Residential care in Australia, Part I

Service trends, the young people in care, and needs-based responses

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This is the first of a two-part discussion of the place of residential care services in Australia, which highlights the issues that are likely to influence the development of these services into the future. This paper explores service trends over the past few decades, the current place and focus of residential care services, the nature of the young people being placed into such services, and the imperative for developing a more needs-based approach to service delivery. It concludes with a review of recent calls for the development of therapeutic or treatment-orientated models and the initial steps in this direction that have been taken around the country.

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This is the first of a two-part discussion of the place of residential care services in Australia, which highlights the issues that are likely to influence the development of these services into the future. Residential care is the poor relation of the Australian out-of-home care sector. Approximately 95% of all children in out-of-home care in Australia are in some form of foster care (AIHW 2008) but it is widely recognised that the foster care system across the country is struggling to meet the needs of many children and young people with complex needs and challenging behaviours (see, for example, Ainsworth & Hansen 2005; Barber & Delfabbro 2002; Delfabbro, Barber & Cooper 2000; Delfabbro, Osborn & Barber 2005). When we consider that residential care provides a critically-needed option for some of the most disadvantaged, vulnerable and challenging young people in the care system, the neglect of this care modality in the literature is hard to understand. A recent national report on research into out-of-home care highlighted the 'small amount of research that has been conducted in Australia into forms of care other than foster care' (Bromfield et al. 2005, p. 50). In that report, fewer than five pages were needed to review the research into residential care in a report numbering over 130 pages.

The primary emphasis of this paper is on the place of residential care services and their shape and focus, rather than the internal transactional features that contribute to service quality. It starts with a review of recent service trends, moves on to an examination of the nature of the young people being referred for services, and then explores the implications for the development of a more needs-based approach to residential services. This is followed in Part II by a review of recent local and international publications, and a summary of the key themes and issues which are likely to inform the development of residential care into the future.

AUSTRALIAN SERVICE TRENDS AND THE PLACE OF RESIDENTIAL CARE[1]

Early estimates of the numbers of children in out-of-home care were quite unreliable and tended to combine children and young people placed for reasons of disability, delinquent behaviour and welfare needs. The report of a Senate Inquiry

[1] Parts of this paper are adapted (with updates) from discussions in Bath (1998, 2001/2, 2002/3).

conducted in the early 1980s suggested that there had been a peak of around 28,000 in group care alone in 1968 (Senate Standing Committee on Social Welfare 1985, pp. 43-44). However, from that time a process of de-institutionalisation took hold, driven by a belief that children and young people were best cared for within a family environment. By the early 1980s, there had been a drop of 65% in the numbers of children in group care settings.

In the early 1980s there were an estimated 17,000 children in out-of-home care in Australia, of whom 7,140 (or 42%) were in child welfare residential care settings. From 1983 to 1993, the overall number of children in care for child welfare-related reasons decreased to 12,273, while the number in residential care was down to 2,415, making up only 20% of the in-care population (Bath 1994). The number of children in foster care changed little in the decade between the early 1980s and the early 1990s.

Since the early 1990s there has been a rapid increase in the number of children in out-of-home care. Most of the increase has been taken up in new foster care placements as the use of group care continued to decline. As of 30 June 2007 there were a reported 28,441 children in care with only 1,247 (4%) in group care and 27,194 (96%) in various foster-type placements, including those in independent living or in 'unknown' situations (AIHW 2008).

International data in the 1990s suggested that Australia had de-institutionalised at a greater rate than many comparable western countries and also had a greater percentage of children in non-group care (Bath 2001/2). This still appears to be the case. A relatively recent breakdown of the numbers of children cared for in residential establishments in England determined that as of 31 March 2002, there were 34,000 children being looked after by local authorities, 7,930 (22.8%) of whom were in some form of residential care (Department of Health statistics, cited by Clough, Bullock & Ward 2006, p. 19).

Australian placement trends since 1983 are illustrated in Figure 1.

