Residential care in Australia, Part II

A review of recent literature and emerging themes to inform service development

Howard Bath

This is the second of a two-part discussion about the development of residential care services in Australia. It contains a review of some of the recent literature on residential care from Australia, the UK, Canada and the USA. It concludes with a look at the major themes and issues that emerge from this literature as well as the service trends and developments canvassed in Part I.

ACKNOWLEDGEMENT

Parts of this paper were adapted from a larger research project commissioned by Marist Youth Care in NSW.

Dr Howard Bath

Howard Bath has recently been appointed to the position of Children's Commissioner in the Northern Territory.

Prior to this, he was Director of the Thomas Wright Institute in Canberra, which provides a range of consultancy, training and clinical services for organisations, families and individuals.

Dr Bath has a long-standing interest in promoting the welfare of children and young people in out-of-home care.

Email: hbath@twi.org.au

This is the second of a two-part discussion about the development of residential care services in Australia. Part I focused on recent service trends, the nature of the young people being referred for services, and the shift to a more needs-based approach to service delivery. Part II contains a review of some of the recent literature on residential care from Australia, the UK, Canada and the USA. With a view towards the development of residential care into the future, the paper concludes with a look at the themes and issues that emerge from this literature as well as the service trends and developments canvassed in Part I.

SELECT REVIEW OF RECENT LITERATURE ON RESIDENTIAL CARE

Before reviewing some of the recent publications on residential care from the UK, Canada, the USA and Australia, it is important to consider the fact that Australian out-of-home care services operate in a quite different practice context to those of other western countries. Amongst the obvious differences, some of which were canvassed in Part 1, are the following:

- In the USA and the UK, most of the research is undertaken in larger facilities whereas there are few group care environments in Australia with over six residents – two to three residents appears to be the most common group size, whilst services for one resident are common. This phenomenon may be partially related to economies of scale. There are relatively few young people needing residential care in Australia and these are distributed across a large geographical area and eight state/territory child welfare jurisdictions. By way of comparison, the state of New York in the USA, which has a similar population to that of Australia, has around double the children/young people in care and a much higher proportion in residential care, all within an area that is less than 2% of Australia's total (Bath 2001/2).
- The USA in particular has a long tradition of residential *treatment* and many of the studies assume that the role of the facilities is 'treatment' rather than 'care and accommodation' – residential treatment in the USA represents an entire level or stratum of service delivery that is missing in Australia. Even in the UK there is a

more established tradition of residential treatment services for young people.

- In Australia, there is a very low level of residential mental health provision for adolescents, with only a small number of acute psychiatric beds in the entire country and no medium care options – some states have no dedicated acute care psychiatric beds for adolescents at all. Child welfare services assume a de facto role as mental health providers as they are frequently called on to provide residential options for young people with significant mental health conditions. This has profound implications for the design of services, co-placement considerations, recruitment, training, etc.
- The very high rate of de-institutionalisation that has taken place in Australia over the past four decades has resulted in an acute lack of options for young people with high needs. Foster care is usually the only option available for young people, regardless of the level of need, and services are finding it increasingly hard to recruit foster carers. In many states, young people are placed into motels or in services for older, independent youth because of the paucity of residential options. Institutional options still have a central role in the USA, Canada and the UK. In the UK, for example, extensive use is made of special schools for young people with emotional behavioural problems – this service option does not exist in Australia.
- The USA, Canada and the UK all have provision for secure welfare services. In Australia, these only exist in Victoria although they are under active consideration in other jurisdictions. The result is that smaller, less equipped residential homes are sometimes obliged to care for young people with extreme behaviours that pose a danger to themselves, fellow residents and staff members.
- In the UK there is a system of residential homes for young people with intellectual disabilities. In Australia, with very few such options, many young people with intellectual disabilities are placed into the child welfare out-of-home care system – especially services for young people with high needs. This impacts on issues such as program purpose and design, and the safety of residents. In many jurisdictions there continues to be disputation between disability services and child protection departments over who carries statutory responsibility for children with a disability.
- There are different legal imperatives at work. In the USA, many of the young people in residential treatment are on legal orders and placements in such settings are seen as diversionary measures from more secure and intrusive programs. The young people are often aware that failure to respond to the programming may result in their removal to secure facilities

Given these contextual differences, the application of observations and findings from the international literature needs to be undertaken with some caution. There is also considerable variation amongst the Australian states and territories that needs to be considered in the interpretation and application of the research findings.

BOOKS, MONOGRAPHS, REPORTS

James Anglin (2002) *Pain, normality, and the struggle for congruence: Reinterpreting residential care for children and youth*, The Haworth Press.

Although this book is now a few years old, it has only recently come to the attention of the broader residential care sector in Australia and is proving to be very influential. It reports the results of a study of ten residential care facilities in Canada, some of which were small in scale and therefore more comparable with Australian models than the larger facilities common to the USA. For example, one of the group residences had a three bed capacity, four had four beds, and three offered five beds. The author, a respected practitioner and academic, spent many months observing the workings of these facilities and talking with staff and residents. Using a 'grounded theory' approach in which theory is developed from the data, rather than *a priori* assumptions, Anglin gradually builds up a picture of the features and processes of a well-run program. He identifies 11 'interactional dynamics' that characterise a well-functioning program, and three 'basic psychosocial processes' that need to operate 'congruently' to achieve positive outcomes.

The 11 interactional dynamics are as follows (Anglin 2002, pp. 127-128):

1. *Listening and responding with respect* to youth helps them to develop a sense of dignity, a sense of being valued as persons, and a sense of self-worth.
2. *Communicating a framework for understanding* with youth helps them to develop a sense of meaning and a sense of the rationality within daily life.
3. *Building rapport and relationships* with youth helps them to develop a sense of belonging and connectedness with others.
4. *Establishing structure, routine, and expectations* with youth assists them to develop a sense of order and predictability in the world, as well as a sense of trust in the reliability of others.
5. *Inspiring commitment* in youth encourages them to develop a sense of value, loyalty and continuity.
6. *Offering youth emotional and developmental support* helps them to develop a sense of caring and mastery.
7. *Challenging the thinking and actions* of youth helps them to develop a sense of potential and capability.

8. *Sharing power and decision-making* with youth encourages them to develop a sense of personal power and discernment.
9. *Respecting the personal space and time* of young people helps them to develop a sense of independence.
10. *Discovering and uncovering the potential* of youth helps them to develop a sense of hope and opportunity.
11. *Providing resources* to youth helps them to develop a sense of gratitude and generosity.

Anglin spends some time looking at the important features of group care which he terms the 'basic psychosocial processes'. These include the creating of a positive 'extra-familial' living environment and striving to create as 'normalised' an environment as possible given the non-normal conditions.

The most compelling focus of this discussion, however, is Anglin's chapter on 'responding to pain'. He maintains that understanding and responding to the inner pain of the residents is a fundamental task of care workers. His observations led him to conclude that the reality of the inner psycho-emotional pain of the residents (trauma, depression, anxiety, grieving, hopelessness, etc.) was often ignored by staff members who missed the connections between this inner pain and problematic behaviours – 'seldom', he observes, 'did careworkers acknowledge or respond sensitively to the inner world of the child' (p. 108). Anglin (p. 111) concludes that:

> the manner and degree to which this pain is responded to is one of the key indications of the quality of care in a residence as experienced by the youth

and that:

> the key challenge for staff is that of 'dealing with such primary pain without unnecessarily inflicting secondary pain experiences on the residents through punitive or controlling reactions (p. 55).

Anglin's notion of 'congruence in service of the children's best interests' and as a 'unifying theme' is a little more complex, but just as important. He sees congruence as being made up of 'consistency' (in which 'values, principles, processes, or actions', are practiced over time); 'reciprocity' ('mutually demonstrated in the interactions between persons'); and 'coherence' (the degree to which behaviours and activities have an 'overall sense of wholeness and integrity' (pp. 64-65). A key element of congruence is the overall orientation of a program which:

> ... could be discerned at each level of the group home operation and could generally be traced all the way down the organisational hierarchy to the understandings and behaviours of the youth residents (p. 74).

He notes that 'there must be an overriding aim that guides the work within the home' (p. 76).

Anglin's book does not directly address some key questions of interest for residential services. For example, although he emphasises their importance, he does not examine particular theoretical models of care in an attempt to determine what works best for whom. Instead, he explores the features and processes of well-functioning residential environments, whatever the theoretical underpinnings.

The book ends with a useful summary of some of the recent research on residential care, mainly from the United Kingdom, the USA and Canada.

Christine Flynn, Sarah Ludowici, Eric Scott and Nigel Spence (2005) *Residential care in NSW*, Association of Children's Welfare Agencies.

This is the report of a study into the provision of residential care in NSW, the state with the largest number of young people in out-of-home care, with some consideration of developments in other states. The *Foreword* notes that 'This report represents the first comprehensive appraisal of residential care in NSW since the early 1980's', a part of the care system that the authors observe 'has been largely ignored in terms of policy development since the closure of the large institutions began in the 1960's'. The report is based on a comprehensive survey sent to all residential care providers in NSW as well as face-to-face and telephone interviews with 'Chief Executive Officers, program managers or coordinators' and government and non-government representatives in most Australian jurisdictions. The report covers a range of facts about the NSW residential care system and summarises the thinking of the service providers and others about the role and future of residential care.

