Programs for high needs children and young people

Group homes are not enough

Frank Ainsworth and Patricia Hansen

Recently the Department of Community Services in New South Wales and the Department for Child Safety in Queensland have both released information about funding and the award of contracts for group homes and other residential services. In addition, in the 2008 discussion about out-of-home care at the Wood Commission of Inquiry into the Child Protection Services in New South Wales, group homes were discussed in terms of them being less demanding environments than foster care. The view presented was that group homes are appropriate for some young people who are either unsuitable for foster care or who want a less intimate setting than that provided by foster care. This article argues that group homes or residential programs, against the New South Wales and Queensland descriptions, fail to respond to the need for quality residential programs for children and youth. This is partly due to the low level of training for staff in group homes and high staff turnover.

Dr Frank Ainsworth
Senior Principal Research Fellow (Adjunct)
School of Social Work and Community Welfare
James Cook University
Townsville Campus, Qld 4811
Email: frankainsworth@hotmail.com

Dr Patricia Hansen
Head, School of Social Work
Australian Catholic University
Strathfield Campus, Sydney, NSW 2135
Email: patricia.hansen@acu.edu.au

The Department of Community Services (DoCS) in New South Wales recently released information about the short listing of 42 new and existing non-government agencies for negotiations to provide out-of-home care services (DoCS 2008, pp. 1-5). These include group homes and residential care for 'high need kids' (HNK), as this group of children and young people are described by the Department. In Queensland there has also been a recent call by the Department of Child Safety (DChS) for expressions of interest from non-government organisations interested in providing therapeutic residential services (DChS 2008).

At the Special Commission of Inquiry into Child Protection Services in New South Wales discussion early in 2008 (Wood 2008) about out-of-home care, group homes were described by a representative of a non-government agency as being less demanding environments than foster care. The argument put forward was that group homes are more appropriate for some young people who are either unsuitable for foster care or who want a less intimate setting than that provided by family foster care. These developments in New South Wales, and the similar actions in Queensland, are likely to reflect discussions about residential services in other States and Territories. This article argues that group homes or residential care (HNK) as proposed in New South Wales (DoCS 2008) and the therapeutic residential services in Queensland (which are group homes in all but name) (DChS 2007, 2008) fail to address the need for high quality residential programs for a select group of children and young people. These developments are one further manifestation of the reluctance of Australian child care and protection authorities to make proper provision for our most vulnerable children and young people.

WHICH CHILDREN AND YOUNG PEOPLE ARE WE TALKING ABOUT?

Originally, in 2007, the New South Wales Department of Community Services proposed four residential care service models – intensive residential treatment programs for children and young people with complex and high support needs; residential care for children and young people with moderate to high needs; supported family group homes for large sibling groups and young people who have low to moderate support needs; and supported independent living services for young people aged 16 to under 18 years at entry into the program (DoCS 2007a, p. 8; DoCS 2007b, 2007c).

When the document *A better service system for out-of-home care* was made available early in 2008, only residential care (HNK), supported family group homes, and supported independent living were mentioned (DoCS 2008, p. 3).

So which children and young people are likely to be placed in residential care for high need kids or group homes? When describing the supported family group homes, the NSW Department identified these programs as being:

> ... for older adolescents who do not want to live in a family situation or a large sibling group who cannot all be placed together in a relative, kinship or foster home care placement, a supported family group home may meet their needs (DoCS 2008, p. 3).

Not that dissimilarly, the Queensland Department of Child Safety indicated in their documents about therapeutic residential services that:

> the purpose of the funding is to enable non-government organisations to deliver ... therapeutic residential services ... each providing four places within a residential setting ... for young people referred by the Department of Child Safety ... who are in the custody or guardianship of the Chief Executive and have complex and extreme support needs (DChS 2007, p. 2).

