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Practice Commentary

Weighing Up the Evidence and Local Experience of Residential Care

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Therapeutic residential care is currently seen as an answer to managing the increasing disruption experienced by many young people in care. Yet the history of residential care in Australia is problematic and the international evidence for the efficacy of therapeutic approaches is very poor. The author's own agency's experience of providing residential care also indicates that caution is needed before increasing the numbers of residential 'beds'. Problems include young people's dislike of residential options and the stressfulness of an environment that involves shift workers and multiple transient relationships. Further, residential care can be a financial drain on child welfare budgets (being tendered to non-government agencies at over seven times the cost of community care), and has the potential danger – when beds are empty – of being used for young people who do not need this level of care. Residential care may appear to be the only option for a handful of adolescents no longer suited to foster care; but before developing therapeutic residential care further, government must be able to guarantee, at a minimum: a safe environment, a nurturing and healing environment, continuity of care, and the capacity to meet young people's developmental and permanency needs. These standards must be met, not just now, but over the long term.

■ **Keywords:** Out-of-home care, residential care, foster care, community care

Since children in out-of-home care tend to remain in care for long periods and present with complex emotional and behavioural issues, policy makers have turned their attention to how best to keep them safe and remediate the harm they have experienced (Australian Institute of Health and Welfare 2017; Whittaker et al., 2016). Across Australia there is renewed consideration of therapeutic approaches in residential care (McLean, 2016b). For example, the New South Wales government has recently released a new therapeutic care framework (New South Wales Department of Family and Community Services, 2016) and, in the Australian Capital Territory, a newly implemented 5-year strategy called 'A Step Up for Our Kids' is seeking to ground residential care firmly in a therapeutic approach (Australian Capital Territory Government, 2016). There has also been active debate amongst practitioners, including among the contributors to the Children Australia Special Issue in 2008 (Bath & Smith, 2015).

However, this reconsideration of residential care is being undertaken in the context of far-reaching criticism of past residential practice and worrying current trends about the management of existing residential facilities. Influential commentary includes the Royal Commission into Institutional Responses to Child Sexual Abuse (2014–2017), commentary that led to apologies to children who previously lived in residential care, namely the Stolen Generations (Human Rights and Equal Opportunity Commission, 1997), and the Forgotten Australians and Former Child Migrants (Australian Government, 2009). Concern is also evident in current practice. In 2016, for instance, the NSW Coroner conducted high-profile, publically reported investigations into deaths of young people in NSW residential units (State Coroner's Court of New South Wales, 2016). In the closely related area of juvenile justice, there has also been growing awareness of sour institutional cultures and harm to young people, resulting in the Royal Commission in the Northern Territory (Australian Government Attorney General's Department, 2016) and public concern about riots and unrest in Victorian and Queensland institutions.

This paper outlines issues for policy makers and practitioners to consider in conjunction with proposals to increase residential beds – even where the intent is to offer

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therapeutic care. It suggests some basic standards that need to be met and explores the most recent international evidence on the effectiveness of therapeutic residential care, as well as reflecting on the Australian residential care context through the lens of an Australian care agency (James, 2015; McLean, 2016a; 2016b). In doing so, this paper raises questions about the appropriateness of residential care for Australian referrals and its capacity to promote permanency.

Throughout this paper, I define residential care as group or, in some cases, individual care in a residential building, the purpose of which is to provide placements for children using paid staff (Australian Institute of Health and Welfare, 2013). In the Australian context, residential care is primarily used for young people who have been abused or neglected. It is rarely designed with the purpose of providing a 'permanent home' but often becomes so by default after the failure of foster care options (Thorburn, 2016). Typically, young people are likely to remain in residential care until they turn 18 or a community care option becomes available.

The therapeutic residential care programs being proposed in Australia are variously defined, but are understood here as programs intended to provide safe, trusted and well-connected care to help young people to cope with their myriad external and internal challenges, to cope adaptively with their unusual circumstances, and safely manage their frequently overwhelming emotions and impulses (Bath & Smith, 2015). Therapeutic care varies, however, and is increasingly standardised, based on models imported from the United States (examples of packaging of professional skills identified by Fairclough, 1992 as 'technologisation'). These models of care may include the use of therapeutic specialists, high staff ratios to actively engage young people, careful matching of placements and planned transitions, use of trauma and attachment theories, time-limited interventions, participation of the young person, family, community or cultural group, post-care support, and evaluation (Jones & Loch, 2015; McLean, 2016b). This paper does not discuss 'secure care' which is the subject of longstanding concerns reinforced in recent reviews of the research evidence (McLean, 2016a). Nor does it discuss residential units used for short-term respite or assessment.

