage inherited the "demons" and mistakes of the previous era. Each stage incorporated key concepts from the previous areas. For example, the "Protection-Segregation Era" integrated the concept of basic care and protection from the earlier stages. Previous areas served as foundations for the next stage whereby new concepts were added onto previously developed interventions.

It is also important to realize that the establishment of a facility or program under the philosophy of a certain era did not mean the disappearance of previously established organizations or institutions. In fact, orphanages which were philosophically under the "Reformation-Rescue Era" continued **to** operate in this country with few changes in their programs well into the 1960s. Many child welfare services, particularly their affiliated group homes, still operate to a large part as an extension of protection-segregation or child saving philosophy.

While many of the services established during the three eras were, in retrospect, quite intrusive, moralistic and destructive, they were set up with the best of intentions. They were attempts, however misguided, to deal with perceived social problems. If they are now considered to be hierarchical, patemalistic/matemalistic and culturally and religiously chauvinistic, then we should not be surprised. They were reflections of the societies in which they were established. Within the context of their times, they were perceived by most, although probably not service consumers, to be humanistic expressions of a caring and concerned society.

Although many of these institutions are now regarded with the same opprobrium as are the facilities depicted in some of Dickens' novels, it would be a mistake to believe that the facilities were all bad. One of us recently attended the 75th anniversary celebration of an adolescent treatment centre that began as an orphanage. Numerous former residents of the facility attended this reunion, some from the 1930s, and many had fond and loving memories of the institution. To them it was a family reunion. The care and attention given them by staff while they were residents of the orphanage was more of a living memory than any shortcomings of the programs.

There can, however, be no doubt that there were others with negative experiences, although few of these people come to reunions. As we are currently discovering, or perhaps finally admitting, many of the facilities set up under the philosophies of the three

aforementioned eras were often much more abusive to young people than the families and communities from which they were to be "saved." Harsh punishment, isolation, neglect, as well as physical and sexual abuse were not uncommon occurrences within many facilities. At the very least, the institutions can be criticized for the rigidity of routines and interventions, the depersonalization of the care, and the isolation from the communities of origin of the residents (Ainsworth and Fulcher, 1981). The result was that many young people were victimized by the very organizations that were established to assist them.

It was the abuses of these three areas as much as their contributions which proved to be the turning point in the development of more effective forms of residential care. The realization of the potentially destructive nature of total control over a persons' environment led in part to the acceptance of the concept of therapeutic milieu. While Bettleheim (1955), as one of the founding fathers of the concept, based the development of his first milieu community upon adult mental institutions, it is probable that, in Canada, an examination of the orphanages and residential schools led in part to the acceptance of the concept. Reformers foresaw that if a negative environment could produce negative consequences for the child, then the establishment of a controlled, positive environment could produce positive consequences.

Recent Springs

The fourth stage, the "Treatment-Intervention Era," which can be traced to the 1940s and 1950s, was greatly influenced by the mental hygiene and child guidance movements (Grellong, 1987). Intervention with young people became more formalized and was guided by the growing professions of social work and psychology as well as by the increased movement within psychiatry towards a specialization in children. The control of existing organizations and the power to establish new programs were passing from lay community people and religious orders into the hands of professionals. Although this "professionalization" was not completed until recently, it was greatly accelerated in the years immediately following the Second World War.

During this period the responsibility for basic care, and in many cases protection, passed from institutions to foster care. While foster care had been available as an option for many years, it had often been used as an alternative when institutional services were not available.

By the 1950s many institutions were moving towards the provision of treatment for "disturbed" young people and away from the rescue-protection area. It was during this era that treatment centres and group homes were first established. There was a movement away from the use of large congregate facilities such as those found in the ward structures of large institutions to the use of smaller "cottages" and community homes. Many orphanages were transformed into treatment centres during this era. The intervention philosophy changed from the belief that the living situation was a place of basic care while the child waited for therapy in a psychotherapist's office, to the concept that a positive milieu itself was a means of therapeutic intervention (Foster and VanderVen, 1972; Grellong, 1987).

There was an attempt in milieu settings to control the entire environment of the young person. It was and, indeed, is still believed that a restructuring of the living, social and school environment will positively affect the individual's functioning. Through living in an environment which provides opportunities for learning positive interactional and behavioural

skills, it is believed that the young person will acquire a functional set of skills which can then be transferred to his or her community life upon discharge (Polsky and Claster, 1968).

It can be argued that this model was, like the earlier ones, quite paternalistic/maternalistic and moralistic in nature. The primary difference between it and its predecessors was that now professionals were running the facility and that there was

a conscious effort to structure the living environment in a positive manner. But the new language of treatment, with its complex terminology, was in many cases a thinly disguised way of stating the same messages given by the care-givers of the earlier areas. The saving of the young person's psyche was attacked with the same zeal as the moralist-saviours had done in earlier years. Residential care and treatment was still something that was imposed on young people. It was still a case of a segment of society dictating the "appropriate" way for young people to act and behave.