The specified age range for these services is between 12 and 17 years. The Queensland services will also have to be 'accessible and relevant to Aboriginal and Torres Strait Islander young people' (DChS 2007, p. 4)

In New South Wales the residential programs will offer places for 4-5 or 2-6 children or young people, while in Queensland the capacity will be 4 children and young people per residence, although there will be a link to 'two less intensive places in an alternative form of out-of-home care' (DChS 2007, p. 2). What is revealing is the information that can be obtained from the New South Wales Department of Community Services costing manual for child and family services (DoCS 2006, pp. 37-40). The manual classifies group homes as 'standard (non-high needs) residential accommodation'. Group homes have one staff person during the day plus one staff person on sleepover duties. This results in a staff/resident ratio of 1:1.3 with an indicative cost of $105,000 annually per young person. Figure 1 summarises this and subsequent data.

Unfortunately, the first and last line of the description is contradictory. Firstly, it states that the group home is for those who 'do not want to live in a family situation' and then names the placement as a 'family group home'. Moreover, the description goes on to say 'care will be provided in a family-like atmosphere by live-in carers as opposed to models of rostered staff'. The New South Wales Department also indicates that 'twenty four hour care and supervision of children living in supported family group homes will be provided by couples or single people' (DoCS 2007b, p. 3). Confusion reigns. It shows that the program model is not a contemporary model of group care but is that of 'family' in spite of the fact that the notion of family as a model for residential programs has long since been discredited (Hansen & Ainsworth 1983).

On the other hand the description of residential care (HNK) is:

> A small number of young people aged 12 years or older are unsuited to family-based placements because of their challenging behaviours and high support needs, or their stated preference may benefit from placement in a small (2-5 residents) residential service (DoCS 2008, p. 3).

The documentation states that residential care (HNK) differs from intensive residential treatment programs in terms of:

- 'the intensity and comprehensiveness of the therapeutic program provided; and
- the length of placement in this model type. Whereas the intensive residential treatment program is time limited (6-12 months), this model provides a placement option available for as long as required according to individual case plans' (DoCS 2007c, p. 3).

Figure 1: Service type, number of places, staffing, costs and duration of stay by state

	New South Wales*				Queensland*
Service type	Intensive* residential care	Residential* care (HNK)	Supported* family group homes	Supported* independent living	Therapeutic* residential services
Age and number of places		Over 12 years 4-5 places	Over 12 years 2-6 places	16-18 years 1-4 places	12-17 years 4 + 2 intensive foster care
Staffing model and ratio		Rostered model 1:1.4	Live-in couple or single people 1:1.3	No residential staff	Co-ordinator, 1 person 24/7, 1 person/core hours plus 1 person weekends
Recurrent costs		Indicative $226,000 pa	Indicative $105,000	Indicative $34,500	$1.5 m (Brisbane) $1.25 m (Cairns and Townsville)
Duration of stay		6-12 months	Not specified	Not specified	Up to 18 months

SOURCE: Department of Community Services: *Costing manual for child and family services in New South Wales* (2006); *Out-of-home care service model: Supported family group home* (2007b); *Out-of-home care service model: Residential care* (2007c); *A better service system for out-of-home care* (2008). Department of Child Safety: Therapeutic residential services (2008); *Grant funding information paper 2007-08: Therapeutic Residential Services* (2007).

Direct care staff in these programs will be employed on a rostered basis.

The costing manual classifies this service as 'high and complex needs residential accommodation'. The service is shown as having two staff persons at all times with one staff person awake at night while another is asleep, resulting in a staff/resident ratio of 1:1.4. The indicative cost is $226,000 annually per young person (DoCS 2006, pp. 37-40).

In each case, these services will have a similar population of either older adolescents or young people aged 12 years or over. This population is made up of young people who for one reason or another have not settled in foster care. This is an estimated 20% of young people placed in foster care who typically have had numerous prior placements (Barber & Delfabbro 2004) and who manifest mental health and other behavioural problems, including an inability to live peacefully with others (Ainsworth & Hansen 2005). Alarmingly, the service description for the residential service (HNK) states that the aim is 'to move (*the client*) to a less intensive placement option', thereby ensuring one further placement change. This proposal is made even though it is known that part of the challenging behaviours that have resulted in a placement in residential care (HNK) is associated with the experience of having multiple earlier placements (DoCS 2006, p. 39).

