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Out of Home Care in Australia: Looking Back and Looking Ahead

Howard Bath

Dr Howard Bath was most recently the Northern Territory Children's Commissioner, first appointed in 2008 and re-appointed in 2012. Trained as a Clinical Psychologist, Howard has studied and worked in both Australia and the USA. He has worked as a youth worker, manager, Agency Director and clinician and was the inaugural Chair of the Child and Family Welfare Association of Australia, the peak body for service providers representing all states and territories. Howard has presented widely at conferences and training seminars and has authored numerous research reports and articles on topics including family preservation services, out-of-home care, behaviour management and child protection. Howard joined the Anglicare NT Board in April 2015 and now provides consultancy services through Allambi Care in NSW. He has been a longstanding supporter of the *Children Australia* journal and his generosity over the years in helping with a range of journal-related tasks, including being a former Editorial Consultant is very much appreciated.

Forty-two years ago, just before *Children Australia* arrived on the scene, I started out in my first job as a child and youth care worker. In various positions across Australia, I have been a witness to, and participant in, some of the very significant developments in the child welfare field and out-of-home care (OOHC) in particular. Given the turbulent nature of that history and the certainty of ongoing change, the following observations on a few key issues are perhaps more about my hopes than expectations.

Looking Back

From the late 1960s to the early 1990s, momentous developments in both broader society and the child welfare domain saw not only a dramatic drop in the numbers of children in institutional care, but an overall fall in the total number of children being cared for away from their families – an estimated 28,000 children in institutional care alone in the late 1960s – had fallen to just over 7000 by 1983 with a further 10,000 children in foster care. Total numbers in care (based on a point-in-time count) continued to fall to around 12,000 in 1993 but have rebounded significantly to over 43,000 today, with foster and kinship care now accounting for 93% of placements (Australian Institute of Health and welfare (AIHW), 2015; Bath, 1994, 1998, 1999; Senate Standing Committee, 1985). Residential care numbers continued their decline into the mid-2000s and even today numbers of children and young people in this form of care have increased only marginally from what they were 20 years ago.

It is not just the number of children being placed into care that is notable, but also the *rate* of placement which is rapidly increasing. Twenty years ago (when the quality of the data records started to improve) the rate of placement in OOHC was 2.7 per 1000 children; today the rate is 8.1 per 1000, a threefold increase (AIHW, 2015; Bath, 1994, 1998).

Not so apparent in the statistics are the key drivers of change: a developing understanding about the needs of children and the harms resulting from forms of institutional care, the importance of family and identity, the desire to use the "least restrictive" care environment, and of the need to "normalise" the care of children. When I started work, de-institutionalisation was just starting to take hold and family group homes were emerging as the preferred, "less restrictive", more "normalised" placement option. Now none of those institutions exists and family group homes, for the most part, have also disappeared. They have only partially been replaced by small residential units with rostered shift workers. Such units used to routinely house 10 or more children – now four or fewer is the norm. The vast majority of children in care are now in various forms kinship and foster care; many more who might previously have been placed are now maintained in their family homes, perhaps with the provision of family support services that have emerged as a key component of the service system.

There have been many other developments, not apparent from the statistics, that are contributing to positive outcomes for children and young people and to improved service quality. These include the establishment of this journal (and, in 2001, *Developing Practice*); the emergence of the *Australian Association of Young People in Care* in 1993 now known as *CREATE;* the formation of *SNAICC*

ADDRESS FOR CORRESPONDENCE: Howard Bath.
E-mail: howardianbath@gmail.com

(*Secretariat of National Aboriginal and Islander Child Care*) with similar representative bodies in several jurisdictions; the removal of the so-called "status offences" from child welfare statutes in all jurisdictions; the continuing development of peak service bodies in most jurisdictions along with foster care associations; academic child protection and wellbeing research centres attached to universities; the devolution of most OOHC services to non-government organisations; the belated involvement of the Commonwealth Government in child protection with the release of the first *National Framework for Protecting Australia's Children* in 2009; and, most recently, the establishment of the Royal Commission into Institutional Responses to Child Sexual Abuse.

The child protection system, however, is under more pressure than any time in its history. The most recent report from the AIHW indicates that in 2013–14, 2.7% of all Australian children received some form of child protection service and just under 1% (0.98%) of all Australian children (51,539) were in OOHC at some time during the year (AIHW, 2015). The OOHC sector has struggled to keep up with this relentless demand for services, but also with the nature of the children being placed and the complex needs they bring with them. At the same time there has been a strong imperative for services to respond effectively to the compelling research findings on the developmental needs of children exposed to severe adversity and trauma.