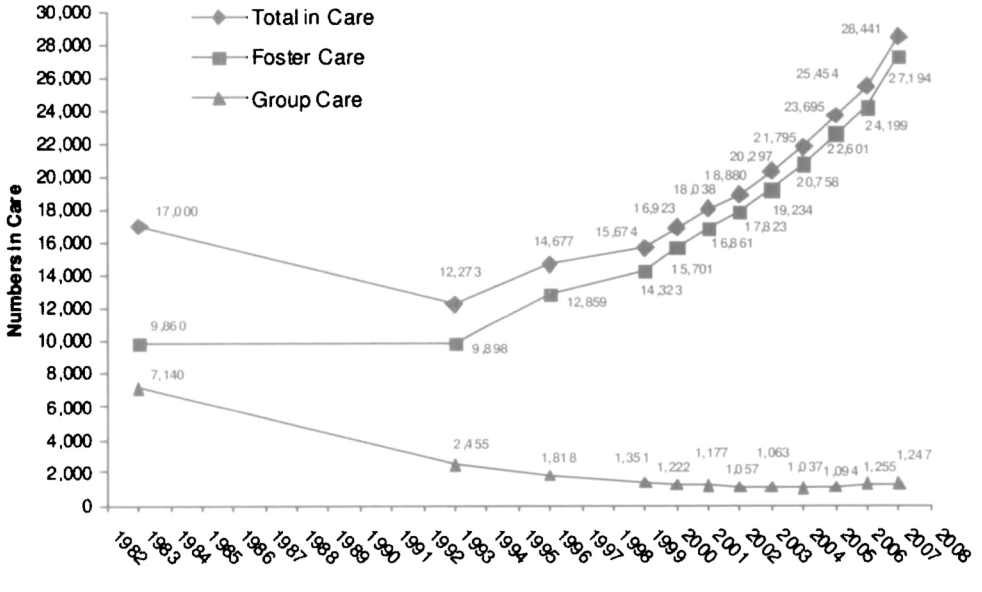
PRACTICE DRIVERS AND THE DECLINE IN RESIDENTIAL CARE SERVICES

Various ideological practice drivers such as 'de-institutionalisation', 'normalisation', and 'localisation' have influenced these trends. These ideals and principles were based on emerging understandings of child development, such as early findings into the importance of attachment. Disenchantment with institutional and residential care was fuelled, in part, by widespread reports of abuse and neglect in institutional settings. Apart from ideology, the much greater costs of group care cannot be discounted as a major driver of the reforms.

Demand for foster care services, usually considered a less restrictive and more 'normalised' care option, remained largely unchanged in the decade from 1983-1993 whilst residential care numbers decreased rapidly. It is likely that foster care services began to cater for children with behavioural problems who might previously have been accommodated in residential services. During this period, a number of specialised foster care services emerged which targeted previously institutionalised populations such as adolescents, disabled children, and those with emotional and behavioural difficulties. It can be seen that all the recent increase in out-of-home care provision (and more) has been taken up in foster care.

Because of the 'precarious state' of group care in Australia (Ainsworth 1998; Ainsworth & Hansen 2005), foster care is usually the only available option for children and young people needing a

Figure 1 Australian out-of-home care trends, 1983-2007



Adapted from AIHW Child Welfare Series (1997-2008) and Bath (1994, 1998).

Note: Group care includes residential care and family group homes.
Foster care includes kinship care, independent living and 'other' placements.

placement. However, the foster care system is in crisis – despite a dwindling supply of carers, demand is increasing rapidly. Moreover, those who do volunteer to provide care are being asked to take on children who are, on average, older and more behaviourally challenging than has been the case in the past. As Delfabbro and Barber (2002) have observed:

> Only those children with the most serious needs are given placements, so that the population of children in care is increasingly made up of children with more challenging behaviours, and/or physical and mental disabilities.

This has resulted in high breakdown rates and children experiencing multiple placement failures. Being the only placement option available in many areas, foster care is being misused to the detriment of both the children and their carers – this is particularly the case for children with behaviour problems (Delfabbro, Barber & Cooper 2000; Stubbs, Spence & Scott 2003).

Previously, group care was an option of choice; it now tends to be an option of last resort. Where abuse risk is identified, the first approach is always a preventative one with the goal of supporting the family through family support programs. Where a placement is indicated, a family preservation service might first be tried, or temporary/respite care. Short-term foster care is the next option, followed by longer-term care if the family problems are more chronic. Residential care is generally only considered after multiple foster care failures. Even at that point there used to be a range of residential options, including institutional care, family group homes, and group care with rostered staffing. The result of this process is that more troubled children and young people are being placed in foster care, with residential care serving as a default option, reserved for those with complex needs and entrenched, challenging behaviours. Unfortunately, these more needy and behaviourally troubled young people are placed into a care modality that has been run down and neglected and thus struggles to respond to the demands placed on it.

The trend data do suggest that after several decades of decline, there is evidence of a stabilisation in the numbers of young people in residential care.

Developments in residential care

A number of significant developments are not readily apparent from the quantitative data. As the larger institutions were closed, smaller, cottage-based programs were developed, many being known as 'family group homes'. Generally these were run by a married couple and operated as large foster groups. In time, some of these married couples were assisted by rostered youth workers and eventually programs staffed solely by youth workers became the norm. Family group homes, once the mainstay of group care, have now all but disappeared as a significant service option except in Tasmania and Western Australia.

In the 1970s, it was not uncommon for ten or more children to be resident in one group care facility, whereas now four or fewer is typical. Overall, residential care, considered by some to be the most restrictive and 'abnormal' out-of-home care option in the child welfare system, was increasingly used as a last resort for troubled and troubling children rather than for those simply needing care. This trend rapidly became an imperative as the number of available beds diminished and as care costs escalated, with declining staff-child ratios and economies of scale.

