Caring for: Caring about: Caring with

Tronto explains, ‘caring for’ includes hands-on care; ‘caring about’ describes our emotional investment in and attachment to others; ‘caring with’ describes how we act together to transform our world[1]

In adopting this framework we can move between ‘physical and emotional care, through theorising caring infrastructures and the nature of overarching politics of care, to conceptualising acre for strangers and distant others’[2]

At some time in life every person has need of dependency. It is necessary. With regard to our bodies and minds we avoid thinking about it filling our minds with a full sense of agency. We avoid thinking about the dependency on all the people doing all the things necessary for living in a modern world. From before first waking till sleeping and even through the night we are dependent on some somewhere that we probably have never met or will ever meet. Dependency is part of the human condition. It is beyond entitlement.

If dependency is unseen it is not given a value. Dependency relies on care being present. That care is conceived of as a familial responsibility is to reduce or remove its value, and all the easier for it to be commodified in a market economy. As care within a family is available at no cost then the move outside of the family is seen as having a limited competition and therefore can be given a low value and price. Low price leads to low wages. If we look at care in all settings as reproductive labour it is given a different value.

There is an accompanying, and unhelpful, hierarchy applied to care settings with the family at the base vertically rising to residential child care at the apex. This is to make access to all levels of care beyond the family subject to failure, of the family or child. Behaviourally, socially, educationally, emotionally, learning and physical ability the child/ family have a deficit model applied.

If we are to ensure the right child is in the right place at the right time there are four thought patterns to be accepted.

Firstly, that all options are horizontal and where the child lives is a matter of choice, safety, and specialism (a warm birth family can be as specialist as an therapeutic community).

Secondly, that outcomes in any care setting need to be understood as the correlation of factors current and historical (so outcomes from residential settings inherit all that has gone before, these contribute to the outcomes they are not necessarily attributable to the residential setting, needs originating in early years trauma, unrecognised but made harder to remedy by a journey through care perhaps with tens of ‘placements’ results in adverse outcomes which are the responsibility of many rather than the residential setting from which the child ‘leaves care’.

[1] Joan Tronto Caring democracy; markets, equality; justice New York University Press 2013
[2] Care Manifesto p 22

Thirdly, we need to challenge the idea that 'all children need a family' (this may be so however some children at some time in their lives may need something other for reasons of choice, safety, specialism, perhaps recovering from family life, or being prepared for family life, it never having been a nurturing experience and the child needing to understand that nurture can be given unconditionally and without trauma attached).

Fourthly, a child can accept multiple care givers and significant others/parenting figures into their social and emotion al world (having a person in a parenting role called a key worker in a children's homes does not supplant the birth parents, or others, but can exist alongside providing differing roles and functions for the child). It is a Western view of family life that excludes networked child care, but then not completely as in my child hood friends and neighbours were called 'aunts' and 'uncles'. What is nursery and child minding if not networked child care?

Perhaps we might approach all settings as families of choice[3]. Each family is one of necessity and from expanded affective relations of care and intimacy. [4] We have taken on this learning that family or friends could be kinship carers but have yet to extend it to other non-family based settings. The experience of being cared for knows no artificial imposed definitions can be just as it is within a family. In the Quality Standards we find the following expectation in the Positive relationships standard: 'positive relationships,' consistency and unconditional positive regard for the child on the part of the carer; the carer acknowledges the importance of understanding and responding to the child's lived experience of care. Positive, stable relationships help the child to feel secure and cared about and for'[5]. In the Guide to the Quality Standards Key Principles we find

- Children in residential child care should be loved, happy, healthy, safe from harm and able to develop, thrive and fulfil their potential.
- Residential child care should value and nurture each child as an individual with talents, strengths and capabilities that can develop over time.
- Residential child care should foster positive relationships, encouraging strong bonds between children and staff in the home on the basis of jointly undertaken activities, shared daily life, domestic and non-domestic routines and established boundaries of acceptable behaviour.

Not only is it good practice for a child to be loved within positive relationships children's homes are the only setting where this is a matter of legislation[6]

Placing care front and centre is to appreciate that we are all responsible for care; without care we cannot live our lives. Appreciating this leads us to revaluate care. It is first base. Care needs 'prioritising the social, institutional, and political facilities that

[3] Kath Weston Families we choose Columbia Univ Press 1991

[4] Sasha Roseneil and Shelley Budgeon Cultures of intimacy and care beyond the family Current sociology 52(2) 2004 p 153

[5] Quality Standards for children's homes

[6] There are echoes of Bowlby and Winnicott, attachment starts from the parent; of Levinas the self is constituted only through its relationship to the other; of Derrida's 'limitless hospitality' and this connecting to Edward Lyward describing Finchendon Manor as ' a place of hospitality'.

enable and enhance our capacities to care for each other'[7]. Care being present leads to the potential for fulfilling lives.

This potential has to be resourced. 'Only with adequate and secure resources can anyone, however fragile and in need of specific assistance, develop and maintain whatever capacities they have to enable some sense of autonomy, and escape from the pathologies of being rendered completely helpless and passive.' [8]

For care to be front and centre means having the goal of each person being able to exercise 'self determination, or forms of interdependence in which autonomy and control over their lives is key.'[9]

To be able to provide this definition of care requires a deep participatory democracy, of care receivers and care givers. Care is not something given, or distributed, it is created as a collective endeavour. In adopting this stance the notion of commodification, monetising, buying and selling care is placed front and centre for scrutiny. Care can only be a public space, it is a common space. It loses if it is moved to a private space.

For care to be established requires 'creating and defending the commons: collectively owned, socialised forms of provision, space and infrastructure.' [10]

'All forms of care … should be valued, recognised and resourced equally, according to their needs or ongoing sustainability' [11]. This is an ethics of care that then stretches beyond what a market will provide, low incidence and high risk care are not attractive financial investments but needed, to 'a more capacious notion of care.'[12]

Any state of any complexion that is placing care front and centre 'would furnish both carer and cared for with the legal, social and cultural recognition and resources they need'[13]

[7] Care Manifesto p 26
[8] Care Manifesto p29
[9] Care Manifesto p 29
[10] Care Manifesto p31
[11] Care Manifesto p 40
[12] Care Manifesto p 41
[13] Care Manifesto p 42