Looking ahead, it is issues and challenges that have been with us for some time that are likely to shape the sector over the next few decades. Some of these issues have been festering for years now; and there is none more important than the over-representation of Aboriginal and Torres Strait Islander (A/TSI) children in OOHC.

Aboriginal and Torres Strait Islander Children in Out of Home Care

From the earliest OOHC records, it has been clear that A/TSI children have been greatly over-represented in the care population. In 1993, it was estimated that 2416, or around 20% of the 12,273 children then in care, were A/TSI (Bath, 1994). The rate of placement was 20 per 1000 or 2% of all A/TSI children. From the latest AIHW figures (as of 30 June 2014), there are now almost 15,000 A/TSI children in care (at a given time) and their placement rate is a staggering 54.4 per 1000, over 5% of all A/TSI children – in NSW the most populous state, the figure is 7%. Indigenous children are now almost 10 times more likely to be placed into OOHC than non-Indigenous children – the rate ratio being 9:2 (AIHW, 2015). Despite all the attention and controversy this issue has garnered over the years, the overall disparity has continued to grow.

This is not the place to explore in detail the reasons for and the meaning of the over-representation, but they are clearly linked with both historic and current disadvantage and the impacts these have had on the wellbeing of A/TSI children and families. Although many of the drivers of the over-representation lie outside of the system itself, that does not absolve those from within it from taking decisive action to address the disadvantage and disparity that is within their remit.

New South Wales, despite the very high numbers of A/TSI children in care, seems to have moved further than other jurisdictions in ensuring that such children are cared for within their extended families and cultural groups to the point where the large majority A/TSI children in that state are now placed through Indigenous services. NSW has also led the way in providing kinship care placements with the highest proportion of Indigenous children being with A/TSI carers. Although the data collection in this area is poor, Australian services, in general, still struggle with the development of culturally relevant services and, in particular, the employment and retention of sufficient numbers of A/TSI staff members and foster carers.

It is axiomatic that we must as a nation continue to invest in "closing the gap" in terms of economic opportunities, health outcomes, education outcomes and other wellbeing indicators for families and children. As the gap closes, so should the disparities evident in the child protection statistics. Within the OOHC sector, I hope that we continue to see the development of more culturally-appropriate family support, family preservation and re-unification services along with Indigenous child welfare services offering both foster/kinship care and residential options.

Services for Children and Young People with High Needs and Challenging Behaviours

Back in the early 1980s, the Senate Standing Committee on Social Welfare held an inquiry into the care system and its report drew attention, amongst other things, to "the rising proportion of children with severe emotional and behavioural problems being placed into substitute care" (Senate Standing Committee, 1985, p. 76). The need to provide adequate care options for this group of children with high support needs, an issue repeatedly raised in the literature since that time, has led to many of the changes that have already occurred, including the shift to smaller residential units with rostered staff and the marked decline in the number of young people housed in each unit. It has also been responsible for the phenomenon of residential programs developed around the needs of individual young people. Such changes, however, were largely instituted in response to the imperative of effectively managing such young people and not as a result of a considered appraisal of their emotional, behavioural and developmental needs.

I was part of a posse of writers (e.g., Ainsworth, 2001; Ainsworth & Hansen, 2008; Bath, 1998, 2002/3, 2009; Delfabbro et al., 2005; McLean, Price-Robertson, & Robinson, 2011; Osborn & Bromfield, 2007) in the late 1990s and 2000s who called for the development of treatment or therapeutic options that are designed to move beyond the "care and accommodation" paradigm to address the broader needs of children in care. Thankfully, the last decade has

indeed seen the gradual emergence of therapeutic foster care in some jurisdictions and some specialised residential treatment options. The imperative to develop therapeutic services has been enshrined in the legislation of some states, there have been numerous conferences and seminars addressing therapeutic care issues, pilot programs have been funded, commercial residential treatment models have been developed and there is some early encouraging research into the effectiveness of particular approaches (Verso Consulting, 2011). Two jurisdictions fund specialist therapeutic services for children and young people under statutory supervision (*Take Two* in Victoria and *Evolve* in Queensland) while others are continuing the development of therapeutic models of care. It is still early in this process, but the direction of change has been unmistakeable and welcome.

