Beyond the continuum

New perspectives on the future of out-of-home care in Australia

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In almost all current debates concerning services for young people in out-of-home care it has been customary to define services in terms of the so-called 'continuum of care', a hypothetical typology of placement options that differ in varying degrees from conventional family life. According to this philosophy, children should always be placed into family foster care rather than congregate care because foster placements are more normalised, nurturing, and place fewer limits on children's individuality and freedom of choice. In this paper, we argue that this approach is limited because it fails to consider the diversity of actual services and structures possible at different points in the hypothetical continuum. In our view, future policies may be better served by a dimensional approach that views placement options as a configuration of factors including: the physical and living environment, service type, and staffing characteristics. In this system, the quality and suitability of placement options is no longer defined by names or labels (eg, family, group or residential), but by the actual nature of the placement provided. Appropriate combinations of these elements, rather than a choice between fixed categories, may assist in the development of innovative options better able to meet the needs of young people not suitable for existing care arrangements.

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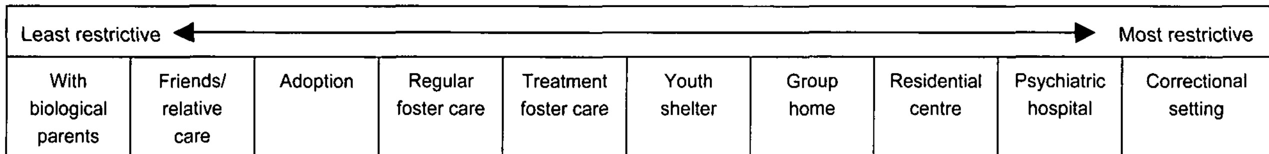
THE CONTINUUM OF CARE

In most discussions of out-of-home care, it has been conventional to differentiate programs based upon their position on what is commonly referred to as 'the continuum of care' (Stroul & Friedman 1986). Although there have been some variations in how this term has been defined, the continuum usually refers to a typology of placement options that differ in terms of their 'restrictiveness' (Handwerk, Friman, Mott & Stairs 1998). Restrictiveness generally refers to the extent to which children are free to make choices concerning their own actions and experiences, and is usually compared with the typical environment experienced by children living at home with their biological parents. In more restrictive placement options, children are typically placed with a larger number of other children in a less nurturing environment where rules and routines, rather than individual choices, substantially govern the nature of daily activities and the living environment.

An example of a series of different placement alternatives ordered in terms of their restrictiveness is provided in Figure 1 (Herrick, Williams & Pecora 2004). Although not all of these options necessarily apply only to children in the care system (eg, minors can be placed into psychiatric units or correctional settings with a formal placement order), these are all nonetheless arrangements into which children in the care system can find themselves. As indicated in Figure 1, children are generally thought to experience a very normalised or less restricted life if they are placed with relatives, are adopted by a family, by strangers, or if placed into regular family foster care. In such environments, life is thought to be generally similar to what it would be if they were living at home. Treatment or therapeutic foster care is placed slightly further along the continuum because children are usually expected to adhere to a greater number of rules and may be kept under quite close supervision by their foster carers. Further along again are youth shelters and group homes[1], in which young people may be required to share

[1] Youth shelters are a form of short-term accommodation where young people can sleep and have meals when they have no other place to stay. Shelters usually focus predominantly on providing safety rather than nurturance or therapeutic care. The resident population may often vary considerably from one month to the next. By contrast, group care homes are usually designed to provide nurturing and care for a smaller number of young people, where the same young people live in the same location as their primary place of residence. The primary difference between group homes and residential care is that group homes are rarely located on a campus and tend to have smaller numbers of young people.

Figure 1: The continuum of care



Least restrictive ◄									► Most restrictive
With biological parents	Friends/ relative care	Adoption	Regular foster care	Treatment foster care	Youth shelter	Group home	Residential centre	Psychiatric hospital	Correctional setting

resources and adhere to house rules, and where they may be less able to mould their living environment to their own needs or preferences. Finally, at the other end of the continuum are more institutional services in which it is assumed that the living environment is quite different from family life, with most aspects of everyday behaviour subject to routines, monitoring and control. Such a situation would, of course, be most strongly exemplified in a correctional institution[2] where young people no longer have the right to leave the premises or undertake many actions without formal permission (Hawkins, Almeida, Fabry & Reitz 1992).

