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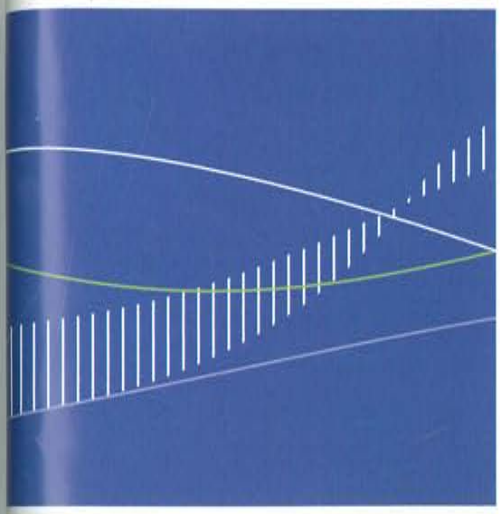

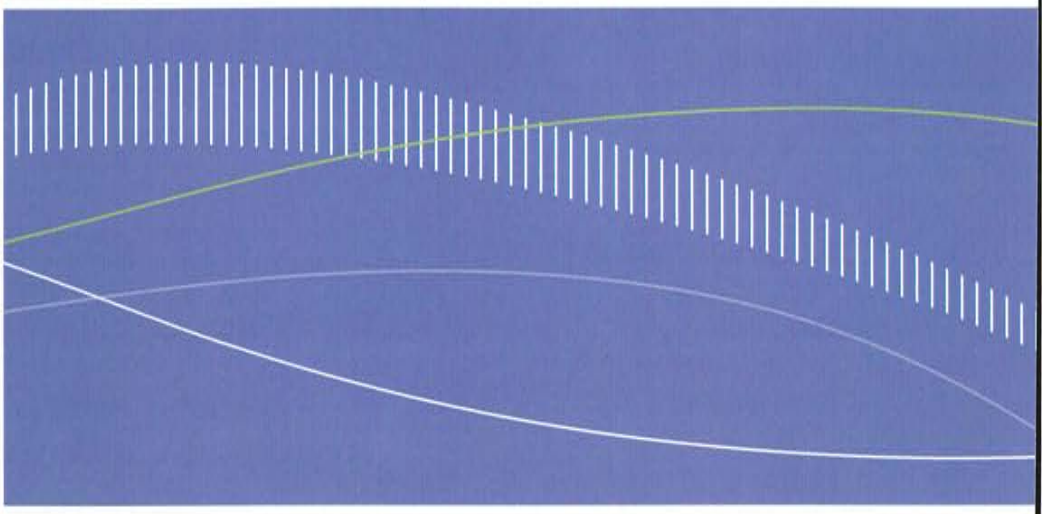

RESIDENTIAL CARE

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For more information on this report contact:

Coleen Clare
Chief Executive Officer
Centre for Excellence in Child and Family Welfare
5/50 Market Street Melbourne Victoria 3000
Australia

Telephone: +61 3 9614 1577
Fax: +61 3 9614 1774
Email: admin@cwav.asn.au

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Community Based Intake
Stability, Kinship Care and Permanency Planning
Leaving Care, A Model for Victoria

RESIDENTIAL CARE

Not the last resort:
An intervention to meet the needs of children and young people

FOREWARD

The passing of the Children, Youth and Families Act 2005 heralds significant changes to the child and family welfare system in Victoria. One of the key intentions of the new Act is to put the best interests of the child first in developing interventions for children, young people and their families.

In this context, the Centre for Excellence in Child and Family Welfare (the Centre) felt that it is very timely to look at the residential care system and identify some of its unique strengths as an intervention for vulnerable children and young people.

We know from the research and the practice wisdom of our members that residential care can be very appropriate for young people with attachment issues, who as a consequence of previous abuse and neglect are acting out, whose kinship and families links are unsafe or not strong enough to support them or who find the environment of foster care unsupportive.

Historically however, residential care has been seen as a last resort, a part of the service system that children and young people 'fail into' (Hillan 2006). Yet repeatedly young people and their carers report significant benefits from placement in residential care. For many it is the most useful short or long term intervention they will receive. Therefore it is no longer appropriate to conceptualise or talk about it as an intervention of last resort and it is no longer appropriate to identify young people in residential care as worthy only of a last resort intervention. For many of them such a label, coming on top of a history of abuse and neglect, is the last straw that breaks their already battered esteem and further weakens their resilience.

The purpose of this Monograph is to consolidate in one place the practice wisdom, theoretical underpinnings and program overviews that will enable us to work from the strengths of residential care to further improve it.

I hope this Monograph contributes to the ongoing development of residential care in Victoria and informs the implementation of the service improvement through the sharing of knowledge across the sector.

The Centre is very grateful to all its member organisations who participated in the Think Tank, and to Sherrie Coote of Sherrie Coote Consulting, for undertaking this work on behalf of the Centre.

Coleen Clare
Chief Executive Officer

TABLE OF CONTENTS

Introduction **6**

SECTION I **7**

THEORETICAL MODELS INFORMING RESIDENTIAL CARE PRACTICE **7**

1. Pain, Normality and the Struggle for Congruence (Anglin, J) **7**
1.1 Interactional Dynamics **8**
1.2 Impact of Key Interactional Dynamics on Children/Young People **8**
1.3 Flow of Congruence **9**
1.4 Carework **9**
1.5 Familial Verses Extra-Familial Living Environments **10**

2. The Sanctuary Model (Bloom, S.L.) **12**
2.1 SAGE and SELF **13**
2.2 Components of the Sanctuary Model **14**

3. Creating a Trauma-Sensitive Culture in Residential Care (Farragher, B and Yanosy, S) **16**

4. What Works in Residential Child Care (Clough, R, Bullock, R & Ward, A) **19**
4.1 Models of residential work with children **19**
4.2 Conditions for Effective Practice **21**

5. Reclaiming Residential Care (Hillan, L) **27**
5.1 Key Themes **27**

6. Dartington – i (The UK) **37**
6.1 Recording and Assessment (UK materials) **37**
6.2 Common Language **37**
6.3 Practice Tools **37**
6.4 Matching Needs and Services **37**
6.5 Paperwork **37**
6.6 Structure, Culture and Outcome **38**
6.7 Going Home **38**
6.8 Prediction **38**
6.9 Aggregating Data **38**

7. Victorian Department of Human Services (DHS) **39**
7.1 HoNOSCA Survey **39**
7.2 Strengths and Difficulties Questionnaire (SDQ) **40**
7.3 Listen to Children in Care - and their Dreams for the Future **40**

8. MacKillop Family Services Literature Review **42**
8.1 Introduction **42**
8.2 The Children and Young People in Residential Care **42**
8.3 Residential Care Trends and Options **44**
8.4 Service Implications **45**
8.5 Educational Disadvantage and Out-of-Home Care **46**
8.6 Reasons for Poor Educational Outcomes **47**
8.7 Policy, Ideology and the Education of Young People in Care **49**
8.8 Options and Innovation for Disadvantaged Young People **50**
8.9 Residential and Education Service Integration **52**

8.10 The Need for Educational Alternatives for High Needs Young People 52
8.11 Towards a Typology of Alternative Education Models 54
8.12 Conclusion 55

SECTION II 57

EXAMPLES OF PRACTICE WISDOM, EMERGING AND GOOD PRACTICE 57

1. Theoretical Frameworks Underpinning Residential Services 57
1.1 Residential Care Unit (Menzies) 57
1.2 Organisation Holistic Model of Practice (2005) (Westcare) 57
1.3 Adolescent Practice Framework for Out-of-Home Care (MacKillop Family Services) 58
1.4 Re-development of Residential Care (Anglicare Victoria) 60
1.5 Take Two (Berry Street Victoria) 63

2. Engagement of Young People in the Admission Process 65
2.1 Welcome Booklet to Clarkson Street – Adolescent House (Lisa Lodge) 65
2.2 Charter of Rights for Children in Care (Lisa Lodge) 65

3. Interventions and Behaviour Management Tools 66
3.1 Champions Mentoring Program (Lisa Lodge) 66
3.2 Residential Unit Admission Procedure and Behavioural Checklist (Lisa Lodge) 67
3.3 Young Person's Behaviour Plan (Lisa Lodge) 67
3.4 Crisis Plan Tool (Westcare) 67
3.5 Sages Cottage Farm (Menzies) 68
3.6 Animal Assisted Therapy (AAT) and Creative Arts Therapy (Menzies) 68
3.7 Aggression Replacement Training (ART) (Menzies) 69
3.8 Going Places, Creating Memories Program (Westcare) 70
3.9 Creating Dreams Project (Westcare) 71
3.10 Journeys Program (MacKillop Family Services) 71

4. Case Management Practice 73
4.1 Looking After Children (LAC) 73
4.2 Intensive Case Management Services (Central Hume/Berry Street Vic/Westcare) 73
4.3 Health Team (Berry Street Victoria) 74
4.4 Practice Wisdom regarding Case Management (Various organisations) 75

5. On-Call and After Hours Support 75
5.1 Roving Support Team (Berry Street Victoria) 75

6. Family Involvement 77
6.1 Parent Support Group with Kids in Residential Care (MacKillop Family Services) 77
6.2 'My Family First' Group Program (Glastonbury Child & Family Services) 78
6.3 Family Reunification Unit (Glastonbury Child & Family Services) 78

7. Innovative and Culturally Responsive Practice 80
7.1 Aboriginal Liaison Worker (MacKillop Family Services) 80

8. Alternate Educational Services 82
8.1 WARPed – Work, Recreation and a 'little' bit of Education Program (Eastcare) 82
8.2 Education Program (Westcare) 82
8.3 Optimal Learning (Lisa Lodge) 84
8.4 BEST Centre (Berry Street Victoria) 84
8.5 Best @ The Shed (Berry Street Victoria) 84
8.6 VACCA Educational Support Program 84

8.7 Rice Education and Youth Services 86

9. Consumer Advocacy 88
9.1 CREATE Foundation 88

10. Post-Care Services 90
10.1 Investing for Success: (The Centre) 90
10.2 Leaving Care: A Model for Victoria (The Centre) 91
10.3 Coming of Age Guide – Independent Living Skills Training Manual (Various orgs) 92
10.4 Transitions from Care Project - Leaving Care Handbook (2004) (MacKillop FS) 93
10.5 Leaving Care Project (Berry Street Victoria) 94

11. Occupational Health and Safety Practice 95
11.1 The Centre/HSUA Safety Development Fund Project 95

12. Professional Training and Development 96
12.1 Residential Care Learning and Development Strategy (RCLDS) (The Centre) 96

13. Future Directions 99

14. Contacts 101

15. References and further reading 104

Introduction

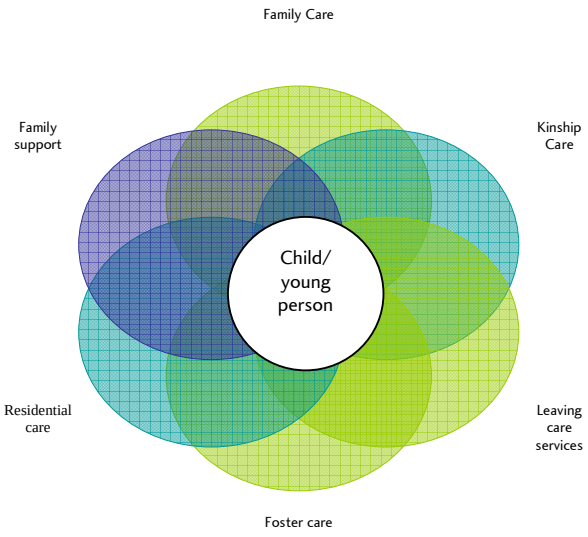
This Monograph grew out of a Think Tank on residential care convened by the Centre in April 2006 which brought together the providers of residential care to reflect on current practice, identify best and emerging practice and to flag future directions for residential care. Twenty two senior staff from across the sector attended the day which was facilitated by Sherrie Coote of Sherrie Coote Consulting.

The purpose of the day was to reflect on the future directions of residential care in the light of the systemic changes arising from the implementation of the new Children, Youth and Families Act 2005. The day was also designed to identify best practice, practice wisdom and emergent practice in relation to residential care.

This Monograph commences with an overview of information from Australian and international sources. This includes details of work in Canada, the United Kingdom, the United States, Queensland and Victoria. The purpose is to give an overview of a range of theoretical models for working with children and young people in residential care. Whilst it is not exhaustive it seeks to capture some of the best thinking about residential care at present. The reading list and references drawn from the papers reviewed, in particular *What Works in Residential Child Care A review of research evidence and practical considerations* (Clough, R., Bullock, R. and Ward. A. 2006) and the *MacKillop Family Services Literature Review*, undertaken by MacKillop Family Services as part of the redevelopment of the RICE Education Program are at the end of the Monograph.

The Monograph then goes on to describe a range of programs currently operating in Victoria, grouped according to their intervention type. The programs described have been identified by the sector as having both significant current merit and the scope for further development. The programs included are not exhaustive of good practice or practice wisdom, however they have been identified by senior practitioners as exemplars of good practice. It is hoped that by bringing them together in one document it will be possible for practitioners to reflect on both these programs and their own programs and identify ways of further enhancing outcomes for children young people and their families.

The final section of the paper is a collation of the thoughts from the Think Tank on emerging directions in residential care. This is provided as a starting point for planning the ongoing development of residential care into the valued and respected part of the service system that it deserves to be. Rather than being seen as the end of the line, the intention of this paper is to consolidate residential care as a valuable intervention for children and young people who are currently unable to live in other care environments. Residential care should be seen as one of a range of services that surround a young person in need of care, supporting them until they are able to take their place in the community as independent young adults.



SECTION I

THEORETICAL MODELS INFORMING RESIDENTIAL CARE PRACTICE

1. Pain, Normality and the Struggle for Congruence Reinterpreting Residential Care for Children and Youth (Anglin, J)

James Anglin is Professor and Director of the School of Child and Youth Care, University of Victoria, British Columbia, where he has been on faculty since 1979. He began his career as a front-line residential child and youth care worker and has held numerous policy and management positions in the residential care area. Dr Anglin has published extensively and presented papers and keynote addresses in more than twenty countries. Currently he is technical advisor to the Adolescent Health Unit at the World Health Organization, Senior Associate Editor for Child and Youth Care Forum, and serves on the editorial boards of Child and Youth Services, the Journal of Child and Youth Work and Reclaiming Youth at Risk.

Anglin conducted extensive research across the residential care services in North America, with the purpose of constructing a theoretical framework that would explain and account for well functioning residential facilities for young people that in turn could serve as a basis for improved practice, policy development, education and training, research and evaluation. He used a grounded theory approach (identification of core variables) to construct a theoretical model to understand residential care. Several variables emerged as vitally important to understanding group home life and group home work. The variable that emerged to be the most significant was the "congruence in services of the children's best interests." Residential services may demonstrate "congruence" or "incongruence" to varying degrees across its provision of services. Anglin's study[1] identified that each home studied was found to be in a "struggle for congruence" and what was found to be at the centre of most of the struggles was the intention to serve "the children's best interests." Other major competing interests included cost containment, worker preferences and maintaining control that impacted on serving the best interests of the child.

Anglin identified three dominant[2] and pervasive psychological processes related to the central problems in the "struggle for congruence in service of the children's best interests":

- *The extra-familial living environment*

The overall aim of the residential care program is the development of a home-like setting which is not attainable within an institutional facility and removes the emotional intimacy and intensity of a family environment. Residential care staff – whilst not replacing families, take on the functional aspects of parents as a component of their role. A fundamental tension is inherent in this form of care due to the extra-familial home dimension and management and staff not understanding this defining aspect of group home life.

- *Responding to Pain and Pain-Based Behaviour*

Responding to pain and pain-based behaviour is the primary challenge at the level of carework staff. However, there is a tendency to ignore the deep-seated and often long-standing pain carried by these youth. Anglin coined the term "pain-based behaviour" to describe "acting-out" behaviour and internalising processes such as "depression" which are often the result of triggering this internalised pain. An ongoing challenge in dealing with this pain in residential care is not to unnecessarily inflict secondary pain experiences on residents through punitive or controlling reactions from staff. This lack of awareness of pain-based behaviour is a major area of incongruence and makes acting in the best interests of the children very difficult.

[1] Anglin, J. Pain, Normality and the Struggle for Congruence. Page 52
[2] Ibid., pages 55-56

Treatment and healing is the central component to residential care – recognising that children/young people have had experiences of significant trauma, abuse and loss.
Training residential staff to understand the nature and scope of trauma-related behaviours and supporting them in learning how to respond to such behaviour appropriately, is central to a congruent, successful therapeutic residential program.

- *Developing a Sense of Normality*

The key element of developing a sense of normality[3] in a residential service is to ensure that despite the trauma and abuse and 'lack of normality' these children and young people have experienced, they still need to have 'normal' life experiences. The residential setting can provide a bridging experience and be influenced by the way staff respond to the young person's pain and pain-based behaviour in the extra-familial living environment.

1.1 Interactional Dynamics

From his research, Anglin identified the key ingredients of an effective residential care system to create a family environment, respond to trauma and abuse and develop a sense of normality:

- Listening and responding with respect.
- Communicating a framework for understanding.
- Building rapport and relationships.
- Establishing structure, routine and expectations.
- Inspiring commitment.
- Offering emotional and developmental support.
- Challenging thinking and action.
- Sharing power and decision-making.
- Respecting personal space and time.
- Discovering and uncovering potential.
- Providing resources.

These interactional dynamics provide a means for understanding and assessing the degree of "congruence" throughout the residential facility and its overall functioning. The degree to which a group home is functioning well or poorly can be examined by viewing these ingredients through the central theme: "congruence in service of the resident children's best interests". Congruence[4] refers to the degree to which all of the behaviours and activities of an individual (worker/manager), a group (a team), the home, the system of care have an overall sense of integrity or cohesiveness.

1.2 Impact of Key Interactional Dynamics on Children/Young People in Residential Placement

In order for a residential service to operate in even a "well-enough functioning" manner, the 11 interactional dynamics[5] needed to be present in a largely congruent manner at all and across levels of the organisation: extra-agency, managerial, supervisory, carework/team and (to at least to an ever increasing extent) youth and family.

1. *Listening and responding with respect*

Helps young people develop a sense of dignity, a sense of being valued as a person, and a sense of self worth.

[3] Ibid., page 56
[4] Ibid., page 65
[5] Ibid., pages 66-71

2. *Communicating a framework for understanding*
Helps young people develop a sense of meaning and a sense of rationality within daily life.

3. *Building support and relationships*
Helps young people develop a sense of belonging and connectedness with others.

4. *Establishing structure, routine and expectations*
Assists young people 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*
Ensures young people develop a sense of value, loyalty and continuity.

6. *Offering emotional development and support*
Assists young people develop a sense of caring and mastery.

7. *Challenging thinking and actions*
Assists young people develop a sense of potential and capacity.

8. *Sharing power and decision making*
Encourages young people to develop a sense of personal power and discernment.

9. *Respecting personal space and time*
Assists young people to develop a sense of independence.

10. *Discovering and uncovering the potential*
Assists young people develop a sense of hope and opportunity.

11. *Providing resources*
Assists young people develop a sense of gratitude and generosity.

1.3 Flow of Congruence

Anglin observed another phenomenon in the struggle for congruence, what he called the "flow of congruence"[6] which refers to the tendency for the philosophy and practice orientation of the residence/group home manager to permeate through the residential service and even into the experiences and ways of thinking of youth residents. Fortunately in his study, the flow of congruence observed occurred more often in positive ways than negative influences.

1.4 Carework

Anglin uses the interesting term "carework"[7] to describe the direct, hands-on work on the residential staff. Given the traumatic background of residents, the carework function has two purposes:
- a developmental purpose
- a therapeutic purpose.

He comments that the process of carework is complex and demanding, an important aspect of residential life but the literature consistently acknowledges that paradoxically, it is the least respected, valued and understood element of residential care.[8] Residential care is often viewed (by the public) as a punishment for young people rather than protection for young people who have been abused or neglected by their parents and their behaviours are the consequence of their exposure and

[6] Ibid., page 72
[7] Ibid., pages 97-98
[8] Ibid., page 97

experiences of the neglect and abuse. Carework has a significant role in the healing process and treatment of young people's trauma and distress.

1.5 Familial Verses Extra-Familial Living Environments

Seven characteristics[9] of group home environments were identified in Anglin's research (from discussions with young people and staff) differentiating the benefits and advantages of group home care as compared to more intimate, familial foster care for this population of young people living in group home settings :

1. Staff-youth relationships

Group homes should not strive to be surrogate families as children and young people already have a family. A group home may be a preferred setting for young people rather than foster care due to age, complexity of individual needs and past trauma. Younger children who have the ability to relate to a surrogate family may be more suitable for foster care placements.

2. Physical setting

In a well-functioning group home, a young person knows that staff will be able to accept more challenging behaviours and can offer a safer environment while they work out their problems compared to a foster home where it is more likely their behaviour will not be tolerated due to disrespecting someone's home and personal belongings resulting in emotional hurt and financial burden and possible placement breakdown.

3. Number of people in the household

Having more staff in a residential facility is preferred by some young people who cannot cope with the level of intimacy in a foster home. In a foster care setting there is greater pressure for the relationship to work as compared to a range of full/part-time and relief staff found in a residential setting. Young people in the study expressed appreciation of the caring relationships that came without the expectations of close or ongoing intimacy. Staff were "adult carers" within a family environment, not surrogate parents.

4. Time element (of carers on site)

Young people preferred longer staff shifts (three to four days straight) than 8 or 12 hour shifts. The residents were also cognisant that staff needed a break to refresh themselves if they were going to work effectively. Staff also favoured regular and frequent breaks given the demanding needs and behaviours of the residents.

5. Style of care

For young people suffering from the effects of trauma who had difficulty in controlling their "acting-out" or "pain-based behaviour," the less intimate and more youth-centred attention of staff members (compared to the intimacy of foster care) may make the difference between the experience of change and another failure experience.

6. Intensity of care/treatment

Well-functioning family group homes in the study were continually seeking to provide therapeutic care and consistency of structure and expectations with an intensity that is virtually impossible to maintain in a family or foster care setting. Many young people indicated they needed such intensity of interaction with staff for significant periods of time while they struggled with their problems, the pain and the associated anger that interfered with their relationships and at times their own safety.

7. Supervision of carers

In a foster care setting, parents are on their own except for visits from their supervising agency and usually offered less support in caring for youth with complex needs than residential facilities. Well-

[9] Ibid., pages 98-105

functioning group homes provided close and direct supervision (from supervisors usually seasoned and experienced) both in the moment and over time. Attentive and competent supervision was a core and essential element contributing to a well-functioning group home. Staff under stress can be relieved and given appropriate support and/or advice regarding management strategies. Supervision also offered protection against abusive or excessive reactions that can occur in a volatile and stressful environment.

Anglin concludes[10] that from the findings of his study, "group homes need to be appreciated for their strengths as extra-familial developmental and therapeutic environments and ought not be denigrated for not being "natural" or "real" families." He goes on to state that "a service that is not valued or that is considered always to be unsatisfactory or a second-rate option will inevitably deteriorate and will ultimately reflect these self-fulfilling expectations." His study provides insights and a theoretical framework in how to develop "well-functioning group homes (residential units) that offer an intense, supervised, staffed, structured, less emotionally charged and more consistently responsive environment for promoting the personal growth and development of youth who require intensive care and support."

[10] Ibid., page 105

2. The Sanctuary Model (Bloom, S.L.)

Dr Sandra Bloom developed the Sanctuary® Model, a trauma-informed model of residential treatment for children from a short-term, acute, inpatient psychiatric setting for adults who were traumatised as children. The Sanctuary® Model is a trauma-informed method for creating or changing an organisational culture in order to more effectively provide a cohesive context within which healing from psychological and social traumatic experience can be addressed. It is a whole system approach designed to facilitate the development of structures, processes and behaviours on the part of staff, children and the community-as-a-whole that can counteract the biological, affective, cognitive, social and existential wounds suffered by children in care[11]. Bloom reports that for most residential children in the US, there is a lack of clear, consistent, comprehensive and coherent model for delivering care that takes into account the impact of exposure to violence and other forms of traumatic experience of children in care. Treatment still focuses on one-to-one interventions that are limited in scope and there is commonly a lack of coordination and shared system of meaning between therapist, the child care staff and educational staff.

The Sanctuary® Model is a response that moves away from the focus of attention exclusively on the child's behaviour – or misbehaviour and instead focuses on the complexity of the child's dynamics and injuries that are often lost in the struggle to simply control the behaviour in residential care or at school. Staff often find the work difficult, frustrating and stressful; organisations are also under a variety of pressures such as economic performance, safety concerns and funding body requirements. Bloom comments that as a result, complex, parallel process interactions occur between traumatised clients, stressed staff, pressured organisations and hostile economic, political and social forces in the wider environment. Inadvertently, residential care programs can recreate the experiences that have proven toxic for the children in their care, as well as frustrate and demoralise staff and administrators in ways that can lead to worker burnout, turnover and secondary trauma.