The significant facts about residential care in NSW to arise from this report are as follows:

1. At the time of the interviews there were 42 service providers across NSW providing care for 330 residents in 181 properties. Total capacity of all current providers was estimated at 420 placements.
2. According to the AIHW statistics, NSW has the lowest number of residential care placements (4%) as a proportion of total out-of-home care placements and the second highest number of young people in residential care (behind Victoria).
3. The Productivity Commission's report on government services in 2005 estimated that there were 46 indigenous children and young people in residential care as at 30 June 2004. With the AIHW establishing that there were 296 young people in residential care in NSW at that date, Aboriginal/TSI young people make up 15.5% of the

total, a lower proportion than Aboriginal/TSI children in any form of out-of-home care.

4. Most of the providers stated that they provided care for children and young people 'with high and/or complex needs'. The monograph used a client description of this target group adapted from an expression of interest document from the Department of Community Services (DoCS 2004):

> Children and young people with experience of multiple or traumatic placement disruption and abuse histories, present challenging behaviours or socio/emotional difficulties, (often in combination) such as: poor impulse control and/or stress intolerance, high risk-taking behaviour, alcohol or other substance abuse, poor self-image, self-harming behaviour, social isolation and limited capacity to form relationships, sexually inappropriate behaviour, anti-social behaviour including aggression or violence, criminal behaviour, mental health issues, physical health issues, intellectual disability and educational difficulties (p. 10).

5. With respect to specific target groups, there were no programs specifically designed for Aboriginal/TSI young people although at least one agency has attempted to establish such a program in the past. One program was for clients with sexual behaviour problems; two were exclusively for female clients; one specialised in caring for young people from a specific cultural background; seven agencies stated that they could care for children or young people with 'physical, intellectual or developmental disabilities and/or mental health problems' (p.11).

6. Where 'exclusions' were stated, they included: 'unmanaged mental illness, unmanaged drug or alcohol addiction, severe physical or intellectual disability, extreme violence and sexual offenders or sexually predatory behaviour' (p. 11).

7. The age of residents differed widely. Eighteen of the service providers looked after children younger than 12 years of age. Several providers gave their minimum age as being in the 6-10 year age group.

8. Placement duration tended to be longer than planned and ranged up to 8 years in one case. Several of the very long terms placements (over four years) had originally been planned as 3-month placements (p.13).

9. 'Individual residential care' had emerged as a significant component accounting for around one-third (108 residents) of all residential placements. The primary reason for choosing this type of placement for a young person was 'very challenging or violent behaviour, including assaults against other children or young people ... sexual offending, chronic absconding behaviour, self-harm and mental health issues were also mentioned as reasons' (p.14).

10. Twenty three of the agencies did not allow the use of physical restraint whilst 18 did allow it as a safety measure of 'last resort'. Many of the latter said that it had not been used for many years or had never been used.

11. All current residential care providers said that they provided a 'program of individual case planning' but 'most did not systematically apply a clinical therapeutic regime in the service'. Most services used the services of psychiatric and psychological consultants but '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).

12. Theoretical models and approaches listed as being used, included 'strength-based practice, cognitive behaviour therapy, solution focused brief therapy, Therapeutic Crisis Intervention, harm minimisation, dialectical behaviour therapy, family therapy, narrative therapy, sand play, art and music therapy, therapeutic community, trauma counselling, motivational interviewing, Positive Peer Culture' (p. 20).

13. Most services provided care using a rostered staff model – only one family group home was identified and one that used a mixed model of live-in carers supported by rostered staff.

14. At the time of the report, there had been a significant increase in the number of fee-for-service programs, many being for-profit operations (this trend has been significantly reversed in the last year).

15. After care provision was erratic and tended to be partially funded or not funded at all by the Department of Community Services. Twenty-eight services stated that they provided some after care without any government funding.

16. Fourteen of the agencies stated that they employed psychologists on staff, with three having full-time psychologists; eight agencies employed teachers or tutors to assist in special schools or schooling.

17. Required staff qualifications differed greatly – generally a degree in social work or psychology was a requirement for team leaders, house managers, supervisors and coordinators.

Some of the shared views about residential care that emerged were as follows:

- There is a definite place and future for residential care in the service spectrum.
- Most respondents felt that residential care should be provided for specific target groups of children including those with high or complex needs, sibling groups, young

people moving into independent living, young people whose foster placements had broken down, and Aboriginal/Torres Strait Islander (A/TSI) children.

- There was strong support for the development of more specifically 'therapeutic' residential care programs, and some support for the development of secure options was expressed.
- Two-thirds of the respondents felt that there was a need for a focus on assessment services so that the key needs and issues affecting the young person could be identified and sound intervention plans could be developed. There was, however, some opposition to the focus on assessment with some respondents stating that the information obtained would be unreliable, that it would compromise the young person's privacy, or that the information could be misused.
- There was a diversity of opinion about the merits or otherwise of individual residential care, with some feeling it was necessary for a certain group of young people, to provide safety and stability and to be able to 'address underlying issues'. Those that opposed the use of such placements highlighted the following concerns:
  - 'social isolation from peers, especially if the resident is excluded from school
  - intense scrutiny, leading to a 'hothouse' unnatural atmosphere
  - problem of having all the attention on one person
  - setting up of unrealistic expectations about continued individual attention
  - potential to develop abusive relationships
  - failure to address issues if a containment rather than a therapeutic approach was used' (p. 15).
- There was a generally expressed belief that 'small congregate care models of two to four children or young people in each residence was the best residential care option, with attention given to the 'mix' of residents' (p. 32).
- The transition by young people from residential care to independent living needed specific attention by service providers and policy makers.
- Many providers questioned the policy limitation (in the accreditation guidelines published by the NSW Children's Guardian) of using residential care only for young people over the age of 12 years.

Findings from the interstate part of the report were generally consistent with those from the service providers of NSW although there are some differing emphases on the role of and reliance on residential care in the out-of-home care spectrum. The report notes that:

> in all states people consulted thought there needed to be improved planning, a greater diversity of models, and increased emphasis on development of therapeutic models for dealing with clients with high and complex needs (p. 42).

The report concludes with the observation that residential care is, and will continue to be, an important part of the care system, particularly for children and young people with 'high and complex needs', but that it needs to be provided 'at a high standard ... to be informed by research and practice evidence and subject to independent evaluation'. Although 'very few residential services can be characterised as therapeutic ... there is a strong view that more therapeutic residential care is needed'; although there is a need to clarify what is meant by 'therapeutic', it is not in dispute that 'some need a more therapeutic intervention that aims to address their needs' (p. 44).

The small scale of Australian residential care services could thus be seen as a strength in that the risk of iatrogenic effects is minimised; however, small-scale services also tend to lack economies of scale that allow for the provision of specialist services.

Clough, R., Bullock, R. & Ward, A. (2006) *What works in residential care: A review of research evidence and the practical considerations*, National Centre for Excellence in Residential Care, National Children's Bureau.

This recent volume provides a comprehensive summary of the literature on residential care in the UK, focusing primarily on the last decade. The work was commissioned by the National Assembly for Wales as part of a larger review of out-of-home care services and the focus is therefore on extracting information from the research and descriptive literature that speaks to the future place of residential care in the service spectrum.

In addition to a critique of research methods in this field and the complexities around the application of findings, the book provides a useful summary of the major themes that have emerged from studies undertaken in the UK over recent years. The authors provide a review of statistical data which reveals, for example, that in Wales, there are significantly more children being cared for in special boarding schools than in children's homes. In England, the statistics reveal that, overall, around 14.3% of children and young people in care are in some form of residential establishment; this

percentage rises to 22.8% if we focus on those in the 10-18 years age bracket.

Some of the major themes the authors identify are as follows:

- There is an increasing focus on the mental health needs of the young people in care with several studies finding a high level of psychiatric symptomology and a corresponding paucity of relevant intervention options (pp. 11-12).
- Much of the literature consists of common-sense advice and exhortation and 'often the atheoretical tone of the writing becomes wearying to the reader' (p. 31).
- Where theoretical perspectives are articulated, they tend to be based on psychodynamic perspectives including attachment theory (e.g. Fahlberg 1990; Rose 1990, 1997).
- A lot of the literature in the UK focuses on the dynamics of well-functioning residential homes such as transactions between staff and residents, the development of positive cultures, the level of staff training and expertise, the characteristic of an effective child care worker, and the skills and perspectives of the 'heads' of homes.
- Various residential care trends are identified, such as the shift to smaller homes, the increasing age of residents on entry, the increase in young people with mental health problems, greater ethnic and racial diversity, more private services, rising costs and shorter stays

In terms of the development of residential care services, the authors identify the following key issues:

- **The children in care**

Planning for residential care begins with an understanding of the 'reality and experiences of the children'. The authors draw attention to the extreme psychological turmoil and disruption that attends placement into care and the resulting 'very high levels of apparent psychological disorder'. It is clear, they observe, 'that the main reason for choosing residential care is to control or improve difficult behaviour' and that such behaviours are often associated with trauma and abuse. One consistent finding that impacts on the existing levels of behavioural disturbance, is the 'huge disruptive impact on settled groups of children in long-stay homes of emergency and short-term admissions of the most troubled children' (pp. 67-68).

- **Criticisms of residential care**

The authors review the frequently-repeated criticisms, including the risk of bullying, sexual abuse, the creation of 'delinquent cultures', the presumed inability to address attachment needs of young people, and concerns about the quality of care.