The continuum of care has been strongly emphasised in out-of-home care for two reasons. First, it is generally assumed that young people fare best in environments that best resemble, or which are most proximal to, their local communities (FFTA 2004; Stroul & Friedman 1986). These views are enshrined in the policy documents of every Australian State and feature very strongly in many overseas polices, including Britain's Children Act 1989 and the Adoption and Safe Families Act 1997 in the United States. In family arrangements, children are thought to have a better chance of forging stable and secure attachments, and are more likely to develop interests and friendships within their local neighbourhoods.

Second, in Australia and in the United Kingdom in particular, the existence of numerous accounts of previous abuse in more expensive forms of State-funded institutional care (eg, Australian Senate 2005; Layton 2003; Queensland Crime and Misconduct Commission 2004) has led to the conclusion that non-family-based forms of care are potentially harmful to children and therefore undesirable. Accordingly, it has become a standard element of modern practice to commence placement decisions by considering only the least restrictive forms of care before proceeding to more restrictive options (Armstrong & Evans 1992; Gottlieb, Reid, Fortune & Walters 1990; Tuma 1989).

[2] A correctional setting is any form of secure placement where young people are not free to leave without breaking the law. Correctional centres go by various names, including: detention centres, prisons, training centres. In the US, the term 'boys or girls home' has also been used, although such terminology is less common now.

CONSEQUENCES OF THE CONTINUUM MODEL

As pointed out by Barber (2001), one of the visible outcomes of these philosophies in Australia has been the rapid decline in the availability of residential or non-family-based forms of care. Compared with 1983 in which approximately 40% of children in Australian out-of-home care lived in some form of residential care, less than 10% of the total care population now live this way, with family foster care being the placement option of choice for over 95% of placements. Fortunately, these foster care arrangements appear to work well with most children showing small, but significant improvements in psychological and social adjustment during their time in care (Barber & Delfabbro 2004). However, as is also clearly evident, the demise of alternative placement options has meant that any failures in the conventional care system cannot be easily accommodated. In Australia in particular, studies have consistently shown that approximately 15-20% of young people placed into out-of-home care have significant emotional, behavioural and social difficulties that make it very difficult for them to be supported in conventional care (Delfabbro & Barber 2004b; Victorian Department of Human Services 2003). Most foster carers do not have the skills or inclination to care for children or young people with these difficulties, and a substantial proportion of these young people, particularly those who have reached adolescence, dislike foster care because it isolates them from their peers and restricts their independence. As a result, Australian foster care systems are experiencing very high rates of placement breakdown, with many children currently being referred into care having experienced twenty or more previous placements in their lifetime (Delfabbro, Barber & Cooper 2000).

With the current emphasis on family-based placements, the current solution to meeting the needs of challenging children has been to supplement existing foster care payments with extra payments or loadings (Delfabbro & Barber 2004b), or by arranging expensive support packages usually through private not-for-profit organisations. However, these strategies only serve to buttress existing placement options, and do little to extend the range of services available. In this sense, these measures do not fundamentally address many of the recommendations of recent reviews into child protection services in Australia such as the 2003 Layton report in South Australia, which emphasises:

> ... that for some children and young people who have very complex needs, family based foster care is not an adequate option. In these situations the State must provide the type of care that meets the specific needs of the child or young person in question. South Australia must urgently extend its range of care options (p.118).