In Australia, the residential care sector is now rarely used for young people whose primary need is for accommodation, except where services provide for emergency placements or enable larger family groups to stay together. Its use is generally considered when other less restrictive options have failed to meet a young person's complex needs and there is a need to safely contain challenging behaviours. There are currently few children under the age of 12 in residential care programs although there is some evidence that increasing numbers of younger children are being assessed as being in need of residential services (e.g. Flynn et al. 2005).

Residential services for Indigenous children

Despite the fact that people who identify as being Aboriginal or Torres Strait Islander (A/TSI) make up less than 3% of the Australian population, around 28% of the children in care are A/TSI and in some jurisdictions, such as the NT and WA, the percentages are much higher – 67.5% and 41% respectively (AIHW 2008). The child welfare system has attempted to adapt to the particular needs of this population through mechanisms such as the Aboriginal Child Placement Principle now adopted by all States/Territories, the development of indigenous care and protection services, the promotion of kinship placement programs and the use of family conferencing models of decision-making. There have, however, been fewer innovations with respect to residential care. Notwithstanding the widespread adoption by programs of culturally sensitive approaches to working with A/TSI young people, there are few examples of residential care models specifically developed for A/TSI young people and scant reference to the need for such programs in the literature. There have been attempts to develop targeted care and treatment models utilising indigenous staff members but these have rarely developed into sustainable programs and there are no current descriptions of such programs in the literature. The survey by Flynn and colleagues (2005) in NSW reveals that the proportion of A/TSI children in residential care in that State is significantly lower at 15.5% than the overall proportion of A/TSI children in care – currently 31% (AIHW 2008). The well-documented mistakes of the past involving the forced removal of A/TSI children to group homes and boarding schools – as

graphically described in the 'Bringing Them Home Report' (HREOC 1997) – are salutary reminders of the harm that can result from the ill-considered use of out-of-home care. However, it is possible that because of this history, policy-makers are failing to consider the potential benefits of well-designed, culturally-sensitive, residential care and treatment options.

Disenchantment with institutional and residential care was fuelled, in part, by widespread reports of abuse and neglect in institutional settings.

RESIDENTIAL CARE TODAY

Contemporary residential care is generally provided in smaller units with rostered staff. Numbers range from as few as one to around four or five. In NSW, for example, most are for what used to be termed 'level three' young people, those with significant behavioural problems, although there are a few units for young people without significant behaviour problems and for emergency/short term care. A similar situation exists in most other states although there are some larger hostels operated by the Department for Child Protection in Western Australia and two larger 'secure care' facilities in Victoria.

Residential units for young people are rarely stable for any significant period of time and, as pointed out in a recent review by Erik Knorth and his colleagues (2008), some maintain that they just do not work at all. In the mid-1990s, Robin Clark reviewed the then new residential units that had been established following the closure of a number of larger institutions operated by the NSW Department of Community Services (Clark 1997, p. 4). She found that although the units were funded for six young people, the average occupancy was four, but many had only one or two residents. She also found that extremely challenging behaviours were common and that access to specialist psychiatric services was needed but rarely available. There were similar findings from reviews of residential services in other states (DHS 1997).

Although smaller residential units have many advantages over the older congregate facilities, given their more 'normalised' locations, appearance and living regimens, they struggle to provide a safe and stable environment for many young people. It is not unusual for essentially untrained staff members to be caring for young people with significant abuse histories, long juvenile justice records, serious substance abuse issues, histories of sexually exploiting other children, and/or frank psychiatric symptomatology, all together in the one small and isolated residential unit. In addition, a significant proportion of young people in residential care have intellectual or other developmental disabilities (Redoblado-Hodge 2004; Rutter 2000). A recent discussion of potential dangers with residential programs pointed to the serious problems that can emerge with the 'mixing of clients with multiple needs' (Pumariega 2006).

There is some research evidence which suggests that the placement of even a small number of behaviourally troubled young people together may actually serve to increase problem behaviours (Dishion, McCord & Poulin 1999; Dishion, Nelson & Bullock 2004; Dodge, Dishion & Lansford 2006). The most common formal and informal diagnoses (apart from disability status) given to boys in residential care are Conduct Disorder (e.g. McCann & James 1996), and the related Oppositional Defiant or Attention Deficit Hyperactivity Disorders, which are common co-occurring conditions. Kazdin (1997, 2002) reviewed the research on the efficacy of a number of psychosocial treatments for conduct disorder and found that, notwithstanding a number of promising research findings, there was still some way to go before any approach could be said to be truly effective in ameliorating symptoms of the disorder. However, he did suggest that the literature has given us clear pointers on what does *not* work. Kazdin noted that group treatments have often been used for conduct-disordered youths, but on reviewing the research outcomes, he concluded that 'placing several such youths together can impede therapeutic change and have deleterious effects' (1997, p. 172).