- **Issues yet to be clarified by the research**

The authors maintain that the research evidence to date does not definitively answer questions related to the role of training and professional qualifications; optimal staff numbers and staff-child ratios; whether greater choice for young people would lead to better outcomes; and what size of facility is optimal.

In their recommendations for the development of out-of-home care in Wales, the authors maintain that services will need to address the needs of three groups of young people:

1. **Children with relatively simple or straightforward needs**
   These children will generally return to their families after a placement in foster care. They will be at some risk of developing psychological problems but will not need specialised treatment. Most will remain in regular schools – some of these children may need residential care.
2. **Children and families with deep-rooted, complex or chronic needs**
   These are children with extensive histories of abuse and neglect with exposure to chronic domestic violence. They are likely to have had multiple episodes of out-of-home care and 'the main evidence of their distress and emotional instability may be their unsafe, self-harming or unpredictable behaviour'. These children are likely to need specialist services offering 'emotional and psychological support and treatment' which can be offered in either foster or residential care, along with specific family work.
3. **Children with extensive, complex and enduring needs compounded by very difficult behaviour**
   The problems of these children result from early traumas of physical and sexual abuse. Their behaviours will often have led these children and young people into the juvenile justice or mental health systems.

   > These children are likely to require more specialised and intensive resources such as a therapeutic community, an adolescent mental health unit, a small 'intensive care' residential setting or a secure unit.

   The authors go on to observe:

   > The level of need in such young people is great, and without successful intervention at this stage they are most likely to spend large proportions of their adult lives in prison, psychiatric services or homeless (pp. 100-101).

Given the varying needs of the children and young people, the importance of 'a thorough and constructive assessment of their emotional and psychological need (as well as their educational, health and other needs)', is stressed by the authors. They observe that this assessment needs to inform a 'positive plan for their care and treatment rather than as a (possibly unhelpful) label' (p. 101).

Clough and his colleagues go on to describe residential services that address the needs of children and young people at each of these three levels of need. These include 'children's homes' (category 1); 6-8 bed residential treatment units 'with access to a range of specialist support services such as psychiatric and psychological advice, special education support, employment, counselling or other therapeutic input for individual children ...' (category 2); and regional 'high support units' for the third category of young people which might be operated either along the lines of a therapeutic community or a 'more behaviourally-based model' (pp. 105-106).

CREATE Foundation (2006) *Children and young people in care consultation for the Office of Children's 'Improving outcomes for children and young people in residential care' project*, CREATE Foundation and Department of Human Services.

This report was selected as a recent example of the type of work that is being undertaken by consumer groups, demonstrating what can be achieved when young people in care are encouraged to share their thoughts and aspirations and to participate in the re-shaping of care programs. The principle of consumer participation is now being written into child welfare legislation in the various states (e.g. Ford 2007, p. 31).

With funding from the Victorian Department of Human Services, staff from CREATE organised a series of consultations with young people in a number of residential units around Victoria. CREATE designed the format of the consultations, identified the residential service providers, recruited peer facilitators, oversaw the consultations and wrote the resulting report.

Some of the issues raised by the young people are similar to those that would be expressed by young people everywhere; for example, calls for more pocket money, better food, more clothes, freedom to watch what they want on TV, and access to alcohol. However, many of the concerns relate to critical personal development issues such as opportunities for education and counselling, and other issues raised speak to concerns about the quality of care being provided.

Some of the key issues raised by the young people were as follows:

- There is a need to pay more attention to the matching of young people with each other so that individuals are not victimised or otherwise disadvantaged by misplaced peers.
- There is a need for residents to be provided with more access to 'normal' community activities with peers.
- Residential units need to be made more 'home-like' so, for example, young people feel free to invite friends back to visit .
- More attention should be given to the issue of matching staff with young people so that the needs of the latter can be more effectively addressed (the example was given of a young man whose carers were all female and who wanted to be accompanied to the football by a male worker).
- More creative educational opportunities need to be provided for young people who are unable to attend regular schools.
- Young people expressed concern about the need for privacy and the fact that they sometimes hear staff members talking with each other about them.
- There was a call for more input into everyday decisions in the residential care environment.
- Some young people were upset that specialist counselling was very hard to access.

The data collected in these consultations are qualitative in nature and need to be understood as the thoughts and opinions of a relatively small sample of young people in residential care. However, it is interesting that many of the issues correspond with those raised in the broader residential care research and professional opinion.

Leon Fulcher and Frank Ainsworth (2006) *Group care practice with children and young people revisited*, New York: The Haworth Press.

This volume is essentially an updating and re-issue of an earlier volume (entitled *Group care practice with children*) which was published in 1985. It contains a rich range of articles from eminent practitioners and researchers that covers the range and quality of direct transactions with children in care, indirect quality enhancement endeavours (such as working with the wider system and developing a shared language of practice), team dynamics and organisational and career issues.

Of particular interest to this review is the summary chapter to this volume entitled 'Conclusion – looking ahead' in which the authors draw attention to the 'important themes thought likely to influence the continuing development of group care services for children and young people in the decade ahead' (p. 285).

The first theme is the continuing poor quality of training offered to direct care workers. The authors note that:

> with few exceptions worldwide, child and youth care practitioners working in group care settings remain a significantly under trained occupational group, a position that continues to amaze and appal given the complexity of educational and therapeutic tasks they are expected to perform (p. 286).

The second theme is that of the paucity of 'multi-disciplinary' approaches to service delivery and training.

The authors point out that most training in group care is dominated by schools of social work, psychology or education and often fails to cover the rich tapestry of theories and practices that are required for effective group care practice. They call for more interdisciplinary education and training to address this failing.

The authors then call for the development of more 'centres of excellence' which provide a similar function in the child welfare system to that provided by the teaching hospital in health care with respect to 'scholarly and professional achievement ... in service training, qualifying studies and consultancy services' (p. 288). They identify a small number of such services in the UK and the US but believe there needs to be many more such centres to support the poorly served out-of-home care sector worldwide.

Another theme identified by the authors relates to the need for 'a diversified range of programs' for young people 'in receipt of residential education and treatment'. They note that thus far the policy emphasis in most places has been on the development of alternatives to group care, but they note that in some countries, principally the United States, there has been an increased emphasis on the provision of mental health programming.

Looking specifically at 'new trends and issues shaping the future', the authors note the following shifts:

- to smaller, more 'individualised and personally tailored services'
- from rural to urban centres and to more community-based initiatives
- to 'more culturally sensitive and responsive practices'
- towards the recognition of consumer rights and 'enhanced consumer participation in planning and decision-making'
- towards the inclusion of family members as 'essential partners'
- from grant-based funding to individual contracting with a focus on regular reviews and a 'focus on service outcomes and effectiveness'
- from voluntary, non-profit initiatives towards 'private, fee-for-service and for-profit agencies', which are, particularly in the US, dependent on health insurance funding
- from motivations based on 'religious convictions, professional values, and codes of practice' to imperatives based on 'new demands for performance accountability and complex regulatory requirements that are not always compatible with such values'
- to an increasing involvement of legal issues in child welfare decision-making (pp. 289-290).

The authors conclude with the following call:

> More than ever before, the field of group care warrants close consideration for the positive contribution it makes to the service continuum of services much needed by children, young people and their families in the education, health care, social welfare, or justice system. Ideologies that have driven service reforms over the past quarter century have commonly assumed that group care is a negative choice in the continuum of service alternatives, only to be used as a last resort after all other options have failed. Such simplistic reasoning ignores the many positive examples of proactive group care programs available, as well as the many instances of close working partnerships between group care programs and family members (p. 292).

Lisa Hillan (2006) *Reclaiming residential care: A positive choice for children and young people in care. An exploration of differing models and outcomes of residential care provision for young people, with an examination of the links to evidence and research in the design and evaluation of out-of-home care*, report prepared for the Winston Churchill Trust of Australia.

This document is a report of Lisa Hillan's recent Churchill Fellowship in which she examined residential care provision and some related issues. She visited residential programs and talked with researchers, academics and administrators in Scotland, Canada and the USA. The report contains a number of recommendations and then lists what she has determined to be the 'key factors' in the 'delivery of high quality residential care'.

Amongst the many recommendations are the following:

- residential care can provide a 'quality care environment ... and should be embraced as a positive option for young people ... not simply as a last resort'
- there is a need to look carefully at the types of residential care provided to ensure that these match the needs of the presenting young people
- the needs of young people should be identified on entry into care to determine the best intervention options – to include psychological assessments
- partnerships should be entered into with universities to undertake evaluations of 'models and methods'
- residential programs should have access to therapy and therapeutic consultancy
- family work/therapy should be incorporated into residential care models
- there needs to be a renewed focus on the needs of older young people
- residential programs should focus on the quality of relationships between residents and staff members

- there is a need to consider the interface amongst the different systems affecting young people in out-of-home care
- there is a need to focus on ensuring the safety of residents and staff members
- minimum standards of staff training need to be developed
- clear policies need to be developed with respect to secure care and the use of physical restraint
- special models of care need to be developed for young people who exhibit 'highly complex behaviours'
- trauma theory should be recognised and incorporated into the practice frameworks of residential care providers.