It is now much more likely that a foster care or residential program will operate from a clearly articulated therapeutic premise; that intervention goals will be set; and that a formal intervention plan will be followed. Some services focus on the development of therapeutic environments whilst others, particularly in foster care, focus on addressing the therapeutic needs of individual children/young people. Some services, including both for foster care and residential care, now employ their own clinical specialists to assist with program design, assessment, the development of intervention plans, training and individual counselling – others contract in such services. Regardless of the approach, the overall shift to a therapeutic or treatment framework is well underway.

The drive to develop therapeutically-oriented services has been strongly influenced by the compelling body of research on the impact of early adversity and trauma on brain development (e.g., Enlow et al., 2012; Teicher et al., 2003; van der Kolk, 2003) and on problematic life course outcomes (Felitti & Anda, 2010; Felitti et al., 1998; van der Kolk, 2014), as well as the translational work of Sandra Bloom, Dan Hughes, Bruce Perry, Bessel van der Kolk, Daniel Siegel and a host of others. There is also an emerging research emphasis on what works to remediate the developmental harm of early adversity on post-traumatic growth, and on factors that promote resilience and healing (e.g., Masten, 2013; Rutter, 2013). This "trauma-informed" perspective (which usually incorporates attachment-related insights) is especially relevant in the OOHC arena given that, by definition, we are engaged in supporting children and young people who have been exposed to severe adversity and trauma.

There is a potential problem, however, in the almost universal take-up of this perspective. It seems that in Australia there is currently an assumption that *traumagenic* needs are all that really matter and that "therapeutic" automatically means variants on this "trauma-informed" approach. It could be seen as a wholesale *out with the old* (the behavioural, social learning, group work, and cognitive-behavioural perspectives and tools) and *in with the new*.

There is great diversity among the children and young people placed in OOHC and a broad range of needs that must be addressed (see for example, Redshaw, 2012). Although the majority have been exposed to severe early adversity, the trauma perspective may not always be the most useful theoretical framework to respond to individual needs, indeed, in some instances it could well make matters worse.

Some young people in care have been placed because of issues arising from developmental problems such as autism spectrum disorders, global intellectual disability, foetal alcohol spectrum disorders (FASD), or congenital conditions such as Fragile X or Klinefelter's Syndrome. Others may have frank mental health conditions whilst still others may be in care because of entrenched behaviours that threaten their own safety or that of others. Many different approaches and theoretical perspectives, including family-based interventions, are needed to effectively respond to this diversity of needs. Even within trauma-informed programs, insights and skills derived from other theoretical perspectives will always need to be employed. The recent volume on international approaches to therapeutic residential care (Whittaker, de Valle, & Holmes, 2015) wisely reviews a broad array of theoretical approaches under the rubric of "therapeutic" interventions.

I hope that the sector will mature into one which develops a truly needs-based perspective where the emphasis is on a high quality, individualised assessment of need, and where the individual child (and his/her family) is at the centre. In Australia, poor economies of scale mean that most agencies need to respond to a wide variety of young people, needs and circumstances – given this, reliance on a single, pre-determined theoretically-driven intervention model is always going to be problematic.

Where a service has been designed around a particular theoretical model there needs to be a capacity to carefully select and screen clients to ensure they are likely to benefit. This will require something of a culture shift for most governmental funding agencies which have to balance the high level of demand with the relatively few residential placements available. The resulting pressure for services to accept all referrals has led to serious problems arising from the aggregation of ill-matched young people in small residential units.

I hope that future decades will see the development of a variety of therapeutic and treatment programs, in both foster and residential care, and that the focus on understanding and effectively responding to the diverse needs of children and young people will become the default approach and not a specialist option for a select sub-set of clients.

Placement Stability and Continuity

While we are on this topic of needs, consideration must also be given to the issue of placement stability and continuity of care – this is another as yet unresolved issue that has been with us for a long time. Back in 1996, Cashmore and Paxman, in their study of young people leaving care, observed that "the degree to which children and young people experience continuity and stability in care is probably the most important factor influencing outcomes . . . " (p. 2).

This need for continuity is frequently raised by young people in care or who were previously in care, to enable them to develop longer-term, stable relationships with people, programs and places. There are two elements to this issue: the need to maintain and support good placements where possible and the need to maintain continuity where change is unavoidable. In far too many instances, a placement breakdown leads to a change of program, agency, case management, school and domicile.

Placement stability should clearly be a priority for all involved in case management, but sometimes changes are an inevitable result of court processes, personality clashes, developmental stresses and changing needs. A young person who may need a specialised residential program at one point, may well need one or more foster placements at others. He/she may also transition back to the care of family and perhaps need ongoing support in-home.