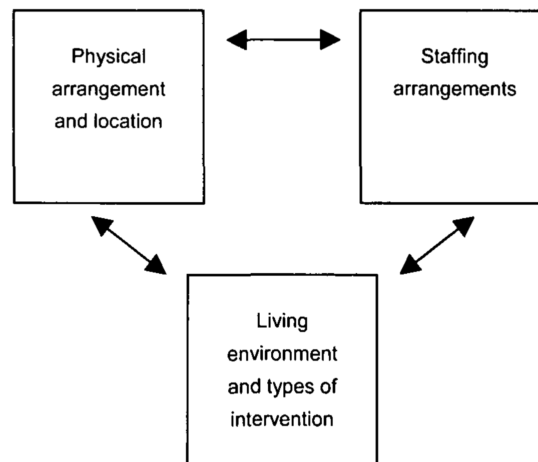
As with the 2004 Crime and Misconduct Commission report in Queensland, the Layton report suggests a need to extend the existing range of services to include professional or treatment foster care placements, as well as greater use of residential care. However, despite making such recommendations, the report provides little guidance about how existing criticisms and prejudice against non-family-based forms of care are going to be addressed. Since most policy documents emphasise a preference for foster care over other forms of care, and adhere strongly to the continuum model when considering the appropriateness of placement options, it appears difficult to imagine how other forms of care, including residential care, could come to be more widely accepted in Australia, especially given its reputation as a 'second-best option'.

In our view, this state of affairs has come about as a result of discussions about out-of-home care being overly dominated by the continuum model described above. Instead of looking at what services actually do and how they differ, much of the debate has been based upon simple categorisations and overly generalised views of congregate care (any placement option involving more than the typical number of children found in a biological family). Traditionally, any placement arrangement that involves multiple children living in close proximity and not in a house in the community has been considered less desirable than family-based care, but this ignores the fact that: (a) services are comprised of many different elements, and (b) these elements have to be confined to any one part of the 'continuum of care'. Views similar to this were expressed by Stroul and Friedman (1986) in their influential monograph on services and programs for young people with severe emotional and behavioural disorders. Rather than referring to a 'continuum of care', Stroul and Friedman preferred the term 'system of care' to capture the broader range of factors that must be taken into account when designing and implementing effective services. As they indicated, a system of care:

> ... includes the program and service components, but also encompasses mechanisms, arrangements, structures, or processes to ensure that the services are provided in a coordinated, cohesive manner. Thus, the system of care is greater than the continuum, containing the components and provisions for service coordination and integration (1986, p.3).

Admittedly Stroul and Friedman's emphasis was less to do with specific services and predominantly to do with the possible linkages that might be forged across different

Figure 2: The principal dimensions of care



services, but their view nonetheless suggests that a greater appreciation of the potential range of services for young people could be obtained by looking beyond the continuum model.

In our view, one useful way in which this might be done is to look more carefully at the specific nature of agencies and programs rather than differentiating forms of care solely based on the number of children living at a particular location, or in terms of the label attached to the agency or program. This is because arbitrary classifications based upon such terms as residential, home, or foster care may be limited in that the actual service falling under each of these labels may be open to considerable variation or flexibility. Thus, depending on the specific nature of the service, it does not always follow that a 'home-based' program will always be similar to conventional family environments. In fact, there may be some residential programs that share more in common with conventional family care than some foster care programs, depending on what elements one considers.

THE DIMENSIONS OF CARE

To highlight these complexities, we have sought to identify what we believe to be the principal characteristics or dimensions that might be usefully considered as the basis for differentiating between programs, assuming that each is, of course, adhering to some basic principles or standards of care[3]. In other words, these are the elements which we feel to be the basic building blocks of a service and which provide perhaps the most useful insights into the type of care

[3] By this, we mean that, before one could even consider a particular service as a viable option for young people, one would need to ensure that it met some minimum standards of service provision (eg, appropriate staff training and physical resources, good quality living environment, and appropriate intervention methods).

young people are likely to encounter in different placements. The three most important of these dimensions are:

(a) the physical arrangement and location of the service

(b) its staffing arrangements, and

(c) the nature of the living environment and interventions or services provided[4] (Figure 2).