Internationally, the literature does not yet endorse the efficacy of such therapeutic residential care models (Whittaker et al., 2016) and the author's agency's experience of running therapeutic residential care indicates that there are serious questions that are not being considered in the Australian context. These cautions stem from young people's poor experiences of residential care, the financial drain on the wider service system, inherent difficulties created by the use of rostered staff, stressful living environments and the potential for inappropriate use of residential beds for children under 12 years of age. The paper outlines some basic standards to be observed when residential care is considered either as a pilot program or because of limited alternatives (for example, with older adolescents who have had poor experiences of community options such as fostering). The bottom line is that welfare administrators must be able to guarantee to meet young people's needs for a 'home', healing and development and a sense of permanency. These standards must be upheld over many decades – and certainly long after the enthusiasm of initial program implementation has passed.

The International Evidence on Therapeutic Care

Internationally, there is very poor evidence to justify heavy public expenditure on therapeutic residential care. There are some overseas research papers on residential care that tentatively endorse it as a permanency option for young people (Thorburn, 2016) or as a means of delivering specialist therapeutic techniques (James, Alani, & Zepala, 2013). However, the applicability to the Australian context of worker skills and child welfare practices is unclear and there is no Australian research on outcomes over the short-and medium-term. This is not to deny that there may be examples of individuals who have found stability and meaningful adult relationships in residential care after fleeing dangerous homes or escaping homelessness. However, good public policy must be based on critical assessment of the overall evidence and take into account Australia's social conditions.

There are some recent local and international research reports that are useful to consider. A special report on therapeutic care for the South Australian Royal Commission highlighted the difficulty of introducing overseas models because residential care here frequently has a different structure (McLean, 2016b). The report also points out that overseas models deal with different population groups (such as children who have mental health issues and come from engaged families). Importantly, McLean points to difficulties in retaining and recruiting staff in Australia, and in setting realistic expectations of what can be achieved. It is unlikely in Australia, for example, that programs would be able to employ staff with PhDs as they do in the United States. She goes on to claim that two widely emulated programs, the Sanctuary and CARE therapeutic models, currently lack an evidence base, arguing: 'At this stage, therefore there is little evidence to support either the CARE or the Sanctuary model or distinguish between the relative effectiveness of these models' (McLean, 2016b, p.14). In considering the Sanctuary model, McLean states that there appears to be 'only one significant evaluation [Victoria's Verso evaluation discussed below] . . . [and] in general . . . research and evaluation on this form of service provision has largely been ignored' (McLean, 2016b, p.20).

The Verso evaluation, referred to above, provides a rare instance of positive findings from its evaluation of therapeutic residential care, and claims therapeutic placements to be cost-effective in comparison to standard residential care. The three 'milieu' interactive models implemented in Victoria were said to show 'better outcomes for children

and young people than standard residential care practice' (McNamara, 2015, p.74). Certainly, descriptions of staff turnover and young people's experience in regular Victorian residential care have been a cause of concern, but it is unclear whether these improvements reached or improved on standards in other states such as the NSW Child Safe Standards for Permanent Care (New South Wales Children's Guardian, 2015). Importantly, long-term outcomes for young people were not assessed by this evaluation. Despite this, the Victorian government is continuing to move away from residential options (Centre for Excellence in Child and Family Welfare, 2016).

Overall, international literature on therapeutic residential care draws attention to the dearth of research about its short-term or medium-term impacts and a lack of consensus about the precise model to be used (Whittaker, DelValle, & Holmes, 2015 p.30). In a detailed review of evidence-based therapeutic practices, James (2015) concludes that there is an inadequate knowledge base for selecting therapeutic approaches to implement in residential settings, such as client-centred approaches, whole of 'milieu' interactive models (like Sanctuary) or therapeutic programs offered in the community. Confirming this analysis of the literature, the International Work Group on Therapeutic Residential Care consensus summary states that: 'At least in the US, therapeutic residential care has not yet had the benefit of anything like a similar resource allocation for research and development [compared to wraparound services], particularly in the area of model specification and implementation' (Whittaker et al., 2016).