Our OOHC system with its categorical funding models is not currently designed to allow for the flexibility and continuity most young people need. We need to develop funding models that provide for a holistic approach to support and treatment; that allow agencies to provide a range of accommodation, treatment, and family intervention or support options; that provide for smooth transitions across these options; and that promote relationship continuity with youth workers, case managers and therapists, as well as with school communities (see also Leichtman, 2006). My hope for the coming decades is that such flexible, holistic program models will become the norm.

Staff Stability and Continuity

Stability and continuity also apply to the nature of the staffing team. There have been numerous concerns expressed over the years about high staff turnover rates in the sector, but the widespread use of casual and temporary staff in residential settings, in part a result of the high turnover, seems to be a relatively recent phenomenon. A recent Victorian residential care workforce survey (Centre for Excellence, 2014) found that an astonishing 55% of workers in the sector were casual; a further 19% worked part time.

This increasing use of casual staff in the sector is of great concern for a number of reasons; it affects the stability of services, the integrity of intervention models, the quality of adult–child connections, and the emotional safety of the young people. The development of stable staffing models with workers who can provide relationship continuity and stability is a given if the quality of our care and support programs is to improve. The retention of experienced workers must be a priority for residential programs into the future.

Qualifications and Training

Another problem that has dogged the sector for a long time, centres on the very low requirements around qualifications and skills required to work with children and the patchy quality of training that is available. This is, in part, a reflection of the broader society's understanding of, and valuing of, the work that is undertaken. If anything, this is more of a problem today than it has been in the past because of the trend towards the use of casual workers who are often more poorly qualified than permanent staff.

A survey of residential programs across Australia undertaken in 1979, determined that "approximately one third of staff had no qualifications" (Gregory & Smith, 1982, p. 91). In 1997, Robin Clark surveyed NSW residential programs and found that although 74% of workers in residential programs in NSW had some form of formal qualification (not necessarily directly relevant to residential care), 26% had no qualifications at all. Fast forward to 2014 and the Victorian residential care survey (Centre for Excellence, 2014) which found that 55% of workers in the sector were casual workers, many of whom are engaged through employment agencies. Of these workers, 68% had no qualifications at all. Even amongst full time workers who made up 26% of the workforce, 24% of had no relevant qualifications.

In the coming decades there must be a meaningful improvement in the skill and qualification level of direct care providers. The peak service bodies in Victoria, NSW and Queensland have recently made significant investments in the development of workplace qualifications and my hope is that within a short period of time such qualifications will become the minimum requirement to work in the sector. In addition to the employing organisations, the funding bodies and the regulatory agencies also have key roles in ensuring that our most vulnerable children and young people are cared for by formally qualified and highly skilled practitioners.

Accountability

Across service sectors that are (largely) funded by government, there is an increasing imperative to demonstrate both an efficient use of funds and positive outcomes. The focus in the past has been on quality improvement, accreditation processes, inputs and outputs including the number of children served, service hours, staff numbers and the like. Whilst these remain important elements, the discernible shift, so far as funders are concerned, has been to a focus on value for funds provided in terms of the achievement of desired outcomes. In the case of OOHC, there has been talk for some time about the need to demonstrate positive outcomes for children and their families as well as meeting the needs of the system itself, but actual contracting based on such outcomes has been slow to emerge. For service providers, the impetus to demonstrate positive outcomes should derive as much from a values perspective as from contracting requirements.

We now have available a number of standardised measures for children and young people that look at issues such as emotional adjustment, externalising behaviours, risk and wellbeing. Specific measures designed for OOHC programs (looking at rates of family contact, school engagement,

aggressive behaviour, absconding, self-harm, and the like) have been used in the Australian research (e.g., Verso Consulting, 2011) and can be readily adapted and captured in OOHC case management systems. I believe that the regular use of such measures as baseline and progress indicators in OOHC case management will facilitate sound program evaluations, promote service quality and help ensure accountability. The systemic use of such measures is likely to be an increasing feature of OOHC services into the future.

Conclusion

There are, of course, many other issues and priorities, both within and outside of the OOHC sector, that will help determine its shape and directions into the future. Beyond the challenges and developments of the recent past it is hard to predict what these changes will be. It is clear, however, that there will continue to be a strong impetus and appetite for innovation and positive change based around the shared goals of improving outcomes and ensuring positive futures for our most vulnerable children and families.

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