There is an urgent need for local examples of residential programs that are carefully designed and powerful enough to counter the negative synergy that is often a feature of residential care. It might be noted that there is good evidence that group interventions *per se* may not be the cause of the behavioural deterioration or 'deviancy training' that is sometimes reported from such interventions, but that this results from poorly managed group interventions which allow unstructured and unsupervised peer interactions (Weiss et al. 2005). It could also be argued that where young people who have experienced multiple traumas are essentially 'failing' their way into residential care, it is unfair to blame these services for any negative outcomes that may result. Using a medical analogy, it is akin to blaming medical facilities for the poor outcomes of some patients with serious conditions.

The individualised service approach (sometimes called 'individual residential care', e.g. Flynn, Ludowici, Scott & Spence 2005, p. vi) has become an increasingly common feature of the service system in some states. Such approaches are generally considered for young people with histories of serious behavioural problems that pose a risk to themselves or peers and where it is considered that a placement with peers would increase, rather than moderate,

risk. It appears that there are many examples of such service models across the country and, in 2003, they reportedly accounted for around one-third of all residential placements in NSW (Flynn et al. 2005, p. iv). There is, however, very little by way of formal reporting on numbers and costs, nor is there much discussion of this model in the literature.

Individualised services may involve the provision of 24-hour, one-to-one staffing (occasionally two- or even three-to-one) for a young person living in a house or flat. There are many Australian examples of such programs being operated from motels where no appropriate facilities exist. Case management is sometimes very intensive with recreational, educational and clinical services either being provided directly by an agency or through brokerage. At other times the 'program' that is offered may be little more than a form of surveillance or containment.

Some of the advantages of the individualised care approach are that there is scope to tailor interventions to address the specific needs of the young people, the negative synergy effects of group care are avoided and, at the less intensive end of the service continuum, care can be provided in a fairly 'normal' setting. Disadvantages include the high cost of such arrangements, the potential for isolating young people (see Clark 1997, p. 34; Flynn et al. 2005, p. 35) and the reinforcement of any sense of being different or abnormal they may hold about themselves. Moreover, individualised models have the same difficulties in accessing and retaining specialist supports that other services have. We might also question the premise that an effective service for the young people with the most complex and intensive needs can be simply created or cobbled together because funds have been made available. With respect to the use of individualised service models, Fulcher and Ainsworth (2006) have observed that:

> it is paradoxical that many professionals from across the human service spectrum continue to make a concerted effort to explore virtually every service option other than group care including, unbelievably, isolating troubled youth in rented houses and even motel rooms with twenty-four hours supervisory staff (p. 293).

Sometimes these individualised services are referred to as 'wraparound' models but the local examples differ significantly from the 'wraparound' or 'individualised care' models described in the literature (e.g. Brown & Hill 1996; VanDenBerg & Grealish 1996). In the USA, such services – at least those with a specific child welfare focus – trace their roots to the court-ordered repatriation of young people held in secure treatment centres, often in distant states (VanDenBerg 1988). Faced with the imminent return of young people with extraordinarily challenging behaviours, statutory and non-government agencies were forced to develop flexible, multi-dimensional responses in the young person's home community, and usually within their family homes. The term 'wraparound service' does not usually refer to young people being cared for away from their family homes, but there are local examples of individual residential care services that do offer an extraordinary range of services and supports akin to those commonly understood as using a 'wraparound' approach.

THE ADEQUACY OF CURRENT RESIDENTIAL SERVICES

There is an increasing gap between the number of young people who need residential care and the availability of services to meet their needs – see, for example, the analyses in Delfabbro, Barber & Cooper (2000) and Ford (2007). This has resulted in many young people being sent to youth services designed for older, more independent (and often streetwise) young people where they may be exposed to negative modelling and/or abuse. Others are temporarily accommodated in motels, crowded into full facilities (e.g. Ford 2007, p. 37) or simply left to fend for themselves.

WHO ARE THE YOUNG PEOPLE WITH HIGH AND COMPLEX NEEDS?

It is generally accepted that residential care today is a service for young people with high and complex needs. However, the statistics do not provide a clear placement picture of the children and young people designated as being at high risk. Some such children and young people are being looked after in non-residential settings, including specialist foster care, but little is known about their placement dispositions within the various jurisdictions. Barber, Delfabbro and Cooper (2001) have estimated that, based on their research criteria, up to 20% of young people referred for foster care might be considered to have high needs, but there are as yet no widely accepted definitions or criteria to facilitate data collection nor has the Australian Institute of Health and Welfare (which compiles the official statistics) attempted to define 'high risk' or 'high needs' children for data collection purposes.

PERSPECTIVES, CLASSIFICATIONS AND LABELS

Three decades ago, the 'typical' child referred to residential care was considered to be *dependent*, that is, a child in need of care because his/her parents could not meet their basic developmental and protection needs. Today, a young person is almost certainly referred to residential care because of his/her challenging behaviours, and in particular, aggressive behaviours. All the less restrictive options have been tried, and multiple support programs have been provided for their parent/s, many of whom, the research informs us, are likely to be affected by intellectual disability, substance abuse and/or psychiatric problems (Osborn & Delfabbro 2006). Most of these children and young people have been neglected and abused, many sexually. Most have experienced multiple placements out-of-the-home which

have resulted in an impaired ability to attach and trust, and the vast majority have educational problems.