The explicit assumption of the Sanctuary® Model[12] is that traumatised children cannot heal within traumatising organisations and that instead such organisations can make their problems worse. The goal of the Sanctuary Model is to facilitate the development of an organisational culture that can contain, manage and help transform the terrible life experiences that have moulded and often deformed the children in residential care.[13]

The Sanctuary® Model was originally developed in an inpatient setting for traumatised adults. The Model has since been adapted by residential treatment settings for children, domestic violence shelters, group homes, outpatient settings, substance abuse programs, parenting support programs and has been used in many settings as a method of organisational change.

The aims of the Sanctuary® Model guide an organisation in the development of a trauma-sensitive culture with seven dominant characteristics all of which serve goals related to trauma resolution and that model good relational and parenting skills:

[11] Bloom, S.L., The Sanctuary Model of Organisational Change for Children's Residential Treatment. Page 1
[12] www.sanctuaryweb.com. Summary information taken from the web page.
[13] Ibid., page 2

TRAUMA-SENSITIVE CULTURE[14]	
1. Culture of **Non-violence**	Helping to build safety skills and a commitment to higher goals.
2. Culture of **Emotional Intelligence**	Helping to teach affect management skills.
3. Culture of **Inquiry & Social Learning**	Helping to build cognitive skills.
4. Culture of **Shared Governance**	Helping to create civic skills of self-control, self-discipline, and administration of healthy authority.
5. Culture of **Open Communication**	Helping to overcoming barriers to healthy communication, reduce acting-out, enhance self-protective and self-correcting skills, and teach healthy boundaries.
6. Culture of **Social Responsibility**	Helping to rebuild social connection skills, establish healthy attachment relationships.
7. Culture of **Growth and Change**	Helping to restore hope, meaning and purpose.

2.1 SAGE and SELF

Why two acronyms? The model began using this conceptual framework with adults and liked the idea of adults becoming wiser - becoming SAGE's. It was then extended to work with children, and needed simpler concepts AND the idea of children developing a healthier sense of SELF was liked. SAGE and SELF represent the four non-linear, key areas of recovery that provide an organising framework for the complex problems presented by trauma survivors, by families with problems and by dysfunctional organisations.

S	SAFETY		S
A	Affect Management	Emotional Management	E
G	Grief	Loss	L
E	Emancipation	Future	F

SAGE and SELF offer:
- A way of organising complexity.
- A simple method for getting everyone on the same page.
- A dynamic and non-linear conceptual framework.
- A framework that is conceptually applicable to children, families, staff and organsiation.

The foundations of the Sanctuary® Model are multi-dimensional, grounded in principles of the therapeutic community and include:
- Biological/medical perspectives: Trauma-informed, evolutionary perspective.
- Relational/social: Social learning, attachment and the need for community.
- Educational: Emotional literacy, psycho-education.
- Political: Democratic processes, human rights.
- Philosophical/Ethical/Spiritual: Values-based, non-violent, visionary, explicit moral purpose, complexity theory.

The Sanctuary Model takes into account and respects individual differences between people while still recognising that group processes exist – both conscious and unconscious – whenever people come together to complete tasks.

[14] Source: www.sanctuaryweb.com. Information sourced from the web page.

Complex, parallel process interactions occur between traumatised clients, stressed staff, pressured organisations and hostile economic and social forces in the larger environment. As a result, our systems can inadvertently replicate the very experiences that have proven to be so toxic for the people we are supposed to help. Not only does this have a detrimental effect on clients, but it also frustrates and demoralises staff and administrators, a situation that can lead to worker burnout or secondary trauma with all its attendant problems. Ultimately, the inefficient or inadequate delivery of service and the toll this takes on workers, wastes money and resources. This vicious cycle also lends itself to a world view that the people receiving the services are the cause of the problem and that their situations are hopeless and they cannot really be helped. Parallel group processes can serve or can undermine the intentions and goals of the individuals within the group and the group-as-a-whole.

2.2 Components of the Sanctuary Model

A primary component of the Sanctuary® Model is the creation and maintenance of a non-violent, democratic, therapeutic community in which children/youth are empowered as key decision-makers to influence their own lives and their community. This democratic model of care focuses on two central expectations: *each member of the community must share responsibility for the well-being of residents and caregivers alike and there must be a system-wide commitment to non-violence*.

The building of a therapeutic community requires staff to share the same assumptions about the underlying treatment approach and to use a common language to refer to issues being addressed. The entire community of residents and staff must continuously define and renegotiate a shared set of values and beliefs. For this to occur, time must be devoted to building strong interdisciplinary teams and effective staff/resident community meetings.

The following components contribute to a Sanctuary® Model Toolkit:

- Training in trauma theory for all administrators, staff and support staff.
- Training in milieu management for all administrators, staff and support staff.
- Values clarification process – commitment to non-violence and democratic process.
- SAGE/SELF - training.
- Integration of Sanctuary/SAGE concepts into regular interactions.
- Treatment planning.
- Team meetings.
- Community meetings.
- System level policies and procedures.
- Trauma diagnosis and treatment planning for all clients with their involvement.
- Concrete behavioural goals within SAGE/SELF framework.
- Psycho-educational materials.
- Psycho-educational groups based on SAGE/SELF framework.
- Trauma-specific treatment.
- Continuing education materials for staff.
- On-going, interdisciplinary milieu management and case reviews.
- Regular individual/group consultation and supervision.
- Prevention of secondary trauma.
- Evaluation of outcomes.

Bloom highlights the impact of a trauma-sensitive culture[15]:

- Less violent and safer place for clients and staff.
- Greater understanding of the damaging impact of trauma and abuse on children, staff and the organisation.
- Less victim-blaming and less punitive and judgmental responses.

[15] Bloom, S.L., from a Powerpoint presentation 2005, resourced from www.sanctuaryweb.com

- Clearer and more consistent boundaries.
- Higher expectations and greater sense of responsibility.
- Improved ability to articulate goals and create strategies for change.
- Better understanding of re-enactment behaviours – staff and childrens.
- More democratic at all levels.
- Better staff morale and less turnover.
- More success with real and lasting change.

The Sanctuary Leadership Development Institute offers training and offers:

- Five-day intensive training of the leadership team.
- Core team development.
- 30-month consultation.
- Peer-review Sanctuary certification process.

3. Creating a Trauma-Sensitive Culture in Residential Care in a Therapeutic Community (Farragher, B., and Yanosy, S) [16] Andrus Children's Centre, New York

Brian Farragher, Chief Operating Officer at Andrus Children's Centre in New York provides an organisational perspective of the Centre's struggle to become a trauma-informed and trauma-sensitive treatment program.[17] About four years ago, the Centre employed Dr Bloom as a consultant to work with the organisation to implement a cultural change and institution of a trauma-focused and trauma-sensitive treatment environment.

His reflections of this cultural change journey include:

- *The Sanctuary Model (SM)*

This reshaped the entire residential program and made Andrus a better community for all its members. The first important lesson is that when you start to change things, it is hard to predict what you will learn and where you will end up.

- *The impact of trauma on children*

Children who have witnessed violence or have been victims of interpersonal violence often have difficulty in forming relationships; they can be hyper-vigilant or reactive; they often perceive the actions of others as threatening, unfair or malevolent; they become rigid and respond to situations and people with the same self-defeating responses over and over again; they stir up trouble and crises; they frequently feel wildly out of control, hopeless and helpless to do anything about these feelings; they often appear disconnected, cold, uncaring and unfeeling.

- *Reenactment*

It is easy for caregivers to see these children as bad, mean, sick or crazy in response to their troubling behaviour. What is often missed is that injured children repeatedly "reenact" yesterday's traumatic experiences with today's carers. Care staff who are inadequately trained, over worked and stressed get pulled into these reenactments, act out the assigned role at the risk of retraumatising children they want to help.

- *The impact of trauma on staff*

Working with traumatised children can take its toll on experienced clinicians, who are advised to seek training, supervision and balanced case loads and self-care. Residential care is often staffed by inexperienced, marginally trained, low-paid care staff who have no choice about how many traumatised children they work with, work long days and whose self-care strategies are limited. Staff in residential care services are exceedingly vulnerable to the effects of vicarious trauma given the intensity and duration of their day-to-day exposure. Also, staff have little understanding of the impact of trauma on the children they care for let alone understanding how these children impact them as caregivers. Staff engage in coercive practices to maintain control of the group of residents and are usually supervised by staff who have limited knowledge of trauma. Over time, staff become traumatised, increasingly less hopeful, more rigid and less creative, lose empathy, become overly controlling, coercive and sometimes abusive. These staff responses serve to affirm children's negative world view and at worst further injure and traumatise them.

- *The impact of trauma on the agency*

The organisation experiences stress and complex demands related to residential care often resulting in leaders in residential centres become extremely risk aversive. Organisations are operating in tight financial situations, political demands, located in neighborhoods that are not thrilled at having such troublesome neighbours plus coping with the impact of challenging children. The residential service becomes less about treatment and recovery but more about control and coercion. The organisation

[16] Farragher, B., and Yanosy, S., Creating a Trauma-Sensitive Culture in Residential Care in a Therapeutic Community: The International Journal for Therapeutic and Supportive Organisations, 2005.
[17] Ibid.

slowly becomes more concerned about self-preservation than about actually accomplishing its stated mission. It functions in a state of crisis – communication breaks down, decision-making becomes top down, people stop thinking through problems and teamwork disintegrates. Staff burnout and leave and new inexperienced staff begin. Children are at risk of further injury and trauma.

- *Sanctuary Model*

This allows organisations to reclaim their treatment focus and recommit to the mission of helping children recover from their injuries and trauma.

For Andrus, the Sanctuary Model was a vehicle for creating a trauma-sensitive culture and for building protective factors necessary for the staff and organisation as a whole to do this challenging work. Creating a trauma-sensitive culture involves a deep examination and transformation of agency dynamics and includes all community members, upper management, families, middle management, children, line staff as well as every department and function.

This change management strategy had five components[18]:

1. Integration

Creating a unified and healthy organisation where all members are active participants in decision-making and all accept responsibility for each other's well-being and safety. A multi-level, multi-disciplinary core team was established and met twice monthly with Dr Bloom for a year to discuss issues and learn about how trauma effects not only individuals, but entire organisations. The cross agency core team looked at their own department's strengths, shortcomings, styles of interactions and assumptions that had been driving current behaviours and functioning. This work resulted in the development of shared assumptions, beliefs and values that were common to the entire agency which fostered agency integration and participation. The core team trained staff in trauma theory to form the basis of a common language – the language of trauma.

Benefits of this common language (SELF) were:

- Language to describe the behaviours staff were seeing and a greater understanding of responses, led to improved communication between staff and children.
- Easier to talk about the problems and formulate solutions, rather than blame each other for bad outcomes or ignore them altogether.
- Opportunity to address loss and grief, rather than focus on the behaviour/s.
- Offers a level playing field and a common purpose of the focus of interventions.
- Encourages a focus on the future and encourages children to work towards change.

2. Understanding trauma

All staff participate in a six session training covering the basics of the psycho-biology of trauma, reenactment, the language of SELF and vicarious trauma. Training also incorporated how personal values and beliefs and staff's own experiences can impact on work; understanding of how working with traumatised children and families can be traumatising to staff; managing vicarious trauma and staff support. Children were taught about trauma and its impact and children were encouraged to teach their families what they had learnt about the impact of trauma. The language of trauma was also incorporated into family therapy sessions.

Assessment procedures were revised to focus on traumatic experiences (exposure to trauma and trauma symptoms) rather than problem behaviours. This creates a greater openness around trauma and allows staff to have some insights into a child's experience, anticipate triggers and responses for children.

[18] Ibid., pages 9 - 16

3. Avoiding reenactment

Train staff to understand the traumatised person's tendency to reenact the trauma and to reenact traumatic relationships and how not to respond punitively or overly permissively to a child's provocative behaviour and become engaged in the traumatic reenactment. This understanding of traumatic reenactment allowed staff to recognise when they were being pulled into a child's reenactment, recognised such behaviours as part of a normal response to trauma which required specific and empathic intervention. It also allowed staff to depersonalise the negative behaviours of children and use more planned and less reactive forms of interventions. This training was supported by the development of teamwork and regular meeting times to plan and address emerging issues/safety and support for each other in the intense residential environment. It was important for the team to view itself as the treatment delivery system rather than one or two individuals doing all the work. A constructive crisis resolution approach (whereby staff step in where they see a staff member working outside the boundaries and shared beliefs and values) is utilised to avert trauma and crisis creating a safer environment with reduced reliance on physical restraint. Skilled supervision was another important factor to support staff development.

4. Fighting rigidity

As mentioned earlier, a damaging effect of trauma is rigidity and inability to see things from a new or different perspective. In a trauma-driven organisation, responses are rote and reactive, planning is minimal. In a trauma-sensitive culture, responses to problems are explored through a more democratic system of shared decision-making. This democratic style confronts hierarchical models of decision-making that usually do not involve staff at the client coal face. Instead the decision-making process is creative, everyone is free to offer suggestions; at times it feels risky and unfamiliar to members of the community. However, working democratically can take more time and in times of crisis where quick decisions are required to ensure safety, the fall back position of upper management/authority is available. Rigidity may also define treatment definitions and who can deliver treatment. In a trauma-sensitive culture, all members of the team are providing treatment by influencing and creating the therapeutic milieu. Therapy includes new group and individual therapy models.

5. Embracing non-violence

Children who live in residential care have experienced violence from those who were supposed to care for and protect them. In many residential settings, this violence is unwittingly reenacted over and over again by well-intentioned, but misinformed staff. In a trauma-sensitive culture, staff and children use their understanding of trauma and its impact to make conscious choices to avoid violence through safety planning. A formal meeting between staff and the child can document triggers to aggression, staff responses that might exacerbate aggression and lead to more appropriate interventions and a decrease in violent and aggressive behaviour. A child must have a plan of action, outlining steps to be taken to avoid violence when triggered. Embracing non-violence also means embracing shared power and decision-making and reducing the abuse of power and creating opportunities for open dialogue throughout the organisation to avoid a phenomenon known as collective disturbance, an unresolved, unspoken conflict. Collective disturbances can manifest in excessive call-outs, lack of communication between staff, inability to make decisions, errors in techniques, unwillingness to solve problems and a sense that something bad is going to happen. Recognising what drives a collective response of the staff and children allows for intervention and resolution. It is important to learn from incidents of violence and utilise them as learning and teaching tools rather than punitive and blaming responses. Mandatory team reviews or red flag reviews are required for incidents of violence and physical restraint. The review is used to discuss alternative or proactive responses for the future, as well as the team and child meeting to brief the incident and revise the safety plan.

Farragher concludes by commenting that the Sanctuary Model provided Andrus with a model not just to help "children recover" but also a model for "organisational recovery" that helped overcome the impact that stress and trauma can have on individuals, staff and organisations providing residential care services.

4. What Works in Residential Child Care
A review of research evidence and practical considerations
(Clough, R., Bullock, R. and Ward. A.)

This review was the first stage of a larger review of residential services undertaken by the authors for the National Assembly for Wales followed up by the second stage that considered the implications for practice in Wales.[19] The National Centre for Excellence in Residential Child Care has published the report which is available on its website.[20]

A comprehensive summary of the review outlines the research evidence identifying significant elements to put in place a successful strategy for residential child care. The review identifies that effective residential child care can be achieved with good knowledge, appropriate processes and best practice. It emphasises the importance of correctly assessing the needs of young people and matching these to placements. Importantly the review describes what helps residential child care to be successful, focusing not only on the processes within settings but what needs to be provided externally to support success.

The authors argue that too much of what has taken place (in residential care and foster care) has been the consequence of individual beliefs that are not necessarily founded on evidence; and further, there has been too little research to know what is effective. Also, children/youth who reside in residential care are likely to face pervasive problems that have not been easy to manage in other settings. A summary of the key findings follows.

4.1 Models of residential work with children

There are many models[21] and schools of thought surrounding residential care for children. The review identified eight approaches.

1. Procedural approaches
This approach tends to address the residential care function as a logistical or procedural task and gives guidance and advice as to how things should be done. This approach is devoid of clearly articulated theory and publications of this kind often form the basis of short courses or training days for residential staff on specific themes, telling staff what to do without understanding why they are doing it.

2. Psycho-social theory
At the other end of the spectrum there is a range of theoretical material drawing on the psycho-social perspective, combining a psychological understanding of the experience of care from the view of the child, family and carers with a social understanding of the context within which these relationships are provided. The following therapeutic perspectives were noted as approaches in this model:

- Psychodynamic and therapeutic.
- Therapeutic care versus ordinary mainstream care.
- Attachment theory.
- Other approaches to emotional need.

3. Systemic approaches
The systemic approach uses an open systems model that explores the connections between task and method, input and output. The approach also considers the impact and demands of the wider society on residential care settings and factors that may impinge on staff's ability to engage with the

[19] www.childrenfirst.wales.gov.uk/content/foster-res-care-review-e.pdf and www.childrenfirst.wales.gov.uk/contnet/foster-res-care-review-stage-2-e.pdf
[20] What Works in Residential Child Care. A review of research evidence and practical considerations available from the National Centre for Excellence in Residential Child Care. Download from www.ncb.org.uk/ncercc
[21] Ibid., page 31 - 38

emotional demands of the work. The systemic approach offers a useful framework for managers and staff when exploring the congruence of aims and methods in practice.

4. The use of groups and groupings

A central theme in residential care is that young people and staff are living and working in groups which require considerable skill and understanding in both formal and informal groupwork on the part of the carers. Groups of residents are increasingly viewed as offering risk rather than opportunity for children. Also, the policy towards smaller and smaller homes of one or two children means the group element of care has little relevance.

5. Focus on family inclusion

The vital question of children's links with their families has been quite under-represented in the residential child care literature until recently, a gap which has probably both reflected and contributed to the relative lack of attention given to this area in much earlier residential practice. Ainsworth[22] (1997) proposed a model of family-centred group care for children. Hill[23] (2000) argues for a more inclusive conceptualisation of the residential task aiming to preserve and wherever possible, to strengthen connections with their birth parents and family members. This model will work well for the majority of children but not for all. Hill (2000) and Sinclair and Gibbs[24] (1998) argue that for a minority of children family contact may be problematic and in some cases dangerous, especially where there is a risk of continuing abuse. In these situations, the task for residential care staff is not one of facilitating contact but more one of helping children to understand and recover from what has happened to them and learning to live with little or no contact.

Another issue that faces many children is their rapidly changing family of origin circumstances and/or multiple moves through several substitute families before entering residential care thus the question of family contact is further complicated. Here the challenge is one of enabling the child to make sense of and maintain (sometimes selective) contact with the extensive network of contacts – different generation of their families of origin, siblings, and former foster families rather than one original parental home. The task of inclusion is challenged by the acknowledgement and understanding of earlier trauma and continuing risk, rather than active contact. The concept of working with the "family in mind" may mean very different things for different children.

6. Meeting socio-political concerns

This theoretical approach takes the empowerment of young people as the central theme. The purpose of the residential unit is clear and the small unit is an integral part of the wider child care system, itself based on an ethos of support and prevention. The connection between the extent residential staff themselves feel informed and empowered (especially in relation to decision-making about the children) and their ability in turn to provide empowering care to young people is therapeutic.

7. Ensuring a positive role in welfare systems

The focus of this approach is the interaction between the care career of the individual client and the group living system in the home, exploring structures, cultures and sub-cultures within the organisations.

8. Ensuring ethical standards

This model is aimed at preventing abuse and neglect and promoting general welfare in institutions. The authors conclude that there is no single theory of child behaviour or residential practice that provides all the answers and the range should be considered complementary.

[22] Ainsworth in What Works in Residential Care. page 35

[23] Hill in What Works in Residential Care. page 35

[24] Sinclair and Gibbs, What Works in Residential Care. page 36

4.2 Conditions for Effective Practice

The research identified seven aspects that had an impact on achieving optimal outcomes for children and families using residential care, as follows:

4.2.1 The culture of residential establishments

The review identified culture or ethos as an important condition for effecting residential care practice. Cultures have been shown by research to be important because they directly affect the behaviour of children and staff, not just in terms of conformity or deviance, but also in shaping attitudes. Several large-scale empirical studies that researched what contributes to a positive culture in residential care provide information to help understand better how residential care establishments work:

1. Working in Children's Homes: Challenges and complexities (Whitaker, Archer and Hicks, 1998).
2. Children's Homes: A study in diversity (Sinclair and Gibbs, 1998).
3. Making Residential Care Work: Structures and cultures in children's homes (Brown and others 1998).

The first takes a relatively unusual starting point of the experience of staff; the second analyses the factors that predict optimal outcomes, and the third looks at the relationship between staff and cultures, to unravel precisely what causes what.[25]

1. The Working in Children's Home Study

This study identified key influences[26] that impacted on the development of distinctive cultures which were influenced by the specific circumstances that staff faced. Key influences were:

- Rate of turnover of the young people.
- Proportion of emergency placements.
- Mix of young people.
- Number of young people not in school.
- Stability of membership in the staff group.
- Composition of both young people and staff with respect to ethnicity and gender.
- Feelings of security among staff within their own organisation.
- Presence or absence of conflict with managers.
- Level of morale.

2. Children's Homes: A study in diversity

The second book[27] explored variations in the immediate and long-term outcomes of the 48 residential homes studied in order to explain the variation in outcomes in terms of the characteristics of residents, structural features of the homes and the regimes adopted. It found that the background circumstances of children did not explain the wide variations in such outcomes as young people's offending behaviour or absconding. Difficult social environments in the residential homes were not related to previous difficult behaviour by residents or levels of staff training.

Young people appreciated homes:

- If they were not bullied, sexually harassed or led into trouble.
- If staff listened, the regime was benign and other children/youth friendly.
- If they showed some tangible improvement, such as education.

[25] Ibid., page 39-40
[26] Ibid., page 40
[27] Ibid., page 41-2

Most young people wanted contact with their families but not necessarily to live with them.

Sinclair and Gibbs found that residential homes did best if:
- They were small.
- The head of the home felt his/her role was clear, mutually compatible, not disturbed by reorganisation and that he/she had autonomy.
- Staff agreed on how the residential home should be run.

Also, the study concluded that the connection between regime and outcomes for children was that young people adjusted better socially if the head of the home had a clear idea of the ways in which the aims were achieved and staff turnover was not high.

Clough et al advocate[28] the following policy implications informed by this research:

- Children's homes should be kept small.
- Heads should be appointed only if they have a clear philosophy, agree with management on how the home should be run, are sensitive to the needs and wishes of residents and can unite the staff group.
- Contact between children and families should be encouraged while acknowledging that many residents do not want to live at home.
- High staff to child ratios and high levels of staff qualification are not sufficient conditions for successful work in residential settings.
- The work complementing residential care is important; emphasis might be put on adequate preventive work before admission; an ability to handle discharge at the resident's own pace and providing adequate aftercare.

3. Making Residential Care Work: Structure and Culture in Children's Homes

The third book[29] details the relationship between the structure of the homes and the staff and child/youth cultures within them. The authors argue that residential homes pursue three different types of goals:

- Societal - those implied by law or expectation.
- Formal - the representation of societal goals in local management practice.
- Belief - reflect the underlying values of managers and staff.

The relationship between these three goals forms the basis of structure of the residential home. If goals are out of balance or the relationship is contradictory, no amount of work on staff and child cultures will improve the situation. Structures are seen to influence staff cultures, which, in turn, influence child cultures.

4.2.2 Quality of relationships between children and carers

The quality of relationships between children and carers is a key factor in successful residential care practice. Clough's[30] research outlines factors that he contends are intrinsic to resident-centred practice:

- The starting point is an attempt to understand the resident: this is an active search.
- The daily life within the home is built from an attempt to produce systems that best match resident's wants and needs.

[28] Ibid., page 41-42
[29] Ibid., page 43-44
[30] Clough in What Works in Residential Child Care. page 45

- There is time within the daily routine to listen to individual residents.
- Residents are involved in negotiations about the life of the establishment.
- Staff worry about residents: they are concerned for residents, hold on to their interests and continue to think about what works best for them, even when they are not with residents.
- Residents must feel that they are the centre of the life of the home that their interests and well-being matter to staff.
- The key to good experience for the residents is that they feel they matter, that they are cared for and cared about.
- In effect, the experience of the resident should be at the heart of practice.

Further, Whitaker, Archer and Hicks[31] state that good practice includes:

- Being ready to listen, both to the evidently momentous and to the apparently mundane.
- Being sensitive to the young person's readiness, or not, to talk and to share feelings and experiences.
- Combining non-verbal symbolic forms of caring with verbal, explicit ones.
- Noticing good or admirable behaviour and crediting the young person for it.
- Marking special occasions in the young person's life with a celebration.

Berridge's[32] research on characterising good relationships between staff and young people indicates the most effective staff in this respect:

- Are informal in approach, easy to talk to.
- Respect young people, listen to what they say, try to understand and not lecture them.
- Are frank and sometimes challenging, rather than pushy and nagging.
- Are available, punctual and reliable.
- Keep confidences.
- Do practical things to help.
- Keep their promises.

The quality of relationships between carers and children/young people is fundamental to the quality of the residential environment which in turn nurtures and influences children's responsiveness to interventions and outcomes.

4.2.3 Staffing and training

- Impact of qualification

- The employment of qualified staff does not predict better outcomes for children: (Sinclair and Gibbs, 1998)[33] however it is clear that the staff world is an important factor in successful work.
- It may be that a certain level of training is essential for good outcomes and that some other staff factors such as confidence, morale, culture and leadership are more influential than training.
- Training is a necessity, but not on its own a sufficient condition for good practice:
  - training courses need to be appropriate to the residential care task
  - staff need to put their training into effect.
- Training should be informed by both theory and what actually works in practice.