In addition to the recommendations (of which those presented above are a selection), Ms Hillan highlighted what she believes are the factors that determine care settings of high quality. These are as follows:

1. Programs must have a 'well-developed philosophy and model development' that includes an understanding of trauma and loss and provides access to therapeutic supports.
2. There is a recognition of the centrality of the young person in decision-making.
3. There is a need to create a sense of home and belonging for the young people.
4. There is a commitment to training throughout the organisation.
5. There is a commitment to 'continuous learning, evaluation and research'.
6. There is a need for a 'continuum approach that ensures a suite of programs, living environments and interventions' with a 'capacity to meet educational needs, family work, foster care and residential care within an integrated approach'.
7. There is a belief that residential care is a positive choice, not merely a last resort.
8. The program is well-resourced.
9. External support for training and research is provided.
10. There is a high degree of 'congruence in the supporting literature from governments' with respect to policies and standards.
11. There is a high level of congruence within programs amongst stated aims, care models, engagement and service delivery.
12. Funding is available for an 'holistic' approach to service delivery that includes education, therapeutic interventions, specialist assessments and recreational activities.
13. The program is integrated with external systems of support such as mental health and community services.
14. Specifically tailored models may be suitable for children as well a young people, with a view to their transition into more 'normalised' settings.
15. There is a focus on family and community work (pp. 57-59).

Alexandra Osborn and Paul Delfabbro (2006) *National comparative study of children and young people with high support needs in Australian out-of-home care*, School of Psychology, University of Adelaide.

Osborn and Delfabbro's recent study is significant because it represents the first time there has been an Australian inter-state study of children and young people with high needs. This is not a study that directly relates to residential care, but to those children and young people in the care system designated as having high support needs. It is essentially a descriptive study of 364 children from the states of South Australia, Victoria, Queensland and Western Australia who were selected on the basis of the fact that they had experienced two or more placement breakdowns in the previous two years or a breakdown during the first four months that they were in care. These selection criteria were derived from an earlier study (Barber, Delfabbro & Cooper 2001). The authors utilised a number of measures to assess the participants, including the widely-used Strengths and Difficulties Questionnaire (SDQ) and an Attachment Problems Checklist which they developed.

The findings of the study in terms of the difficulties faced by the children are generally as might be expected, although there were some state-to-state variations. For example, it was determined that almost three-quarters of the children came from households that were characterised by domestic violence or physical abuse; two-thirds of the sample had parents with substance abuse problems; and around half of the parents had histories of mental health difficulties, homelessness or serious financial difficulties. Around three-quarters of the sample had experienced physical abuse; nearly as many (65.9%) had experienced sexual abuse; and 58.2% had reports of neglect in their case histories. In terms of educational history, around one-third of the sample had been suspended from school in the previous six months and 12.7% had been excluded from school. Low levels of family contact were recorded across the country.

In terms of behavioural problems, 'the majority of the children fell into the abnormal range for conduct disorder on the SDQ' (p. 10); around half fell into the abnormal range

for hyperactivity and emotionality problems; and two-thirds had peer-related difficulties. Around 60% fell into the abnormal clinical range for 'Total difficulties' score on the SDQ.

In terms of social functioning, poor scores were evident across the entire sample. It was noted that non-indigenous children tended to obtain poorer social functioning scores than indigenous children.

In terms of attachment-related symptomology, the scores indicated 'a relatively high level of attachment-related problems in the total sample' (p. 11). Significantly, 'those children with the highest levels of emotional and behavioural disturbance were also noted as having higher levels of previous placement breakdowns' (p. 11).

Amongst the conclusions of the authors was the observation that the characteristics of the children in the various states were very similar, 'suggesting that it is possible to adopt a national perspective when discussing policies and services suitable to meeting the needs of this population' (p. 94) and that, given the clustering of 'domestic violence, substance abuse and physical violence and neglect ... out-of-home care policy cannot and should not, be considered in isolation from other important areas of social policy and public health' (p. 94).

In terms of the development of services to meet the needs of these children, the authors conclude with the following pertinent observation:

> any attempt to meet the needs of this population of young people needs to be undertaken with a clear understanding of the links between the child's current behavioural and emotional functioning and their previous family and placement history. Therapeutic interventions involving the treatment of trauma, the establishment of better attachments and social functioning, must therefore be emphasised in addition to interventions that seek to stabilise and control the behaviours contributing to placement breakdowns (p. 95).

PUBLISHED PAPERS

Frank Ainsworth (2007) 'Residential programs for children and young people: What we need and what we don't need', *Children Australia*, 32(1).

This recent paper by an Australian researcher of international repute was written in response to further negative publicity about residential care, as well as recent calls for a renewed emphasis on the development of innovative residential care services.

The primary thrust of the paper is that there is certainly a need for well-run residential programs but, unless there is clarity about the purposes of the new programs, sound structures and processes, and well-trained staff members, the outcomes of such programs will inevitably be poor.

The following are the central points made by Ainsworth:

- There needs to be clarity about the purposes of residential programs; for example, will they be for accommodation, education, treatment or containment?
- There needs to clarity about the target population of young people; for example, is the program designed to 'treat' young people with conduct disorders or sexual behaviour problems? Vague, global targeting leads to poor or even abusive outcomes. Ainsworth points to problems that emerged in government operated services in Western Australia where target group guidelines were ignored and a heterogeneous group of young people were mixed together, leading in time to reports of abuse.
- Based on the Western Australian experience that is documented in two formal reports, Ainsworth believes that government services, given that they are subject to political, judicial and union pressures, should focus on accommodation, whilst the non-government sector should develop treatment and educational services.
- Well-functioning residential programs need to have very clear structures and processes; a clarity of staff roles; a positive youth culture; a crisis management training system for staff members; and a 24/7 curriculum if negative 'peer-deviancy' training is to be avoided. Each of these factors needs to be congruent with the stated goals and philosophies of the program.

Ainsworth also draws attention to the currently poor levels of staff training and the low expectations with respect to formal qualifications. These, he maintains, need to be significantly improved if residential programs are to achieve their goals.

Richard Barth (2005) 'Residential care: From here to eternity', *International Journal of Child and Family Welfare*, 14.

Richard Barth is not a noted commentator on residential care, but his long and distinguished involvement in child welfare research, particularly with respect to family preservation and foster care, makes his views worth noting. In his comments as editor of a journal issue dedicated to residential care issues, he indicates that he believes residential care is something of a necessary evil given the long-standing problems relating to abuse in care and apparently poor therapeutic outcomes. The title of Barth's paper suggests that despite the bad press that residential care has received over the years, we had better get used to it and try to improve it as there are no alternatives on the horizon to address the needs of some young people with problematic behaviours.

Dr Barth ranges over some familiar themes as he discusses the content of the journal articles. He notes the call for more family-centred residential care, with a focus on post-

treatment discharge and the involvement of family members in programming; he notes the objection that residential care is not in a good position to address the individualised needs of the residents as determined by comprehensive pre-placement assessments; he re-visits the criticisms of group environments as being inherently detrimental to child development; and he explores the issue of iatrogenic treatments which lead to adverse developmental outcomes, especially through what is termed 'peer deviancy training'. Barth also calls attention to the critical need for conceptually sound programming that allows for individual tailoring of interventions, especially those that take account of an individual young person's learning style. Finally, he calls for residential programs to integrate more 'evidence-based' interventions into their programming. Somewhat pessimistically, Barth observes that 'residential treatment has evolved into a form of care that appears to offer little benefit at high cost' but he grudgingly observes that it 'is often needed as a service response to a perceived safety crisis'.

Eric Knorth, Annemiek Harder, Tjalling Zandberg and Andrew Kendrick (2008) 'Under one roof: A review and selected meta-analysis of the outcomes of residential child and youth care', *Children and Youth Services Review*, 30.

This recent paper has been included because it addresses the crucial issue of program effectiveness, that is, *have residential services been shown to achieve positive outcomes for children and young people?* The paper begins with a useful summary of research undertaken over the past few decades which shows that most of the research *does* demonstrate that positive results can be achieved. For example, the authors refer to research which suggests that the use of very structured environments along with a focus on social skills training is effective in treating young people with 'severe psychological problems'. Other studies have demonstrated that the use of behavioural and cognitive-behavioural methods along with a family focus and comprehensive assessments have been effective in the treatment of behaviourally troubled young people in residential settings. Meta-analyses have suggested that residential treatment programs (in the 1980s and 1990s) were able to achieve a moderate reduction in recidivism in delinquent behaviours of between 9% and 14%.

The meta-analysis by Knorth and his colleagues which covered a range of residential environments (including the domains of child welfare, mental health and justice), came up with similar findings. Although they called attention to a number of problems with the research such as the frequent lack of specificity with respect to what actual interventions were provided, they were able to identify a number of positive outcomes. Specific findings were that more improvement was demonstrated with the so-called 'externalising' behaviour problems (as opposed to 'internalising' ones); the adoption of a family focus for intervention led to better results; better results were achieved for very troubled young people when treated in residential care rather at home; specific training in social-cognitive and social-emotional skills was an important element in the attainment of positive outcomes.

The authors state that the 'main conclusion' from their analysis is that:

> children and youth, after a period of residential care – on average – improve their psychosocial functioning. The 'indisputable evidence' (claimed by some) that this form of care has mainly negative consequences for individual children and for society at large ... has not been supported. The effect sizes that we found are in most cases positive and can be characterised as 'medium', sometimes as 'large' (pp. 100-101).