The first two of these are discussed in some detail below, and also in a separate paper (Delfabbro & Osborn, submitted) in the interests of providing an appropriate level of detail for both papers. An immediate implication of Figure 2, which sets it apart from the continuum model, is that it no longer follows that one is bound by service classifications. Instead, it now becomes possible to see a variety of programs as arising from the combination of different service elements. It becomes possible to:

(a) consider a range of different service options that combine these critical elements in different ways, and

(b) describe services more in terms of what they are actually like, and what they do, rather than in terms of the name that is implied to them, and their assumed position on the 'continuum of care'.

... the demise of alternative placement options has meant that any failures in the conventional care system cannot be easily accommodated.

This capacity therefore has the potential to encourage more flexible and creative debates concerning the nature of existing and potential service options for young people, and may help to dispel the view that placement options to the right of the continuum are necessarily poorer than those to the left. Residential care becomes nothing more than a label that could apply to a variety of care options, many of which may differ considerably in their nature.

As an illustration of this, our discussion below refers to home-based arrangements that are very restrictive in that children are subject to very strict treatment regimens and given few privileges. Conversely, we argue that there may be residential programs located on campuses which may nonetheless have staffing arrangements and intervention styles that very effectively replicate family life in the community. Moreover, as will also be argued, the implicit assumption that so-called less restrictive forms of care are necessarily in the best interests of children often does not consider children's access to professional services. It may be, for example, that residential programs are better able to concentrate professional services than conventional foster care because of the existence of a campus or other infrastructure that allows an ongoing involvement by professional workers in the areas of education, health and vocational guidance.

PHYSICAL ARRANGEMENT AND LOCATION

The first of these components has two facets. The first relates to the general location of the service and the second to the physical layout of the infrastructure. Services can be received either in the general community or from a service or institution located on a campus or grounds separated from the community. In community-based arrangements, young people spend much of their lives using publicly available spaces and resources, and can interact with other children in their surrounds in much the same way as any other child. On the other hand, a campus arrangement usually means that young people either visit or live in an institution or location that is separated from the community. A greater proportion of daily routines would therefore be undertaken within the confines of the organisation and many resources (eg, play areas, lunch rooms) would be provided in-house. With regard to this characteristic, it is generally accepted that care options located in the general community are preferable to those located on campuses because of the capacity for greater community involvement, the development of local social networks, and ease of parental visiting, and that this is one of the reasons why residential care is less desirable. However, residential care units do not have to be located on a campus, be isolated from the local community, or discourage these outside connections to occur. There are examples of services in North America, for example, that actively encourage community activities, sports and club memberships, and which have specifically designated community and vocational guidance workers.

The second component of physical layout refers to the configuration of living arrangements; in particular, whether young people live in a single dwelling unit, or in multiple (and usually physically separated) dwellings. As Bryant (2004) points out, the potential advantage of separated dwellings, and particularly those in the community, is that this can facilitate the development of new relationships and reduce the influence of unhealthy peer groups. For example, in many Australian and British residential units that accept children referred from regular out-of-home care services, it is not uncommon for young offenders to be placed there as well, so that residential care can become the transmission point for a wide range of antisocial behaviours including drug use and petty crime (Barber & Delfabbro 2004; Colton 1990). However, it does not follow that all residential arrangements necessarily have to involve situations where

[4] There are arguably two elements here. One aspect is the way in which the young person's life is regulated and controlled. The other aspect is the type of intervention used (eg, attachment therapy vs. behavioural style).

Figure 3: Program types based on variations in physical arrangement

	In community	*Separate campus/location*
Single dwelling	(A) Foster care / therapeutic house/ group homes	(B) Residential unit / in-patient psychiatric unit
Multiple dwellings	(C) Community village / cluster of supervised foster homes	(D) Residential village

these problems occur. It depends on the nature of the living arrangement and is also likely, as indicated below, to be strongly influenced by the nature of the intervention and the staffing arrangements.