- The staff worlds

Keeping staff is as much about investment in the young people as in the staff themselves. Keeping staff is influenced by the following[34]:

[31] Whitaker, Archer and Hicks in What Works in Residential Child Care. page 45
[32] Berridge in What Works in Residential Child Care. page 46
[33] Sinclair and Gibbs in What Works in Residential Child Care. page 48

- Motivational factors such as team work, children's progress, knowing there is support available and pride in work.
- Clear guidance and information for staff to carry out their work.
- Handovers are important.
- Internal management being aware of what is happening in the residential home and external management to acknowledge the experience of staff who work directly with young people.
- Being valued for their strengths.
- Being supported in the areas of their work that they found difficult.
- Management committed to adequate resource allocation, progress of children/young people and participation in education.
- Training on specific issues and access to ongoing training.

- Professional support and development

Professional development and support is paramount if staff are to be able to give their best, especially given the population of young people in residence, particularly the high incidence of disturbed behaviour and mental health problems. In addition to the general positive impact of effective leadership, mechanisms for staff support should include:

- Team meetings – importance of access that staff have to decision-making mechanisms, communication and information etc giving staff the "power to care" for the young people.
- Supervision – quality and relevance of the content important, rather than standardisation.
- Consultancy.
- Training and professional qualification.

- Training for management

Research evidence is clear as to the positive influence on all aspects of the care experience of clear, knowledgeable and sensitive leadership. There are few opportunities in the area of professional training for managers in residential care, an area that needs to be developed.

4.2.4 Leadership

The review highlights the importance of leadership and its influence to successful outcomes for both young people and staff. Managers of residential homes are leaders in the sense that they have to supervise and develop a staff team offering therapeutic work with children, young people and their families.

The leadership role[35] is wide in its role dimensions:

- Supporting and developing staff and ability to influence practice.
- Being sensitive to the needs of individual children whilst setting boundaries and controls for the group.
- Sustain the work of the unit through tough times.
- Develop effective strategy/ies for handling children's behaviour which increases staff morale and consistent management of children/young people.
- Management of placements and decisions.
- Line management responsibilities for the residential home.
- Managing and developing staff; monitoring and controlling the service.
- Managing stakeholders involved in the service.

[34] Mainey in What Works in Residential Child Care. page 53
[35] Ibid., pages 56-58

4.2.5 Listening to children

Many texts on residential care place strong emphasis on the importance of good quality experience in daily life, but there has been relatively little in the details of how this should be provided, or at least in a form accessible to practitioners or how the experience relates to the wishes of resident children. Some approach[36] this theme from the perspective of management and control of behaviour, while others acknowledge that it is often responses to the everyday challenges of residential care that staff help children to feel a sense of being understood and valued and that some of the most therapeutic opportunities arise from this context. The more positive cultures tend to be the ones in which staff are more considered, constructive and consistent in their responses.

4.2.6 Size of home

The issue of the optimal size of a residential home is an important one and widely divergent views are held in regard to the size of the home. Gibbs and Sinclair's(1998)[37] study leads to a clear statement that on the whole, it is better to keep the size of children's homes small as better outcomes were achieved. Chipenda-Danshokho et al[38] (2003) argue that a model that considers size in the context of institutional aims and structures is a more fruitful approach to understanding the significance of size in service development.

Further small homes are:

- Costly to operate.
- Emulate some characteristics of foster care without continuity of care.
- Offer a greater potential for children to disrupt the stability of the residential home due to his/her behaviour.
- Deny the potential for children to be supportive to others in groups.

4.2.7 Information and sharing

The review highlighted the need for improved recording and sharing of information[39] about children looked after and their families:

- Better outcomes were achieved if information was properly communicated to all involved.
- Information could be used to predict outcomes in all areas of the child's life – more realistic expectations about the future as well as tailor interventions to the specific needs of each child.
- Information should ensure a workable fit between child/ren placed in the same setting.
- Information is aggregated to inform policy, practice and training developments.

4.2.8 Conclusions: What Works in Residential Practice

At the practice level, good practice of effective residential care incorporates[40]:

- Appropriate contact with family members.
- Involvement of children and, as appropriate, parents in decisions about their lives.
- Children being treated with respect.
- Children having the same access to education, health, employment and leisure as their peers.
- Children having access to special services they may need.

[36] Ibid., page 60
[37] Sinclair and Gibbs in Works in Residential Child Care. page 61
[38] Chipenda-Danshokho et al in Works in Residential Child Care. page 61
[39] Ibid., pages 61-62
[40] Ibid., page 63

- A reduction in the aspects of behaviour that are known to be poor indicators for a child's development.
- Children being supported on leaving care both in practical skills and in coping with potential loneliness and insecurity.

Residential care staff reported on what helped them do their jobs properly[41]:

- Being valued for their strengths.
- Being supported in areas of their work that they found difficult.
- Good, regular supervision that is recorded and action taken when required.
- Realistic caseloads.
- High-quality ongoing training and other resources, such as access to a library.
- Contact with good practice initiative by other agencies.

From this review of What Works in Residential Child Care, the authors comment that we know more about the conditions necessary to fashion effective residential services than achieving effective outcomes for children in care. The research seems more certain about what is harmful than what is enriching to children in care (instability and poor attachments recur as factors likely to impair children's development).

In summary, conditions[42] necessary for effective residential services are:

- Knowledge about the needs of all disadvantaged children.
- Sound audit and assessment information and materials to gather and analyse it.
- The need to take a holistic and longitudinal view of children and families.
- The provision of a continuum of services.
- Clear perceptions of service avenues in response to different needs.
- Clear thresholds that allow children to follow different care careers.
- A well managed and supported process.
- (most important of all) The application of interventions that produce optimal outcomes for children and families.

[41] Morris in What Works in Residential Child Care. page 64
[42] Ibid., page 87

5. Reclaiming Residential Care
A Positive Choice for Children and Young People in Care (Hillan L)

Lisa Hillan's Churchill Fellow Report,[43] Reclaiming Residential Care – A Positive Choice for Children and Young People in Care reports on the 29 organisations (residential services, peak bodies, research institutions, universities and government children's services, individuals and young people in care) she studied on her Churchill Fellowship. Her report provides a comprehensive international overview of issues and challenges facing residential care service providers which are relevant to the Australian context.

Her report reflects on the different contexts visited and identified 14 key themes:

- The place of residential care.
- Environment and space.
- Assessment.
- Family work.
- Relationships/attachment.
- Trauma.
- Mental health of young people.
- Service model development in mental health.
- 17-18 year old young people staffing.
- Secure care – issues and views.
- Restraint.
- Staffing.
- Training and support.
- Evaluation.

5.1 Key Themes

5.1.1 The Place of Residential Care

Residential care services worldwide have experienced significant changes and there are varying opinions on the place of residential care in the service system from having "no place to some level of residential care to provide quality environments to meet a variety of needs of children and young people."[44] Residential care tends to offer a restricted environment for children with challenging behaviours, histories of neglect, trauma as well as multiple placement disruptions and failures.

Hillan comments that we need to better define what we mean by "residential care" and to identify the essential elements that residential care should incorporate. Also, there are often low ambitions for residential care, with a limited sense of what people think residential care can achieve.

A number of experts[45] view residential care offering:

- An option to be considered positively and not seen as a last resort – the range of care options are a range or continuum with different options appropriate for different circumstances; the continuum should not be viewed as a hierarchy, with an automatic preference of one form over another without regard for the individual circumstances.
- A focus on therapeutic care.
- A positive choice for children and young people; not a destination but a transitional service of one to two years of intense work to assist young people.

[43] Hillan. L., Churchill Fellow Report. Reclaiming Residential Care – A Positive Choice for Children and Young People in Care. 2006
[44] Ibid., page 21
[45] Ibid., page 22-23

Residential care should not be seen as a last resort as this communicates a grossly unfair message to young people. Hillan[46] recommends that residential care does have a place and should be:

- Viewed as a positive option for young people in meeting their needs; out-of-home service systems need to define the types of residential care required and develop a system of residential care options that match the needs of children and young people within a range of out-of-home care and support options.
- Children and young people entering residential care should have their needs identified to match the level of intensity of the service they require; available options should exist on the continuum of services that do not place them unnecessarily in services that are either over-restrictive or under capacity to meet their needs.

5.1.2 Assessment

Hillan commented that most therapeutic programs overseas had access to psychologists and other consultancy services including therapeutic teams that assisted care staff in their capacity to make sense of young people's behaviour and design an appropriate intervention. This ensured the care environment was one of therapy and change rather than of containment.

A Canadian[47] residential program had a care plan consultancy team that provided a skilled practitioner to assist a care team in their continued planning and implementation of the assessment. Other advantages of the external point of reference supported an often stressed and overtaxed system to keep focus on a plan for a young person; as well as extra support to the system to provide a quality of care that was born out of research, evaluation and experience.

Having good assessment tools, rigorous thinking and planning about the needs of children and young people, using assessments to design individualised care plans, plus an ability to map progress, defined those programs in her study that were succeeding in affecting change and providing high quality care.

Hillan[48] recommends:

- That young people entering residential care should have basic psychological assessments undertaken including an assessment of their learning needs to ensure that an adequate care plan and intervention is designed to meet children and young people's needs.
- Processes are in place to regularly review assessments ensuring staff are using the information in ongoing care.
- Residential care systems have access to therapy and therapeutic consultancy to assist staff to better plan interventions and assist children and young people develop the skills to allow them a better life within our society.

5.1.3 Family Work

Hillan's study identified that residential care services were rarely working with the family system, even though services quoted statistics that up to 80% of youth returned home to their family on exiting care. This was due to placements being away from family and local community, but generally she found that if therapeutic work was done on family of origin issues, it was work with youth in isolation from their parent/s. However, Sycamore in Scotland[49] overcame the distance of families challenge by providing two flats for families (attached to the residential care program) to stay and children/youth could stay with their visiting families; staff had opportunities to work with families as well.

[46] Ibid., page 24
[47] Ibid., page 30
[48] Ibid., page 30
[49] Ibid., page 31

A number of other programs she visited addressed family work by:

- Life diary/story work[50] with children and young people – life story work included contact with parents, siblings, aunts, uncles, grandparents, neighbours, foster carers, courts, police, teachers, social workers. Comprehensive interviews and searching for materials assisted children and young people making sense of their story and connections with lost people in their lives and to also rebuild connections with family.
- A Canadian[51] program employed a family therapist/counselor to work with each young person on family of origin issues, conduct family group work and group care meetings for young people.
- The importance of supporting children and young people to make sense of their family of origin and the painful reality of family issues – the concept of "family in mind" means different things for different children/young people depending on their circumstances of abuse and neglect and their safety.

Hillan commented that often work with the family was divorced from residential services due to over worked case workers, limited time, or limited skills in family work. This lack of resolution of family issues contributed to a fragmented service and failure to treat past trauma and family of origin issues that lead to placement. She goes on to hypothesise 'if family work was a greater component of residential care whether shorter stays would be an outcome?'

She recommends[52]:

- Family work/family therapy be incorporated into residential care models to ensure that the whole needs of children and young people are met and that children and young people are enabled to reconnect with family and kinship systems important to them on leaving care.

5.1.4 Relationships/Attachment in Residential Placements

All services Hillan visited spoke of the central needs of children and young people having good quality relationships with staff - quality relationships with young people made the difference to outcomes.

She commented that it is clear from the research that the best experiences of residential care are those where young people have caring relationships. She quotes[53] Berridge's research (2002) on measuring successful residential care according to the interaction between young people and the adults - young people routinely used terms that included empathy, approachability, persistence, willingness to listen and reliability.

The challenge is how to produce a good quality relationship between children, young people and carers? This is further challenged by the fact that residential workers are trying to build relationships with children and young people whose prior relationships have been characterised by distrust, pain and lack of care. Hillan[54] offers some insights to building and maintaining relationships with young people:

- A key worker model, identifying one worker who has the primary responsibility for building a relationship with young people and ensuring that their needs were met within the program; to advocate for the young person's well-being and interests at team meetings.
- The key worker model is essential to develop new patterns and experiences as valuable and likeable regardless of their behaviour; young people often experience difficulty in breaking past

[50] Ibid., page 32
[51] Ibid., page 31
[52] Ibid., page 32
[53] Berridge 2000 in Hillan. L. page 34
[54] Ibid., page 34-37

patterns of their inability to establish relationships or feelings of not worth being cared for due to past family experiences and multiple placements prior to entering the residential program.

- Staff need support in understanding how to build relationships, how to build investment with children and young people and to focus on managing relationships with self and others in the highly charged emotional environment of residential care. (For example, the Sanctuary Model at the Andrus Children's Centre through daily routines/environment provides opportunities for children/young people to learn affect regulation but also develop a sense of relationship with staff and residents. Community meetings are also held at the beginning of each day allowing children and young people and staff to identify personal goals for the day and to discuss how they were feeling).

- The issue of relationships being disrupted by the system - relationships change with placement; limited capacity to maintain established relationships to transition to new environments, including home, foster care or independent living need to be addressed.

To overcome the discontinuity of relationships and attachment issues in residential care, Hillan[55] recommends:

- Models are developed in residential care that make use of the relationships established with children and young people and to use these relationships thoughtfully to assist young people transition to new care environments.

- Children and young people are enabled to make use of the residential care relationships they have established for a period of time post the residential care experience to ensure that they have a sense of connectedness and value.

5.1.5 Trauma

The issue of trauma (coupled with multiple placements and past abuse and neglect) was a key issue highlighted in Hillan's visits to international residential organisations. She comments however, that the philosophical understanding of trauma and its impact was lacking in residential care environments. Trauma of any kind was often neglected when thinking of children and young people's behaviour and work with them to assist them deal with the impact.

Anglin[56] argues (2002 pg 55) "responding to pain and pain based behaviour is the primary challenge for carework staff….Perhaps more than any other dimension the ongoing challenge of dealing with such primary pain without unnecessarily inflicting secondary pain experiences on the residents through punitive or controlling reactions can be seen to be the central problem for the carework staff."

Hillan found that most programs visited continued to struggle to find the balance between addressing behaviour and treating trauma. Many programs worked daily to address these issues; holding a trauma framework does not negate addressing behaviour either.

She cites the Sanctuary Model of care at the Andrus Children's Centre[57] as an example of using a trauma based framework in the context of both their school and residential program. A social worker is placed in each residential care unit who assisted residential care staff make sense of behaviour and address the needs of children whilst assisting children and young people to change behaviour.

[55] Ibid., page 37
[56] Ibid., Anglin, J. Pain Normality and the Struggle for Congruence-Reinterpreting Residential Care for Children and Youth. The Hawthorn Press Inc (2002 pp 55) in Hillan, page 48
[57] Ibid., page 49

Also included was:

- Significant training of staff in understanding trauma.
- Assisting young people to understand the impact of trauma on themselves through a social educational model and group work.
- Young people talked about the groups giving them an idea that they could act differently and providing them with new skills and ideas in managing their distress.

The flip side of trauma for children and young people is that many staff who work in residential care have their own histories of abuse and distress, with many not having an opportunity to address their own pasts. The impact of hearing these stories and living alongside young people's pain-based behaviour often results in not understanding young people's behaviour as adaptive to the environments in which they have had to live and survive. Service designs do not help as they expect young people to conform to the structure of services, rather than the structure of services meeting their needs.[58]

A challenge facing residential service providers is to understand the pain and trauma associated with these living environments and look at how to support the staff caring for children and young people. At the same time the challenge is how to give staff the capacity to deal with their own pain to gain greater understanding of how to care compassionately and affectively with children and young people who have been traumatised.

As Anglin[59] points out (2002): "Given the severity of the difficulties encountered by the young residents in their daily lives and the depth and pervasiveness of their psycho- emotional pain, it seems imprudent at best and negligent at worst to place inexperienced untrained staff in such a demanding and complex environment. Furthermore, it cannot be in the resident children's best interests to be exposed to ineffective or repressive staff reactions to the resident's painful attempts to take action, however misguided within their often incomprehensible and frightening situations."

Hillan[60] recommends:

- Trauma theory and practice be incorporated in all residential care staff training and staff are to be provided practical measures to respond to pain based behaviour in young people.
- Responding to trauma and pain based behaviour is a central part of all models of residential care.
- Children and young people are provided opportunities and information to understand the impact of trauma on themselves and others so to be provided with an opportunity for change.

5.1.6 Mental Health of Young People and Service Model Development[61]

In the UK, the office for National Statistics recently did a study of 10,000 children aged 5-15 and their mental health across England, Wales and Scotland. Within the general population 8.5% of children displayed mental health issues and the rate increased to 45% in the looked after population (5 times the average). Mental health is a neglected area in out-of-home services.

Hillan reported that Glasgow has made a substantial investment in mental health services for young people who are looked after and established a multi-disciplinary team to undertake this work. This team sees all children in residential and foster care and accepts referrals if there is a concern about a child/young person without them having to present with a diagnosable mental health issue. The team provides assessment, direct services to children or referral to another part of the system; work with

[58] McCoy (2006) in Hillan. L. page 49
[59] Anglin, J., (2002 pp 114) in Hillan. L. page 50
[60] Ibid., page 50
[61] Ibid., pages 44-47

residential service providers to look at how they may be of assistance to them, including consultation - a member of the team working alongside the residential service as an ongoing consultant.

Hillan[62] visited a number of services that had acknowledged mental health issues and developed models to meet the mental health needs of young people.

The following list highlights service characteristics to meet mental health needs:

- Defining a spectrum of mental health needs and mapping a spectrum of service provision – "mental health capacity and need" (Scotland).

- A Canadian residential service that offered a multi-disciplinary team/mental health service to provide residentially-based and an outreach, home based approach based on attachment and family systems perspective. The multidisciplinary team consisted of psychiatrists, psychologists, nursing staff, social work, child and youth care staff and a recreation team. The service offered a three month residential component and ongoing respite if needed as part of a care plan. Services provided include mental/psychiatric evaluation, multi-disciplinary assessment and plans of care, family therapy, education and support, educational opportunities, vocational and recreational opportunities and social interactive experiences, ongoing outreach and respite services and ongoing program evaluation.

  An adolescent parenting group - "Connect Parent Group" based on attachment theory, teaches parents and caregivers attachment skills and empathic responses to young people. This is a compulsory part of young people coming to the program both externally and internally.

  Care plan meeting - meeting brings together, the young person, care givers, case worker and any other relevant services with the multi-disciplinary team that have undertaken assessments over the course of the treatment, (including, psychological, a family social history, educational assessments and psychiatric assessments). Assessments are discussed with the group, including the young person. A care plan is presented to the team that is based on the assessments and designed to assist the young person live back in the community with community supports. A care plan consultant is assigned to set up a meeting post the discussion to assist the group in the community enact the care plan in the community.

- A Chicago program has developed an in-house treatment and consultation program for residential services and has a team undertake an assessment and treatment plan and works with the residential service provider in an ongoing consultancy role to assist them in constructing care environments that meet young people's needs. This significant assistance is designed to preserve relationships with residential services but also ensures that young people are being provided an intervention that is least restrictive but well planned and supported.

  Hillan[63] recommends:

  - Models of care should be developed to provide specialised care for children and young people who exhibit highly complex behaviours.

5.1.7 17-18 Year Old Young People in Residential Care

The issue of transition[64] from care and supporting young people post-care was raised as an issue in the UK where most young people leave care at 16, with the legislation stating support until 23 years of age. Services indicated that young people were not ready at 16 -17 years of age to live alone, but

[62] Ibid., pages 44 - 47
[63] Ibid., page 47
[64] Ibid., page 33

where funding was tied to young people individually, then the funding followed the child. When services were no longer funded, they provided a much more limited service to young people, if at all.

In Canada, young people as young as 16 were being placed on youth agreements that allowed them to access independent living and support but with conditions. Young people were provided with a flat and some subsidies for their income but had to sign a contract regarding attendance at school, employment/training and drug programs (if relevant) or other conditions as per an agreement with a case worker. This often resulted in many young people living in low cost housing, in dubious neighbourhoods with some limited support. Many young people could not sustain the contractual conditions and became homeless.

Universally, residential systems expected this group of disadvantaged young people in care to demonstrate a level of competence and independence that the general population was not expected to have. Most young people experienced limited skill development for independent living post-care.

Hillan[65] recommends:

- There be a renewed focus on the needs of older young people in care with further model development undertaken to ensure positive options for young people leaving care.
- Continued higher levels of care should be available for this group (if needed) with specialist support offered post-care.
- Development of independent living skills program/s in all residential care facilities to ensure that young people leave with appropriate skills that equip them to live independently.

5.1.8 Staffing

Hillan[66] commented that good staffing ratios were critical and allow young people to build relationships. Staff need time and capacity to be able to build relationships with young people in the context of interventions. A key worker role is successful model to facilitate relationships and care. Also, staffing levels are about safety, providing a safe environment for young people and staff.

In the majority of services Hillan visited, staffing levels were 1 staff to 2 children or young people. At peak periods of after school, dinner, bed times, this was often increased to 1.5 staff to 2 residents or in a 4-5 bed residential, three staff were on at these critical times. This gives staff the capacity and flexibility to respond to young people one-on-one, offer some respite and prevent escalation of behaviours.

From her visits, Hillan[67] formed the opinion that there was international concern about the low status of residential carers. Many reported that youth work was paid at a higher rate, yet residential workers had to work in highly traumatic environments, where verbal and physical abuse was part of the everyday life and they were expected to undertake therapeutic care and reflection (often overseas staff were paid less than waiters).

Anglin[68] (2006) believes that an upgrade in status of residential carers is needed: "we owe it to children – they need to know they are cared for by someone who is respected…..Good care is not produced by tools – it's provided by people and investing in carers is investing in the heart and soul of children."

The majority of organisations believed that a new deal was needed for residential staff - they should be paid at higher levels than other youth work in recognition of their exceptional skills and care

[65] Ibid., page 34
[66] Ibid, page 50
[67] Ibid., page 51
[68] Ibid., Anglin, J., (2006) in Hillan. L., page 51

required for the job. Hillan comments that: "It is evident this will not occur unless the value of residential care is recognised for children and young people. Unless we see residential care can be a quality option, we will not provide it with quality status".

Hillan[69] recommends:

- Residential care staff need to be valued by the system they belong to and remuneration levels need to be assessed against the care they are required to provide.

- Staffing levels of residential care facilities need to be adequate to provide safe care for children, young people and staff. Staffing models should be mapped against the types of care environments being provided and the levels needed to provide quality outcomes for children and young people.

5.1.9 Training and Support

Hillan[70] observed that across the jurisdictions visited workers who had most responsibility in caring for often complex and traumatised children/young people had the least or in many case no training to assist them in this important role. She endorses the need for carers to have a good understanding of trauma, its impact on young people and effective strategies for intervention that sit alongside behaviour management.

She lists a range of international initiatives working to address training deficits for residential care workers:

- Scottish Institute for Residential Care at the University of Strathclyde was making a significant impact training residential carers though dedicating a research and training centre for residential care that was assisting to professionalise care offered. Social work was offering degrees and master's qualifications for managers and carers specifically in residential care.

- The Kibble Residential Program in Scotland CEO believed that children and young people needed to see their value in their staff being valued. There was also the belief that children and young people would not value education if they did not see staff engaging in further education. 80% of staff had undertaken further training and many were engaged in further education.

- Pat Petrie in the UK has been exploring the concepts of social pedagogy that form the basis of residential care in Denmark and Germany. Social pedagogy relates to overall support for child development – in pedagogy, care and education meet. Social pedagogy training focuses on assisting carers to help young people connect through art, sport and the sensual parts of their world.

  Petrie[71] advocates the following training areas:

  - Theoretical subjects in behaviour and social sciences.
  - Skills training such as group work, working with conflict, challenging behaviours and team work.
  - Creative and practical subjects such as art, drama, wood work, gardening, music – media through which carers can relate to children.
  - Arts and practical subjects are valued for their general therapeutic effect – helping children enjoy life.
  - Optional study modules and placement for specific settings.

[69] Ibid., page 52
[70] Ibid., page 52
[71] Petrie (2006 pp 118) in Hillan. L. page 53

- In Canada, the schools of child and youth care have combined the expertise of early childhood, social work, psychology and education to provide a course for students with a particular focus on understanding of the life world of the child and viewing interventions through the life space of the child. There is also particular emphasis on the use of self and therapeutic self-awareness. Students are encouraged to understand their own values and beliefs, assumptions, how this shows up in their thoughts and learning to ask for feedback. There is a strong emphasis on laboratory work and testing skills through role playing.

Child and youth care degrees and diplomas were offering skills in the following areas:

  - Group work.
  - Recreations skills.
  - Behaviour management.
  - Family systems theory.
  - Life span development.
  - Psycho-educational models.

- Training to be practice based, providing students the opportunity to apply their theory in practice.

- Greater training in mental health and supports due to high incidence of mental health disorders of young people in residential care requires much more thoughtfulness about the mental health training and support given to residential carers:

  - Access to therapeutic consultancy (in-house or external).
  - Multi-disciplinary teams in residential care – offer consultancy and increasing support and training to carers.