Martin Leichtman (2006) 'Residential treatment of children and adolescents: Past, present, and future', *American Journal of Orthopsychiatry*, 76(3).

This article by Leichtman was published as part of a recent special issue of the *American Journal of Orthopsychiatry* focusing on residential treatment. The author reviews the history of residential treatment and how the term emerged in the late 1940s to describe institutions that blended a variety of therapeutic and care-related roles. He notes that confidence in residential treatment was at its peak in the period 1950-1970 which saw the establishment of peak bodies and significant publications. It was during this period that an understanding emerged that the three key characteristics of residential treatment were:

1. 'formal psychotherapeutic interviews';
2. 'the use of life experience in a therapeutic fashion'; and
3. 'marginal interviewing'.

The author observes that many now feel that residential treatment is somewhat overused in the USA and notes that, as a service modality, it has been facing pressures from funding agencies, and other forms of shorter, less-intrusive and (frequently) less expensive interventions such as family preservation, multisystemic therapy, and wraparound services. Leichtman (p. 286) goes on to observe that there has been some blurring of the concept of residential treatment to the point where the label is applied to a range of options from 'highly structured institutions closely resembling psychiatric hospitals to those that are indistinguishable from group homes, half-way houses, or foster-care homes'. He also notes that they differ with respect to target group and philosophy. Leichtman goes on to point out that the growing use of psychotropic medication has had a dramatic effect on residential treatment services in that many of those who formerly would have been referred can now be treated and supported in the community. A focus

on family-focused interventions has led to a re-configuring of residential models so that they have had to become more integrated into broader systems of care 'in which children move quickly from inpatient to outpatient programs'.

Of the three key definitional characteristics of care that emerged in earlier decades, the author observes that the one that has been changed most dramatically is that of 'formal psychotherapeutic interviews'. A variety of interventions has been added over the years including 'pharmacotherapy, family therapy, group therapy, substance abuse counselling, and other specialised treatments', including those for young people who have sexually offended. The notion of using 'life experience in a therapeutic fashion' continues to be a central feature as does the marginal interview, now referred to as the 'life space interview'.

Leichtman describes key structural differences between residential treatment and more medicalised institutions. First, residential treatment models are less enamoured with medical models and terminology and tend to focus more on 'parenting' assumptions with a focus on factors such as 'common sense, dependability, empathy, patience, support, structure, and integrity'; second, the primary therapeutic agents in residential treatment are direct care workers; third, residential systems are less stratified with flatter management structures; fourth, division of labour and specialisation boundaries are less marked than in medical settings; fifth, there is an emphasis on 'horizontal' rather than 'vertical' communications; and sixth, there is an emphasis on 'attachment' and the emotions rather than 'instrumental' action. The major adaptations undertaken by residential programs in order to survive fiscal and ideological pressures include the shift to more time-limited treatment programs, the incorporation of more family-centred practices, and the 'delegation of responsibility' to direct care practitioners.

Leichtman then speculates about the future of residential treatment programs in the USA. He foresees the following:

1. Residential treatment will continue to play an important role in the spectrum of services because there will always be some clients with needs that other less intensive and restrictive services cannot address.
2. Because of cost pressures there will be further restrictions on lengths of stay in treatment programs.
3. There will be 'far fewer free standing residential centres ... most will be integrated into a continuum of care' with a need to move clients on to less restrictive settings such as 'intensive outpatient services, group homes, therapeutic foster homes ...'
4. There will be an even more intensive focus on working with families.
5. Many different types of residential treatment programs will be used including therapeutic boarding schools and wilderness programs.
6. The type of treatment offered will be 'increasingly specialized ... targeted at particular populations (e.g. children with ADHD and learning disabilities, Asperger's Disorder and Developmental Disabilities, or Oppositional Defiant and Conduct Disorders)'.

He (p. 290) goes on to observe:

> It is easier to speak about the future of residential treatment as treatment and particularly about its long-term acceptance ... regardless of what it is called, residential treatment is based on the premise the caretaking is not ancillary to sophisticated therapies, but the most vital service that can be rendered children. It assumes that what troubled children require most is what all children require – parenting that will help them form positive attachments, manage the tasks of daily living, and deal with symptoms and whatever other obstacles threaten to interfere with the mastery of those tasks and derail development. It is also based on the premise that therapies ... should not be limited to a few sessions a week, but rather incorporated into the work of the treatment team as a whole ... repeated in as many forms and as many times by as many people as possible.

Leichtman concludes with a reminder about the fundamental requirements for effective residential treatment programs – the central role of direct care workers who are carefully chosen, trained, supervised and supported; the critical importance of having a 'unifying theoretical framework'; the necessity of ensuring smooth teamwork and coordination and negotiating conflict; and the importance of team and environmental stability. Without these vital ingredients, he maintains, the treatment may end up exacerbating the problems of the residents.

Andreas Pumariega (2006) 'Residential treatment for youth: Introduction and cautionary tale', *American Journal of Orthopsychiatry*, 76(3).

In this introductory piece to the *American Journal of Orthopsychiatry*'s recent special edition on residential treatment, Andreas Pumariega draws particular attention to what can go wrong in residential treatment. He focuses on his experiences with an abusive program where staff members ended up abusing many of the residents, eventually leading to the closure of the program and the charging of staff members.

Pumariega outlines the historical development of the problems in the program and offers the following 'cautions':

1. The program 'combined populations of adolescent and young adults with a wide spectrum of disorders and prided itself in never refusing any youth, which in itself

suggested some degree of programmatic chaos and lack of therapeutic focus'.

2. A lack of focus in developing community-based alternatives 'pushes the placement of youth into such facilities'.
3. The 'for-profit organizations operating such facilities, (use) the relative lack of regulation ... in the child welfare and juvenile justice systems'. He observes that 'once the profit motive enters into the equation, the first things to suffer are levels and quality of staff (leading to the 'rogue staff' phenomenon) ... the second is the level and quality of clinical intervention ...'

THEMES INFORMING THE DEVELOPMENT OF RESIDENTIAL CARE

The following key themes and issues have emerged from the review of service trends (Part I) and the recent literature on residential care. They are likely to be the issues and trends that will inform the development of residential care in the immediate future.

THE CONTINUING CHALLENGES TO RESIDENTIAL CARE

Since the late 1960s, residential care has been serving an ever-diminishing number of children and young people, a trend that only recently appears to be levelling out. The initial challenges came from the critiques of developmental researchers such as John Bowlby (e.g. Bowlby 1958) who highlighted the attachment needs and poor developmental outcomes of young children placed into institutions, and sociologists who described the damaging interpersonal and structural dynamics inherent in institutional care (e.g. Goffman 1961; Polsky 1962). These critiques (along with other ideological and cost considerations) led to rapid and pervasive 'de-institutionalisation' and calls for the 'normalisation' of care settings, thus favouring the development of family-like group home settings and foster care. Reports of abuse in care settings continue to this day and serve to reinforce the negative stereotypes.

More recent challenges to residential care provision have been highlighted in a number of the works cited here and in Part 1. The emerging body of work that highlights the so-called iatrogenic risks of residential care and, in particular, the risk of what has been termed 'peer deviancy training', is one of the greatest threats. This body of research and commentary (e.g. Dishion, McCord & Poulin 1999; Dodge, Dishion & Lansford 2006; Kazdin 1997, 2002) has the potential to further damage the standing of residential care, and any new initiatives will need to demonstrate how they can counter the demonstrated risks inherent in group interventions. The proponents of some intervention methods such as multisystemic therapy (e.g. Henggeler 2001) specifically position their programs as alternatives to residential care which avoid the negative developmental consequences of placing troubled young people together and which cost less.

An understanding of the processes involved in so-called 'peer deviancy training' (e.g. Dishion, Nelson & Bullock 2004; Weiss et al. 2005) and the development of positive alternatives (e.g. Brendtro, Mitchell & McCall 2007; Malia, Quigley, Dowty & Danjczek 2008) must inform the residential program of the future. One way that Australian services for young people with high support needs have adapted to this challenge, is the development of very small group environments with as few as two young people in each, where negative group effects can be minimised. Such approaches have been documented overseas and Barth (2005, p. 150) suggests that these approaches do 'offer an alternative to programmes in which deviancy contagion is a very significant threat to the wellbeing of children'.

The small scale of Australian residential care services could thus be seen as a strength in that the risk of iatrogenic effects is minimised; however, small-scale services also tend to lack economies of scale that allow for the provision of specialist services. For example, a program funded to provide three or four beds would not normally have the funds to employ a psychologist or educational specialist. Likewise, it may wish to implement a rich activity program but would have limited resources. The same applies to the scope and quality of training programs. Without economies of scale, agencies need to rely on external specialists and these are rarely available in the wider community or not available when they are needed. Frank Ainsworth (2001) has questioned the Australian preoccupation with small services, pointing out that some things can only be achieved with larger-scale programs such as the residential treatment programs in the USA (a theme also echoed by Delfabbro, Osborn & Barber 2005). Larger scale programs can, of course, address the specialist needs of their young people whilst minimising problematic effects of group synergies by providing centralised services for young people accommodated in smaller, geographically diversified clusters.

Other contemporary challenges include criticisms that residential programs tend to exclude family involvement to the detriment of future family relationships (Barth 2005), but a plethora of publications on family-focused group care programs (e.g. Ainsworth 2006; Garfat 2003; Halliday & Darmody 1999) suggests that this criticism is somewhat dated.