As indicated in Figure 3, when one combines these two physical characteristics, it becomes possible to develop a typology comprising a variety of out-of-home care arrangements, many of which could easily be classified as residential or semi-residential under current definitions, but which overlap considerably with foster care. The left hand quadrant (A) comprising single dwellings located in the community would clearly describe the form of most conventional foster care arrangements, and this would be clearly distinguishable from quadrant (B) where a large number of children were located in a single building on a specific campus or grounds. However, the division between the two forms of care becomes less marked when one considers the other diagonal. Therapeutic or group homes in which 5-10 young people live with a carer or staff member in a residential house in the suburbs and receive intensive treatment and support during the day by visiting staff, or live-in house-parents, are not markedly different from family foster care, especially given the large numbers of children often placed in single Australian foster homes. Another style of program could combine elements of both home-based and facility-based care. One example indicated in (C) is the community village arrangement, in which foster homes are clustered very closely together so that they can be served by a nearby management building. Another example might be campus-based programs in which children live with permanent live-in carers in separate houses, where other services are available on the same campus. Both of these examples allow young people to adapt to a stable living environment in the company of other children, but also provide the ongoing supports and opportunities for therapeutic treatment. It is very difficult to place these care options on different positions on the continuum of care.

STAFFING ARRANGEMENTS

Although it is usually expected that agencies should provide appropriate management and training for all staff involved in their programs (FFTA 2004), there are several ways in which staffing arrangements can vary across programs, and so where one might observe important differences that are unrelated to the factors that superficially locate programs on the care continuum. These principal variations relate to:

(1) the employment status of agency staff

(2) the nature, range and status of professional staff, and

(3) whether supports are co-ordinated or provided by the service.

The role of agency staff

The first factor that needs to be considered is whether carers live with children on a more permanent basis as conventional parents, whether they are rostered, or provide only daily visits. In most foster care programs, children live with the same carer in the community and have the opportunity to develop a stable attachment with the same parental figure. By contrast, in other organisations children may sleep at the location in the presence of paid staff members, and receive visits from professional carers during the day. Another system might involve different carers at different times of the day in a shiftwork system, and there may be still other arrangements where carers sleep at the premises, but only do some days of the week. The type of arrangement is significant because it is likely to have important implications for the type of people willing to act as carers, as well as influence how children respond to the program. Clearly, only those carers who are willing and able to adopt a more formal parenting role would be capable of assuming the role as full-time carers. On the other hand, the fact that an agency chooses not to have stable carers may limit children's exposure to family-style environments and opportunities to forge long-term parent-child relationships.

An assumption of the continuum model is that group homes and residential care arrangements are less likely than foster homes to have permanent carers who live with children on an ongoing basis, and so children are less likely to develop appropriate attachments in any other arrangements. To a large extent this is probably true in many current Australian residential units. However, it should also be noted that this is not necessarily so for all residential placements, and nor does it have to be. Examples of residential programs exist in a number of countries where children live with permanent carers in individual houses on a campus (eg, The Children's Home of Easton – Pennsylvania; The Harbor House for Teens in Oklahoma), but the program would still nonetheless be considered residential care because of the number of children housed on the same location. Moreover, much of the discussion concerning attachments ignores the possibility of children being able to develop healthy relationships with people other than foster carers (eg, staff), or the fact that many older teenagers may be more likely to find appropriate

role models amongst adults who have certain professional skills associated with their recreational, educational or vocational interests.

The nature, range and employment status of professional staff

As outlined in most foster care standards or policy documents, it is important for all young people in care to have access to appropriate professional assistance to ensure their healthy physical, psychological and educational development. Despite this, the range of professional expertise available to young people can vary considerably across organisations, irrespective of their place on the continuum of care. However, at a bare minimum it is usually assumed that young people will have access to medical practitioners, opticians, dental health services, speech pathologists, psychologists and psychiatrists, educational assistance, social workers/child support workers and vocational guidance counsellors. Other organisations may further supplement this list with specialist cultural and spiritual workers to meet the needs of particular cultural groups (eg, indigenous people in Canada, Australia or New Zealand), or those with particular religious beliefs.

Such advantages of non-family care seem to have been relatively unexplored in most Australian care systems, where residential care units have often been seen more as containment centres rather than as places where therapeutic interventions could be concentrated.