Hillan[72] recommends:

- Minimum standards for training of residential care staff should be developed within Australia.
- Any training developed should incorporate an emphasis on mental health, attachment, trauma, life span development, loss and grief.
- All training should have a focus on assisting residential carers to develop personal reflective skills.

5.2 What makes Residential Care Successful?

Hillan's[73] study identified the following key factors important to the delivery of high quality services:

1. A well developed philosophy and model development that is thoughtful, reflects theory and can be demonstrated at all levels of the organisation. Key elements in the theory development that include at a minimum a framework that incorporates trauma, attachment and loss. This includes appropriate access to resources including multi-disciplinary teams of therapists, psychologists and consultant physiatrists to make this work.

2. Young people at the centre of service delivery and firmly embraced by all staff as the most important client group including administrative and auxiliary staff.

3. A sense of creating a home for young people – sense of belonging, importance and care by all staff. Young people being claimed.

[72] Ibid., page 55
[73] Ibid., pages 57-59

4. A commitment to training and a significant investment in all those caring for young people – creative and at all levels including administrative and auxiliary staff.

5. A commitment to continuous learning, evaluation and research demonstrated through the involvement of staff in projects across the residential and with the input of consultants and universities.

6. The development of a continuum approach that ensures a suite of programs, living environments and interventions are available for young people that meet their needs and is able to track with them over time. This includes a capacity to meet educational needs, family work, foster care and residential care within an integrated approach.

7. A belief in residential care and its place for children and young people as a positive option not a last resort.

8. A resourced system to ensure that residential care is a positive option, with staffing models, environments and accesses to resources demonstrating this to staff and young people.

9. Support through training and development and centres dedicated to the training, research and resourcing of the residential sector.

10. Congruence in the supporting literature from governments including articulated policies well developed standards that are easy to understand and target young people (refer to example of Scottish standards) and consistent monitoring systems.

11. Congruence within the residential between stated aims, model of care, engagement and treatment of staff and delivery of services to young people and their families.

12. Funding arrangements that allow for adequate staffing and significant holistic interventions including supporting education, psychological and therapeutic interventions, specialist assessments and recreational input.

13. Integration with the systems that support children, young people and families including mental health and treatment services – ones that operate on concern and are not diagnostically driven, giving opportunities for early intervention and assistance to carers who are dealing with our most vulnerable children with the least training and support.

14. Residential care can be used effectively for younger children if it is therapeutic, healing wounds and actively addressing distress for young children that prepares them for foster care. This type of model could prevent many younger children from undertaking too many foster placements and successfully transitioning to a new family. This should be short term and have foster care linked to the program or significant family intervention models. Children under six years should not be placed in this type of program. It could be argued that it should be time limited from the start one year at most with an exit strategy built in at the beginning.

15. A focus on family and community work allowing residential staff to outreach and assist young people connect to the systems that are important to them. Focusing on continuity of relationships and continuing attachments, learning new skills in a supported environment to be able to moderate their connections over time.

6. Dartington – i

6.1 Recording and Assessment (UK materials) [74]

Founded in 1998, Dartington-i seeks to use the language and ideas of research to develop, evaluate and disseminate good practice about children's services. In common with other activities of the Warren House Group at Dartington, the primary goal of Dartington-i is demonstrably improved outcomes for children in need. The mechanisms for achieving this objective include:

- Common Language.
- A range of practice tools.

These practice tools may be of interest to residential care managers and practitioners in planning and designing services.

6.2 Common Language

Common Language is an attempt to improve the understanding of children in need and society's response to their predicament by using evidence to facilitate communication between those who support their upbringing: parents, practitioners, managers, policy makers and researchers as well as the children themselves. The project draws on health, education, social and police perspectives on children in need. Research also shows that children's needs are similar from one cultural context to another; the project cooperates across international boundaries.

6.3 Practice Tools

There are numerous practice tools emerging from Dartington-i and its partner organisations. These practice tools are intended to help those working with vulnerable children to use rigorously assembled information on the needs of children to plan more effective services (including residential services) and then to evaluate them to see if they are having the desired effect. All the tools provide empirical facts about children in need and their families. Professionals may know these facts but the instruments encourage a different perspective and reveal new links between familiar pieces of information. Everything rests on real cases, very often the practitioner's own workload. This is what makes using the tools exciting.

6.4 Matching Needs and Services

This practice tool is designed to improve the planning of services for children in need. It offers a way of auditing referrals to services to establish a pattern of need on which a new service can be built; in turn, this can be used to plan more effective services. The approach also includes a way of finding out whether the new services are more effective than the old.

6.5 Paperwork

Paperwork is a single assessment framework designed for use with all children in need and their families. The instruments assist multi-disciplinary teams of practitioners to arrive at consistent assessments of risk, protection and needs and to use this information to make a judgement about the seriousness of a child's situation. Paperwork helps practitioners to identify realistic outcomes for children and to design services needed to achieve those outcomes. The instruments have also been designed to provide aggregated information on all of these aspects to assist managers in the planning of services and the monitoring of outcomes.

[74] Source: www.dartinngton-i.org/projects and www.whg.org.uk/commonlanguage/pages/tools/index.html

6.6 Structure, Culture and Outcome

Structure, Culture and Outcome is intended to help those providing out-of-home services to focus on what the placement is intended to achieve and to re-orientate the culture of the placement so that it achieves stated goals.

6.7 Going Home

Going Home comprises a series of checklists based on validated research from Dartington that helps practitioners predict which children separated in state care can safely be returned and what additional supports are appropriate for those children where there are risks associated with the re-unification.

6.8 Prediction

Prediction is a word seldom used in the language of children's services professionals. But faced with a difficult situation, it can help to ask: 'what will happen to this child if we do not intervene?' And, having thought about the answer to that question to ask: 'what can we do to encourage the good things we predict and to eliminate the bad?' The Prediction practice tool shows how prediction can be an important and creative aspect of work with children and families.

6.9 Aggregating Data

There are many ways of generating management information for children's services, but few are tailored to the specific requirements of agencies and authorities. The tool is designed for two dedicated managers working with relatively little administrative support to collect essential management information. Building on the Matching Needs and Services methods, it offers a quantitative solution to the requirement for sound data on which to base good planning for children in need.

7. Victorian Department of Human Services (DHS)

7.1 HoNOSCA Survey
The Health of the Nation Outcome Scale for Children and Adolescents Survey

The HoNOSCA Survey[75] tool was developed in the UK. It is a mental health outcome assessment tool which consists of 13 separate scales clinicians use to rate their clients. Clients are assessed using HoNOSCA at the point of intake and again 3, 6 or 9 months later. Changes in scores over that time are compared giving an indication of whether or not treatment the client is receiving is having an impact on their problem behaviours.

The thirteen scales are:

1. Issues with disruptive, antisocial or aggressive behaviour.
2. Issues with overactivity, attention or concentration.
3. Non-accidental self-injury.
4. Issues with alcohol, substance/solvent misuse.
5. Issues with scholastic or language skills.
6. Physical illness or disability issues.
7. Issues associated with hallucinations, delusions, abnormal perceptions or beliefs.
8. Issues with non-organic somatic symptoms.
9. Issues with emotional and related symptoms.
10. Issues with peer relationships.
11. Issues with self-care and independence.
12. Issues with family life and relationships.
13. Poor school attendance.

In 2000, DHS conducted a trial HoNOSCA survey of residential care services. The purpose of the HoNOSCA trial was to seek information:

- On the client group homogeneity or whether there were different levels of complexity within the residential care client group?
- A link between client complexity and resource utilisation?
- Specific client attributes or behaviours which indicated higher or lower costs were likely to be incurred in caring for them?

In April 2006, DHS conducted a second HoNOSCA survey of residential care which provided comparative data to the 2000 outcomes. The HoNOSCA tool is very useful in establishing a base line understanding of residential care client needs, complexity and identification of problem behaviours and comparing current resource allocation (funding unit types) to respond to these needs. The outcome data does not track individual clients to report on the impact on problem behaviours but instead reports on a group cohort of youth residing in residential care at a particular time.

The HoNOSCA tool is a useful tool that could also be applied therapeutically and used to track individual clients throughout their period in residence in assessing needs and impact of interventions on problem behaviours thereby contributing to practice knowledge of what works with this group of young people.

DHS is working to analyse the data collected from this process and will be publishing a series of papers on improving outcomes in residential care in Victoria.

[75] Source: Analysis of Residential Care Surveys – 26th July 2006 Working Group Meeting, DHS Victoria. page2-3

7.2 Strengths and Difficulties Questionnaire (SDQ)

DHS[76] also administered the Strengths and Difficulties Questionnaire (SDQ) in April 2006 across residential care. The SDQ is a reliable clinical and research tool for identifying children and young people who may have, or are at risk of having behavioural and mental health problems. It can be used as a proxy measure of the level of complexity of children and young people's needs.

There are separate questionnaires for children aged 4-10 years and young people aged 11-17 years. The SDQ has 25 items that address strengths (pro-social behaviour) and difficulties (emotional issues, conduct problems, peer relationships and hyperactivity problems).

Scores for the prosocial and individual difficulties subscales can range from zero to 10. A higher score for strengths corresponds to positive behaviour. A lower score for difficulties corresponds to less difficult behaviour. The total difficulties subscale is the sum of the individual difficulties subscale and scores can range from zero to 40, with a lower score indicating less difficult behaviour. Five additional questions are used to assess the impact that the child's difficulties have on his or her everyday life/carer. A score of zero corresponds to no or very little impact, whereas a score of one or two indicates moderate or high impact on the child and carer.

According to research in the UK[77] children and young people with total difficulties between 14-16 are "borderline" and scores of 17 or above are at "abnormal" risk of having a diagnosable mental health disorder.

DHS is currently working to analyse the data from this questionnaire and will be publishing the information arising out of this work in the near future. The use of questionnaires such as this is important as it enables the system to establish benchmarks against which to assess improvement over time. The hope is that such tools will become a standard part of Victorian practice leading to improved service planning.

7.3 Listen to Children in Care - and their Dreams for the Future

Giving every child in out-of-home care 'every child every chance': the Resilience Congress brought together 450 carers, community service organisation staff, DHS employees and educators, in a lively and passionate two day Congress in Melbourne focussed on building resilience in children and young people in care.

Professor Harriet Ward of the UK, architect of the Looking After Children framework and Raymond Lemay of the Prescott-Russell Services for Children and Adults in Ontario illustrated time and again their experience in building on young people's strengths, using data to make change happen, and establishing a care team where respect and shared information were paramount. Listening to the young persons' goals is the start.

Krystal and Josh from CREATE, who have themselves been in out-of-home care, used the analogy of a bouncing ball to show the meaning and importance of resilience and each young persons' potential – and poignantly illustrated the importance of dialogue. Input from two young people with care experience added significantly to the day.

The second day of the Congress focused on education. The importance of the partnering agreement between DHS and the Department of Education & Training was highlighted – especially the role it can play in maintaining school connection for children in care. Andrew Fuller, a Melbourne-based psychologist and resilience expert, illustrated work from a strength-based perspective. A showcase of

[76] Source: Analysis of Residential Care Surveys – 26th July 2006 Working Group Meeting, DHS Victoria. page 1
[77] Source: Analysis of Residential Care Surveys – 26th July 2006 Working Group Meeting, DHS Victoria. page 6

innovative educational programs reinforced what could be done for hard to reach young people, students with disabilities, and those dropping out of the system.

The Congress was an event not to be missed - full of energy, hopefulness and a palpable sense of the commitment of people who are doing things to make children's lives better. The challenge now lies in taking the energy sparked by the Congress and translating this into how we work with children and young people in care.

Stories from participants of resilience in young people, Congress presentations, and information on how we will build on the momentum initiated by the congress, will be on the 'every child every chance' website – www.dhs.vic.gov.au/everychildeverychance

8. MacKillop Family Services Literature Review

This literature review was undertaken by MacKillop Family Services as part of the redevelopment of the RICE Education Program. We are grateful for the opportunity to reproduce it here.

8.1 Introduction

This literature review was prepared as part of the 'Review of the Strategic Direction of Rice Education and Youth Services'. It focuses on service responses to the multiple needs of young people in residential care and, in particular, their educational needs.

The review[78] begins with a review of out-of-home care placement trends and examines the needs of the children and young people who are referred. Moving on to the broadly expressed concerns about educational disadvantage experienced by young people in the care system, the review explores directions and options for meeting both their care and education needs.

8.2 The Children and Young People in Residential Care

In the late 1960's there were over 28,000 children in some form of group care in Australia (Bath, 1994). After a sustained process of de-institutionalisation there are only around 1,000 today (AIHW, 2003). There have been many ideological drivers for this process in the child welfare domain including the widely-accepted notions of de-institutionalisation, normalisation (a preference for placement in the most 'normalised' setting available) and localisation (a preference for placement in or near to the child's home community). Later, other guiding principles emerged in child welfare practice including a preference for placement in the least restrictive environment, family support/preservation as an intervention preference and permanency planning. These guiding principles all led to an emphasis on maintaining children at home if it was possible, and then using a more 'normalised' or less restrictive options such as foster care when a placement must be considered.

Residential care used to be an option of choice in Australia, it has rapidly become an option of last resort. The changes to the intervention process have helped to define the young people that are referred for residential care today. Child welfare decision-making now follows what has been termed a cascade model – firstly, intervention is avoided if at all possible. If it is clear that a family needs help with their children, the parents may be offered parent training groups or referred to counselling. If this does not meet the protection and management needs of the children, then the family will be offered a family support service. If this does not meet the need then they might be offered respite care to reduce stress and provide practical support. Where this level of intervention does not meet the need then some form of foster care may be tried. When foster care fails, it is attempted again and again as the research of Delfabbro et al. (2000) has highlighted. It is only after multiple failures in foster care that residential care is considered.

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

[78] Source: MacKillop Family Services gave permission for the literature review prepared for Review of the Rice Education and Youth Services - The Transitional Integrated Educational Residential Services Report, 2004 (authored by Bath, H. and Long, R.) to be published in the Monograph.

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

Some of the major behavioural, developmental and psychiatric issues that need to be considered are:

8.2.1 Conduct Disorders

Whether or not a young person meets the formal diagnostic criteria for a conduct disorder (CD or Oppositional Defiant Disorder, ODD), challenging behaviours including aggression, that violate the rights of others, are a defining feature of many young people in residential care, indeed, they are usually the primary reason that they are referred in the first place. As Dodge and his colleagues have pointed out (Dodge et al., 1997), there are different types of aggression, and troubled young people have characteristic patterns of aggressive behaviour. There are many different reasons why a young person engages in aggressive behaviour and there are two major patterns – one in which the aggression used is primarily planned and instrumental (proactive) and one in which it is primarily reactive and impulsive and marked by frustration, anger or fear (reactive). These categories parallel but are not identical to what used to be referred to (in the American Psychiatric Association's Diagnostic and Statistical Manual) as Unsocialised Conduct Disorder (reactive) and Socialised Conduct Disorder. The current (APA, 1994) classifications of Childhood-Onset type and Adolescent-Onset overlap with the reactive-proactive distinction to some extent but these are essentially different constructs.

The research from Dodge's group has demonstrated that there are different developmental profiles behind the characteristic patterns and different implications for intervention. The majority of the young people in out-of-home care with aggressive behaviours, have reactive patterns of behaviour which are linked to histories of abuse and neglect, harsh and erratic discipline, and constitutional vulnerabilities (Dodge et al., 1997). Programs to address the needs of such young people are quite different to those that tend to be useful with proactively aggressive young people.

8.2.2. Trauma/Abuse-Related Symptomology

The majority of young people in residential care come from backgrounds of abuse and trauma and many show the characteristic behavioural and emotional sequelae. Some have formal Post Traumatic Stress Disorder (PTSD) whilst the majority have some trauma-related symptomology including avoidance, concentration problems, hyper arousal, hyper vigilance, restlessness, reactive aggression, traumatic replay, mood swings, self-harming ideation and gestures. Some relationship-trauma behaviours manifest themselves as attachment problems (the anxious avoidant, anxious ambivalent and disorganised/disoriented types) or more formally as Reactive Attachment Disorders. It is understood that certain personality disorder patterns that are frequently seen in out-of-home care populations (especially Borderline Personality Disorder-type patterns) may develop as a result of traumatic abuse – they are increasingly considered to be complex trauma reactions.

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

have been proposed that are organised around our emerging understanding of trauma-based symptomology (Bloom, 1997; Abramovitz & Bloom, 2003).

8.2.3 Young People with an Intellectual Disability

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

8.2.4 Neuro-Developmental Problems

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

8.2.5 Mental Illness or Disorders

Some of these young people have formally diagnosed mental health problems often including one of the mood disorders (such as depression or bi-polar disorder), anxiety disorders (such as obsessional-compulsive disorder or a phobia), or early onset schizophrenia. In most such cases, the mental health needs of the young people are the primary consideration for both case planning and intervention.

8.2.6 Behavioural Disorders

Some young people have other specific behavioural problems including substance abuse or sexualy abusive behaviours. Typically, they also suffer from one or more of the conditions identified above, but their behavioural problem largely determines the type of setting that is appropriate and the intervention priorities.

In addition to the behavioural, developmental and psychiatric issues faced by most young people in residential care (and sometimes as a result of them) virtually all have chronic school problems including learning difficulties, behavioural problems and truancy.

8.3 Residential Care Trends and Options

Residential care today is an extraordinarily challenging enterprise and the care system as a whole has been slow to adjust to the changing demands. For the most part, the changes have been quantitative – to cope with the increasing complexity of the residents, numbers in care have been reduced to the point where the common occupancy target in residential programs for high needs young people is down to four. Even this small target has been hard to achieve as Clark pointed out in her review of services in NSW (Clark, 1997). It is not uncommon for programs with around-the-clock staffing to be established for single residents, and on occasions, two staff members have been provided to care and monitor a particularly challenging young person (Bath, 2001).

The system is still wedded to a 'care and accommodation' paradigm – the primary task is still considered to be the provision of care and thus relies on essentially unskilled or semi-skilled carers; qualifications and training are still seen as desirable but non-essential; conceptual and theoretical articulation is sadly lacking in our services; and policy development is largely dominated by traditional

social and welfare work models and values with the focus on care, rights, social inequality and political action.

There has been little change in critical qualitative measures that define how we understand the task, how it should be done, who we think should do it, how they should be trained and supported, and how the task should be evaluated.

Several commentators (eg Ainsworth, 2001; Bath 2001) have called for a 'paradigm shift' that weds a 'treatment' focus to our care and accommodation models.

The care system urgently needs:

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

A growing body of research literature highlights the effectiveness of treatment approaches ranging from preventive models such as Multi-systemic Therapy (Henggeller 2001; Henggeller et al., 1988), to 'treatment' or 'forensic' foster care (eg Fisher & Chamberlain, 2000), and residential treatment programs (eg Ainsworth, 2001; & Vorrath and Brendtro, 1985). Some of these have been developed in domains such as juvenile justice and mental health, but all have relevance for the focal sub-group of children and young people in our child welfare system. There are also compelling examples of comprehensive treatment models being developed as a result of interdisciplinary and inter-departmental collaboration. The Youth Horizons Trust in Auckland, New Zealand is a service developed by the then Department of Social Welfare to provide a range of intervention options for young people with severe conduct disorder problems. The child welfare body recruited psychiatrists, psychologists, educationalists and others to design a program for this target group that was based on best practice principles and sound research findings.

Despite the pressing need, there are very few home grown examples of true treatment models within the statutory child welfare sector and little discussion of the issue is found in the Australian literature. It also appears that there is a very slow take-up of the compelling research findings from overseas. For example, there is an impressive and growing body of research findings about various 'treatment' foster care models from the USA (eg Moore et al., 2001; & Reddy & Pfeiffer, 1997) which are used for young people with conduct disorders and even young people with sexual behaviour problems. However, apart from some 'professionalised' foster care services with higher levels of remuneration and smaller casework loads, there are few examples of such models here in Australia.

8.4 Service Implications

Any residential program in Australia today needs to carefully consider the breadth of its resources and its capacity to respond to the range of young people who will be referred and the complexity of their needs. The key service design implications are as follows:

1. Residential programs need to move beyond a 'care and accommodation' paradigm to develop responses to a range of developmental, emotional, social, behavioural needs.

2. Such programs need a range of qualified and experienced professional staff including psychologists, social workers, counsellors and, if funding allows, recreational/occupational specialists and educators.
3. Careful and comprehensive intake assessment will need to be provided so as to identify the young people that can and cannot be assisted; to identify the areas of need that must be addressed; to develop meaningful intervention and case plans; to match the young person with suitable residential and educational options; and to minimise risk for the young person, his/her peers and staff.

4. Care may need to be provided in a range of different accommodation options with different group sizes. Options may include small residential units, regular houses and flats, and even non-traditional options such as caravans. Group sizes may range from four or five down to one.

5. Training needs to be comprehensive, covering the broad range of issues that workers will confront.

6. Strong linkages will have to be developed with external specialists and services where such services cannot be provided centrally.

8.5 Educational Disadvantage and Out-of-Home Care

The Report Card on Education September 2003 published by the CREATE Foundation, documents the challenges faced by young people in care and their typical educational outcomes. The research by CREATE and many others (eg the NSW Office of the Children's Guardian, 2002; Spence 2001; Degenhardt and Gostt 2000; Cavanagh 1996; and de Lemos 1997), shows that, compared to their peers, young people in out-of-home care suffer on nearly every indicator of educational outcome. These young people are much more likely to have learning disabilities, to truant, to have behavioural problems, to achieve poor academic results and to leave school earlier than the average school student.

A review of substitute care in the ACT (Clark. 1998) found 74% of school age children were attending school regularly (p. 58). Behavioural difficulties were recorded for 38% of the children (p. 57). It also found that 46% of children had more than one placement change in their first year of care, an event often accompanied by a change of school.

Francis's (2000) study in Scotland confirms previous findings that many educational and behavioural problems are present when children enter care. Almost half the children in this study experienced periods of exclusion prior to placement. The study also found that little emphasis was given to educational attainment by social workers and carers.

There was also evidence of a lack of early information exchange between departments of education and social work. By the time social workers became involved, many problems at school were entrenched, and these contributed to the decision to place the child in care. School difficulties were found to contribute to breakdowns in care arrangements. In fact, difficulties in maintaining school arrangements led to many children changing from family placements to residential care. School records were found to be incomplete and unsystematic. Even detailed attendance records were not on file.

Numerous studies in the 1990s confirmed that children in care were not performing well in the education system (Jackson 1988-9, Biehal et al 1992, Stein 1994, Cheung & Heath 1994). Stein (1994) describes how many children in care felt "the odd one out" at school, the subject of curiosity, teasing and even abuse. The study reveals many stories of outright discrimination and labelling. A similar pattern of disadvantage is revealed in studies from the USA (eg Courtney & Pillavin, 1998; Nevada, KIDS COUNT, 2001).

Jackson (1994) reviews research over 20 years that shows foster children consistently fall behind those living with their own families. She highlights a number of important issues, particularly, the growing problem of exclusion from school and evidence of discrimination against children in care. She is also concerned about the deep split between education and care that runs through institutions and services for children and points to the need for young people in the care system to be heard.

Researchers in the US undertook extensive research into the issue in the 1990s, because of the growing awareness of the poor educational performance of children in care. This issue was also highlighted as a result of a class action lawsuit on behalf of children and youth in the custody of the Illinois Department of Children and Family Services (Haymes & Vidal de Haymes 2000, p 8). Research has shown great variations in the numbers of children in care functioning below grade level, ranging from Fanshel's finding of 33% to 67% by Zimmerman (in Haymes & Vidal de Haymes 2000).

Haymes and Vidal de Haymes (2000) examined the educational experiences and achievement of children in care in the Chicago Public School system. They have undertaken a major data analysis survey of 11,072 active and 4,520 inactive cases on public school and department data files, as well as school level characteristics. Their discussion highlights how contemporary attention in welfare has focussed on two primary concerns, safety and permanency, at the expense of other crucial dimensions, particularly education. The study found 96.4% of children in care in Chicago public schools functioned below grade level in reading comprehension, and 95.5% were not meeting national norms for maths for their grade level, and 27% had an identified disability. They describe many of the factors that may be contributing to such poor outcomes.

8.6 Reasons for Poor Educational Outcomes

Spence (2001, p. 2) lists the following as key criteria for experiencing successful educational outcomes:

- Stability and continuity.
- Learning to read early and fluently.
- Having a parent or carer who valued education and saw it as a route to a good life.
- Having friends outside care who did well at school.
- Developing out of school interests and hobbies.
- Meeting a significant adult who offered consistent support and encouragement and acted as a mentor and possible role model.
- Attending school regularly.

The NSW Office of the Children's Guardian submission to the Inquiry into Issues in the Education of Children in Out-of-Home Care (2002) reinforces many of the points made by Spence. The submission emphasises the importance of stability, clinical assessment and research with regard to addressing the issue of disadvantage with children and young people in out-of-home care and educational outcomes.

Some studies of children in out-of-home care have reported high levels of disabilities and special learning needs, social and emotional problems, and health problems that can impact on school performance, high levels of dropping out, and grade retention. Blome (1997) also found that adults in the lives of foster children were less likely to monitor homework, and that children in care spent less time doing homework.