Some (Barth 2005, again) suggest that by offering group programming, residential programs may fail to address the specific issues and needs of individual young people – for example, their need to attach to particular caregivers. It is certainly the case that providing for the emotional and attachment needs in residential care is a complicated process, but a number of practitioners and writers have

demonstrated how this can be achieved. For example, Maier (2006), in his discussion on the tensions between individual and organisational demands, points out that '*individualized nurturing care* has to be conceived as the central ingredient of group care work with children who have experienced many separations and disruptions in their lives' and then he goes on to demonstrate some of the ways this might be achieved (pp. 106-7). Residential programs in the future will need to clearly demonstrate how they can assess and address the identified developmental needs of individual young people who are being cared for in a group context (see, for example, Malia et al. 2008).

If organisations are going to offer care for young people designated as being at 'high risk', it is imperative that they have a clearly articulated, theoretically-sound and empirically grounded basis for the program they offer.

THE SHIFT TO NEEDS-BASED MODELS OF SERVICE DELIVERY

A consistent theme in the literature has been the pressing need for residential (and other out-of-home care) services to develop needs-based models based on a comprehensive assessment of the needs of the young people. Such models will invariably move beyond an exclusive focus on the provision of care and accommodation (as critical as these are) towards the provision of a richer array of services and interventions. Given that most of the young people in residential care today are referred because of behavioural and emotional problems rather than dependency needs, and that their ability to maintain family and peer relationships and to function successfully in the community is compromised, it is incumbent on service providers to develop intervention models that attempt to address these concerns whilst at the same time meeting the normal developmental needs of the young people.

Depending on the approach taken, and philosophical positions with respect to understanding needs and the responses required, the services provided may be characterised as *treatment* or *therapeutic* services, or more prosaically as *purposeful interventions.* There have always been examples of such programs in the Australian service sector but, given the nature of the population group, all residential services and, increasingly, foster care services will need to adopt an approach that is based on identifying and then attempting to address the multiple needs of the young people and their families.

Where a young person is likely to be in a residential program for an extended period, the need for 'treatment' must be carefully balanced with the young person's need for 'normality' (Anglin 2002), connections, security, continuity and sense of home.

CONCEPTUAL AND THEORETICAL MODELS

The general lack of conceptual models to inform the development of residential care in Australia has been noted by a number of writers (e.g. Bath 1998; Gosbell, Jenkins & Spence 1999; Hillan 2006) and it is a problem that is also experienced in other countries. Berridge and Brodie (1998) undertook a major review of residential programs in the UK and found, amongst other issues, that:

> the strongest relationship we uncovered with the quality of care provided by the home was the extent to which the head of home could specify a clear theoretical framework or therapeutic orientation ... (p. 163).

This issue was also highlighted in Anglin's (2002) study of residential care in Canada. He observes that there 'is a need for a clear, accessible and useful framework that could offer a degree of understanding and some guidance for practice' (p. 139). This theoretical and/or conceptual framework includes, but is not limited to, the need to develop a 'shared language' (e.g. Casson 2006).

If organisations are going to offer care for young people designated as being at 'high risk', it is imperative that they have *a clearly articulated, theoretically-sound and empirically grounded basis* for the program they offer. This conceptual model (or models) must also specify the target group of young people the organisation can effectively serve with their model and the way in which it will meet their needs. Beyond the mere statement of a conceptual framework, the organisation needs to demonstrate how it will recruit workers who are committed to the ethos of the organisation and the articulated model, and how it will orient and train workers in the model, provide supervision and support for direct care workers, and evaluate for effectiveness.

There are a number of theoretically-based model descriptions for residential services that describe particular approaches to the provision of services (e.g. Abramovitz & Bloom 2003; Fahlberg 1990; Hobbs 1994; Vorrath & Brendtro 1985). However, the unique features of the Australian out-of-home care sector (including the recent service trends, the nature of the young people referred to residential services, the legal context, numbers in care, small economies of scale, etc.) mean that it is unlikely that any of these models can be adopted without significant amendment and contextualisation. Furthermore, given the likelihood in Australia that there will be a heterogeneous group of young people in any residential program, there will need to be some flexibility and tailoring of intervention approaches in order

to be able to address a variety of assessed needs. It is likely that a number of different theoretical models and strategies will need to be integrated into the larger intervention framework. This being the case, each program should be able to articulate the following:

- an understanding of the target young people, their needs and behaviours, and how these needs and behaviours developed
- an outline of the guiding philosophies, values and assumptions on which the program is based
- a description of the key theoretical models that will drive practice
- a description of the range of intervention/s to be provided that are congruent with the theory base, including a rationale for their use, and reference to the relevant evidence
- an explanation of how the individual needs of each young person will be addressed within the larger intervention framework.

It might be noted that although the research indicates that a clearly articulated theoretical or conceptual model (or models) of the program's approach to intervention is needed, and that this approach needs to be clearly understood and applied by all staff members, the specifics of the approaches that are chosen appear to be relatively less important. The research on positive change in psychotherapy indicates that there is generally very little difference in outcome between the various generally accepted psychotherapies if they are applied by skilled therapists. Much of the therapeutic change that does occur does so because of the so-called common, or non-specific, factors such as the nature of the therapeutic alliance, warmth, empathy, therapist expectations and so on. For example, Asay and Lambert (1999), from a review of the published research on therapeutic change, determined that, on average, the nature of the therapist-client relationship accounted for around twice as much of the positive outcome variance than the specific therapeutic approaches employed (30% vs. 15%). Given the relative dependence of children and young people, it might be assumed that the importance of sound therapeutic alliances are even more important than they are with adults in psychotherapy – this is a view that finds support in recent research on resiliency (Benard 2004). How we assist residential care staff to undertake this work and enact the theoretical constructs provided is one of the key challenges for residential care providers and one that needs greater exploration.

Responding to trauma and pain

In his research aimed at determining the features of well-run residential programs, Anglin (2002) lists a number of processes that are essentially 'trans-theoretical' in that they apply to all services, regardless of the theoretical orientation. However, he specifically observes that whatever the articulated approach, it must be sensitive to and be able to directly address the fundamental issue of the clients' experiences of socio-emotional 'pain'. Anglin prefers this everyday term to the more technical ones such as trauma, attachment disorder, depression and the like, because it captures the essential subjective experience of the residents given their backgrounds of abuse, neglect and (sometimes) abandonment. He and others (e.g. Brendtro & du Toit 2005) point out that this pain underlies many of the problematic behaviours that care workers face, and if not understood, can lead to the re-abuse and re-traumatisation of the young people. On a practical level, this consideration may lead to the introduction of a new range of intervention strategies based on engagement and teaching, and to some popular behaviour management techniques being proscribed by agencies because they rely on the infliction of pain (or distress) to ensure compliance.

Trauma theory and the emerging findings on neuro-development and attachment (e.g. Stein & Kendall 2004; van der Kolk 2005) are beginning to have a significant impact on the design of both residential and foster care services (e.g. Abramovitz & Bloom 2003; Department of Human Services 2007; Jenkins 2004; Success Works 2005).

Targeting of services

As indicated earlier in this review, there are dangers in failing to recognise the heterogeneity of the young people in need of residential care. For a start, any intervention needs to be tailored to the identified needs of each young person rather than the shared needs of a group of presumably homogenous young people (Malia et al. 2008, pp. 47-48). Alongside this individualised focus, however, needs to be a clear understanding of the young people that the program is equipped to work with and the types of behavioural or mental health issues that the program is designed to address.

In NSW, the Flynn et al. (2005) report identified the following major target groups for residential care services:

- children and young people with high and complex needs that cannot be managed in foster care
- those aged 14 years or older who need 'targeted programs to support their transition to independence'
- some Aboriginal children and young people who cannot be placed in other services by indigenously-managed programs (p. 43).

Other possible target groups mentioned include younger young people and children (under 12 years of age) because of the 'increased complexity of presenting behaviours' (p. 46) and young people with specific behavioural issues such as sexual behaviour problems or substance abuse. There are currently a number of programs that specialise in providing

residential care for girls or young people from specific ethnic or cultural groups. In NSW and Victoria there are a few residential programs and family group homes that cater for young people who do not present with the highest level of behavioural difficulties and there is some support for the continuation of this approach as many young people do not wish to be placed in a family setting (p. 31).

The literature suggests that programs need to be clear about the nature of their target group and warns about those that have a 'no refusal' policy as no one service has all the answers and this openness implies a vague 'one-size-fits-all' approach to treatment (Pumariega 2006).

A related issue is the tendency for statutory workers, with few realistic placement options, to oblige services to accept young people on an emergency basis, regardless of the impact this might have on existing residents and whether the programs are designed to meet the needs of such young people. Ainsworth (2007) notes that this practice, a direct result of rapid de-institutionalisation, may lead to abusive practices. Likewise, Clough et al. (2006) have observed:

> One consistent finding of the research is of the huge and disruptive impact on settled groups of children in long-stay homes, of emergency and short-term admissions of the most troubled children (p. 68).

LINKAGES WITH OTHER SERVICES

This is an issue that has been explored in a number of publications. For example, Leichtman (2006) believes that the residential program of the future will not be a 'stand-alone' service but integrated into a spectrum of services which provide for young people at different times and with different levels of need. There will be a recognition that residential care can meet the more acute and specific needs of young people (say, for specific treatment or supervision) who might then be moved to less intensive intervention options. There is a need for residential services to be linked, *within agencies*, to related services that can help meet the needs of the young people, especially other accommodation options such as varieties of foster care, less-intensive small-group homes, and independent living arrangements.