In comparison, the Queensland Department of Child Safety documents do not contain the same level of costing detail. Only a recurrent cost figure is given and this varies between $1.5m and $1.25m dependent upon location (DChS 2007). They do, however, articulate a very similar staffing model to that proposed for the residential care (HNK) in New South Wales in an attachment entitled 'Sample service model structure including minimum support features' (DChS 2007, attachment 2, p. 18). Both of these examples and their staffing structures are remarkably similar to those that exist in other States and Territories. The indicative cost will vary in other States and Territories.

Unfortunately, the New South Wales *A better service system for out-of-home care* (DoCS 2008) seems to ignore Clark's (1997) review for the Department of Community Services of a small number of community-based residential units that had been established following the closure of larger institutions. She found that while these units were funded for six young people, the average occupancy was four, and many had only one or two residents (Clark 1997, p. 4). Bath also states that 'residential units for young people have been quite problematic and are rarely stable for any significant periods of time' (Bath 2007, p. 4). Small may not be as beautiful as some people are inclined to think.

Contrary to some views, small group living is not less demanding than family foster care (Wood 2008). How can living with a small group of young people, all of whom have 'challenging behaviours and high support needs' (DoCS 2007a) or 'complex or extreme support needs' (DChS 2007), possibly be seen as less demanding? The changing membership of the resident group and a rotating staff roster also add to the demands. It is fair to state that small group living is just differently demanding, not less demanding. Constant adjustment and adaptation still has to be made (Douglas 1986).

... residential programs need to be dynamic living and learning environments where treatment, re-education or re-socialisation objectives are integral to the programs and are vigorously pursued.

From the 2006 Western Australian Ombudsman *Report on allegations concerning the treatment of children and young people in residential care*, and the more recent Mulligan report, we also know that abuse can and does take place in small residential programs, albeit on many occasions abuse of one resident by another (Western Australian Ombudsman 2006; Mulligan, 2008). In fact, small programs can easily develop a negative peer culture as they do not have the essential 24/7 curriculum that effective residential programs need (Ainsworth 2007) and all too readily they rely on informality and individual staff idiosyncrasies. In the New South Wales Department's documents, there are only vague statements about the group homes and the residential care (HNK) services and who these programs will serve and what function they will perform, other than providing accommodation (DoCS 2007a, p. 3). In group homes and residential programs, it is evident that 'if the function is not clear then the staff will be confused and program objectives will not be achieved' (Ainsworth 2007). In essence, group homes and the residential care (HNK) services are only supportive residential accommodation. The vital treatment interventions that are designed to achieve behaviour change that is desperately needed by these young people will have to be provided away from the group home or residential program. There will be no integrated in-house service but rather a schedule of specialist appointments. In the small residential programs studied by Clark, she found that the much needed specialist psychiatric services were rarely available (Clark 1997, p. 4). It seems there has not been much change in a decade.

Given the capacity of the proposed group homes, residential care (HNK) and the therapeutic residential services, it is more than likely that there will be a mixing of children and young people with a variety of needs and problem behaviours in these programs. This is what has been reported in Western Australia (Western Australian Ombudsman

2006). This pattern of service represents a return to the past. The problems that arise from mixing populations are well known. Under such circumstances, difficult behaviours get copied and the tendency is for staff to make more program rules in an attempt to regain control (Anglin 2002). The more rigidly structured a program becomes, the less there is an opportunity for young people to develop skills and learn new behaviours.

If not avoided, population mixing will almost certainly result in a group home or residential care (HNK) service or the more ambitious therapeutic residential service being unstable and unmanageable (Bath 2008; Dishion, McCord & Poulin 1999; Pumariega 2006).

It is noted with alarm that the target group in New South Wales for residential care (HNK) includes children with one or more of the following difficulties:

- poor impulse control
- high risk-taking behaviours
- alcohol and other substances
- poor self-image
- self-harming behaviour
- social isolation and limited capacity to form relationships with peers and/or adults
- sexually inappropriate behaviours
- anti-social behaviours, including aggression and violence towards people and, in some instances, criminal behaviours
- mental health issues
- physical health issues
- intellectual disability
- education difficulties
(DoCS 2007c, p. 4).