Research has consistently shown a high level of behavioural and emotional disturbance among young people in care and leaving care (Rutter, 2000). Benedict & Zuravin (1996) found that children and young people at the highest risk of not completing school were those who had behavioural, educational and developmental problems prior to, and during, their stay in foster care. Emotional disturbances and academic delay have been found to often predate entry to care (Essen et al 1976, St Clair & Osborn 1987).

Rutter (2000) summarises the interplay of factors that may contribute to the high levels of disturbance found among children in care. He points out that children who enter care come from families with diverse psychopathology and multiple problems in parenting that give them a developmental background that places them at higher risk of problems. He does not underestimate the enormous impact of adverse environmental factors, but believes these biological risk factors are also significant. He acknowledges that while there is extensive evidence of the important role of genetic influences on emotional, social and educational outcomes, there is a complex interplay with environmental risk/protective factors. Foetal alcohol syndrome, high levels of recreational drug use and higher levels of obstetric complications in disadvantaged mothers all play a role in reducing outcomes for children. He highlights the need to look more closely at "resilience", a developmental asset that leads to relatively positive outcomes despite exposure to deleterious circumstances.

Sheargold (2001) indicates that socioeconomic disadvantage and family and personal circumstances are strong determinants of educational disadvantage. This is also confirmed by Darity, Dietrich and Guilkey (2001) who validate what they term the "intergenerational drag hypothesis". This hypothesis asserts that disadvantage is both intergenerational and difficult to escape. Young people from disadvantaged backgrounds will also join the underclass and more than likely so will their children along with the accompanying symptoms of school failure and behavioural disorders. The work of Thornberry, Freeman-Gallant, Lizotle, Krohn and Smith (2003) shows that antisocial behaviour is also transmitted intergenerationally.

Sheargold's (2001) report states that 50% of all young people in high schools claim they are not friendly places, 40% state that schools are not interesting and that teachers do not understand them. The major concern cited by at-risk young people for school failures was their relationships with teachers (Mukherjee, 2001, p. 7). At risk young people recount that teachers treated them poorly, could not listen, were arrogant, too busy, did not maintain confidentiality and made it clear they did not want them to be there.

Recent research in the US clearly indicates that students in foster care often have serious behavioural problems. Smucker et al (1996) call for the earlier identification of emotional and behavioural disorders and an integrated response rather than interventions that are "too late, too piecemeal, and too tentative" (p 38).

Some research has also looked at the links between school performance, discipline problems and types of abuse. Eckenrode et al (1993) found that neglect had more impact on outcomes than abuse, confirming other studies that showed neglect to be linked with low levels of self esteem and agency.

Barnett, Vondra & Shonk (1996) discuss how school performance, self-perceptions of competence and motivation all tend to be intercorrelated among school-age children. They explore the impact of maltreatment on self-system processes that contribute to children's engagement and performance at school. They conclude that interventions for disadvantaged and maltreated children need to not only target behaviours, but the processes that underlie and sustain their emotional well-being. They see early interventions to treat disturbed and defensive self-processes vital to improving educational attainment for these children.

Emotional adjustment, social development, conduct problems, and anti social and asocial behaviour, such as offending and substance use, all seem to occur at higher rates among young people in care than the general population (Wise 1999a). Young people who have been in care are also over-represented in juvenile justice, homeless, prison and mental health, alcohol and drug service statistics.

Recently there has been a renewed interest in the links between attachment disorders, child maltreatment and behavioural problems of children in substitute care (Howe et al 1999; Page 1999). When one considers the prevalence of behaviour problems among foster children, and the correlation

between behaviour problems and poor educational outcomes, the significance of attachment theory in understanding children in care's educational difficulties cannot be underestimated.

8.7 Policy, Ideology and the Education of Young People in Care

Maunders et al (1999) place the problems of low educational attainment for young people in care in the context of contemporary youth policy, which rests on increased school retention rates. The Howard Coalition Government's goal of 95% of 19 year olds to have completed Year 12 or be enrolled in a post school qualification, is unlikely to have any impact on young people in care unless governments recognise their additional education support needs (Maunders et al., p 17). Over 60% of the young people surveyed in the Maunders study left school at or before Year 10.

Cooney (1997) has also looked at the problems and policy developments in substitute care. She explores the difficulties and contradictions in implementing policies to improve the circumstances of children in a "residualist society", when services are constrained by cost containment and marketisation (p 24). The paper also discusses the problem of the reduction in number of foster carers that has occurred at the same time as demand has increased, through the move away from residential care.

Young people who are placed in foster care and then move to residential care are progressively marginalised from most mainstream services. Most of these young people require specialised education services which are flexible, creative and responsive with programs and interventions based on a clear understanding of the developmental, emotional and social needs of the young people. The mainstream education sector remains divided on the issue of alternative education but generally appears committed to an ideology of inclusion (actively led by the ACT and Queensland Departments of Education). Such a policy framework may suit the majority of youth at risk, but fails to adequately address the complex needs of many young people in residential care. Alternative positions have also been advocated, primarily by non-statutory interests such as the Dusseldorp Skills Forum (www.dsf.org.au) in the development of Learning Options for young people in education (see further the Learning Choices Expo July 2004 http://dsf.org.au/learningchoices/).

Whilst it has been a common trend in the education community since the 1970s to favour "inclusion" as the best way to deal with problems in schools, the history of career and academic pathways of students from alternative education programs runs counter to this. Contemporary special educational researchers and experts outside of schools espouse the notions of collaboration, integration and "a non-categorical approach" in pedagogy with special needs students. The non-categorical approach or "Inclusion Movement" as it has become known is convinced that all children can learn given effective instruction and that it is more just and productive to have all children in the school system. Whilst educators admit that labelling is generally destructive to the needs of children there are several factors which work against the implementation of the ideal in education regardless of what is believed about good education (Marginson 1993, pp. 55ff). The cost of lower class sizes, support staff, extra professional development and alterations in curriculum design inhibit the implementation of educative measures in schools with "special needs" students. In such cases it is easier to resort to simplistic teaching methods and curriculum designs which are more controlling and cost effective but less educative.

Clark et al (1999, p. 58) document a range of concerns about the impact of policy trends on Victorian schools. These have led to larger schools; more competition between schools, a focus on high achieving students; reduced support for young people having difficulty with school work; closure of the technical schools; closure of smaller 'alternative' schools; and closure of institutions that previously housed some of the 'wards of the state' and which provided on-site schools. The result of these changes is said to have been that young people with extreme levels of disturbance have been increasingly excluded from education. Not only is there a lack in commitment to these young people, but a paucity with respect to innovation and service development.

The problem of school exclusion is also of growing concern in Australia. The Victorian Council of Social Services (2000) has looked at school exclusion. It identifies the need for the development of a whole of government approach that adopts a case management model that links schools, welfare and other organisations. It highlights the need for comprehensive tracking of young people who are leaving school early. It also identifies the need for special educational and behaviour management supports for young people with behavioural problems, including classes with higher staff: student ratios and individually structured programs with access to more diverse, practical and vocational curriculum.

8.8 Options and Innovation for Disadvantaged Young People

With respect to the 'shape' of alternative schooling options, it is important to question the educational, social and psychosocial wisdom of running short term programs with schoolish-type programs for young people who already feel so alienated from school that they are unlikely to return to mainstream school anyway. Essentially one cannot solve schooling-paradigm problems with the mainstream schooling-type solutions. Similarly it is illogical to set up cognitive behaviourally-based instructional solutions for a significant sector of the school population who are school refusers (Dorn, 1996). Most high needs young people feel that schooling has failed them and so a new approach is needed.

Whilst it is not possible to discuss in depth the ethos and structure of the kind of education high needs young people need, it is axiomatic that such services should:

- Develop a sense of homeliness assisting identity, acceptance and belonging.
- Address the experiences and prejudices regarding schooling held by students.
- Focus on the learning of social skills adequate to participate with others.
- Focus on holistic and community-based approaches to case management.
- Develop a sense of responsibility for achieving personal learning goals.
- Develop a more positive attitude towards learning and respect for others.
- Enhance civics and basic communication skills.
- Increase levels of self-respect and self-esteem.
- Approach curriculum in a menu and choice style approach to learning.
- Embrace methods of assessment which track development from the young person's perspective and journey.
- Enhance participants' knowledge and skills in a wide array of educational and skills-development contexts.
- Develop literacy and numeracy skills incidentally through immersion and project/play strategies.
- Learn living skills relevant to cooperative living.
- Foster positive attitudes and habits in basic hygiene.
- Encourage positive attitudes to safety.
- Provide skills in food and home living technologies.
- Help young people to learn how to function and cope with a learning situation.

Research indicates that new pedagogies and learnings are dictated by new contexts in education (Nevis, DiBella & Gould, 2000, p. 2). The precedent of context dictating pedagogy has been discovered in innovations in Cairns with the school consortium which has established a primary school in Festival Faire Shopping Centre (http://cairnsconsortium.qld.edu.au/). Similarly the Philadelphia Parkway Program, Metro High in Chicago and Exploration Quarter in Atlanta (Earthman, 1999, Middleton, 1982, p. 176) in the 1970s discovered that new pedagogies developed within new contexts. Proposals for similar schools were undertaken by Beare (1975) and Wright (1976) in Australia [79].

[79] (The Ultralab schools in the UK (Learning in the New Millenium http://research.ultralab.anglia.ac.uk/) have also demonstrated how new models and contexts construct new innovations in pedagogy.

Recent research by the Northwest Regional Educational Laboratory (2001) shows strong links between student performance and the built environment. Copa (2001, p. 11) argues:

> *We already have a lot of small schools in this country. But if small schools operate no different than big ones – if they have the same departments, bell schedules, and all the rest of it – then you don't get the benefits of smallness. You have to change the way you do learning in school. Break paradigms. Break out of the ruts in terms of how we do school in this country. But if we keep designing new schools just like our old schools, we're not going to get any better results than we get today.*

Copa makes the observation that developing a sense of meaning in education is established through "connectedness". This "connectedness" is assisted or hindered by the way we design our educational spaces. Preston and Symes (1992) in the tradition of critical social theory (Soja, 1989; Spain, 1992) make it clear that all use of space is value laden. Learning by Design 2000 (2001, http://www.asbj.com/lbd/index2.html), a special edition on school architecture published by the American School Board Journal shows that school conditions have a real impact on student achievement and behaviour. Similar research by the Department of Education Training and Youth Affairs indicates the importance of design upon student outcomes (http://www.detya.gov.au/schools/latest_additions.htm).

Sherman (2001) comments about several new school settings in the USA - a charter school located in a museum and a school based in a Zoo. In conjunction with Howard Gardner (Learning Intelligences) he suggests the time is right for new ideas in schooling. The underlying question "What is a school?" must be opened up for greater discussion. Most schools are still variations on the old factory model – efficient but especially alienating to high needs students. Bingler of Concordia Architects in New Orleans (2001, in Sherman, p.6) observes:

> *New schools that don't consider different ways of delivering education, schools that continue to isolate students from their community, "are dinosaurs on the day they open".*

The reality is not much by way of structure and pedagogy has really changed in schools in the last 100 years. Schools might have more advanced technological fittings than before but fundamentally schools are still spacially monotonous and dictate a pedagogy centred around teachers and didactic teaching methods.

Educational scholars and management experts have used various images to explain the personality of schools, school management and learning. Scholars such as Friere (1972), Neville (1989), Handy (1985), Gardner (1993), Keirsey & Bates (1984), deBono (1992) and Larsen-Ko (1998) have used various images (the gods of antiquity, Jungian personality types, economic metaphors, "thinking hats" and symbols of nature) to describe the dominance of certain types of learning and management in schools. These images are used by these scholars as tools to illustrate the marginalisation of certain young people in schools because they do not "fit the mould".

The UK Department for Education and Employment (DFEE, 2002) notes that there has been a growing awareness of the lessons to be learned from research and practice. The DFEE guide highlights findings from the National Foundation for Educational Research (NFER) (Fletcher-Campbell, 1997) to the effect that successful interventions require a truly corporate effort, particularly political ownership and leadership from senior management, and that innovative effective practice fails to become embedded in policy and funding because it is time limited and project based. The factors contributing to success were found to include: stable and consistent care, early reading, regular school attendance, support from well informed foster parents, having a mentor, understanding the importance of education on future life chances, and financial support for further and higher education (DFEE, 2002 p 8).

The DFEE guide advocates the use of Personal Education Plans to ensure access to educational services and support and to record educational progress. It also recommends that schools designate a teacher to act as a resource and advocate for children in care, and highlights the lack of reliable data about the educational circumstances and outcomes of children in care. A designated teacher can help overcome the significant barrier to educational achievement that results from the lack of consistent parental advocacy, especially if they are working closely with community services. These two policies have been recently implemented in the ACT, and are still in the process of being put into practice.

In sum, when working with a population of young people with histories of disadvantage and exclusion from regular schooling options, it is imperative that new conceptual parameters are considered that include not only the goals and methods employed, but also the physical settings used.

8.9 Residential and Education Service Integration

There are few examples in the Australian context of full service integration. Withers and Russell (2001) in their documentation of Full Service School projects in Australia highlight the way in which most education support programs for young people at risk are isolated from a range of other support services. Some services such as the Ted Noffs Foundation integrate schooling and education support in their programs. The Ted Noffs program in the ACT, for example, endeavours to assist young people with substance abuse issues by providing a day program and holistic case management as a part of their service. This is provided by the integration of teachers, youth workers, social workers and psychologists on site however, the aim of the program primarily addresses substance abuse and related mental health issues.

Burt, Resnick and Novick (1998) document a range of services in the USA which focus on service integration. The primary approach to service integration is through centralised coordination, such a model is currently being piloted by the ACT government (Turnaround Project http://www.deyfs.gov.au). The purpose of service integration is to streamline services and case coordinate services. Rothman and Sager (1998, pp. 70ff) demonstrate the necessity for integration of services in their work on case management. The benefits of service integration for the client and financial savings for government are also demonstrated. Burt, Resnick and Novick (1998, pp. 208-224) map the scope and variety of factors and services in a full service integration model. In their work they note that very few services are truly integrated due to territorial silos, professional boundaries and proximity issues.

Whilst the theory of service integration makes good sense the obstacles in achieving service integration are significant as demonstrated in interim findings for the Turnaround Project. Suffice it to say the TIERS attempt at service integration stands out as one of the few models in Australia. Whilst this is commendable it also demonstrates the level of difficulty in achieving the goal of integrating services.

8.10 The Need for Educational Alternatives for High Needs Young People

Gardner (1991, p. 127) defines school as:

> *... an institution in which a group of young persons, rarely related by blood but usually belonging to the same social group, assemble on a regular basis in the company of a competent older individual, for the explicit purpose of acquiring one or more skills valued by the wider community.*

The Youth and the Future: Effective Youth Services for the Year 2015 report (Sercombe, 2000) commissioned by the National Youth Affairs Research Scheme (NYARS) calls for initiatives in the structure of schools. Echoing the sentiments of the Schools and Community Links report (Cobbold, 2000) Sercombe (2000, pp. 9, 10) calls for a stronger focus on community and full service school

models[80]. The NYARS report also urges reforms such as providing youth workers in schools, integrating schooling and private sector business, training for entrepreneurship and the setting up of alternative modes of education pathways for youth.

The establishment of alternatives external to the mainstream school system are important for students with complex needs because they themselves believe that the system has failed them, their perception is that it offers them no solutions (Webber and Hayduk, 1995, p. 113). Young people who are trapped in cycles of failure and self-fulfilling prophecies must be offered a new environment where they can believe that they can change their own future (Stacher, 1995, p. 1).

In proposing new models and contexts for schooling this discussion makes certain sociological assumptions about the dynamic of institutionlisation. The work of Weber (Gerth, pp. 245-264), Berger (1963, pp. 104-107), Babbie (1988, pp. 74-93), Morgan (1990, pp. 64-93) and Handy (1990, p. 74ff) establish that the purpose of institutionalisation is the fixing of paradigms in order to capture the "charisma" and dynamic on which they were founded. Whilst this is productive at the outset it needs to change over time. A good example is the institutionalisation of comprehensive schooling as a result of reforms in 1962 which are currently breaking down due to historical factors (Angus, 2000, pp. 24-26). It is important to remember that mainstream schools have been institutionalised to such an extent that any substantial change will be resisted by the very purpose and dynamic of institutionalisation (Preston and Symes, 1998, pp. 172-194). Preston and Symes argue convincingly that school architecture carries its own meanings and imperatives. The notion of the non-neutrality of space is convincingly argued by Foucault (Rabinow, 1984, pp. 18-21).

As schools and education departments grapple with the changing nature of society and its impact on institutions they have focused their attention on pedagogical and curriculum change. The initiation for new pedagogies in learning is premised upon changes in society, relevance to young people and context, all discussed comprehensively by Brennan (2000, pp.3-8). Brennan's emphasis indeed, the emphasis of the New Basics Project (Ladwig, Lingard and Smith, 2000) is upon bringing education up to speed with changes in society. The restructure of the curriculum in the New Basics Project draws together the synergies of old subjects with new collaborative pedagogies dictated by changes in technology, employment, culture and economics. The focus of the proposals in this paper take societal changes into account through an emphasis on incidental learning, immersion, learning through play and tracking competencies outside the current emphasis on subjects. New approaches to assessment and Brennan's portfolio and "Real-life" projects model are relevant in this respect. A stronger exploration of family-based and community-based assessment indicators needs to be investigated. Unfortunately such changes are too little too late for most high risk youth who left the mainstream years ago. The goals of the New Basics is still oriented to traditional values in learning and traditional modes of assessment.

Alternative approaches to education are founded on freeschooling and deschooling ideology clearly articulated by scholars such as Illich (1971), Freire (1972), Macklin (1976), Apple (1982, pp. 1-37), Middleton (1982, pp. 2-6), Meighan (1986, pp.142-62, 235-9), Preston and Symes (1992, p. 34ff), Jamrozik and Sweeney (1996, pp. 34-52), Goodman (1999) and Burt, Resnick and Novick (1998). Advocates of radical alternatives in education, including non-assessed curriculum and incidental learning, base their views on research into early childhood education and on findings which establish the relevance of pedagogies of play and choice in early childhood learning to models of education in the youth and adult years. The effectiveness of democratic pedagogies has been established with work undertaken at Youth Haven (Long, 1998). Claxton (1999, pp. 5-120) argues that learning after the early childhood years is imbalanced and is fixated on cognitive behavioural approaches to learning. At-risk young people reject the traditional cognitive behavioural approach in schools and tend to be able to continue in educational endeavour in a variety of alternatives. Alternatives in education in Australia tend to be a merging of what Brady (1985, pp. 140-211) terms "interactional" and "transactional" models of education.

[80] This refers to the work undertaken by Dryfoos, 1994, not the DETYA program

A key component of alternative options is incidental learning (Ornstein, 1969; Swift, 1975; Claxton, 1999). Claxton's work (1999) in particular emphasises the failure of intensive remedial work with at-risk youth in achieving positive outcomes. Claxton's arguments are based upon research into learning through play, early childhood pedagogies and the latest indicators in studies in learning theory. Goodman (1999) argues that the key to the viability of learning options and alternatives in education are rooted in the dynamic of acceptance. Goodman (p. 18) argues that acceptance enables high needs young people to begin to view themselves as loveable and capable. For high needs young people an ethos of acceptance is a stark contrast in a process which was once viewed as an adversarial exercise.

8.11 Towards a Typology of Alternative Education Models

In Australia, whilst there is a range of alternative education settings in each state and territory, there are very few programs, such as TIERS, which intentionally target young people in residential care. The authors are aware of only two other formally-accredited schools in Australia that are dedicated to the education of young people in residential care – these are the Boystown program in Engadine, Sydney (which provides a week-day only educational and residential program) and the Galilee program in the ACT (Long, 1998).

The Galilee charity commenced an alternative Day Program in 1996 for high needs young people in residential care. The program is located on Youth Haven farm in the southern suburbs of the Australian Capital Territory and delivers a genuinely alternative approach to education.

Brooks et al. (1997, p. vii) list six intervention models which categorise common initiatives in addressing the needs of "at-risk" young people in schools. These are:

- Community-based partial withdrawal - students are withdrawn from mainstream school on a part-time or temporary basis to a project operating in a community setting, with the aim of eventually reintegrating students back into mainstream schools (32% of sample).
- School-based partial withdrawal - students are withdrawn from normal classes to participate in an alternative program operating within the school. The initiative may operate as a full-time or part-time annex within a school or as a "time-out" program parallel to normal classes (23% of sample).
- Community school - comprehensive education and support program operating as an alternative to mainstream school. Participants are usually not expected to return to mainstream school (18% of sample).
- Outreach services - provision of specialist support services to a number of schools within a particular geographical area (12% of sample).
- Integrated whole school - a whole school approach to target "at-risk" students within the school community through innovative curriculum and welfare measures (12% of sample).
- Event-based - focus on one particular intensive activity, such as a wilderness excursion or cultural camp (3% of sample).

Further presentation of models including a comparative table of educational factors follows (Table 1).

The current structure of the Rice Program (as with Boystown, Sydney and Galilee in the ACT) is based on Brookes' community model - the curriculum is modified to meet the needs of the young people in a setting separated from a mainstream school, even though an explicit goal is to return students to the mainstream where this is possible. The buildings at Maidstone are designed like a school but are limited in their capacity to deliver the variety of curricula and pedagogical styles most suited to this group. In many ways the design of the facility does not suit the development of an alternate program. The structure of the program and pedagogy are minimalist as constrained by building design and behavioural threats.

The following table provides a comparative illustration of various models of alternative education including placing the Rice Program into the scope of alternative options. It is important to note that there is no definitive research in Australia which establishes which of the following models is most successful with high needs young people.

8.12 Conclusion

The relatively small number of young people in residential care today are likely come with a range of behavioural, developmental, emotional and social problems which seriously challenge the traditional residential and educational services that have been provided to meet their needs. Care and education responses to such young people need to be based on a careful assessment of individual needs, individualised programming, a multi-disciplinary approach and conceptual innovation that promotes the exploration of non-traditional methods and settings.

Table 1.

Rice and Alternative Education Models

	Space	Curriculum	Behaviour Management	Assessment	Staffing	Pedagogy
Rice	School Design Small Classrooms	Teacher Centred Minimalist Random	Reactive YP Associative Power	Descriptive Relative	Mixed Teacher Youth Worker	Relational
Mainstream School	Traditional Buildings	Syllabus	Withdrawal Exclusion	Criterion Formal Year 12 Exit	Teachers and Assistants	Didactic
Modified School	Technics Building Perimeter	Off line TAFE focused Hands On	Strict Exclusion	Formal Trades Work Experience	Practical Teacher	Instructional Experiential
Modified Alternative	Off School Site Youth Centre Integrated Commercial	Comprehension Syllabus TAFE Social Skills	Flexible Withdrawal	Semi Formal Trades/Arts Work Experience	Mixed Professions Volunteers	Collaborative Experiential
Home Schooling	Home	Informal Incidental	Home rules	Parental Informal	Non Teacher	Incidental
Tutoring	Home or Learning Centre	Formal and informal	Relational Individualised Personal	Elective	Teacher or volunteer	Formal
Radical Alternative	Farm Isolated Setting	Menu-based Psychosocial	YP/staff Parliament	Non assessed	Mixed Professions Volunteers	Incidental Learning Relational
Residential Treatment	Confined	Syllabus	Containment	Assessed	Teachers Clinical Psychologists	Formal

SECTION II

EXAMPLES OF PRACTICE WISDOM, EMERGING AND GOOD PRACTICE

1. Theoretical Frameworks Underpinning Residential Services

1.1 Residential Care Unit[81]

Example of Emerging Practice

Menzies Inc

Menzies manages four residential care homes in the Frankston and Mornington Peninsula areas. Each unit usually accommodates up to four children. One home is used for short term or emergency accommodation while the remainder are for medium to long-term placements.

Menzies is in the process of documenting their residential program model of care which is underpinned by Professor James Anglin's theory and practice of "responding to pain and pain/trauma related behaviours" presented by children/youth in residential care. It is anticipated that this documentation will be finalised by the end of 2006.

1.2 Organisation Holistic Model of Practice (2005)

Example of Organisational Good Practice

Westcare, The Salvation Army

The Salvation Army, Westcare developed the Westcare Holistic Model (2002/2005)[82] to provide a rationale for staff to guide their practice in the provision of residential care for high-risk adolescents in their Intensive Living & Learning Environments. The model covers whole of agency: residential and home-based care, case management and outreach service responses. The model was developed by practitioners and the management team over a number of years.

The model includes theories that informed thinking; clarification of values and beliefs, as well as essential organisational infra-structure or building blocks that contributed to the development of the organisational "culture" or "way of doing the work" in residential care. The culture is characterised by "a learning organisation framework", providing "unconditional care/ we never give up attitude" on the young people and their families and an equal focus on "staff health and well-being" for them to be able to provide this care. Westcare learned that "whatever we do for children, young people and families, we need to do for each other."

The holistic model is made up of the following base building blocks:

- Clear vision, mission, strategic plan, goals, objectives and planning.
- Theoretical and practice frameworks including:
  - Child development.
  - Attachment and bonding.
  - Client centred case work.
  - Risk assessment.
  - Learning organisation.

[81] Source: Menzies Inc

[82] Source: The Salvation Army Westcare – Holistic Model Paper, July 2005.