Clark (1997), Bath (1998) and Osborn and Delfabbro (2006) have described this group of young people in residential care who, over time, have been variously described as being emotionally or behaviourally disturbed, conduct disordered, high risk or, more recently, as having high or complex needs. These global descriptors can be misleading and convey an impression of homogeneity that is far from accurate. The behavioural, developmental and psychiatric problems experienced by young people in the care system are varied and complex (Haugaard 2003) and they need to be carefully considered in the design of programs that are set up to provide care, treatment or education.

In their summary of issues to guide the development of residential services in Wales, Clough and his colleagues (2006) observed that:

> it remains essential to start with examining the behaviour of the children and asking, what would best help them? (p. 88).

Some of the major behavioural, developmental and psychiatric issues that need to be considered in the development of services are listed below. It should be noted that the various categories and issues are interrelated and may represent different perspectives rather than categorically distinct phenomena.

... more troubled children and young people are being placed in foster care, with residential care serving as a default option, reserved for those with complex needs and entrenched, challenging behaviours.

Aggressive behaviours and the conduct disorders

Whether or not a young person meets the formal diagnostic criteria for a conduct disorder (CD) or Oppositional Defiant Disorder (ODD), aggressive behaviours that directly harm and that violate the rights of others are a defining feature of many young people designated as being 'high needs' (Osborn & Delfabbro 2006). Indeed, they are usually the primary reason that they are referred for placement and they are the most common reason provided for placement breakdown (Barber & Delfabbro 2002; Delfabbro, Barber & Cooper 2000; Flynn et al. 2005, p. 14). The same observations apply to residential programs overseas. In the recent review of residential services in the UK by Clough and his colleagues (2006), it was observed that:

> the main reason for choosing residential care is to control or improve difficult behaviour

and that:

> lack of control and behaviour that is difficult to manage are the two overwhelming predictive factors for a residential placement (pp. 69-70).

As Dodge and his colleagues have pointed out (e.g. Dodge 1991; Dodge et al. 1997), there are different types of aggression, and troubled young people tend to have characteristic patterns. There are two major patterns – one in which the aggression used is largely planned and instrumental (proactive) and one in which it is primarily reactive and impulsive and marked by frustration, anger or fear (reactive). Connor (2002) observes that:

> there is growing research evidence to support the distinction between reactive and proactive aggression

and that:

> these subtypes have currently been investigated in over 4,000 children and adolescents.

He goes on to suggest that, unlike some other conceptual distinctions, the reactive-proactive dimension 'does suggest more specific treatment interventions' (p. 18).

The reactive and proactive categories parallel, but are not identical to, what used to be referred to (in the American Psychiatric Association's *Diagnostic and Statistical Manual*) as Unsocialised Conduct Disorder (reactive) and Socialised Conduct Disorder (proactive). The current (APA 1994) classifications of Childhood-Onset type and Adolescent-Onset overlap with the reactive-proactive distinction to some extent but these are essentially different constructs.

The research from Dodge's group has demonstrated that there are different developmental profiles behind the characteristic patterns and different implications for intervention. He points out that:

> problems of chronic reactive violence have their origins in early life experiences (such as early traumas of parental rejection, exposure to family violence, and family instability) and/or constitutional abnormalities, whereas problems of proactive violence have their origins in social learning during school years (Dodge et al. 1997).

Allan Schore has discussed the early development of these contrasting patterns of aggressive behaviour and how particular types of attachment relationships may lead to the different neurological regulatory characteristics that underlie these patterned behaviours (Schore 2003, pp. 141-146).

The majority (but not all) of the young people in out-of-home care with aggressive behaviours have reactive patterns of behaviour which are linked to histories of abuse and neglect, harsh and erratic discipline, and constitutional

vulnerabilities (Dodge et al. 1997). The root causes of these behaviours are complex, involving multiple developmental, temperamental, neurobiological and social factors (Rutter 2000). Intervention programs need to be based around skilful, comprehensive assessments. Programs to address the needs of such young people are quite different to those that tend to be useful with proactively aggressive young people. Moreover, placing young people with reactive patterns of aggression with those with more proactive patterns places the former at grave risk of being abused and/or being misled and manipulated into engaging in illegal behaviours.