The Department of Child Safety documents identify a similar list of characteristics for those children and young people who will be referred to the therapeutic residential services (DChS 2007, attachment 1, pp. 17-18). There is no mention of possible specialisation of function for any of the New South Wales or Queensland residential programs. In fact, the Department of Child Safety 2007 document states that:

> therapeutic residential services *must* accept all referrals from the Department for the support of young people with complex and extreme needs

and that:

> service providers *must* be prepared to accept these referrals and facilitate the young person's entry to the program (italics added) (DChS 2007, p. 5).

Given these requirements, an explosive and dangerous mix of residents is inevitable. It is worth noting that the issue of gender is not mentioned in these documents.

What a residential program needs to be

Residential programs for children and young people are a critical component of any mature child welfare system (Ainsworth & Hansen 2005; Bullard & Johnston 2005). They are part of a continuum of out-of-home care services that range from foster care (kinship care, family foster care, intensive foster care, treatment foster care) to various forms of residential provision (respite care, group homes, residential education, residential treatment). In particular, residential programs need to be dynamic living and learning environments where treatment, re-education or re-socialisation objectives are integral to the programs and are vigorously pursued. Programs must not just be warehouse-type accommodation (Miller & Gwynne 1972) where hard-to-place young people can be dumped when all other options have been exhausted. Therefore, residential programs for children and youth need to be highly selective in terms of who gains admission, and have a clear, specialised function. They must also be used as a positive choice, not just as a last resort (Ainsworth 2007; Wagner 1988).

A key characteristic of any residential program is 'the group', especially the resident group – although other groups are also important. The staff group and the staff-resident group must be consciously used as a vehicle for intervention. In effective residential programs, the group and group processes becomes the principal means for building a positive peer culture (Vorrath & Brendtro 1985) that can be harnessed in the pursuit of treatment, re-education or re-socialisation objectives. The EQUIP program (Gibbs, Potter & Goldstein 1995), with its emphasis on peer helping and the focus on correcting thinking errors as well as anger management (Goldstein 1998), is a fine example of the skilled and positive use of the resident group in a re-education and re-socialisation program.

To provide a developmentally focussed residential program, processes must be planned to ensure that both residents and staff are accountable for progress toward positive behaviour change for residents. Staff team selection, staff roles, the processes through which individual resident needs are met, as well as program supervision and leadership, have to be part of a total program model.

This is reflected in the following imperative:

> A residential education or treatment program has to have a 24/7 curriculum that sets out the place and timing of program events and the activities that children and young people will pursue in order to achieve the behaviour change objective against which

> they were selected as program participants. These are all matters which must carefully match the program objectives and the desired measurable outcomes (Ainsworth 2007, p. 34)

The objective is to establish a therapeutic milieu that is stable, comfortable and emotionally warm, and that offers a foundation from which behaviour change can emerge. Put another way, a residential program has to be a place for young people 'to live and learn' and 'learn to live' (Maier 1975).

Residential programs must also have a settled and highly skilled workforce. This is something which residential programs in health and residential schools in education achieve. The achievement of stable, effective residential programs in these systems may be linked to issues of program capacity and the knowledge building and career opportunities that larger programs can offer staff. Health and education systems have been less committed to the notion that residential programs must have a capacity of 6 places or less (Ainsworth 2003). Unfortunately, a stable and highly skilled workforce is not a characteristic commonly associated with group homes and small residential programs (Clark 1997).

What we have learnt at the expense of two generations or more of vulnerable children and young people is that foster care cannot serve every child or young person, and that some highly selective, specialised, residential services with clear therapeutic objectives are needed.

STAFF TURNOVER

In the debate about child care and protection, much is made of the importance of permanency, especially for young children. The argument is that for healthy development, a child requires stability of placement and continuity of caregivers. Most of the population of children and young people who are likely to be considered for placement in a group home, residential care (HNK) or therapeutic residential services will have a history of multiple foster care placement breakdowns. It is also clear that the best predictor of placement breakdown is a prior foster care breakdown (Barber & Delfabbro 2004).