- Health, safety and well-being: comprehensive policies, practice procedures, service documents and team building/supervision/support and team well-being program; on-call and re-call and debriefing.
- Training, development and education program – Register Training Organisation; professional development/education and a specialist education program for youth excluded from mainstream education.
- "Unconditional care" approach by committed workers – teamwork, reflective practice and mentoring – "we factor".
- Looking After Children case management.
- Family centred practice – reconnecting and involvement of families in placement.
- Theoretical frameworks integrated into practice:
  - Comprehensive service documentation.
  - Commitment to quality service outcomes/quality assurance.
  - Reflective group process.
  - Access to specialist, multi-disciplinary consultation services.
  - Multi-disciplinary case management services.
  - Professional development/training and development pathways for workers.
- Quality assurance, evaluation and research.
- Creating Memories Program.
- Creating Dreams Program.

To implement the above model, Westcare identified that accredited training and development was the tool to ensure they retained the committed workforce. Westcare recently conducted a workforce analysis on staff turnover and report the average length of staff employment is 7.1 years. Out-of-home care services had 848 combined years of staff experience. All residential workers have completed Certificate IV in Protective Care and most have youth work qualifications.

The success of Westcare's whole of agency approach to out-of-home care services is strongly predicated on the importance of organisational culture developed through a whole of agency approach.

1.3 Adolescent Practice Framework for Out-of-Home Care "The Way we Work with Young People" (2005)

Example of Emerging Practices

MacKillop Family Services

The "Way we Work with Young People"[83] practice framework provides MacKillop Family Services residential programs a common framework resulting in cohesive teamwork and a unified approach to understanding the needs of young people in their care.

The practice framework is underpinned by the following theoretical models - developmental theory and a strengths based approach. The framework provides a basis of understanding and explaining the behaviours exhibited by the young people (responding to the developmental and emotional needs rather than the chronological age). Staff focus is on understanding the young people's behaviour to ensure practice addresses needs rather than only managing and containing behaviours.

The framework is heavily influenced by approaches that develop resilience and self-esteem, in particular the Circle of Courage model. The conceptual framework:

[83] Source: The Way we Work with Young People Program Documentation. MacKillop Family Services. 2005

Developmental Needs	Resilience Approach	Self-esteem Research	Circle of Courage
- Attachment	- Connections	- Significance	- Belonging
- Achievement	- Continuity	- Competence	- Mastery
- Autonomy	- Dignity	- Power	- Independence
- Altruism	- Opportunity	- Virtue	- Generosity

MacKillop utilises a "Building Block" practice approach adapted from The Circle of Courage model. The Building Block approach supports young people to successfully overcome past difficulties and develop strengths in four major areas:

- Belonging – vital for young people to develop trust and confidence that their basic physical, social and emotional needs can be met consistently and positively. This fundamental building block is critical to assisting young people develop in the other areas.
- Competency – encourages growth by the development of skills to learn that they can achieve.
- Independence – encourages creating life choices in a safe environment so that they have control over their lives.
- Sense of community – achieved when young people can step out and think beyond themselves; through contributing to others, youth can see that there is purpose to their lives.

- Application to Practice

Relationships are developed in a culture of respectful alliances, characterised by trust, co-operation and engagement, rather than adversarial encounters characterised by distrust, antagonism and detachment. Each Building Block has a set of key behaviours and the therapeutic relationship is used to assist young people learn care about themselves and other. Assessment of behaviours indicates an absence of development, or distorted manifestations of a particular stage which contributes to understanding the need these behaviours relate to in order to implement relevant strategies. The practice framework outlines a range of interventions and strategies that staff can utilise to support the young person's development in each Building Block.

The practice framework is supported by:

- Staff training in the framework.
- Regular monitoring and review of compliance with practice framework.
- Demonstration of achievements in developing belonging, competency, independence and a sense of achievement for this high-risk target group.
- Building Blocks Case Management Tool.
- Handy hints to start building engagement and strategies for engaging young people tip sheets.
- Best practice when responding to client risk-taking behaviour[84].
- The practice framework is also supported by MacKillop's organisational policy on: Defusing and Debriefing[85].

[84] Source: The Way we Work with Young People Program Documentation. Appendix 2, pp 12-15. MacKillop Family Services. 2005

[85] Source: Operations Manual: Section B.26 Defusing & Debriefing. MacKillop Family Services

1.4 Re-development of Residential Care

Anglicare Victoria

From July 2005, Anglicare[86] undertook an extensive review of their residential care, a scoping of the wider residential care service system and analysis which resulted in a Redeveloped Residential Services Model to be implemented over three years from June 2006.

Anglicare's review included:

- a literature search
- identification of common themes across the different programs reviewed:
  - The value of multi-disciplinary teams.
  - Assessment as an essential component of placement.
  - The importance of qualified and trained staff.
  - Staff need to be focused on client needs-psychosocial and educative responses to clients.
  - Flexibility and responsiveness is required to meet individual client needs.
  - Trauma can often lead to attachment disorder.
  - Affect regulation - often difficult for traumatised young person or those with lack of attachment; assist client control affect, emotions, response and reaction; important in recovery.
  - Construction and modelling of alternative behaviours.
  - The importance of education through everyday settings.
  - Engagement is crucial.
  - Group work.
  - The voice of children / young people needs to be heard.
  - Family work is a key residential care program component.
  - The importance of creating a therapeutic environment.

1.4.1 Vision Statement

'Anglicare Victoria is committed to providing a residential care service with the goal of creating a therapeutic environment that assures the safety, stability and best interests of children and young people, and endeavours to enhance their spiritual, emotional, psychological, physical and educational well being'.

Anglicare's proposed model has been influenced by Professor James Anglin's work, Director of the School of Child and Youth Care, University of Victoria, British Columbia. "Pain Normality and the Struggle for Congruence – Reinterpreting Residential Care for Children and Youth" is the product of Anglin's extensive research conducted across the residential care services in North America, with the purpose of constructing a theoretical framework that would explain and account for well functioning residential facilities for young people that in turn could serve as a basis for improved practice, policy development, education and training, research and evaluation. He uses a grounded theory approach to construct a theoretical model that speaks to the primary challenge residential care services face every day – responding to pain and pain-based behaviour in residents.

The core focus of Anglicare's proposed service delivery model is working in the child's or/ young person's best interests.

> 'Our focus then becomes not one of knowing why things happen but how our clients make sense of their experience and how we might assist them to make sense of things differently'.
>
> Michael Durant (1993)

[86] Source: Anglicare Victoria - Residential Services Redevelopment Paper: Service System Analysis. 2006

Children/young people who have experienced profound abuse and/or neglect can present with a range of trauma-related behaviours, can be deeply challenging to residential staff and those who seek to assess and address the child's/young person's needs. The re-developed residential care service will provide children/young people with a holistic, dependable, predictable living environment, which can be used to challenge all the negative (direct and secondary) aspects of their abusive experience. Anglicare will implement the key components of Anglin's model across their residential services.

1.4.2 Key Components of Anglicare's Residential Services Model

- *The Extra-Familial Living Environment*

The overall aim of the residential care program is the development of a home like setting which is not attainable within an institutional facility and removes the emotional intimacy and intensity of a family environment. Residential care staff – whilst not replacing families, take on the functional aspects of parents as a component of their role.

- *Responding to Pain and Pain-Based Behaviour*

Treatment and healing is the central component to residential care – recognising that children/young people have had experiences of significant trauma, abuse and loss. Training residential staff to understand the nature and scope of trauma-related behaviours, and supporting them in learning how to respond to such behaviour appropriately, is central to a successful therapeutic residential program.

- *Developing a Sense of Normality*

The key element of developing a sense of normality in the residential service is to ensure that despite the trauma and abuse and 'lack of normality' these children and young people have experienced, they still need to have 'normal' life experiences.

1.4.3 Core Components of the Treatment Approach

- *Attempting to bring about directed change in a person*

Directed change means goal directed, planned and integrated activities, supported by written recording and feedback to the goal planning activity.

- *Through individualised attention*

Individualised attention entails the existence of a personal treatment plan, followed by personalised service delivery, and regular, relatively frequent review of plans.

- *On the basis of a guiding theoretical framework*

A guiding theoretical framework can be identified as being derived from a body of legitimate knowledge and will generally be informed by the experience and formal training of the workers in the program.

- *With a suitably comprehensive and in–depth assessment of the situation*

An assessment encompassing a review of the individual's behaviour, condition, and life situation, is based on relevant information gathered over time; includes hypothesis including diagnosis; and is regularly updated.

1.4.4 The primary goals of the Anglicare's Redevelopment of Residential Services:

- Promote children/young people's ability to recover from the effects of abuse, trauma and loss.
- Resource residential staff to provide nurturing, therapeutic, reparative care for children/young people who present with complex needs and challenging behaviours, using a trauma framework.
- Ensure that children/young people are provided with opportunities and assistance to participate in decisions that affect their lives.

- Ensure a systematic, integrated, coordinated, consistent and holistic response to the needs of children/young people and residential care staff.
- Promote placement stability in residential care and improve opportunities for children/ young people to successfully transition residential care.
- Work with families of origin in a supportive, inclusive and respectful way.

1.5 Take Two

Example of Good Practice: Therapeutic Treatment

Berry Street Victoria
in partnership with
Austin Child and Adolescent Mental Health Service
La Trobe University Faculty of Health Science
Mindful Centre for Training and Research in Developmental Health

Take Two[87] is Australia's first dedicated therapeutic service for children and young people in the Child Protection system. It provides a lifeline for young victims of abuse. Children and young people who have suffered profound abuse or neglect can be referred to Take Two for therapy, and for other specialist assistance by their protective case managers. The service commenced operation in January 2004.

Take Two is auspiced by a partnership between Berry Street Victoria, the Austin Hospital Child and Adolescent Mental Health Service, the La Trobe University School of Social Work and Social Policy and the Mindful Centre for Training and Research in Developmental Health. Berry Street Victoria is the lead partner and fund-holder.

Take Two provides safe and therapeutic relationships for children and young people. Within the context of secure and attentive relationships with therapists and others who care for these children and young people, complex emotional and behavioural issues are addressed and overcome. Therapy is primarily delivered via outreach and Take Two therapists take responsibility for the engagement of the therapeutic relationship.

Take Two has 42 specialist therapeutic clinicians deployed throughout Victoria. Within its clinical establishment, Take Two employs a team of Aboriginal staff; currently comprising two permanent senior clinicians, and one contracted Aboriginal clinician, to ensure its services to Aboriginal children and young people are culturally sensitive and competent. The Take Two service provides a clinical service through Victoria. There are Take Two offices in every DHS region. Offices are located in: Ballarat, Bendigo, Box Hill, Campbellfield, Dandenong, Flemington, Geelong, Horsham, Mildura, Morwell, Seymour, Wangaratta, the DHS Secure Welfare Facilities, La Trobe University and Mindful.

The La Trobe University School of Social Work and Social Policy oversees the Take Two research and evaluation. Take Two research tracks the outcomes of children who receive therapeutic assistance in relation to their emotional and behavioural well-being and their social networks. The La Trobe University evaluation of Take Two is monitoring program progress in relation to client needs and program outcomes. The Mindful Centre for Training and Research in Developmental Health assists Take Two train its own staff in best practice with traumatised children and to disseminate this knowledge to other people who work with child protection clients.

In order to be eligible for the Take Two service, a child or young person must have suffered from substantiated abandonment, lack of care, physical harm, sexual abuse, developmental or medical harm as defined by Victorian law.

Each referred child is assessed for the trauma they have suffered and their coping capacities. The stresses and resources of their family and others who care for them are also assessed. Treatment planning is collaborative with all parties and is designed to assist each child directly, as well as many of the adults who care for the children. Take Two can only achieve high quality intervention outcomes in cases in which the protective case manager convenes and supports a care team for the client, and in

[87] Source: http://www.berrystreet.org.au/services_taketwo.htm

which Take Two clinical staff can make mental health and wellbeing interventions into a comprehensive case plan that also considers child safety, security, general health and education.

Services of child and family support, child safety and out-of-home care have been available to abused Victorian children over many years. Take Two is the first systematic attempt to deal with the trauma these children have suffered through specialist clinical assessment and treatment. Although it is not a direct provider of out-of-home care itself, Take Two attempts to supplement out-of-home care systems throughout Victoria by bringing complex clinical understandings of the needs of young people to care-provision, via primary and secondary therapeutic consultation.

2. Engagement of Young People in the Admission Process

2.1 Welcome Booklet to Clarkson Street – Adolescent House

Examples of Good Practice

Lisa Lodge
Ballarat

The Welcome Booklet[88] to Clarkson Street is written in "youth-friendly" language with accompanying graphics to inform young people of the expectations and rules of group living in the adolescent house. A message of respect, privacy and safety (for all) is up front and reinforced throughout the booklet. The booklet gives advice how to make living at the unit happy and hassle free, explaining the early weeks of settling in, pocket money, visitors, phone calls and behaviours that are unacceptable such as aggressive behaviours, drug use and weapons, plus the consequences of breaking the law. For young people not attending school, residents participate in a Day Program.

The house operates on a "levels program" which is linked to privileges and behaviour – levels 1, 2 and 3 are reviewed weekly by the young people and staff at the house meeting and levels are adjusted accordingly. Accompanying the levels program is a list of privileges related to house activities, such as bed time, curfew, phone calls and social activities. As well, expectations about house routines and personal hygiene, visitors and unfair treatment are discussed. Another important aspect of the booklet is the weekly house meeting where residents plan meals, discuss issues of annoyance, activities and suggestions or plans for the house.

Lisa Lodge has a documented **Clarkson Street Residential Unit Admissions Procedure**[89] that is completed and accompanies the Looking After Children EIR. This documentation is further supported by the **Residential Unit Admissions Checklist**[90] which covers a range of behaviours and frequency to assist staff in the admission and engagement phase of youth into residential care.

2.2 Charter of Rights for Children in Care

Lisa Lodge

Lisa Lodge developed a Charter of Rights for Children in Care[91] presented in a "youth-friendly" booklet. The Charter identifies the child's rights to have access to a wide range of support services relevant to their needs whist living in residential care. The Charter is quite specific in terms of health care and support services; continuity of care with family relationships; respect and safety; participation in case planning and case worker; continuity of care; living in a safe environment free of abuse; a right to cultural heritage and religious beliefs. The Charter is a useful tool to monitor children's rights and advocate on their behalf if breeched. The booklet is given to young people on admission into out-of-home care services.

[88] Source: Welcome to Clarkson St Adolescent House Booklet. Lisa Lodge
[89] Source: Clarkson Street Residential Unit Admissions Procedure documentation. Lisa Lodge
[90] Source: Residential Unit Admissions Checklist documentation. Lisa Lodge
[91] Source: A Charter of Rights for Children in Care. Lisa Lodge

3. Interventions and Behaviour Management Tools

3.1 Champions Mentoring Program

Example of Good Practice

Lisa Lodge
Ballarat and Horsham

The Champions[92] is a volunteer mentoring program run by Lisa Lodge for young people who need a stable, positive influence in their lives. Champions is targeted to 24 young people aged 12-18 years old:

- 12 young people on the high risk register.
- 12 young people who are known to Protective Services (presenting significant challenges to the system).

Champion's objectives:

- Develop a significant relationship with an adult who can offer support, advice and assistance to a young person.
- Develop links with recreation and other positive social activities.
- Strengthen the development of positive self-esteem.
- Manage the transition from turbulent adolescence into adulthood.
- Experience a sense of belonging to social groups, activities and community.

The Champions mentoring program provides a one-to-one relationship between an adult and a young person where the older experienced mentor provides support, advice and a sense of community. A mentor is someone who provides positive role model for a young person and develops with the youth a long term relationship of implicit trust, unconditional acceptance and support. Through this relationship, the mentor provides the young person recreational opportunities, guides them into safer risk-taking practices and links them back into the mainstream community. On a personal level, the young person would experience a reduced sense of isolation, marginalisation, increased self-worth and renewed optimism.

The Champions Mentoring Program is documented and offers:

1. The Mentoring Program Guide
Instruction manual that provides clear, sequential, step by step advice on the various tasks involved in establishing a mentoring program. It covers each phase of program development — recruitment, training, screening of applicants, accreditation, matching, mentor support and program evaluation. To assist mentoring project coordinators to prepare all the necessary articles of documentation, removable checklists have been created. Where appropriate, sample documentation has been included. An action sequence map provides an overall coordination plan.

2. The Training Manual
This provides a full course for equipping volunteer mentors with all the necessary skills and knowledge required to fulfil the mentoring role. It contains session plans, worksheets and trainer's aids.

3. The Mentor Manual
This is a companion volume to the Training Manual. It contains readings on all the issues covered in training, including statements on professional guidelines for mentors. It functions both as a text for the training course and a reference tool for the working mentor.

[92] Source: Champions Mentoring Program documentation. Lisa Lodge

3.2 Residential Unit Admission Procedure and Behavioural Checklist

Practice Wisdom

Lisa Lodge
Ballarat

Lisa Lodge's Clarkson Street Residential Unit Admissions Procedure (which accompanies the Looking After Children Essential Information Record) outlines clear procedures for case work staff admitting a young person into a residential unit. A useful **Behavioural Checklist**[93] accompanies this process. This Behavioural Checklist of the young persons' behaviours exhibited during the preceding six months prior to placement is completed on referral/admission by the referring DHS worker to assist unit staff in having a baseline of known behaviours and risks this is particularly useful in regards to OH&S.

3.3 Young Person's Behaviour Plan Response Plan to Self-Harming Behaviour[94]

Lisa Lodge
Ballarat

Lisa Lodge has developed a matrix model to resource staff in understanding and responding to challenging behaviours and covers:

- Young person's behaviour – specific descriptors.
- Staff response – hierarchy of responses to the situation.
- Reason for the response – rationale and social learning aspect.
- What staff must not do – specific directions relating to the severity or escalation of the youth's behaviours.

This resource is accompanied by a Debriefing Tool - a proforma used with staff to debrief and reflect on:

- Who was involved?
- The events leading up to the incident.
- Description of the incident.
- What worked and what could have been done better?
- Identified risks following the incident.
- Follow-up regarding the risk/s.
- Other comments.

3.4 Crisis Plan Tool

Westcare
The Salvation Army

Westcare use a **Crisis Plan Tool**[95] for young people in placement. The Crisis Plan covers identification details and planned responses/actions in the following areas:

- If the young person is substance abuse affected.
- If the young person absconds.

[93] Source: Behavioural Checklist. Lisa Lodge
[94] Source: Young Person's Behaviour Plan - Response Plan to Self-Harming Behaviour
[95] Source: Crisis Plan tool. Westcare – The Salvation Army

- If the young person is suicidal or presenting as very depressed/paranoid/psychotic (ie. auditory or visual).
- If the young person is violent.
- Emergency contact numbers.
- Briefings for after hours Protective Services and access to other emergency services.

Under each section, there is a checklist of critical actions to be addressed, which guides the unit staff/after hours on-call staff about crisis management plans. The Crisis Plan also lists under each heading "behavioural triggers" related to particular behaviours/context.

The young person and their family are also involved (where possible) in the development of the Crisis Plan and are aware of the steps that will be taken if a particular circumstance or incidence occurs.

3.5 Sages Cottage Farm

Example of Good Practice

Menzies Inc

Sages Cottage Farm[96] situated at 85 Sages Road, Baxter, offers therapeutic programs, including Animal Assisted Therapy to children who have been exposed to family violence, abuse or neglect which is what makes 'Sages' different to other children's farms. Sages Cottage Farm receives referrals from the community, home-based care and residential care.

Many of the young people involved in the programs are dealing with complex problems. They often have difficulty trusting others, have low self esteem and are less able to feel empathy. The therapy programs are specifically designed to help young people overcome these issues. At the Farm, children develop trusting relationships in a safe environment. They learn how to care for animals and understand how they are feeling, and undertake tasks that require responsibility and problem solving skills.

The local community plays a vital role in the success of the farm. Many students from local primary schools are involved in educational activities learning about health, science and the world around them, while volunteers of all ages are giving their time and talents to the gardening, heritage and animal therapy groups.

Menzies has future plans for families to participate and experience some hands-on activities, held in conjunction with other Farm programs, or just wander around and enjoy the ambience of the heritage listed Sages Cottage and gardens.

3.6 Animal Assisted Therapy (AAT) and Creative Arts Therapy

Menzies Inc

In 2003, Menzies undertook a literature review[97] in the establishment of the Animal Assisted Therapy (AAT)[98] program for children and young people at Sages Cottage Farm in Baxter. AAT clients are children and young people who have experienced domestic violence or other emotional trauma. Referrals are received from the community, schools, other welfare organisations and children/youth in out of home care. The AAT program runs groups with rolling admissions allowing participants to enter

[96] Source: www.menzies.org.au

[97] Source: www.menzies.org.au Literature Review: Animal Assisted Therapy & Young People. RHMSS Pty Ltd. February 2003.

[98] Source: Menzies Inc

the groups when a space opens up.

AAT involves the thoughtful use of animals in the therapeutic setting by a trained clinician who has developed a set of goals for each client, a plan for how to achieve these goals and a plan for how the animal or animals will be used to assist the child and the clinician to achieve the goals of therapy. Animals are excellent tools to engage children and young people.

The programs have also been developed with a combination of animal, horticultural and environmental interventions, creative arts therapy processes and traditional therapy techniques, to address personal issues and develop pro-social behaviours.

The program is built around three key pro-social competencies: trust, empathy and mastery. These are the three elements intrinsic to healing for damaged and at-risk children. Anger management is another core pro-social skill that many of the client group have not yet mastered. Anti-social children often struggle to read body language, have little self-knowledge and struggle to form meaningful relationships, both with adults and peers. All of these skills are targeted throughout the Animal Assisted Therapy programs.

Menzies' program aims to help children and young people deal with low self esteem, behaviour problems, life changes, abuse, grief, anger, and feelings of disconnection from the community. Individual goals are developed with each participant who will participate in group work which will work through three stages of therapy: the empathy stage, the competence stage, and the mastery stage to achieve common goals.

The steps of the empathy stage are:
- Assessment and orientation.
- Observation around the animals.
- Group dynamic processes.

Participants then move into the competence stage which involves:
- Learning comforting touch for the animals.
- Animal care activities.
- Extension activities.

The third stage of therapy is the mastery stage, which involves:
- Sharing and teaching knowledge.
- Joining other programs.
- Giving back to the community.

After each stage of therapy, it is expected to see growth which can involve learning a new skill, or learning something about themselves, other people, or the animals.

Menzies Inc. is committed to best practice and evaluation of services to enhance and improve its programs. Menzies has partnerships with the Centre for Developmental Psychiatry & Psychology at Monash University and the RSPCA.

3.7 Aggression Replacement Training (ART)

Menzies Inc

It is well known that some young people have problems managing their anger. These young people often use aggression to resolve conflict and/or assert themselves among their peers. Typically, children and adolescents who display aggressive behaviour lack the social skills to develop age appropriate friendships. They are often feared and/or disliked by their peers and teachers because of their disruptive behaviour in the classroom and in the playground. In extreme cases, some of these

young people are suspended, expelled or enter the juvenile justice system as a consequence of their behaviour.

Menzies undertook to establish a program to help young people learn ways to control their anger and get along better with others. After investigating a number of programs in Australia, the United States and Europe, it became apparent that there are not many that have been well researched and proven to be effective – especially for young people who live in residential or foster care. One program for which there is supportive evidence is Aggression Replacement Training (ART)[99].

3.7.1 What is ART?

ART is a group education program with three components:

- Skill streaming.
- Anger control training.
- Moral reasoning training.

ART program participants meet three times a week for 10 weeks, that is one meeting each week for each of the three components. Sessions run for about one hour, co-facilitated by two qualified ART trainers. Two of Menzies' staff went to the USA to be trained in the delivery of ART.

3.7.2 Project Evaluation

Because ART was originally developed in America, Menzies is doing a study to see how it works in Australia. The research project is being conducted, in conjunction with Swinburne University and is examining the effectiveness of ART.

The project is being jointly funded by Menzies Inc and the Victorian Department of Human Services. It has the approval of the relevant Ethics Committees

3.8 Going Places, Creating Memories Program

Organisational Innovative Practice

Westcare
The Salvation Army

Often when looking back on our own childhood/adolescent years, we find memories of a trip with family or friends that had an impact on our thoughts and our views in later life. Going Places, Creating Memories[100] is a simple concept of providing a trip for young people to have and retain positive memories. Memories that are their own personal property that no-one can take away from them. The program aims to educate young people through opportunities to experience and learn through travelling to places they would normally not be able to visit. Hence the creation of memories they will carry with them throughout their lives, shape and mould the people they will become, views they can share with friends, family and wider community. For example, the Ceduna project focused on the development of beliefs gained through knowledge and experience. Many of the young people had, or were developing views on Aboriginal issues (often through misinformation or ignorance) without any real understanding of these issues. The Ceduna project provided the opportunity to influence and change attitudes though experience of meeting Indigenous people on the trip, thus gaining knowledge.

Young people and unit staff were involved in pre-planning for the trip that included:

- First aid lecture and skills to deal with dehydration, snake bite and basic first aid.

[99] Source: www.menzies.org.au
[100] Source: The Salvation Army Westcare – Going Places, Creating Memories Program brochure & Paper (undated)

- Discussion with a local Aboriginal elder to prepare young people and staff on local culture and protocols; traditional farewell ceremony.
- Leadership development training (mentoring).