A particular issue facing Australian residential services is the lack of satisfactory options available for young people after their placements and whilst they are still under the direct supervision of statutory departments. Anecdotal reports from around the country suggest that many young people languish in residential care settings for long periods after their placement objectives have been achieved or progress has stalled. The lack of available 'step-down' options leads to young people feeling hopeless and frustrated which then leads to a deterioration in behaviour and an unravelling of treatment gains.

In addition to 'step-down' options, the transition of young people from residential (or foster) care to independent or semi-independent living options has long been a concern of both local and international commentators (e.g. Cashmore & Paxman 1996). The recent call for expressions of interest associated with a new funding roll-out in NSW specified that preference would be given to agencies that were able to provide a range of accommodation options so that young people could, with minimal disruption, transition within services as their needs changed.

SPECIALIST CLINICAL EXPERTISE AND SERVICES

It is imperative that organisations wishing to provide services for young people with high needs have access to skilled clinical personnel and, preferably, that they have such personnel on staff. Given that the young people in question are likely to be affected by mental health and other emotional and behavioural concerns, clinical expertise is needed to help in the design of the intervention and accommodation program, to provide relevant assessments, to develop intervention plans, to provide direct counselling for residents and staff members, and to assist with de-briefing after critical events. In her review of residential services in NSW in the mid-1990s, Robin Clark (1997) observed that community-based mental health services are not often geared to respond to the needs of young people in care settings and it is difficult to secure such assistance in the first place. It is significant that this issue of access to specialist mental health counselling is one that was raised by young people themselves during a recent consultation (CREATE 2006). As noted in Part I, the Victorian and Queensland statutory child welfare departments have recognised this problem and have established state-wide counselling services for young people under statutory supervision ('Take-2' and 'Evolve').

There also needs to be a capacity to provide for specialist clinical work with families given the centrality of family, even those with serious functional difficulties, in the lives of the young people in care. Some programs, such as the St Vincent's program operated by Marist Youth Care in NSW, see family restoration as being their primary goal and have integrated this family focus into the very design of the service. For other residential services, the need to engage, support, coach and otherwise work with family members remains, even where the restoration of the young person to his/her family home is not a realistic goal (e.g. Ainsworth 2006). This is imperative given the significant numbers of young people who return home post care.

It is preferable that provider organisations have skilled clinical personnel on staff so that assistance can be provided as needed. An alternative for smaller organisations may be that they enter into a formal consulting arrangement so that such services and supports are provided on a regular (at least weekly) basis and at times of crisis.

VALUE ADDING WITH OTHER SPECIALIST SERVICES

It is not just clinical and counselling staff that are needed. Fulcher and Ainsworth (2006a) maintain that a broader, 'multidisciplinary' focus will be needed by residential programs into the future if they are to survive. Well-functioning residential services need ready access to a range of professionals including educators, recreation specialists, family workers, and even vocational trainers. Hillan (2006), for example, observes that high quality programs take a 'continuum approach that ensures a suite of programs, living environments and interventions' (p. 58).

The ability to 'value–add' in terms of such specialist services is one of the big advantages of larger agencies with better economies of scale. The observations of Delfabbro and his colleagues (2005) about the North American residential centres, are particularly relevant:

> 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 ... 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 (p. 16).

TRAINING

The training of workers in residential care has long been cause for concern. It is often seen as a desirable but optional exercise and its implementation tends to be piecemeal. Bath (1998) observed that little had changed over two decades in Australia in terms of the basic qualifications required of residential workers and the type of training that was offered. This theme is also echoed in studies from overseas, such as that by Berridge and Brodie (1998) who observed that around 80% of the residential staff in the UK 'remained unqualified' and received little in terms of on-the-job training. Fulcher and Ainsworth (2006a), in their recent review, suggest that this issue of poor training and formal education continues to impair the quality of residential programs around the developed world (pp. 286-287) and, locally, Hillan (2006) has also drawn attention to this issue of the training and qualifications of residential workers.

If organisations are to claim expertise in working with young people with high needs, they will need orientation, initial/induction training and on-going training programs linked with the conceptual formulations discussed earlier. This training program should cover, at the very least:

- the conceptual model/s along with its/their understandings of the young people and the issues that affect them
- the actual intervention framework to be utilised
- legal issues, child rights and provisions in local child welfare legislation
- adolescent mental health issues including depression and suicide prevention, substance abuse, trauma and attachment-related perspectives on relationships, behaviour and management
- communication and relational skills
- the organisation's policy and guidelines around behaviour management
- crisis management policy and procedures (as outlined below)
- specific training around the identified needs of particular young people (e.g. sexualised behaviours, intellectual disability, personality disorders, conduct disorder)
- engaging and working with family members.

It is desirable that all supervisory and coordinator level staff members have sound experience in working with young people and appropriate qualifications in psychology, social work or a related profession. Specific therapeutic intervention strategies designed for supervisory staff have been shown to materially effect the outcomes for young people with high needs (e.g. Dawson 2003).

Given that aggressive behaviour is a defining feature of many young people designated as having high needs (e.g. Clough et al. 2006; Osborn & Delfabbro 2006), and the history of residential programs is that they have to deal with many critical incidents involving physical aggression (e.g. DoCS 2004; Flynn et al. 2005, p.14), service providers will need to be committed to implementing a comprehensive crisis management program. This is particularly important given the fact that many injuries of clients and staff members occur during behavioural crises and young people have died overseas in misguided attempts to manage aggression (Nunno, Holden & Tollar 2006). Programs such as *Therapeutic Crisis Intervention* (TCI) and *Professional Assault Response Training* (PART) can offer training in understanding crises, crisis communication, self-management, de-escalation techniques and closure skills. Where appropriate, they may also offer training in the physical management of crisis situations where verbal de-escalation is not sufficient to ensure the safety of the client or others. Formal crisis management programs offer training to specified levels of competency, and provide clearly articulated policies and guidelines around the management of crises along with best practice standards. The crisis management program should provide guidelines for the safe

implementation of the techniques, including timeframes for 'refresher' training. Formal monitoring of crisis interventions should also occur in all residential programs to assist staff to improve practice in this area and to ensure that the rights and safety of young people are respected.

ACCOUNTABILITY, ACCREDITATION AND STANDARDS

As Fulcher and Ainsworth (2006a) observe, the issue of accountability is one of the significant policy and practice shifts that will affect residential programs into the future. Contracted services need to adhere to practice guidelines (such as those relating to client participation, family contact, behaviour management, and cultural sensitivity) as well as quality frameworks set by the funding organisations in contract documentation. There will increasingly be a requirement that organisations meet external standards such as the out-of-home care standards developed in NSW and administered by the Office of the Children's Guardian. Where specific targeted services are offered without clear accreditation frameworks, those developed by organisations such as the Child Welfare League of America or the Department of Health in the UK can be used as guides.

There has been a trend toward the funding of organisations to work with young people who have specific behavioural difficulties such as sexually problematic behaviours. It is particularly important that appropriately trained and supervised personnel are available to provide such services and that formal accreditation guidelines (such as those provided by National Offence-Specific Residential Standards Taskforce 1999) are used to guide good practice. In this connection, the NSW Commission for Children and Young People operates an accreditation scheme for counsellors working with adolescents (and adults) who have sexually offended (the Child Sex Offender Counsellors Accreditation Scheme [CSOCAS], www.kids.nsw.gov.au).

Quite apart from adherence to accreditation and standards frameworks, residential programs are increasingly being required to demonstrate that they are achieving set goals and objectives, including the demonstration of positive outcomes for young people in their care.

CONCLUSION

There have been significant changes to the provision of out-of-home care services for around four decades and continuing change is inevitable. Although residential care has frequently been cast in negative terms and the policy focus has been on developing alternatives, Knorth and his colleagues (2008) observe that they have a 'clear impression that there has been a shift away from the "last resort" vision which has set the tone for child care policy for the last three decades' (p. 124). Residential care continues to face challenges to its very legitimacy but, at the same time, it is widely recognised that it will be a necessary part of the out-of-home care service spectrum well into the future. At the very least, it will continue because it is the only option when others have failed to ensure the safety of young people or are unable to contain high risk behaviours that cause harm to themselves or to others. As Clough and his colleagues point out, 'it will always be difficult to get residential care right' (2006, p. 88). The challenge to service providers and policy-makers is whether they are content to continue to provide a residual, low expectation, 'end-of-the-line' option, or one that leads the way in identifying the multiple needs of the young people being referred, develops coherent, theoretically and conceptually sound service models, and then adequately trains and equips staff members to meet the needs of these vulnerable young people. Highlighting examples in the UK and the USA, Fulcher and Ainsworth (2006a, p. 288) remind us that, far from being a last resort, residential care has the potential to provide leadership to the field of child welfare with high quality clinical, training and research activities undertaken in centres of excellence. ■

REFERENCES

Abramovitz, R. & Bloom, S. (2003) 'Creating sanctuary in residential treatment for youth: From the "well-ordered asylum" to a "living-learning environment"', *Psychiatric Quarterly*, 74(2), 119-113.

Ainsworth, F. (2001) 'The effectiveness of residential programs for 'at risk' adolescents', *Children Australia*, 26(2), 11-18.