Again, this is a critical element of the continuum that is not often taken into account in assessing the quality of services. In most conventional foster care services, services are usually only called upon when needed, and children therefore may only receive professional assistance when an emergency arises, or when sufficient extra funding or other services can be harnessed. By contrast, it is clear that a significant proportion of residential programs, particularly in North America, provide professional supports in-house. Many have educational programs with specially devoted school or court liaison officers, many employ full-time psychologists, health workers, vocational guidance counsellors, and a range of other professionals. The existence of these supports and the ability to bring multiple professions together on the same campus or physical location is a clear advantage of many residential care programs, and one that is often ignored in discussions of the care continuum and what is in the best interests of young people. Such advantages of non-family care seem to have been relatively unexplored in most Australian care systems, where residential care units have often been seen more as containment centres rather than as places where therapeutic interventions could be concentrated.

The provision vs. co-ordination of care

Another program characteristic that is not captured by the continuum model is the distinction drawn between the *provision of professional care* and the *co-ordination or management of care*. On the one hand, there are many organisations where professional staff are salaried employees who either live on the campus or grounds, or come to work each day. As indicated, a number of organisations in North America have psychologists, medical practitioners and educators who work full-time on the grounds. However, there are also organisations which do not provide professional assistance directly, but merely co-ordinate or facilitate access to these services. In these arrangements, professional people (who are otherwise working with other clients in the community) are identified as being able to provide professional assistance when required. This selection may be on the basis of geographical convenience (they live in the area), relevant expertise, or a willingness to provide services at a competitive rate in return for 'preferred supplier' status when children need to be referred. The best example of this sort of co-ordinated care system is 'Wraparound' in which a team brings together community resources to most effectively meet the needs of individual young people.

These differences in staffing arrangements may also play an important role in influencing outcomes for children and young people and are clearly factors that should be taken into account when assessing the quality of the service. Managed or co-ordinated service arrangements such as these have two important advantages. The first is that they usually provide a more cost-effective, or needs-based, form of assistance. The agency does not have to pay for the service unless it is used. In addition, as Hudson, Nutter and Galaway (1992) point out, making young people use services in the community:

> ... is more likely to result in continued use of these services after the youth leaves the SFC program than would be the case if they were provided by the program with eligibility linked to program participation (p.52).

However, potential disadvantage of these arrangements is that, unless children are actively referred to these services, there is no guarantee that they will receive any more services than other young people in conventional care, who are not involved in this support system. For governments contracting out services to organisations that provide co-ordinated care, this is important because the cost per child is usually quite high. Paying double the normal foster care rate to maintain the child in a stable placement with greater

supports leads to an expectation that the child is receiving a greater number of services, rather than merely a greater 'opportunity' to receive services. Thus, one needs to ensure that the co-ordinated care system is indeed providing ongoing services to children who genuinely need them, rather than doing so only when crises arise (as is often the case in conventional foster care). In Australia, this is perhaps one of the principal concerns associated with intensive support packages offered to foster children through private organisations, and where there may be advantages in more congregated forms of care. As indicated, in any form of care based on the agglomeration of placements either on a simple campus, or specific suburban area (eg, single or multiple group homes), it would be possible for professional people to be employed on an ongoing basis to provide onsite support to children and young people.

(This approach) would be one useful step towards overcoming ideology and directing discussion towards the more central goal of what works most effectively to meet the needs of all children and young people in out-of-home care.

Living environment and types of intervention

Perhaps the most important element that is ignored in the debate concerning the relative quality of foster and other care options is the sort of care that is provided. As indicated in Figure 2, there are two general aspects of service provision that are likely to come into play. One is the degree to which daily rules, structures and routines differ from conventional homes (the living environment). The other is the nature of the interventions or services provided. In terms of the first element, it is generally accepted that residential care or group homes are usually considered less desirable than family care because they impose a more restrictive, less child-centred, and normalised environment than in foster care. Colton (1990), for example, found that British residential care could be differentiated from family care along four principal dimensions of care practice:

(1) the management of daily events,

(2) children's community and family contacts,

(3) provision of physical amenities, and

(4) controls and sanctions applied by staff or carers.