The trip was rich in new experiences, 4WD travel in the bush, camping under the stars, bush tucker, connecting with local Aboriginal people, small plane flights, fishing and much more….

Westcare established Going Places, Creating Memories in 1999 and have traveled with residential youth and staff to Tasmania, Ceduna to Alice Springs, Cape York, Franklin River and Arnhem Land. The program is funded though philanthropic foundations, community organisations, sponsors and the private sector.

Alongside this program, Westcare celebrate their positive work culture through having fun together outside formal staff and client meetings. Four times a year, social events are organised where staff can relax and have fun together at social events such as team sports, boat tour, each team making a video based on a popular television commercial. Teams often go to a restaurant for their staff meeting. Annually, staff or team achievements are celebrated with an award ceremony.

3.9 Creating Dreams Project

Organisational Innovative Practice

Westcare
The Salvation Army

The Creating Dreams Project[101] established in 2004, acknowledges the achievements and dreams of disadvantaged young people in the community and those people who strive to make a difference to their lives. Many young people have to overcome huge barriers on a daily basis to produce extraordinary results – results which often go unrecognised. Often when working with young people the focus is on addressing difficulties and personal achievements can be overlooked. The culture of achievement or success is usually not the norm. The Creating Dreams Project acknowledges the achievements of individuals as unique and meaningful in the hope that young people will recognise themselves as strong and extraordinary individuals capable of producing outstanding results in their lives, despite the circumstances they are faced with. The project offers hope and inspiration for other young people facing similar situations.

The project is funded through an employee contribution fund from Westcare and the broader Salvation Army and corporate sponsors, a grant from The Salvation Army and specific fundraising activities.

3.10 Journeys Program
Adolescent Activities Based – Camping & Groupwork Program (2005)

Example of Emerging Practice: Groupwork with Young People

MacKillop Family Services

The Journeys Program[102] was established in 2005 to work with young inhalant and other drug users. The program was established to assist young users living in out-of-home care or at risk of being placed in out-of-home care to cease or reduce their substance use. The program works with young people aged 13-17 who are struggling with a range of issues such as, drug and alcohol use, grief and loss, relationships difficulties and self-esteem issues. The program works with a maximum of 30 young

[101] Source: The Salvation Army Westcare – Program brochure & Holistic Model Paper (2005)
[102] Source: Journey's brochure and MacKillop Family Services' program description (2005)

people over a six month period. The Journeys Program aims to provide young people with opportunities to have positive life experiences within an activity based program.

The program includes:

- Referral and assessment.
- Commitment to attending and participating in the six month program.
- Attending six weekend camps and participate in:
  - Discussion of life issues within a group setting.
  - Outdoor activities (ie bush walking, fishing, bike riding, karaoke nights and camp fire discussions).
- Attend one group session per week of one to two hour's duration. These sessions are goal focused and review the progress young people are making towards achieving their goals.
- Young people are expected to keep a journal of their "journey" through the program.
- Young people may also be offered individual counselling sessions.

Using a combination of regular monthly camp and weekly group sessions, young people quickly became agents of change over their own lives. Young people who successfully complete the program receive a certificate of participation and may be offered the opportunity to participate in future camps as peer mentors/camp leaders.

All young people who participate in the program are referred to a mentoring program such as White Lion, ASISTA, Big Brother or Big Sister and matched with a mentor.

4. Case Management Practice

Example of Good Practice

4.1 Looking After Children (LAC)

Looking After Children: a case management system which addresses the specific needs of children and young people in out-of-home care.

LAC aims for better life outcomes for children and young people in care by:

- Guiding how information is collected and used in practice.
- Encouraging participation and collaboration in care planning and assessment.
- Making care planning a dynamic, transparent process.
- Providing timeframes for the important things which need to occur.
- Ensuring the child/young person remains the focus of plans and decisions made about their life.

Looking After Children was implemented in Victoria as a joint initiative of the 39 Victorian community service organisations who deliver out-of-home care services for children and young people in partnership with the DHS. Looking After Children provides a framework for identifying the needs of children and young people and developing plans which aim to meet these needs.

LAC covers seven areas:

- Health.
- Emotional and Behavioural Development.
- Education.
- Family and Social Relationships (which also includes Contact and Access Information).
- Identity.
- Social Presentation (which also includes interests, leisure and recreation).
- Self-Care Skills.

The LAC framework attempts to strengthen communication and collaboration between carers, DHS staff, community service organisation staff, other professionals, clients and their families. It prompts all parties involved to consider the things any good parent would naturally consider when caring for their own children. It also provides community service organisations with a common framework for their client records systems which contains all of the information they require to look after a child or young person in the care of their organisation.

4.2 Intensive Case Management Services

Example of Good Practice

Central Hume
Berry Street Victoria - Gippsland & Southern Regions
Westcare - The Salvation Army

The Intensive Case Management Services (ICMS)[103] model was tendered in 1998 and has been operating successfully for a decade. Three agencies reported on the effectiveness of the model as an example of good practice in working with high risk adolescents presenting with complex needs.

ICMS has the following objectives:

[103] DHS Tender Document 1998 and The Salvation Army Westcare's ICMS Service Document, August 2004.

- Provide a region-wide integrated case management and brokerage service response, encompassing both outreach and support services to high-risk young people.
- Provide and promote innovative responses to young people's care requirements, including on-to-one care packages.
- Develop and improve links between DE&T, mental health, drug and alcohol services, juvenile justice and youth services so that clients receive integrated and co-ordinated care.
- Facilitate co-ordination and access to accommodation support services, recreational and vocational services, the police, family support services and the young person's family.
- Provide integrated and flexible care and support options for young people in a holistic and multi-disciplinary framework.
- Ensure service delivery is innovative and informed by review and evaluation.

Young people accessing ICMS are usually a client of Protective Services with a legal order, aged between 13-17 years presenting with multiple and complex behavioural and emotional difficulties, (often) residing in out-of-home care. Each worker has a case load of 4-6 clients – the level of intensity of case management is dependent on the assessed level of risk and may span a two year period.

The ICMS model is multi-disciplinary team and employs drug and alcohol and mental health workers plus intensive case managers. ICMS assigns a case manager for each high-risk adolescent. The case manager has responsibility for developing a trusting relationship with the young person, implementing an individual case plan, ensuring effective planning and co-ordination of services involved, as well as monitoring and reviewing the progress of the case plan. ICMS also ensures adequate exit planning and puts in place accommodation and support services to meet the post-care needs of young people.

The ICMS model has access to brokerage funds to purchase individualised services that are not available through mainstream services, such as educational or vocational programs, mentoring programs, personal development activities or other specialist services otherwise not readily accessible.

ICMS is part of a continuum of services providing a holistic response to young people and their families. Out-of-home care, support and exit planning is achieved by multi-program individual case consultancies where all programs (internal and external) meet to discuss and plan the future and develop crisis plans.

ICMS has contributed significantly to achieving a co-ordinated, multi-agency/disciplinary network of services to better respond to and meet the complex needs of high-risk adolescents, including comprehensive specialist assessments and access to services. Other good practice characteristics include intensive outreach and support and extended hours support to youth and after-hours crisis support and intervention/consultation to residential service providers.

4.3 Health Team

Berry Street Victoria

The Adolescent Health Team[104] works closely with the Intensive Case Management Service (who provide services to residential care clients). Currently the team includes two specialist health positions: the Mental Health Intensive Youth Support and the Specialist Drug & Alcohol Worker:

The Mental Health Intensive Youth Support worker is a joint initiative of Berry Street Victoria and Southern Health Child and Adolescent Mental Health Service. This worker provides mental health consultation to Berry Street Victoria clients as well as direct comprehensive case management to a small number of clients. Berry Street Victoria employs a drug and alcohol worker who has availability for counselling and assessment where appropriate.

[104] Source: Berry Street Victoria's web site.

4.4 Practice Wisdom regarding Case Management

Lisa Lodge
Central Hume
MacKillop Family Services
Westcare – The Salvation Army
Peninsula Youth & Family Services
Berry Street Victoria – Gippsland and Southern

Discussion[105] identified the following practice wisdom in regard to what contributes to successful case management of residential care clients:

- Case worker allocated to each young person in residential services – experience indicates that young people managed by a community service organisation received a more effective service.
- Crisis management and behaviour plans are effective tools to manage young people's challenging and complex behaviours in placement; reviewed at fortnightly team meetings.
- Access to specialist secondary consultants – for example START and Orygn are essential to support residential care workers work with young people.
- Importance of "care team' meetings to operationalise care plans and crisis management.
- Care teams more effective when membership is multi-disciplinary and "lead" or "key worker" role identified to work with young person.
- ICMS case involved in residential team meetings.
- Involve the young person and their family in planning within the context of LAC and the Protective Case Plan.
- Positive working relationships required with Protective Services and DHS Liaison workers to get best outcomes for each young person and their family.
- Effective case management requires families to be part of the team.
- Case managers must have the support and understanding of the whole agency and management team to ensure their ongoing well-being. ICMS cannot be seen in isolation; good practice involves a whole of agency response.

5. On-Call and After Hours Support

Example of Good Practice

5.1 Roving Support Team

Berry Street Victoria
Gippsland & Southern Regions

The Roving Support Team[106] is an example of a good idea from practitioners (in May 2000) becoming a reality with allocation of resources to support the development of a "roving" after-hours, crisis support function for residential care staff caring for high risk adolescents. In May 2002, the "rover" became a recurrent funded program with three positions in Southern Region: a supervisor and two permanent roving staff ($160,000 per annum). The Roving Support Unit operates from 6pm till 2am with flexibility for the rover to stay on to support the residential unit staff as long as required to settle a resident and/or unit.

The philosophy behind the Roving Support Team is to reassure residential unit staff that there is always additional after hours prompt support when required. General response time is usually no more than 15 minutes. The Roving Support Team works closely with the agency 24 hour on-call supervisor who directs the rover's work for the evening. At the beginning of a shift, the rover contacts

[105] Source: Residential Services Think Tank, April 2006
[106] Source: Roving Support Team Paper. BSV – Southern Accommodation Services

the on-call supervisor who advises of hot-spots/concerns about young people or tasks that need to be done in the afternoon/evening. When the rover is called to a unit, strategies are worked out with on-call on route to the unit. The rover keeps on-call informed and updated during the unit consultation. Rovers work collaboratively with unit staff and together seek solutions.

Strategies include:

- Response to a crisis or when problems occur in a residential unit (eg substance misuse by resident or aggressive/threatening behaviours).
- Assessment of resident health and well-being.
- Defusing situations and avoiding further escalation of the difficulty.
- Support unit staff such as the deployment of unit staff and the rover taking their place (ie unit staff go to bed and rover supervises the unit).
- Enhance unit staff and client safety.
- Assist the day-to-day functioning of the unit.

In Gippsland, the concept of "the Roving Support Team" has been adapted due to less funding and geographic limitations of operating a residential care service across a large rural region. The Rover Support Team resources a supervisor and a .5 residential care worker and is based in the Latrobe Valley.

As there is no public transport in the Latrobe Valley after 8.30pm, (in addition to the above strategies), the Gippsland Rover is required to transport residential clients in the evenings as directed by the on-call supervisor and assist in transporting residents in Latrobe Valley units to their education programs in the mornings. On occasions, the rover has been required to assist residents and unit staff at the Bairnsdale and Wonthaggi units.

6. Family Involvement

Examples of Emerging Practice

6.1 Parent Support Group with Kids in Residential Care[107]

MacKillop Family Services

- What is the value of parent support groups?

Parent support groups[108] are such a simple concept, and like so many simple things, their value can be underestimated. In an age of high-powered marketing campaigns and complex technology, we can forget that simple human relationships can be a very powerful tool. Parent support groups capture the very 'essence' of what we are trying to create when we talk about assisting people to 'connect with their community'.

- What is the parent support group?

The idea for the parent support group came out of our work with various families all of whom were asking one question: "Where do parents go for help?" In response to this question and with the knowledge that all of the parents we work with have one thing in common, we developed our parent support group. The group is loosely based on narrative ideas (ie story telling) and aims to provide parents opportunities to:

- Meet and share stories with other parents who have a child or young person living in-out-of home care.
- Hear stories from parents who have had a child or young person living in out-of-home care.
- Meet and listen to young people who have lived in out-of-home care.
- Hear from the occasional guest speakers.

The groups are held on the first Tuesday of every month from 6pm to 8pm at the office in Flemington and provide parents with the chance to participate in a night of good food and informal conversation while hopefully gaining a better understanding about what it is like to have a child or young person in care.

- How has the parent support group helped our work with families?

The outcomes of the parent support group so far have been interesting and have included:

- Parents don't feel as isolated.
- Allows for the creation of better working relationships with parents.
- Parents feel supported and don't feel that they are being judged.

- Where to from here?

MacKillop Family Services is exploring ways to further develop the group such as holding the group away from the office environment occasionally and options for starting a group in the North.

[107] Source: MacKillop Family Services
[108] Parent to Parent West News, July 2006

6.2 'My Family First' Group Program

Glastonbury Child & Family Services
Family & Placement Services

My Family First[109] Group work program is for parents with children recently in care, parents with children in long term care and parents where there is an imminent reunification plan.

The program assists parents by:

- Providing information on child development.
- Different ways to manage a child's behaviour.
- Ways to improve the parent child relationship.
- Increased social and support networks for the parent.

Parent education has been valued and "advocated as a significant component of any comprehensive framework of the prevention of child maltreatment" (Tomlinson 1998). With improved stability of care for children (as per new legislation) there will be tighter timelines for parents to achieve necessary changes so they can have their children return to their care.

The **My Family First** Group work program assists parents to gain skills in their 'different' parenting role.

Aims of the group are:

- To support parents in remaining focused on the needs of their children.
- To assist parents in working through feelings associated with having their children in care/returning to their care.
- To assist parents to adapt to different parenting roles with their children and in dealing with issues relating to their children.
- To promote positive partnerships/collaboration between agencies to enhance service delivery to clients.

6.3 Family Reunification Unit

Glastonbury Child & Family Services
Family & Placement Services

Glastonbury Child and Family Services have extensive practice experience in the provision of intensive family preservation and reunification services, out-of-home care and in-home community based services. The Family Reunification Unit[110] (FRU) was established in 2005 (unfortunately no longer operational due to withdrawal of DHS funding) and provided an integrated service response based on assessment of family needs, reunification readiness with a combination of therapeutic and practical/concrete services in the context of the family's community and social networks. The FRU was designed to access the diverse range of programs offered by Glastonbury Child and Family Services, thereby offering an holistic and integrated service response to meet individual family needs.

The Family Reunification Unit is loosely based on the family group home concept in which a paid caregiver resided within the Unit on a full time basis. Each family had a "care team"- including a specialist worker, specialising in intensive reunification work who co-ordinated each case, a 24 hour live-in caregiver as well as access to additional supports. The model is designed to be flexible to meet individual family's needs, offering placement in the Unit for up to six weeks. Depending on the initial assessment, the Unit could be available for child/ren admission or whole family admission. Support

[109] Source: Glastonbury Child & Family Services
[110] Source: Glastonbury Child & Family Services: Family Reunification Unit Program Documentation, 2005

and interventions offered are flexible and dependant on the selected option to meet the individual family needs.

Options for family reunification work included:

- *Pre-care work with families*

Parents assessed as being prepared for reunification; however, reunification considered not yet appropriate due to parental issues and the child could be placed in the unit.

- *Placement of children in the Unit*

Parents could be provided with respite from the full time care while they worked on their own issues. Children's needs are met in a safe and nurturing environment while parents maintain a high level of involvement, contact and responsibility in their children's lives:

- Parents accessed the Unit on a day-stay basis to learn and practice parenting and appropriate behaviour management strategies.
- Parents attended the Unit at specific times of the day to develop specific skills such as dinner time, bed time or before school routines.
- Where appropriate, parents stay overnight to assist in learning how to develop routines and maintenance of consistency.
- Ongoing assessment regarding the parent's progress and readiness for children to spend some over night stays at the family home.

- *Placement of the whole family in the Unit*

The family assessed as having both the commitment and the capacity to work on reunification issues, a plan is established detailing goals and interventions for preparing the family for reunification. Parents maintain parental responsibility for their children with supports.

- *Therapeutic and practical supports*

The FRU offers a multi-disciplinary team approach and access to a range of services to meet individual and family needs, offering a mix of therapeutic and practical supports:

- *Family counselling* – the reunification worker has regular contact with the parent/s to provide counselling and practical supports to develop parenting capacity and address the protective concerns. Counselling is flexible and provided for individuals (both parent and child), couples, siblings and whole of family work responding to individual family needs. As well, group work programs available within wider Glastonbury programs.
- *Comprehensive assessments* (generic and specialist), including paediatric health, psychosocial and/or educational.
- *Child Behaviour management interventions* – a range of child behaviour management interventions are offered to parents dependent on their individual family needs and circumstances. The reunification worker and carer provide the parent/s support in developing their parenting capacities through specific skill development, role modelling and practical advice through family observations in the Unit or home visits.
- *Practical supports* – financial assistance, transportation, child care access/minding, material aid, recreation and social activities.
- *Practical household supports* (eg. hygiene, food preparation, cleaning, daily care) and budgeting.
- *Secondary consultation* – access to a range of secondary consultation and services in Glastonbury Child and Family Services (consultation/services including mental illness; substance abuse; family therapy, counselling; psychological assessments; art therapy, group work, early years services and intensive family support).
- *Access to external consultation and referral to specialist services.*
- *Brokerage funds.*

7. Innovative and Culturally Responsive Practice

7.1 Aboriginal Liaison Worker

MacKillop Family Services

In 2001, MacKillop Family Services[111] identified the need improve agency responsiveness to Indigenous children, young people and families accessing its services. The Board authorised the formation of the Indigenous Issues Steering Committee to assist the agency understanding community and cultural practice. The Board also provided one-off project funding to employ a Koorie Liaison Worker.

- Aboriginal Liaison Worker Position

The Aboriginal Liaison Worker position is a now permanent, full-time role funded by MacKillop Family Services. The focus of the role is to enhance MacKillop Family Services' practice with Aboriginal children, young people and their families in Melbourne's North West and Southern Suburbs and Geelong. The Aboriginal Liaison Worker has recently developed two key resources to support service delivery and practice change within MacKillop being:

- Working with Aboriginal and Torres Strait Islander Children Manual.
- Aboriginal Resource Information Kit.

- Working with Aboriginal and Torres Strait Islander Children Manual

The Working with Aboriginal and Torres Strait Islander Children Manual is a resource manual for case workers and carers of MacKillop Family Services working with, and caring for, Aboriginal and Torres Strait Islander children which outlines:

- Staff roles and responsibilities in relation to working with Indigenous children in out-of-home care, and working with Indigenous children, young people and families in other MacKillop Family Services' programs. For example, when an Indigenous child or family commences with any MacKillop Family Services' program, the Aboriginal Liaison Worker must be notified and the appropriate checklists completed.

  The Out-of-Home Care Checklist requires MacKillop staff to:

  - Check the Victorian Aboriginal Child Care Agency (VACCA) has been notified.
  - Advise the Aboriginal Liaison Worker of the child/young person/family details.
  - Follow the Aboriginal Child Placement Principles.
  - Complete a Cultural Support Plan within the first month.
  - Ensure non-Indigenous carers have received or are booked into receive cultural awareness training.
  - Ensure the Aboriginal Resource Information Kit has been provided to the carer.
- Legal and practice requirements including information on implementing the Aboriginal Child Placement Principle and instructions on how to develop Cultural Support Plans.
- Good practice principles and advice for working with Indigenous children and their families. A copy of the Aboriginal Resource and Cultural Guide prepared by VACCA and the Caring for Aboriginal and Torres Strait Islander children in out-of-home care resource developed by VACCA and DHS are included in the Manual.

[111] Source: Monograph: Improving services and outcomes for Indigenous children, young people and their families. The Centre for Excellence in Child & Family Welfare. 2006

- **Aboriginal Resource Information Kit**

The Aboriginal Resource Information Kit developed by the Aboriginal Liaison Worker provides carers looking after Indigenous children and young people information and advice on how to maintain links to culture and community and includes:

- A history of Aboriginal people in Victoria.
- Resources on caring for Aboriginal and Torres Strait Islander children in out-of-home care such as the VACCA / DHS document Caring for Aboriginal and Torres Strait Islander children in out-of-home care.
- Information about local community activities such as Indigenous arts and crafts, Koorie Heritage Trust, Bunjilaka Supporters Club etc.
- Contact details for local Aboriginal Community Controlled Organisations (ACCO's) and workers.
- Pamphlets and information on Indigenous specific services such as Link Up.

MacKillop Family Services report a number of benefits and positive outcomes from the establishment of the Indigenous Issues Steering Committee and the Aboriginal Liaison Worker role. In particular:

- A significant improvement in the knowledge and understanding of MacKillop managers and staff of the needs and priorities of the Indigenous children, young people and their families.
- Improved practices by MacKillop staff, including routine identification of the Indigenous status of children, young people and families, improved service coordination by involving VACCA staff and other Indigenous workers in care, better data, and a greater understanding of the needs and priorities of Indigenous people.
- Improved knowledge by carers of the needs of Indigenous children and young people, including the importance of maintaining and supporting links to community and culture; better information about the role of ACCO's and local Indigenous workers and a greater appreciation of appropriate parenting strategies for Indigenous children.

8. Alternate Educational Services

8.1 WARPed – Work, Recreation and a 'little' bit of Education Program

Eastcare – Youth Services
The Salvation Army

WARPed[112] is a day program for young people (aged 14-18 years) who are not attending school, employment or training. Clients are young people on a statutory order and/or juvenile justice order who are not participating in a current full-time day program living in the Eastern Metropolitan Region. Young people must have a desire and commitment to participate in the program.

The program runs three days per week (Tuesdays to Thursdays) over two 20 week semester periods. Arrangements can be made to pick up and drop off young people from their home address. WARPed offers:

- *Education/Vocational*

First aid, driving education, computer skills, regular education sessions, educational excursions (eg. Scienceworks, historical sites).

- *Personal Development*

Art, personal expression, anger management, communication skills, loss and grief, sexual health, healthy decision-making, team building.

- *Recreational Activities*

Horse riding, rock climbing, sailing, surfing, canoeing, bowling, hiking, picnic, bush walks, fishing, movies, zoo visits, swim with dolphins, snorkelling.

The outcomes and benefits of WARPed include:

- Heightened self-esteem and confidence.
- Greater independent living skills.
- Further developed literacy and numeracy skills.
- Group participation and team work skills.
- Enhanced communication skills.
- Motivation and re-established daily routines.
- Hope and direction for the future.

8.2 Education Program

Westcare
Salvation Army

The Westcare Education Program[113] was established in 2002 to offer the Certificate of General Adult Education (CGAE- Year 10 equivalent) to eight young people between the ages of 13 and 18 (currently within a Westcare program or being case managed) who have been excluded from all forms of education due to their behaviour in mainstream and alternative educational settings. The program is currently funded through Westcare's Residential Services and the Hugh Williamson Fund.

Young people are referred to the program for issues such as disengagement from all mainstream and alternative educational options, mainstream options being inappropriate or withdrawn due to extreme behaviours such as verbal and physical aggression, violence, inability to manage anger, drug or alcohol use, sexualised behaviour and/or criminal activity.

[112] Source: WARPed Program brochure. Eastcare – Youth Services, The Salvation Army
[113] Source: Westcare Education Program Report

The Educational Program uses a unique mix of learning and social programs which are designed to creatively maximise client literacy and numeracy, social awareness and social skills, self esteem, behaviour management, recreation, art and science and self-management. The program, run by youth workers with training qualifications, offers a safe and dynamic environment aimed to provide young people with learning or employment pathways.

The program operates on a set of guidelines or rules that young people are expected to follow, outlining behavioural and educational expectations. The CGEA is curriculum based and is delivered through a mix of classroom work and one-on-one-supervision appropriate to the individual client needs, skills and abilities. The program also has an extracurricular program including:

- An art program – offers craft, drawing, painting, sculpting sessions.

- Recreational activities – carried out in conjunction with the Police Youth Liaison Officer for Sunshine to build positive relationships and advice on legal issues.

- Health and personal well-being program:
  - Life skills program – communication, health, nutrition, relationships and sexual health
  - Nutrition – provides food and cooking skills.
  - Alcohol and drugs – weekly visits from the Youth Outreach team to talk to youth about alcohol and drugs, sexual health, safety and harm minimisation.
  - Mental health – weekly visits from mental health workers to provide support and guidance on mental health needs.
  - Hygiene – information on personal hygiene and health issues and resource information/referrals.
  - Social skills and behaviour – work with youth to learn about the impact of their behaviours and modification to assist youth access mainstream education, training or employment.

- Community Networks to provide services to youth:
  - Sunshine Police Youth Liaison Officer.
  - Centrelink.
  - Kensington Community School.
  - Variety Club loan vehicle.
  - Western Education Support Team – offer educational assessments and pathways to further education, employment and training, tutoring and resources to assist learning.
  - Victoria University – places a student youth worker on placement.
  - Westcare staff diverse talents and skills.

The Education Program stages an annual Art and Photography exhibit, showcasing some of the extraordinary work achieved by young people. Supported by the agency, police and community sponsors, the exhibit is an opportunity for the young people to present their work and receive recognition for their commitment and the relationships that they have developed through the course of their studies.