Ainsworth, F (2006) 'Group care practitioners as family workers', in L. Fulcher and F. Ainsworth (eds.), *Group care practice with children and young people revisited*, (pp. 75-86), New York: The Haworth Press.

Ainsworth, F. (2007) 'Residential programs for children and young people: What we need and what we don't need', *Children Australia*, 32(1), 32-36.

Anglin, J. (2002) *Pain, normality and the struggle for congruence: Reinterpreting residential care for children and youth*, New York: The Haworth Press.

Asay, T. & Lambert, M. (1999) 'The empirical case for the common factors in therapy: Quantitative findings', in M. Hubble, B. Duncan, & S. Miller, *The heart and soul of change: What works in therapy*, (pp. 22-55), Washington, DC: American Psychological Association.

Barber, J., Delfabbro, P. & Cooper, L. (2001) 'The predictors of unsuccessful transition to foster care', *Journal of Child Psychology and Psychiatry*, 42, 785-790.

Barth, R. (2005) 'Residential care: From here to eternity', *International Journal of Social Welfare*, 14, 158-162.

Bath, H. (1998) *Missing the mark: Contemporary out-of-home care services for young people with intensive support needs*, Association of Children Welfare Agencies and Child and Family Welfare Association of Australia, June.

Bath, H. (2001/2) 'Is there a future for residential care in Australia?', *Developing Practice*, Summer.

Benard, B. (2004) *Resiliency – what have we learned?*, San Francisco: West-Ed.

Berridge, D. & Brodie, I. (1998) *Children's homes revisited*, London: Jessica Kingsley.

Bowlby, J. (1958) 'The nature of the child's tie to his mother', *International Journal of Psychoanalysis*, 35, 350-373.

Brendtro, L. & du Toit, L. (2005) 'Chapter 1: A portrait of pain', in *Response Ability Pathways: Restoring bonds of respect*, (pp. 1-15), Cape Town: Pretext.

Brendtro, L., Mitchell, M. & McCall, H. (2007) 'Positive Peer Culture: Antidote to "peer deviance training"', *Reclaiming Children & Youth*, 15(4), 200-206.

Cashmore, J. & Paxman, M. (1996) *Wards Leaving Care: A longitudinal study*, NSW Department of Community Services, Sydney.

Casson, S. (2006) 'Developing a shared language and practice', in L. Fulcher and F. Ainsworth (eds.), *Group care practice with children and young people revisited*, (pp. 117-149), New York: The Haworth Press.

Clough, R., Bullock, R. & Ward, A. (2006) *What works in residential care: A review of research evidence and the practical considerations*, National Centre for Excellence in Residential Care, National Children's Bureau.

Clark, R. (1997) *A review of intensive out-of-home care services*, NSW Department of Community Services.

CREATE Foundation (2006) *Children and young people in care consultation for the Office of Children's 'Improving Outcomes for children and young people in Residential Care' project*, CREATE Foundation and Department of Human Services, December.

Dawson, C. A. (2003) 'A study of the effectiveness of Life Space Crisis Intervention for students identified with emotional disturbance', *Reclaiming Children & Youth*, 11(4), 223-230.

Delfabbro, P.H., Osborn, A. & Barber, J.G. (2005) 'Beyond the Continuum: New perspectives on the future of out-of-home care in Australia', *Children Australia*, 30(2), 11-18.

Department of Community Services (2004) *Expression of Interest for children and young people in out of home care with high and complex needs*, NSW Department of Community Services, February.

Department of Human Services (2007) *Hurstbridge Farm – A therapeutic care program for early adolescents (Draft program document)*, Department of Human Services Victoria, Take Two, Melbourne.

Dishion, T., McCord, J. & Poulin, F. (1999) 'When interventions harm: Peer groups and problem behaviour', *American Psychologist*, 54(9), 755-764.

Dishion, T., Nelson, S. & Bullock, B. (2004) 'Premature adolescent autonomy: Parent disengagement and deviant peer process in the amplification of problem behaviour', *Journal of Adolescence*, 27(5), 515-530.

Dodge, K. A., Dishion, T.J. & Lansford, J. E. (2006) *Deviant peer influences in intervention and public policy for youth*, Social Policy Report, Society for Research in Child Development.

Fahlberg, V. (Ed). (1990) *Residential treatment: A tapestry of many therapies*, Indianapolis, IN: Perspectives Press.

Flynn, C., Ludowici, S., Scott, E. & Spence, N. (2005) *Residential care in NSW*, Out of Home Care Development Project, Association of Children's Welfare Agencies, November.

Ford, P. (2007) *Review of the Department for Community Development – Review Report*, Government of Western Australia, January.

Fulcher, L. & Ainsworth, F. (Eds.) (2006) *Group care practice with children and young people revisited*, New York: The Haworth Press.

Fulcher, L. & Ainsworth, F (2006a) 'Chapter 12: Conclusion – Looking ahead', in L. Fulcher and F. Ainsworth (eds.), *Group care practice with children and young people revisited*, (pp. 285-294), New York: The Haworth Press.

Garfat, T. (2003) *A child and youth care approach to working with families*, New York: The Haworth Press.

Goffman, E. (1961) *Asylums: Essays on the social situation of mental patients and other inmates*, Garden City, NY: Anchor Books.

Gosbell, D., Jenkins, F. & Spence, N. (1999) *A home without parents: Young people with high support needs in substitute care – a qualitative research study*, NSW Association of Children's Welfare Agencies.

Halliday, D. & Darmody, J. (1999) *Partners with families in crisis: Parent responses to a system of care*, Richmond, Victoria: Spectrum Publications:

Henggeler, S. (2001) 'Multisystemic Therapy', *Residential Treatment for Children and Youth*, 18(3), pp. 75-85.

Hillan, L. (2006) *Reclaiming residential care A positive choice for children and young people in care. An exploration of differing models and outcomes of residential care provision for young people, with an examination of the links to evidence and research in the design and evaluation of out-of-home care*, report prepared for the Winston Churchill Memorial Trust of Australia.

Hobbs, N. (1994) *The troubled and troubling child*, Cleveland, Ohio: American Re-Education Association.

Jenkins, S. (2004) 'Developing a residential program for children in response to trauma-related behaviours', *Children Australia*, 29(3), 22-29.

Kazdin, A. (1997) 'Practitioner review: Psychosocial treatments for conduct disorder in children', *Journal of Child Psychology and Psychiatry*, 38(2), 161-178.

Kazdin, A. (2002) 'Psychosocial treatments for conduct disorder in children and adolescents', in P. E. Nathan and J.M. Gorman (eds.), *A guide to treatments that work*, (pp. 57-86), New York: Oxford University Press.

Knorth, E., Harder, A., Zandberg, T. & Kendrick, A. (2008) 'Under one roof: A review and selective meta analysis on the outcomes of residential child and youth care', *Children and Youth Services Review*, 30, 123-140.

Leichtman, M. (2006) 'Residential treatment of children and adolescents: Past, present, and future', *American Journal of Orthopsychiatry*, 76(3), 285-294.

Maier, H. (2006) 'Primary care in secondary settings', in L. Fulcher & F. Ainsworth (eds.), *Group care practice with children and young people revisited*, (pp. 87-116), New York: The Haworth Press.

Malia, M., Quigley, R., Dowty, G. & Danjczek, M. (2008) 'The historic role of residential group care', *Reclaiming Children & Youth*, 17(1), 43-51.

National Offense-Specific Residential Standards Taskforce (1999) *Standards of care for youth in sex offense-specific residential programs*, NOSRTF, Holyoke, MA: NEARI Press.

Nunno, M., Holden, M. & Tollar, A. (2006) 'Learning from tragedy: A survey of child and adolescent restraint fatalities', *Child Abuse and Neglect*, 30, 1333-1342.

Osborn, A. & Delfabbro, P. H. (2006) *National comparative study of children and young people with high support needs in Australian out-of-home care*, School of Psychology, University of Adelaide.

Polsky, H. (1962) *Cottage Six: Social system of delinquent boys in residential treatment*, New York: Russell Sage Foundation.

Pumariega, A. (2006) 'Residential treatment for youth: Introduction and a cautionary tale', *American Journal of Orthopsychiatry*, 76(3), 281-284.

Rose, M. (1990) *Healing hurt minds: The Peper Harow experience*, London: Tavistock/Routledge.

Rose, M. (1997) *Transforming hate to love*, London: Routledge.

Success Works (2005) *Evaluation of the Treatment and Care of Kids (TrACK) program*, (Victorian) Department of Human Services, Anglicare Victoria, Australian Childhood Foundation. Success Works, Victoria.

Stein, P. T. & Kendall, J. (2004) *Psychological trauma and the developing brain: Neurologically based interventions for troubled children*, New York: The Haworth Maltreatment and Trauma Press.

van der Kolk, B. (2005) 'Developmental Trauma Disorder: Towards a rational diagnosis for children with complex trauma histories', *Psychiatric Annals*, 33(5), 401-408.

Vorrath, H. & Brendtro, L. (1985) *Positive Peer Culture*, New York: Aldine De Gruyter.

Weiss, B., Caron, A., Ball, S., Tapp, J., Johnson, M. & Weiss, J. (2005) 'Iatrogenic effects of group treatment for antisocial youth', *Journal of Consulting & Clinical Psychology*, 73(6), 1036-1044.