Trauma/abuse-related symptomatology

The majority of young people in residential care come from backgrounds of abuse and neglect and many show the characteristic behavioural and emotional sequelae of what is known as complex trauma. Some have formal Post Traumatic Stress Disorder (PTSD) whilst the majority have some trauma-related symptomatology, including avoidance, concentration problems, hyperarousal, hypervigilance, restlessness, reactive aggression, labile moods, and self-harming ideation and gestures (Stein & Kendall 2004; van der Kolk 2005; van der Kolk et al. 2005). Some relationship-trauma behaviours manifest themselves as attachment problems (the *avoidant/resistant, anxious ambivalent* and *disorganised/disoriented* types) or more formally as Reactive Attachment Disorders. It is understood that certain behavioural patterns that are frequently seen in out-of-home care populations (especially behaviours suggestive of Borderline Personality Disorder) may develop as a result of traumatic abuse – they are increasingly considered to be developmental sequelae of complex trauma (Bremner 2005; van der Kolk 1996).

Bessel van der Kolk and his colleagues (2005) point out that the developmental sequelae of exposure to complex trauma are many and varied. For example, they suggest that those working with such young people need to understand that complex trauma leads to problems around the 'regulation of affect and impulses; memory and attention; self-perception; interpersonal relations; somatization; and systems of meaning'.

Young people with trauma-based behaviour patterns need very careful assessment, understanding and management, and their individual needs should determine the service responses that are offered. For example, the commonly-employed behaviour management techniques based on the reinforcement or punishment of behaviours, may not only be ineffective in changing trauma-generated behaviours (which are often characterised by emotional flooding) but can sometimes lead to re-traumatisation. Likewise, very careful consideration needs to be given to the placement of such young people with peers who may generate anxiety or engage in abusive behaviours. There are also major implications for the quality of training and the supervision of workers with such young people. New residential models have been proposed that are organised around our emerging understanding of trauma-based symptomology (Abramovitz & Bloom 2003; Bloom 1997, 2005; DHS 2007; Jenkins 2004).

Young people with an intellectual disability

The statistics vary but it appears that a large percentage (from 14% to 40%) of young people classified as having complex needs have an intellectual disability, often in the 'mild' range (Redoblado-Hodge 2004; DHS 2002). This has implications for the type of care and education program that is provided and the mix of clients, as such young people are vulnerable to both abuse and being misled by peers.

Neurodevelopmental problems

A significant percentage of young people in residential care have neuro-developmental problems (Redoblado-Hodge 2004; Rutter 2000). Sometimes these are formally diagnosed conditions and sometimes they are inferred by the pattern of behaviours. Known conditions include Autistic Spectrum Disorders, Foetal Alcohol Syndrome/Effect, Attention Deficit/Hyperactivity Disorder, Tourette's Disorder, Right Hemisphere Deficit Syndrome or Nonverbal Learning Disorder, along with a number of chromosomal disorders and learning disabilities. Again, these all have major implications for our understanding of the young person's needs, our management of their behaviours, and the design of intervention programs.

Mental illness/disorders

Some of these young people have formally diagnosed mental health problems, often including one of the mood disorders (such as depression or bi-polar disorder), anxiety disorders (such as obsessional-compulsive disorder or phobias), or, less commonly, early onset schizophrenia (Arcelus, Bellerby & Vostanis1999; McCann & James 1996; Polnay & Ward 2000; Rutter 2000). McCann and James (1996) determined that an astonishing 97% of children in residential facilities in the UK had formal mental health diagnoses (when conduct disorders are included). The authors of another UK study observed that:

> a considerable proportion of young people have a serious psychiatric disorder at the time they enter local authority care but are not being referred for psychological help (Dimigen et al. 1999, p. 675).

A conclusion of the Bromfield et al. (2005) study was that:

> adolescents with mental health problems are less likely to achieve placement stability or display improved psychological adjustment in care (p. 42).

There is an emerging Australian literature on the mental health needs of children and young people in the out-of-home care system (e.g. Frederico, Jackson & Black 2006;

Morton, Clark & Pead 1999; Osborn & Delfabbro 2006; Royal Children's Hospital Mental Health Service 2004).

Specific behavioural problems

Some young people have other specific behavioural problems including substance abuse or sexually abusive behaviours. Typically, they are also affected by one or more of the conditions or issues identified above, but their behavioural problem largely determines the type of setting that is appropriate as well as intervention priorities (Lundrigan 2001; Ryan & Lane 1997). Where a young person has a serious behaviour problem relating to sexuality or substances, direct input from a specialist treatment service is usually required. There are very few such options available to young people in statutory care apart from community-based counselling. At present, there is one residential program in NSW specifically designed to work with young people under statutory supervision who have problematic sexual behaviour – the New Pathways program in NSW (YOTS 2005) – although there are others that have instituted specific programming to address the needs of particular residents.

There is an urgent need for local examples of residential programs that are carefully designed and powerful enough to counter the negative synergy that is often a feature of residential care.

Other issues affecting the young people

In addition to the behavioural, developmental and psychiatric issues faced by most young people designated as having 'high needs' (and sometimes as a result of them), virtually all have chronic school problems including learning difficulties, behavioural problems and truancy histories that have led to suspensions and exclusions (Bromfield et al. 2005, p. 40; Cavanagh 1996). By definition, all young people in out-of-home care also have difficulties with family relationships and connections. They are also at a greatly increased risk of ending up in the justice system (Community Services Commission 1999).