Local Experience of Residential Care

Our local experience, combined with the poor research base described above, has led Barnardos Australia to advocate for a very limited role for residential care in our range of out-of-home care options, and our own services are following international trends by reducing the number of residential placements and making their use increasingly specialised (Bullock & Blower, 2013). Whilst not dismissing the positive work that could potentially be achieved in high quality residential care, we have learned overall that quality comes at a high financial cost and requires strong management to develop an adequate standard of support for young people.

The experience, on which our assessment of residential care is based, has seen us move from congregate care for 20–30 children in the 1920s, to small group homes housing approximately six children during the 1950–1980s, to now having only one specialist residential unit for linguistically diverse young people. Our remaining residential unit provides stability for young people who are all over the age of 12 and come from traumatising, refugee backgrounds. Community placements for this group of young people proved impossible given other families of similar cultural background were recently arrived in Australia and had also experienced trauma. This unit has been able to provide a highly stable program with the bulk of its workers having contributed to the unit for between 20 to 30 years, and bringing their own unique, first-hand experiences of dispossession. Our moves from congregate care to group homes, and then to community care, were driven by a desire for a normal, less stigmatised, community upbringing for children.

Our closed therapeutic residential units were replaced with community programs including specialist foster care over 30 years ago. In 1984, we closed our last NSW residential unit, 'Lindfield', which was designed to be therapeutic for emotionally and behaviourally disturbed children under 12 years of age. It had had dedicated child psychiatric input and high staff ratios. Whilst the unit had periods of positive outcomes, this quality was hard to maintain over the years. Staff were not highly trained and their turnover was high given the career structure of Australian youth workers. Children's behaviour was difficult to contain and costs were disproportionately high. Worst of all, we observed, anecdotally, very little change in children's behaviour and the children longed to move from the stigmatising 'home' to be with a family. Following our decision to close the unit, these 'unfosterable under-12-year-olds' were all successfully moved into kinship care, foster care or adoption through the newly formed community fostering program. Following the 1990s closure of the Lindfield unit, our second permanent care team was established to replace another residential unit we operated in Canberra. A community placement program was subsequently established to find housing for older adolescents in family homes and support independent living. This program was aided by a residential 'respite' option that provided short-term backup for community placements which failed to meet the young person's needs. We believe that this use of a residential unit was very effective for the handful of adolescents over the age of 16, who needed stop gap care while alternative community placements were found.

Our experience shows us that well-resourced and supported alternatives to residential care can be achieved for the vast majority of children and young people needing out-of-home care, either through foster care, supported independent living or 'open adoption'. As indicated, back-up residential crisis care was also very important. Our long-term foster care programs have a high level of caseworker support, with caseloads of 6–8 for the permanent care team. The level of stability achieved by these programs has been consistently high with children settled permanently by their first placement. Since 2000, when detailed records were first analysed, the majority of children have only required one permanent placement (McGarva, 2016). Details of the level of support given to children are described in several publications: for example, the amount of time workers spent on case management averaged 3.5 hours per week per case (Tregeagle, Cox, Forbes, O'Neil, & Humphreys, 2011). Other papers addressed the time commitment of carers (Forbes, O'Neill,

Humphreys, Tregeagle, & Cox, 2011) and the experience of adoption (Tregeagle, Moggach, Cox, & Voigt, 2014).

Our experience has confirmed our now firm view that residential care should not be used for children under the age of 12 years, unless there are extenuating issues such as keeping siblings together. Since the closure of our therapeutic units we have also learnt that, for those aged over 12, community care is also the preferred option. We have sought residential support from other agencies for only a handful of older adolescents over the past 10 years, most of whom were part of a larger group of 400 'hard to place' children and young people. Otherwise, we have only used residential care for adolescents from communities where recruiting foster carers is not feasible or for crisis back-up for a few weeks.

Through our experience we understand that therapeutic, medium-term residential care is difficult to manage effectively. It can be difficult for young people. It presents challenges in providing continuity of relationships because of shift work and staff turnover. Importantly, residential care comes at a high cost and draws resources away from more normalised, community-based care. It requires extensive resources and skills because behaviour management is a priority, both because difficult behaviour by one resident can 'contaminate' others, and because of the challenges associated with preventing bullying or abuse (Royal Commission into Institutional Responses to Child Sexual Abuse, 2016).