In general, he found that residential care tended to involve much greater control and scheduling of daily activities, children tended to have fewer contacts with other people in the local community, they were more likely to share amenities such as furniture, common space, and were generally more subject to rules and other controls.

It is highly likely that similar differences exist in Australia between foster care and residential placements. However, as Colton (1988, 1990) also found in the United Kingdom and in Europe (Colton, Roberts & Williams 2002), these differences were not observed for all residential homes that were studied. Many, in fact, performed very well on the dimensions described above and suggested that 'child-oriented care can be provided in non-family settings' (1990, p. 16). Thus, it was not so much that a residential care model was inappropriate in principle, it was that many units needed to be improved so as to provide a form of care closer to that being provided in specialist foster care. In a similar vein, Ainsworth and Small (1995) have drawn attention to significant variations in the quality of group homes in the United States, with a particular focus on the extent to which these arrangements allow children to maintain ongoing relationships with their biological parents, and the extent to which the views of parents are taken into account in any decision-making concerning the child.

For this reason, one focus of current research being undertaken by the authors is to consider the range of non-family options available in other countries – in particular North America – to determine the extent to which the elements identified by Colton are being successfully replicated outside of foster care. Another component of this research is to look more critically at foster care itself. Although foster care arrangements might appear to provide a more normalised environment, there are many homes where children do not have the freedoms described by Colton (Gilbertson 2002). Many share bedrooms and bathrooms; have highly scheduled outings; have little access to much of the household; are allowed fewer community contacts; and have to abide by many house rules (for example, see programs such as Youth Villages Multidimensional Treatment Foster Care [MTFC] program and the Pressley Ridge Youth Development Extension [PRYDE] program). Such observations make it increasingly difficult to unequivocally place all foster care placements on the left hand side of the continuum of care described in Figure 1.

These views are further strengthened by observations of the specific interventions or services provided in many forms of out-of-home care. As we have described in more detail elsewhere (Delfabbro & Osborn, submitted), many American treatment foster care programs such as those recommended by the Oregon Social Learning Centre, or those applied by the Casey Foundation or Boy's Town, are based on strict behavioural principles in which children are initially given few privileges and then have to earn points to gain access to greater freedoms and opportunities. It is very difficult to consider how placements based on these methods

could be considered less restrictive in that almost every aspect of the young person's life, right down to their emotional expression, is subject to monitoring and controls. Our research already indicates that there are many group homes or residential villages (Jasper Mountain in Oregon, Chaddock in Illinois, Beech Brook in Ohio, and Namaste Child and Family Center in Mexico) using other therapeutic interventions (eg, based on an attachment, milieu or positive peer-influence approach) that clearly provide a less regimented and restricted environment than that which applies in many treatment foster care homes.

SUMMARY AND CONCLUSIONS

In conclusion, we believe that greater insights into the nature and possible design of out-of-home care programs could be achieved by moving away from the traditional continuum model. Rather than classifying programs in terms of how they appear superficially (eg, by name or number of children placed in the same location), it is useful to consider the specific dimensions that potentially differentiate programs and which have implications for the nature of the care provided. In this paper, we argue that the physical arrangement, staffing, the nature of intervention and care environment provided are all factors which can be taken into account when differentiating between different care arrangements, particularly those which lie to the right of conventional family foster care on the continuum. The implications of this are twofold. First, by thinking in terms of these dimensions of care, it becomes possible to construct more flexible placement options that are not necessarily bound by debates concerning the relative advantages of residential versus foster care. Second, in looking more carefully at programs themselves and what they do (or might do), one potentially avoids the assumption that all foster care or residential care arrangements are the same, and necessarily have to be that way in the future. At a time when almost every state is looking to expand its range of treatment options, we believe an approach based upon the dimensions which we have identified would be one useful step towards overcoming ideology and directing discussion towards the more central goal of what works most effectively to meet the needs of all children and young people in out-of-home care. ❖

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