Implications for service development

In their review of the research to set the stage for the development of services in Wales, Clough et al. (2006) observe that we need services that 'match the wants and needs of children' (p. 92). The perspectives canvassed in this paper suggest that the young people referred to out-of-home care services are likely to have a range of complex needs and challenging behaviours. They are individuals that require individualised responses. Simply placing such young people in traditional foster or residential care services fails to address the challenges posed by their complex developmental needs and will certainly do little to address the behavioural problems that have led to their placements in the first place. At the very least, each young person needs a comprehensive psychosocial and educational assessment that attempts to determine the nature of their developmental needs, the nature, range and meaning of their challenging behaviours, the nature and potential of their family and peer and community connections, and their educational abilities and needs. This assessment should form the basis of a comprehensive individualised intervention plan. The out-of-home care services required for such young people must therefore be designed to address a range of needs and they must consider related needs-based issues such as the question of co-placement decisions.

THE SHIFT TO NEEDS-BASED MODELS OF CARE

From care to treatment

There are promising signs across Australia of a shift to a more needs-based and considered approach to the delivery of out-of-home care services. For example, the new child welfare legislation in several states specifically calls for the provision of what are termed 'therapeutic' services and there are examples of services being designed to provide various forms of treatment or therapy. Calls for the development of treatment or therapeutic options, including those based on residential care, have come from formal statutory inquiries (e.g. Ford 2007; Layton 2003; QCMC 2004), reports from academic institutions (Delfabbro et al. 2005; Liddell et al. 2006; Osborn & Delfabbro 2006); from industry peak organisations (CAFWAA 2007), and from other researchers (Ainsworth 1998, 2001; Bath 1998, 2002/3; Flynn et al. 2005; Hillan 2006; Morton, Clark & Pead 1999). Delfabbro et al. (2005), for example, observe that service options for young people with high needs are in short supply and we live in a time 'when almost every state is looking to expand its range of treatment options ...'. They specifically draw attention to the almost exclusive focus on foster care in Australia and to the failure of traditional foster care to meet the needs of many children. Although the cited reports and papers do not all describe the specifics of what is required, they all recognise that current foster care and residential services often fail to address the complex needs of young people in the care system and that a range of new services and approaches is needed.

There have always been some examples of residential care services with a clear intervention focus based on the understood needs of young people and their families – for example, in NSW the St Vincent's program operated by Marist Youth Care (Bath 2004) and Boys Town Engadine

(Halliday & Darmody 1999) have long had a primary focus on family strengthening and restoration, and there have been attempts to create therapeutic communities, such as the former St Andrew's program associated with Burnside in Western Sydney. However, the out-of-home care system in Australia still largely focuses on the provision of 'care and accommodation' – the primary task is still considered to be the provision of care and thus tends to rely on essentially unskilled or semi-skilled carers; qualifications and training are still seen as desirable but non-essential; conceptual and theoretical articulation is primitive; and policy development is largely dominated by traditional social and welfare work models and values with the focus on care, protection, rights, social inequality and political action.

Bath (2002/3) suggested that the Australian care system urgently needs:

- services that are designed to meet the multiple needs of the young people, not just their care and accommodation needs
- to explore new prevention, foster care and residentially-based services with a treatment focus
- to learn from, adapt and adopt treatment models that have proven track records and positive outcome research data
- personnel who are qualified and trained to address identified needs such as substance abuse, personality disorders, anti-social behaviours and other behavioural and mental health problems
- collaborative services that integrate workers and perspectives from different professional backgrounds, including social work, psychology, psychiatry, recreation and education
- services that are goal directed, accountable and can demonstrate positive outcomes.

In this respect it should be noted that the term 'treatment' is not limited to a medicalised understanding of problem definition and intervention. Bath (2002/3, p. 9) defined treatment as 'a purposeful approach or intervention with a clear conceptual or theoretical basis, designed to meet specific change objectives'.

Anglin's (2002) definition of treatment also captures this broader meaning. He suggests that treatment consists of:

1. attempting to bring about *directed change* in a person or persons
2. through *individualized* attention
3. on the basis of a guiding *theoretical framework*, and
4. a suitably comprehensive and in-depth *assessment* of the situation (p. 17).

The *Positive Peer Culture* model (Vorrath & Brendtro 1985) is one widely-used treatment model that eschews medicalised perspectives involving diagnostic categorisations, with the intervention focus being on the development of prosocial values and attitudes within a positive and supportive peer culture. Other widely-disseminated 'treatment' models, such as *Re-Ed* (Hobbs 1994), are also based on non-medicalised conceptualisations and interventions. Some residential programs choose to focus their 'treatment' services on meeting identified educational needs and/or on working intensively towards the goal of family restoration (e.g. Halliday & Darmody 1999)

There are signs, however, of an emerging awareness of the need for residential programs with a treatment or therapeutic focus.