Young People's Negative Assessment

Barnardos' approach is heavily influenced by the views of young people whose experiences of residential care systems are overwhelmingly negative. Australia's peak body for young people in care, CREATE, has reported on young people's experiences of residential care and concluded, 'more attention still needs to be given to improving care experience in residential [care]' (McDowall, 2013a Section 4.2.2). A UK study has also shown that, although young people may appreciate the need for welfare assistance, many experienced significant problems while living in residential care:

> Several of the children interviewed had experienced the culture of delinquent behaviour, bullying and low staff morale known to exist in some residential units . . . The lack of empathy displayed by some residential staff was identified as one of the three most unpopular aspects of being looked after (Ward, Skuse, & Munro, 2005, p.14).

Research into Australian young people's sense of safety in residential care reinforces these concerns. In a study of 27 young people aged 10–21 years, most reported that they were not safe and did not feel safe within residential care:

> Unfortunately, due to the often chaotic and unstable nature of residential care, the constant churn of adults and children and young people through a facility, and the pervasive risks that were present, most of the participants did not characterise residential care as being a safe place. Instead, it was somewhere where they had to protect themselves from multiple personal risks (Moore, McArthur, Roche, Death, & Tilbury, 2016, p. 8).

Young people identified problematic peer sexual behaviour as an intrinsic part of residential care; sexual relationships with workers appeared rare, but young people reported that workers sometimes were 'creepy' and had poor boundaries. Sexual exploitation was also raised by a small number and examples were given of young people engaging in prostitution. The Safe and Sound report noted: 'participants aged under 12 were less likely to believe that abuse-related risks existed within residential care, most talked about bullying, harassment and violence as an ongoing issue for kids in care – an issue that was also raised by those aged 12–21' (Moore et al., 2016, p. 8).

Whilst there is no research that deals specifically with Australian young people's experience of therapeutic residential care – and advocates no doubt hope to overcome the problems described above – there is reason to be concerned. Generally, the high staff turnover that is characteristic of Australian residential units is known to be problematic for young people. Whilst there are no recent studies of the impact of staff turnover specifically in residential care, studies of foster care show that caseworkers' mobility can lead to a lack of stability and loss of trusting relationships (Cashmore & Paxman, 1996). Living in residential care can also create a sense of being different, perhaps even being an outcast and undesirable. For some young people, it is the ultimate form of rejection by the wider community (McDowall, 2013b).

Disproportionate Use of Resources

One of the greatest concerns about residential care, frequently overlooked in debates, is the very high cost of providing residential care and the drain that it imposes on the child welfare system and agencies. By not focusing on the resource implications of residential care, there is relatively little debate as to how else cost-effective support could be achieved, by, for example, making greater use of more normalised intensive foster support and community placements.

Based on the tenders offered to agencies, the cost of caring for a young person in residential care is up to seven times greater than general foster care. Whilst foster care, in 2017, may cost about $41,000 per annum, a realistic price for a residential placement is $200,000–$300,000. These costs can escalate if extensive damage to units occurs, or, there is a need for specialist therapies. However, in considering these costs it is important to note that those young people currently entering residential care are frequently psychologically damaged and are best compared to the 'high needs' category in foster care. Caution must also be used in comparing costs to ensure that similar accounting methods

are used (for example, that support costs are comparable) and long-term outcomes are included.

Stressful Living Environment

Residential care provides a challenging living situation which can be highly stigmatising. This is a particularly pertinent issue when considering the alternatives of foster, community placements and open adoption; all of which offer less stigmatising, community-based care.

Residential care can be overwhelming for children under 12 years of age and some traumatised adolescents. In a residential unit staffed by rostered workers there may be up to 30 different adults working over the course of a year. These include youth workers, caseworkers, psychiatrists, psychologists and casual workers. Often other disturbed young people also move in and out of the care setting. Thus, the possible number of individuals, with whom young people have to maintain relationships, can be between 30–40 people in the course of a week. It is paradoxical that we place young people into a living situation where they are expected to form many significant relationships, when forming quality relationships is an aspect of their lives with which they have the great difficulty. Added to this problem is the high turnover or 'churn' of staff.