The model, although widely accepted by the professional and lay community, began to be questioned even while it was being widely implemented. While many saw this model as the answer for most, if not all, of the problems experienced by young people, others saw the programs within this system as but a reworking of the previous institutions (Fewster and Garfat, 1987; Perry, 1988; Barker, 1988). There was an expressed fear that even in smaller living units young people could become institutionalized and overdependent. Moreover, rather than being exposed to only a positive environment, young people were also exposed to the dysfunctional behaviours of other youth. Young people were still often isolated from their families and their communities which, coupled with the tendency of programs to be relatively long-term, increased the likelihood of permanent parent-child separation. These programs were also extremely expensive in comparison to other types of intervention. Often residential programs, and especially treatment centres, received the largest portion of the children's services budgets.

The "Specialization-Intervention Era" probably peaked during the 1970s. However, there are still many programs which adhere to the values of this model. Because it is still influential, it is difficult to make a conclusive assessment of the advantages and limitations of this model. There is considerable anecdotal evidence that the milieu is a powerful means of educating and re-educating. It appears that milieu concepts represent a powerful methodology for helping children. However, research is required to delineate the milieu concept further: What aspects of the milieu, specifically, have what affects on which children and which problems? How is a milieu best designed and maintained? How are negative milieu components minimized or avoided?

The concerns expressed about this model, as described above, are also relevant. They are, however, not so much concerns about the milieu approach as about the context within which it has been traditionally implemented. A good idea, implemented for the wrong reasons, with inappropriate intent, in the wrong framework, is likely to be problematic. Under such circumstances, the shortcomings of the program are often attributed to the idea or program concept, leading to its abandonment.

There is a danger that this will happen in this situation. While milieu approaches hold much promise, there is a danger that they will be discarded like the proverbial baby with the bath water.

Current Stream

The current stage, the "Consumer-Community Partnership Era," began to emerge in the 1970s. Although it is still developing and evolving, its beginnings can be traced to the widespread development of out-patient and aftercare services by residential facilities. These adjunct programs were established in recognition of the need to provide some continuity between the residential and community environments. A related concern was the recognition that while behaviour change could occur within the treatment milieu, the change was not necessarily transferable when the young person returned to the family and community. While some facilities have a long history of providing these services, it was really not until the last decade that there was a widespread systematic attempt to provide prevention and postvention interventions in conjunction with residential programs.

However, it's becoming increasingly apparent that the provision of such services cannot occur without the co-operation of the young person, the family, and the community. This co-operation or partnership has required a re-conceptualization of the traditional relationship between professionals and lay persons/consumers. It is no longer sensible for professionals to regard young people and their families as passive recipients of services. In order for treatment progress to be made, it is important that consumers acquire some sense of ownership of the treatment process.

Also inherent in the current model is the establishment and acceptance of the consumer's rights movement. This movement was established in part, as a result of the inability of funders and residential programs to police treatment excesses and abuses. Organizations such as the National Youth In Care Network are attempting to bring to the public's attention such issues as the overuse of physical restraint as a means of behavioural control and the lack of services to emancipated young

people. Undoubtedly many other traditional interventions will be challenged in the near future, particularly in light of Canada's acceptance of the United Nations Charter on the Rights of the Child.

The present model has also brought about a rethinking of the time frames within which young people should stay in residential programs. There is a trend towards shorter term programs which focus upon strengthening the positive attributes of the young person as opposed to focusing upon the elimination of negative behaviours. Of course, this has required more of an acceptance of the young person as a unique individual, and abandoning institutional goals of remaking the young person in the image of the "ideal youth" envisioned by the program.

What the future holds for the current model is difficult to predict. However, developments will clearly be influenced by numerous trends currently evident in our country. Prime among these is the increase in troubled and troubling behaviour by young people. In particular, acts of violence and self-destructiveness by youth may well create a public demand for more controlling and intrusive interventions at a time when many programs are heading in the opposite direction.

Clearly, destructive forms of behaviour by young people within programs add stress to facilities many of which, in recent years, have been down-sized and have suffered staff reductions. The irony is that as residential programs finally recognize that they are not the panacea for all of the problems of young people, the public may demand that they become so.

To respond to such demands, it is likely that programs will have to become more specialized. No longer will broadly defined generic programs be able to claim to provide all required interventions. For example, it is long past the time when sexual abuse victims and adolescent sex offenders should be housed in the same facility. In order to respond effectively to the problems being experienced by some young people, programs will have to develop specific expertise. Coupled with the move to smaller facilities, we are likely to see small specialized, issue-specific programs developing in community settings.

Concluding Comments

As this review shows, our current residential system is a mixture of programs which offer a range of services reflecting the philosophies of all five areas of residential care. Because this system is a result of ad hoc responses and adjustments, little planning and coordination has guided its development. Unless a systematic examination of residential care and its place in the child welfare system are undertaken, residential programs, like many of the young people within them, will fall short of expectations.

Social programs, including residential programs, are only a reflection of the society in which they operate. As long as our society ignores or minimizes the needs of young people, residential programs can only partially and inadequately meet their needs and those of their families. In the final analysis, a deeper commitment to effective children's services will be required if residential programs are to develop to their full potential.

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