A growing body of research literature highlights the effectiveness of treatment approaches ranging from preventive models such as Multisystemic Therapy (Henggeler 2001; Henggeler et al. 1988; Ogden & Halliday-Boykins 2004), to 'treatment' or 'forensic' foster care (e.g. Fisher & Chamberlain 2000; Moore, Sprengelmeyer & Chamberlain 2001), and residential treatment programs (e.g. Ainsworth 2001; Brendtro, Mitchell & McCall 2007; Knorth, Harder, Zandberg & Kendrick 2008; Leichtman, Leichtman, Barber & Nesse 2001; Vorrath & Brendtro 1985). Some of these have been developed in domains such as juvenile justice and mental health, but all have relevance for the focal sub-group of children and young people in our child welfare system. Despite the pressing need, there are only few home grown examples of true treatment models within the statutory child welfare sector and there is a slow take-up of the compelling research findings from overseas.

Therapeutic or 'treatment' interventions can be provided for children and young people in the care system in three ways. Firstly, the young people may be able to benefit from normal community services such as counselling, psychiatric consultations, or out-patient treatment. However, as Clark (1997) and others have pointed out, such services are often unavailable or unsuitable for young people in the care system. The second option is that specialist, dedicated services can be developed specifically to address the needs of young people in care. The 'Take-2' program in Victoria and the 'Evolve' program in Queensland are examples of dedicated therapeutic services that have been developed to address the needs of children in care. Such options are a valuable addition to the range of services on offer and reflect a growing understanding by policy makers and administrators of the nature of the emotional and developmental needs of young people in care. The third

approach to meeting the treatment needs of children in the care system is to develop services in which 'treatment' is integrated into the service – where 'treatment' of identified needs is the primary purpose of the placement rather than simply care and accommodation.

CURRENT TREATMENT SERVICE INITIATIVES

As indicated above, two states (Victoria and Queensland) have developed specialised counselling services dedicated to meeting the needs of young people under statutory orders. The 'Take-2' program in Victoria (Frederico, Jackson & Black 2006), itself influenced by an earlier trial initiative (Royal Children's Hospital Mental Health Service 2004), offers a State-wide service from a number of regional centres and within certain facilities. Counselling services are provided directly for the children and young people whilst assistance is also provided for their carers. In Queensland, the Department of Child Safety has funded the Department of Health to provide dedicated therapeutic services for children under orders (called 'Evolve'). Around the country there are also a number of initiatives to establish out-of-home care programs with a specific therapeutic or treatment focus and several state governments have recently provided funding for the development of what have been termed 'therapeutic foster care' services. One example that has been described in the literature is a collaborative initiative in Victoria (Success Works 2005).

The child welfare legislation in the ACT includes what are termed 'Therapeutic Care Orders', which involve some form of what is termed 'therapeutic' containment. Although these orders have been used episodically, there are no specialised facilities in which the specified 'therapeutic services' can be provided safely. In Victoria, the new legislation provides for the 'therapeutic treatment' of young people with sexualised behaviour problems which pose a risk to others.

TREATMENT OR THERAPEUTIC RESIDENTIAL SERVICES

There are fewer initiatives involving therapeutically-orientated residential programs. A recent review of residential programs in NSW (Flynn et al. 2005) found that although the need for such programs was widely acknowledged, most existing programs 'did not systematically apply a clinical therapeutic regime in the service' and that:

> if 'therapeutic' was defined as a program systematically applying a formal clinical therapy, then only a very small number of programs, three or four, could be described as being therapeutic (p. 20).

There are signs, however, of an emerging awareness of the need for residential programs with a treatment or therapeutic focus. For example, a therapeutic residential care program in Parkerville, Western Australia, has been described (Jenkins 2004), as has a new therapeutic residential initiative in Victoria called the Hurstbridge Farm Project which commenced operations in 2007 (DHS 2007). In NSW, the New Pathways program (YOTS 2005) is a residential program in the Southern Highlands that has been developed to provide treatment for young people in the out-of-home care system who have sexually problematic behaviours, and there is also a state-funded initiative to establish therapeutic residential programs in Queensland.

SUMMARY

Since the 1960s there has been a significant decline in the use of residential care services across Australia and the shape and size of such services has changed radically. The few existing programs are struggling to accommodate the number of young people in need of placements and to effectively manage their challenging behaviours. An examination of the needs of young people being referred to residential care suggests that existing programs may need to radically re-conceptualise their task. They need to move beyond a simplistic focus on care and accommodation to adopt a broader 'treatment' or therapeutic perspective that considers and endeavours to address the multiple needs of such young people.

In Part II of this discussion, a selection of recent literature on residential care will be reviewed and the key themes and issues that have emerged from developments in Australia and overseas will be identified. ■

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