Residential care is also problematic since other residents' behaviour can be difficult for children and young people to cope with, and, can contribute to their disturbance. Distress and uncontrolled behaviour by one resident may have a detrimental impact on other residents, and an 'out of control' culture can easily develop and exacerbate poor behaviour. There are also increased opportunities for bullying in out-of-home care that, linked with adjustment difficulties, can create further stress for young people (Pinchover & Attar-Schwartz, 2014). In one Israeli study of residential care, for example, there was 'a concerning level of violence among adolescents . . . More than half of the participants (56%) reported being victims of at least one act of physical violence at the hands of a peer . . . in the month prior to the survey' (Pinchover & Attar-Schwartz, 2014 p. 397).

Residential care facilities can also provide the opportunity for peer-to-peer sexual assault. The Australian Royal Commission has recently highlighted the extent of this issue:

> We have listened to many participants in private sessions who told us of the trauma they experienced as a child being harmed by another child in OOHC . . . child-to-child sexual abuse is a serious and common problem in contemporary OOHC. (Royal Commission into Institutional Responses to Child Sexual Abuse, 2016 p.37).

Finally, there is the danger that when a 'bed' is available in a residential unit it may be judged easier to simply fill it, rather than look for a community placement that would better suit a child under 12 years or young person.

The 'Bottom-Line': Can Residential Care Meet Young People's Needs Over the Medium and Long-Term?

In weighing up the evidence and the concerning characteristics of residential care, the fundamental issue to emerge is that any program must be realistically able to provide a nurturing, child-safe environment and deliver evidence-based therapies to address and ameliorate trauma. Given the type of young people referred to residential care in Australia, the question is, 'Can it actually contribute to their sense of permanency?'

Residential care's first role is to meet the shelter, nutritional and personal care needs of young people, and managers must ensure stability, continuity and safety. Residential care must also meet the young person's developmental needs, ensuring preparation for independent living, the redress of past trauma and provision of a setting where healing can occur. Young people must participate in active case management and have their voices heard. A culture must be maintained over the short and long term which does not run the risk of becoming punitive and fail to protect individuals (Bath & Smith, 2015). All this must be achieved whilst maintaining stable daily living conditions – a real challenge when working with young people who may be 'streetwise' and used to freedom from adult constraints.

In short, state and national Standards for Care must be met and, more importantly, adhered to over the medium and long term. This requires management to be consistent, strong and committed to individual and team stability, to provide continuity and development of teams, and ensure permanency outcomes for children and young people. This must continue over decades.

Managers Need to Guarantee a Warm, Welcoming and Normal Environment

The residential care environment needs to be welcoming and inclusive with a home-like atmosphere. Privacy and confidentiality are particularly significant issues in residential care. Personal possessions and community-standard resources are important to young people, including access to music, mobile phones and digital technologies. Clear communication and an understanding of the role of workers are also essential. House rules must be clear, developed through dialogue and applied consistently. As a home the residential unit needs to be treated respectfully with a limited number of 'officials' coming into the environment.

The residents need to be integrated as much as possible in the neighbourhood and be encouraged to participate in local age-appropriate activities. Creating a home requires a culturally accepting environment which accommodates and strengthens individual identity. Food, celebrations and religious observances need to be appropriate for each individual, and an atmosphere of acceptance among all the residents must be cultivated.

Residential Care Must Guarantee Continuity of Care and Contribute to Permanency

Establishing permanency is critically important for young people entering residential care who have, most likely, experienced many previous disruptions. Recent Australian research (Jones & Loch, 2015) shows that the average placement in standard residential care in Victoria only lasted 7 months. Even when intensive therapeutic care was provided, stays were on average only 30 months. Stays in residential care cannot be used merely as stopgaps until a young person ages out of the system or can be 'held' in a community placement until they reach the age of independence.

Implicit in providing a stable environment is the need for staff stability and units that promote stability of employment. This is difficult in Australia given youth workers' salaries and the career structures. As Vicary observes:

> Australian residential care workers are not paid commensurately to the importance of their work, some still work in poor conditions, have poor training and supervision, are working with increasingly difficult clients, [and] have few prospects in terms of career advancement (Vicary, 2015, p. 276).