A major issue is that of staff turnover in group homes, residential care (HNK) or therapeutic residential services type programs. It is known that the average length of service for staff in group homes and similar programs is at best about 2 years (Clark 1997). When a staff member resigns and a new staff member is appointed, there is a period of adaptation and adjustment for both the staff who remain and the residents. Invariably, this process of adjustment and adaptation creates a measure of program instability. In group homes with a staff ratio of 1:1.3 and residential care (HNK) with a staff ratio of 1:1.4, as well as in the similar therapeutic residential services, this is likely to be quite marked. Program instability is also known to lead to a rise in problematic behaviours by young people as it threatens their sense of security. There is a question as to whether the group homes, residential care (HNK) and therapeutic residential services that are to be funded can provide the stability of placement and continuity of caregivers that is needed to support the healthy development of children and young people. If this goal cannot be achieved, the conclusion may be that 'residential programs do not work'. But this conclusion may be reached because we have not learned from the past, but instead have only recreated it.

STAFF TRAINING

Ainsworth (2007) attached considerable importance to the need for trained staff in residential programs and attention was drawn to the range of methods and skills that such staff must have. For direct work with young people, these methods and skill areas are:

- provision of everyday personal care (food, clothes, warmth)
- formulation of individual care and treatment plans
- developmental scheduling (individual and group), play and activity based
- activity programming (individual and group), play, recreation, and informal education
- group work (educational, activity, and therapeutic formats)
- life-space counselling (individual and group)
- program planning, unit level
- work with families
  (adapted from Ainsworth 2006, pp. 79-82).

These methods and skills also need to interact with each other in order to make for an effective treatment, teaching and learning environment (Ainsworth & Fulcher 1985). An understanding of positive peer group approaches (Vorrath & Brendtro 1985), the life space intervention methods as developed by Fecser and Long (2000) and the de-escalation of crisis techniques (Holden 2001) are other important contributions to any professional training for this workforce. All of the above apply, no matter how small or how large a residential program may be.

RIGHT OR WRONG THEN – WRONG OR RIGHT NOW?

With the benefit of hindsight, it is clear that the plan for 'no more residential care' was a dream gone wrong (Ainsworth & Hansen 2005). Australian child care and protection authorities never did away with residential care for vulnerable children and young people. All that happened was that the population of high need kids was either pushed into supported accommodation and assistance programs (SAAP) or ended up in juvenile justice institutions (Ainsworth & Hansen 2005). What we have learnt at the expense of two generations or more of vulnerable children and young people is that foster care cannot serve every child or young person, and that some highly selective, specialised, residential services with clear therapeutic objectives are needed. In fact policy makers, service designers, service managers and academics who promoted a foster care only system made a mistake. A mature child care and protection system requires some residential education and residential treatment programs.

This need for residential programs exists in every State and Territory. Those who support small group homes, small scale residential care, or therapeutic residential services and who resist the development of specialised residential programs with clear therapeutic objectives are making a mistake again.

CONCLUSION

One step forward would be the establishment of intensive residential treatment programs in all States and Territories. These were omitted from the 2007 DoCS expression of interest (EOI) process. This omission was made even though such a program was described in the documentation that came from the DoCS major out-of-home care project. The description was as follows:

> *Intensive residential treatment programs for children and young people with complex and high support needs* ... the minimum age at entry into these programs will generally be 12 years, although younger children could be considered for admission if comprehensive assessment indicated they have special need that would be best met in a more structured therapeutic setting than can be provided in a home based or less structured residential care option (DoCS 2007a, p. 8).

In that respect, the Victorian development of a therapeutic care program for early adolescents aged 12 to 14 years that is described as the 'vanguard of change for the care system' (DHS 2007) may offer one example of intensive residential treatment. Hurstbridge Farm is the first purpose-built residential care service in Victoria for many years. In that respect it will pilot a therapeutic service for traumatised young people. The attempt is to provide a small scale (up to 8 residents of either gender), integrated, on-site program of care, education and counselling against a backdrop of recreational and other self-esteem building activities (DHS 2007). It is hoped that the results of this pilot program will provide knowledge for the future development of residential programs in other States and Territories in Australia. ■

NOTE: A useful resource for staff working with children and young people in residential programs is the International Child and Youth Care Network <www.cyc-net.org>. This is a free, on-line education and training service.

This on-line network gives access to international journals that address residential care and treatment, learning modules about issues that affect child and youth care practice and a chat room.

An international Board of Governors, many of whom are key writers about residential programs, oversee the Child and Youth Care on-line services.

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DHS—*see* Department of Human Services

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