When staff are in place, they need to be well supported to avoid the burn-out that has been identified as a problem for standard Australian residential care models (Jones & Loch, 2015). It is also important that any use of casual staff is carefully considered as it can mean that many more transient individuals are part of a young person's life.

Whilst the goal of a residential placement may be smooth transition to community or independence, it is essential that young people, often with few other living options, do not experience unnecessary moves. The focus of any residential unit must be on avoiding unnecessary disruption through unplanned placement moves. Every attempt must be made to ensure that young people receive the level of support that they need to stay in stable housing and education. This involves more than a home-like environment; it requires proactive engagement and support.

Residential Care Must Contain Challenging Behaviour

Managing challenging behaviour of all residents is one of the most important elements for maintaining a young person's sense of safety, normality and continuity of care. Unless carefully managed, residential care can escalate behaviour problems and further contribute to the young person's difficulties. However, young people in residential care typically present with risk-taking behaviour and mental health problems (Lyons, Obeid, & Cummings, 2015). They are amongst the most disrupted young people and residential care is often reserved for those whose behaviour has contributed to their experience of multiple placement breakdowns. Their experiences of ongoing change may compound feelings of rejection and increase their inability to trust adults and form meaningful relationships with adults and their peers. Such difficulties may also mean dissatisfaction with school and authority and concomitant challenges in maintaining education more generally.

Behaviour management may take time to be effective. When young people with traumatic backgrounds live together a group norm of testing out new and more 'outrageous' behaviours can develop unless purposefully managed. Peer pressure from within the group may lead young people to engage in more dangerous activities than they otherwise would.

Involvement of police in residential units is highly undesirable and can add to a young person's difficulties by creating (or adding to) a criminal record whilst not getting the young person any help with behaviour. Further involvement with the juvenile justice system can be highly damaging to young people, physically and psychologically, and little positive assistance is generally achieved. Overuse of police to maintain behaviour is an important indicator that a residential unit is becoming dysfunctional.

Residential Care Must Meet the Developmental Needs of Young People

Residential care must have the capacity to case plan for each young person's education, health, and social and relationship skills. An important developmental task for young people during their time in residential care is active preparation for independent living, and residential care must lay down the groundwork for a successful transition. Current funding of units generally stops when young people turn 18 and offers little capacity to support the young person to financial independence.

Residential units must also be able to offer autonomy and help young people develop self-control, and this requires that young people actively experience participation in decision making. Details of the standards expected from residential care are clearly laid out in the NSW Child Safe Standards for Permanent Care (New South Wales Children's Guardian, 2015)

Given the level of trauma and disruption experienced by young people, one of the most important challenges for residential care is to support and enhance mental health and behaviour. Many of the factors described above (such as containing the disruptive behaviour of other residents) will contribute to improved mental health and behaviour management. However, specialised mental health assistance must be considered for individuals. Good quality residential care must maintain and improve mental health by providing stable and secure housing, offering good relationships and role models and maximising participation in decision making. For this reason, the debate on therapeutic care, how it is to be managed and funded, is to be welcomed.

Young people's close engagement in care planning and decisions in the residential environment is important throughout life in care, but is critical as young people move

to independent living. Young people leaving residential care may require a slow transition to independence and benefit from an 'open door' policy that allows them to come back and seek support should things not go to plan. Particularly important in care planning are issues of housing and career pathways, and, for young people with uncertain migration status, getting their status settled. Preparation for transition from care should also include active consideration of the potential role of birth families to contribute to the young person's life. As they become older, issues which previously limited contact may become less significant, for example, young people may be better able to prevent physical assault.

Conclusion

There are many reasons to 'hasten slowly' in developing therapeutic residential care – past experiences of poor residential care and incomplete research on outcomes need to be taken seriously. Whilst there is no doubt about the extensive psychological needs of many young people who have grown up in care, what evidence do we have that they can be kept safe and heal in this context? Those advocating therapeutic residential care need to realistically consider the Australian welfare sector's ability to meet young people's needs given their characteristics and their care histories. Our considerations require a focus on the long term. Given that residential care requires strong management in order to avoid contributing to the disruption of young people, can we guarantee quality care and sufficient resourcing now and in 10 years' time? Can residential care models be implemented in a manner that genuinely provides young people with the experience of permanency?

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