The program is effective due to its integration within Westcare's service system and local community; provision of a non-judgemental, proactive learning environment and assistance with not only educational needs but also life skills and support. The young people reach achievable goals which give them a strong sense of achievement and identification of future pathways.

8.3 Optimal Learning

Lisa Lodge
Ballarat

Optimal Learning[114] is a youth specific Registered Training Organisation that delivers accredited training to young people who have been unable to maintain their place in traditional schooling. Optimal Learning has had a close working relationship with Lisa Lodge since its inception.

8.4 BEST Centre

Berry Street Victoria – Southern Region

The Berry Street Victoria Education School and Training (BEST) Centre[115] is a registered independent school, located in Noble Park. BEST Centre offers individually tailored education programs for young people in out-of-home care who have dropped out of or have been excluded from school.

The BEST Centre incorporates remedial education work, recreational, craft, practical trade activities and life skills training.

Later in 2006, the BEST Centre will open a campus in Morwell, located at "The Shed."

8.5 Best @ The Shed

Berry Street Victoria - Gippsland Region

Berry Street operates a number of programs from two locations in Morwell - The Shed (workshop) and The House[116]. These flexible learning opportunities are for young people who are unable to access mainstream schooling who reside in residential care, home-based care with Berry Street Victoria and other accommodation providers in the Latrobe Valley, independently and/or with their families.

The programs: ScAce and Community Based Victorian Certificate of Applied Learning (VCAL) and the "Young Mums" VCAL are funded by local Secondary Colleges. The former program is funded through the DE&T/ACE Agreement and CIRC funding. Some young people receive all their individually tailored education through these programs, while others access group work opportunities supplementary to their in-school programs. In addition to literacy and numeracy, programs are developed which build on interest areas of the students and include food technology, woodwork, automotive, visual arts, music, personal development and health. Other programs offered from the House to young people (including our residential clients) are mentoring and driver education.

8.6 VACCA Educational Support Program

The VACCA was established in 1978 as a statewide Aboriginal community controlled and operated service. VACCA's objectives include the preservation, strengthening and protection of the cultural and spiritual identity of Indigenous children and provide culturally appropriate and quality services responsive to the needs of the Indigenous community.

The most significant reoccurring issue for VACCA clients living in residential care is their sense of personal and cultural identity. The children living in the Family Group Homes have a longing to know who their family is, where they come from, and how they are connected to the Koorie community. Each child's emotional well-being affects their ability to participate at school.

[114] Source: Optimal Learning. Lisa Lodge
[115] Source: Berry Street Victoria
[116] Source: Berry Street Victoria-Gippsland

- **The Goals of the Program**

The goals of the VACCA Education Support Program are to:

- Provide the children with culturally appropriate resources and supports.
- Engage the children with their learning.
- Help the children celebrate their Aboriginality.
- Ensure that strong partnerships are forged between the school, VACCA and the family group home staff so that the greatest success for the student is met.
- Connect the children to community.
- Enhance self esteem and build resilience.

- **Education Support Workers Role**

- Weekly one-on-one tutoring and education support with children in school and at home.
- Facilitating and organisation of Support Group meetings as outlined in the "*Partnering Agreement*".
- Ensuring that schools acknowledge the cultural needs of Aboriginal students, and that schools are resourced and supported to meet these needs.
- Seeing the need for innovative and creative practice to meet the needs of the children.
- Monitor and evaluate students progress.
- Provide teacher awareness on how to deal with sensitive issues.
- Work to resolve problems as they arise.
- Respect confidentiality.

- **The Programs Strategies**

- To ensure children living in the out-of-home care, have adequate education support, access all appropriate resources and services to maximise their educational outcomes.
- To liaise with teachers, student welfare co-coordinators, psychologists, ATAS tutors, DHS case workers and all relevant personnel to ensure a coordinated approach meets the educational needs of all children living in out-of-home care.
- To provide information regarding educational funding and resources to VACCA caseworkers as requested.
- To work directly with each child living in the family group homes within their classroom and after school at the family group home to ensure regular educational progress is monitored and supported.
- To complete an Individual Education Plan with classroom teachers at the beginning of each year for each child.
- To work with the policy officer to apply for additional education funding to better support Koorie children in care to access quality education and resources.

8.7 Rice Education and Youth Services

8.7.1 Overview of the Program

Rice is a unique and innovative integrated accommodation, education and therapeutic program which centres on the provision of relationship and connection in the daily environment for a specific target group of children, geared toward the complex and long term needs of those who most present with highly trauma–based symptomologies, which manifest in complex mental health and challenging behaviours. This group has often experienced a number of previous accommodation and educational options which have been unable to meet their specific individual needs. The Rice program aims therefore, to work towards effective outcomes for these children and young people by providing consistent and intensive care 24 hours a day for a minimum of two years.

Program location:	Statewide, based in Melbourne
Program target group:	Young people 9 – 15+ years, on protective orders, referred by DHS.
Program numbers:	16 – 20 at a time for two or more years/24 hour care.
Staffing:	30 – 35 staff including residential staff, social workers/case managers, psychologists, administration and management. Education staff include an education leader, four teachers and a youth worker.
Program auspice and/ or funding source:	DHS.

The overarching aim of the Rice Program is to, "become the core provider for each young person of a treatment model of care and living environment which will be a key vehicle for individual development, change and healing". A Care Team approach has been established involving teams of staff from the four components of the program – residential, educational, case management and psychology – as well as the young person on a regular basis and increasingly, other professional specialists and family members.

As Rice is an integrated program, educational programs are intricately linked with other aspects of the daily care and development of the young person however, some of the following aspects are key to the development of a specific program of education for each young person:

- The treatment model and subsequent educational program for each young person is determined by the particular history and characteristics of that young person.
- Always looking for new approaches to learning. Program is set up so that young people can experience success and be encouraged to continue with some form of education.
- Use a mixture of three specific approaches to engage our young people in education.

Rice works on a capability building framework which has been designed by Michael E Bernard PhD Professor, Faculty of Education University of Melbourne.

By promoting capabilities we work on:

- Emotional resilience (emotional awareness, empathy emotion regulation and behaviour control).
- Positive mindset for achievement (academic confidence, work persistence, work organisation).
- Getting along (social confidence, friendship making, conflict resolution rule following and collaboration).
- Social responsibility (honest, respect, fairness, caring and citizenship).

Relationship development is the focus of care and education in order to acknowledge the significant issues of attachment disruption that have occurred in the young person's life:

- Teachers develop 'school capabilities' in young people when they demonstrate the good practice of developing positive relationships with students especially those with behaviour and achievement problems.
- We work towards establishing positive student / teacher relationships.
- Our framework for working with young people has also been based on a building block approach adopted from the Circle of Courage Model (developed by Brentro and Sieta).

  The approach works on building strengths in four major areas:
  - Belonging.
  - Competency.
  - Independence.
  - A Sense of Community.

The curriculum is designed to empower students to cope effectively with the choices, problems and opportunities which face them:

- By providing realistic expectations for achievement and ensuring that behaviours are communicated.
- By offering classes that cater to the diverse interest of students (eg. flexibility in curriculum).
- By providing quality social emotional curriculum instruction and motivation. Teachers therefore model positive attitudes and values and teach life skills.
- Most importantly we aim to provide students with opportunities to be successful in achieving academic goals (ie by providing modified programs and individual education plans).
- Belonging – is the fundamental building block. The young persons needs to develop trust and confidence that their basic physical social and emotional needs can be met consistently and positively. They should feel valued, important, protected, and welcome as part of a group.
- Competency – encourage growth by the development of skills so the young person learns that they can achieve.
- Independence – is encouraged by creating choices in a safe non-threatening environment so that young people feel they have control in their decision making.
- A Sense of Community – this is achieved when young people can step out and think beyond themselves. By contributing to the community they can see purpose in their lives.
- Therefore establishing positive relationships which are based on mutual respect, responsibility, and appropriate boundaries is the crucial determinant to successfully working with the building blocks approach.

8.7.2 Partnerships

Links and partnerships with relevant best practice service providers in areas such as long term therapy (e.g. Take Two) and adolescent mental health care (e.g. the Eagle Unit at the Austin) complement the services offered by Rice as having responsibility for the daily environment and therapeutic care of the young person.

8.7.3 Measuring Success

Rice is developing an intensive initial and then ongoing range of assessment processes which are able to ensure that treatment programs are developed to meet the needs of young people arising from the impact of their early developmental experiences. A specific evaluation project is also being developed to measure the success of this approach.

9. Consumer Advocacy

9.1 CREATE Foundation

CREATE Foundation[117] is a national not-for-profit organisation run by, with and for children and young people in care throughout Australia. CREATE aims to connect and empower children and young people in care and improve the care system through activities, programs, training and policy advice. Established in 1993 (previously known as the Australian Association of Young People in Care) CREATE is the only organisation of its kind in Australia and one of only three internationally.

Young people in care experience levels of educational attrition, homelessness, unemployment, juvenile justice involvement, drug and alcohol abuse and mental health conditions disproportionate to the rest of the Australian youth population. CREATE aims to improve the life outcomes of this very vulnerable group through provision of a comprehensive range of products and services that are designed to connect, empower and change both young people and the stakeholders that play a part in out-of-home care provision.

CREATE has offices in all Australian states and territories. For more information or to order an information pack phone the free call number (1800 655 105) and be connected through to the relevant state CREATE office or visit the website at www.create.org.au

9.1.1 Connect

CREATE Newsletters
A bi-monthly newsletter written for, and by, children and young people in care.

clubCREATE
A free membership club for children and young people aged 2 – 18 years, providing members with regular newsletters, birthday cards, invitations to special events, special deals/discounts and random member prizes.

clubCREATE:fun
A local community building program which connects children and young people to each other and their communities.

CREATE:your zone
An interactive website designed with and for young people in care, offering important and interesting information, fun activities (pictures, games, colouring pages, jokes, movie reviews) and a question and answer section where young people can anonymously ask questions and receive moderated advice from professionals.

9.1.2 Empower

mission:be
A leadership, learning, team building, goal setting and action planning program for young people in care aged 14 – 18 years. The module-based program is delivered over a six month period with three months focusing on community development and three months of one-day workshops, weekend residential programs and community activities (eg. individual community projects).

Show me the …
A fun and creative one-day event for young people in care aged 12 – 18 years and an adult in their life (worker, carer, sibling or significant person). This program aims to strengthen the relationships between young people and the adults in their life through participation in an adventure activity. Show Me the Ropes and Show Me the Circus are two of the models used in local communities.

[117] Source: CREATE Foundation

9.1.3 Change

CREATE Young Consultants Program
Young people with a care experience aged 14 – 25 years are given training that covers the history and objectives of CREATE, the Australian care sector, presentation and public speaking skills. Trained 'Young Consultants' are then supported to participate in policy development, training, research, projects and group facilitation activities. CREATE Young Consultants have trained departmental case workers, discussed their experiences at parliamentary inquiries, and given speeches at conferences and public events.

CREATE:consulting
CREATE contributes to improving the care system through policy advice, project management and delivery, research, training and group consultation with children and young people. Consulting services are delivered by project teams of trained Young Consultants, CREATE staff and external experts as required.

Workplace Learning Programs
Provide opportunities for young people with a care experience to spend time developing skills in a 'real life' workplace. Workplace learning programs are jointly conducted by CREATE and corporate partners and enable young people to make contact with supportive adults, gain generic employability skills, receive current career advice and have a positive workplace experience.

10. Post-Care Services

10.1 Investing for Success: The economics of supporting young people leaving care

The Centre for Excellence in Child & Family Welfare

This report[118] presents the findings of a research project undertaken by the Centre since 2003, with a view to establishing long term costs of current Government policy and estimating the costs of an integrated leaving-care model that will be appropriate for young people leaving care in Victoria. To achieve this objective, the project interviewed 60 young people in the 18 - 25 age group and collected data about their in-care and leaving-care pathways through a questionnaire. The data was analysed for significant associations between variables, both when these young people were in care, after they had left care and their life outcomes.

The research was based on the hypothesis that there are significant factors experienced by young people in the in-care and post-care period which differentiate their outcomes. Identifying these factors and their relative impact on outcomes would inform the process of developing a leaving-care model suited to Victorian conditions.

The data from this research shows that around a fifth of young people are leaving care without any plans for their future. A third of them have a case plan that releases them straight into programs run for homeless people, leaving them in a vulnerable and dependent state, ironically, when they are attempting to take their first steps towards independent living.

Less than a third had completed formal schooling leaving them vulnerable to unemployment in an increasingly competitive employment market. Around three quarters are unemployed and depend on the Government for income support. More than half of the young people leaving care survive on a weekly income of less than $200. Not surprisingly, over half have problems with debt. Their general health and mental health outcomes are also poor.

The literature review in "Investing for Success" has highlighted changes in the Australian society since the 1980s and the fact that transition to independent living and adulthood is now both delayed and extended, and the passage into adulthood is not a single event but a gradual process. It is now known that over three quarters of young people aged 18 - 19, over a third aged 23 - 24 and a fifth in their late twenties from the general population are estimated to be still living with their parents. Over 40 per cent of young people who leave home, particularly for reasons other than marriage, return to live with their parents at least once due to financial, emotional or accommodation problems, with returning home much more common for those experiencing difficulties in making the transition.

The research shows that this state of affairs is unsustainable, also from an economic perspective because there are long term costs which have an enormous impact on other parts of the State's budget. Unemployment, crime, health, housing and child protection costs for intergenerational cycle of care are estimated to cost the State $738,741 per young person leaving care, over the next 42 years. This cost is over and above an estimated average investment of $125,000 that the State has already made in young people while they are in statutory care.

Assuming an average of 450 young people leave each year (based on 03-04 AIHW figures), each year's cohort of young people leaving care will cost the State in the range of $332 million per year over the next 42 years, if current policies remain unchanged.

On the other hand, the model for integrated leaving-care support for young people up to 25 years of age is estimated to cost the State around 11 per cent of the cost of not putting in place any

[118] Source: Investing for Success: The economics of supporting young people leaving care. Sunitha Raman, the Centre for Excellence in Child and Family Welfare, Brett Inder and Catherine Forbes, Monash University, 2005

measures. The positive pathways of some of the young people in our sample provide us with a basis to assume that support programs at critical points in the first few years of transition will enhance the resilience inherent in any individual, lead to positive outcomes and a successful transition to adult life.

The moral, economic and social arguments for investment in leaving-care are before the Government. The message is clear – act now as a caring parent would and support the young people for whom you have assumed parental responsibility. Act now as a responsible Government would in building the capacity of its communities. Act now as a prudent economist would, spend a little more now to save a lot in the future. The cost of doing nothing is detrimental to young people, society and the economy at large.

10.2 Leaving Care: A Model for Victoria

The Centre of Excellence in Child and Family Welfare

The Leaving Care Statewide Forum in December 2005[119] identified the following components of leaving care essential to underpin best practice post-care services. The Children, Youth and Families Act 2005 mandates post-care support to the age of 21 years for young people residing in residential care.

Preparation for Leaving Care

Over the past two years organisations providing out-of-home care services have developed a range of programs aimed at preparing young people for leaving care. The focus of these programs and approaches has been to increase the living skills of young people in care. The work of some organisations has been quite extensive and the resources and ideas developed could be utilised across the out-of-home care system.

Preparation Programs and Approaches

The range of preparation programs and approaches that have been developed by organisations include:

- *Development of living skills manuals*.

These manuals can be used by young people in conjunction with their carers/case workers. Excellent examples of this include the Berry Street Victoria and Peninsula Youth and Family Services manuals.

- *Policy and guidelines frameworks*.

The frameworks attempt to embed leaving care preparation within day to day care and case work practice. The MacKillop Family Services Leaving Care Policy Framework is an example of this approach.

- *Living skills self-assessment tools*.

The tools support young people in assessing their own skills and needs and a number of organisations have developed these tools including MacKillop Family Services, Berry Street Victoria and St Luke's - Anglicare.

- *Driver education*.

MacKillop Family Services has developed driver education that aims to ensure young people leaving care have access to the recommended hours of driver training.

[119] Source: Leaving Care: A Model for Victoria. The Centre for Excellence in Child and Family Welfare, 2006

- *Transition units*.

A range of transition housing models have been developed including self contained independent residential units (Anglicare, Community Connections). St Lukes - Anglicare has a dedicated unit that enables young people to trial independent living whilst still in a care placement.

- *Training for carers*.

A range of organisations have developed specific training for carers that focus on preparing young people for independent living. This includes living skills modules that can be utilised by carers and case managers with young people.

- *Transition planning*.

Organisations have developed transition planning tools and leaving care planning tools. A key focus of the out-of-home leaving care services has been to ensure there is adequate transition planning that covers housing, employment/education linkages and financial support.

- *Living skills group work programs.*

Some organisations are using group work programs that bring together young people leaving care and cover a range of issues including basic cooking, budgeting and housing.

10.3 Coming of Age Guide – Independent Living Skills Training Manual

Example of Good Practice

South Eastern Services Network (SESN)
Peninsula Youth & Family Services
The Salvation Army

Peninsula Youth & Family Service's Two to One Program have developed an Independent Living Skills Manual[120] to assist the young person and their key worker identify strengths and weaknesses around the young person's ability to survive independently leaving care. The Manual is organised into five different phases (currently three phase are completed) that run over five ten-week blocks, incorporating an assessment at the end of each phase. Four hours per week is allocated to work through the Independent Living Skills Manual to assess and educate the young person on all aspects of leaving care and develop the skills required to live independently. The Manual also provides a template of practical and useful exercises (with tools) to develop life skills.

Phase One

- Home making skills, cooking and cleaning.
- Realistic budgeting.
- Basic hygiene and grooming.

During phase one, the young person receives guidance and hands on help from their key worker/case manager. During the practical activities the young person dictates their responses to their key worker/case manager who will write in the manual.

Phase Two

- Knowledge and accessing community services.
- Accommodation.
- Communication skills.
- Family and social skills.
- Basic academia (maths and English).

[120]Source: Coming of Age Guide – Independent Living Skills Manual, 2006. Peninsula Youth & Family Services

Phase Three

- Personal development.
- Health and diet.
- Basic safety.
- Education.
- Employment.

Phase two and three of the manual is designed to give the young person greater ownership over their life and less dependency on the key worker/case manager through assessing their progress and skill development, writing up the evaluations of experiences, feedback on which activities they found useful or unproductive and identification of areas for future skill development. The key worker oversees the skill development process and progress of the young person with a strong emphasis on motivation/encouragement and problem solving.

This manual is a useful tool for workers providing guidance in independent living skill development and assessment of readiness of young people to leave care. In addition to the manual, the key worker/case manager keeps a logbook and journal of the experience. This record includes evaluation of the young person's counselling from the worker's perspective, including notes/minutes from meetings with the young person and other parties involved. Affirmations (eg. positive letters from staff) are used to keep the young person motivated and inspired. The journal is given to the young person on their departure from the program.

10.4 Transitions from Care Project - Leaving Care Handbook (2004)

Example of Good Practice

MacKillop Family Services

In 2004, MacKillop undertook a project to develop a comprehensive Leaving Care Handbook[121] for staff working with young people transitioning from care to independence. Research and experience informs us that young people who have been in out-of-home care are often under-prepared for independent living, which they embark on at a much earlier age than most young people in the community.

The project was thorough in the range of tools and materials it developed to assist workers comprehensively prepare young people for life as they transition from out-of-home care.

The following tools were developed.

1. *Development of a Transition Plan*

The transition planning is the responsibility of case managers with input from carers. Transition planning begins by ensuring the young person is learning needed living skills from age 14-15 years. As the young person gets older, issues such as ongoing accommodation, employment and training etc are built into the plan. The plan is reviewed and revised at least annually alongside the LAC reviews.

A range of documents were listed to develop a transition plan:

- *Living Skills Assessment*

A community questionnaire that covers a range of living skills and asks young people to prioritise skills that need to be learned.

[121] Source: Leaving Care Handbook. Zoe London. MacKillop Family Services - Practice & Policy Unit, March 2004

- *Transition Plan Checklist*

A tick-a-box sheet that young people and workers complete to ensure all areas of transition needs are addressed.

- *Sample Transition Plan*

An example of a plan (for a fictional client) demonstrates how tasks generated from the Living Skills Assessment and the Transition Plan Checklist become incorporated into a clear, action-oriented plan for the young person.

2. Documents associated with other Transition Tasks

- *Client Social Network Map*

To assist in documenting existing networks and supports, plus identifying gaps.

- *Budgeting Form*

A tool to introduce young people to budgeting and practice budgeting, both in care and after they transition from care.

- *Housing Comparison List*

A document to guide the young person as they begin to make decisions about where they will live when they transition from care. It lists pros and cons of accommodation options.

- *Important Items for Independent Living*

A list of items that young people may want to begin acquiring while in care to reduce the burden of purchasing items on transitioning from care.

- *Sample Brokerage Request Form*

An example of how to structure a request to DHS for funds to assist the young person purchase goods and services required for their transition.

- *Transition to Independent Living Allowance Referral Form and Instructions*

Guidelines on how to apply for Federal Government financial assistance for a young person transitioning to independence.

- *Post Care Survival Kit Instructions*

Explanation on how to develop a personalised resource folder for young people for use when they transition from care.

- *Post Care Survival Kit Proforma*

A model for creating a Survival Kit/Resource Folder which includes a comprehensive community directory of relevant resources to support a young person during the transition phase and later independence. Covers emergency information; personal information; personal identification; job search; education; health; legal; housing (crisis and longer term); finance; budgeting form; general information and recipes.

10.5 Leaving Care Project

Berry Street Victoria

Since 2003, Berry Street Victoria has self-funded a project that supports young people while they are leaving Berry Street Victoria's care. This project has developing linkages with housing providers and written a manual for young people who are making the transition to independent living. The Leaving Care Manual[122] is used by the worker and young person in preparation for leaving care.

[122] Source: Berry Street Victoria. Leaving Care Manual

11. Occupational Health and Safety Practice

11.1 The Centre/HSUA Safety Development Fund Project

Example of Good Practice Policy informing Best Practice

Occupational Health and Safety in Residential Care Services to Children and Young People

The Safety Development Fund Project[123] is a pioneering project that identified the drivers behind occupational assaults and stress faced by residential workers providing services to children and young people in Victoria and formulate risk management strategies to manage those risks.

This project was undertaken by the Centre, in partnership with the Health Services Union of Australia, No.1 Branch (HSUA). The Victorian WorkCover Authority, through its Safety Development Fund funded this project. Work on the project commenced in October 2001, and was completed in November 2002.

The project was guided by a Steering Committee comprising members from the Centre, HSUA, Australian Services Union, WorkSafe Victoria, Department of Human Services, Anglicare Victoria, Berry Street Victoria, Melbourne Citymission, Wesley Mission Melbourne and MacKillop Family Services.

This project developed a basic risk-management model and specific strategies to manage the risk of occupational assault and stress to front-line workers. The products developed as part of the project's outputs are:

- A booklet containing risk management strategies.
- Two videos, one for young people and the other for residential workers, to be used primarily as induction tools (in both VHS and CD format).
- Posters to reinforce key health and safety messages from the videos.
- Self paced and trainer led learning materials in CD format with all documentation being customisable for use in organisations or teams.

All the products have been developed through active collaboration with all stakeholders in the Sector, and extensive consultation with residential care staff, management and Chief Executive Officers of organisations providing services to children and young people.

Materials have been provided to every residential care unit in the State as of November 2004.

[123] Source: The Centre of Excellence in Child & Family Welfare 2002

12. Professional Training and Development

12.1 Residential Care Learning and Development Strategy (RCLDS)

Example of Sector Leadership and Capacity Building Practice

The Centre for Excellence in Child and Family Welfare

The Residential Care Learning and Development Strategy is focussed on improving outcomes for the young people, their families, the workers and their organisations involved in residential care in Victoria. It is managed by a Reference Group of representatives from Community Service Organisations who provide residential care, the DHS and the Centre.

Its goals are:

- To develop a residential care workforce with appropriate training and relevant qualifications through developing and supporting pre- and in-service training and supporting TAFE's and RTO's who deliver the preferred package of the Certificate IV in Community Services (Protective Care).
- To promote a culture of ongoing learning in the Residential Care sector.
- To provide ongoing high quality training to the residential sector through brokering priority training identified through analysis of the training needs of the sector.
- To support the development of appropriate services to Aboriginal children and young people in care through promoting cultural sensitivity and awareness by its mode of operation, in training and in learning materials.

In the 2001/2002 State Budget, additional resources were allocated to improve residential care services for children and young people placed in out of home care. From this, recurrent funding was set aside to develop a training strategy to strengthen residential care services in recognition of the link between staff competency and client outcomes. A learning and development strategy was seen as an appropriate way of approaching key training concerns which included a lack of funding for cross sector training, no specific qualification for residential care workers and dissatisfaction from the field in respect to the available generic training and qualification's ability to appropriately train residential care staff. The high turnover of workers in the sector made recruitment and retention of an experienced, qualified and committed workforce who are competent to deal with the increasing complexity of young people's behaviours a high priority.

The need to develop and support a learning culture was identified as a key element in assisting workers integrate training and changes into the workplace. It also supports improvements with issues like significant risk and occupational health and safety, the implementation of minimum standards for residential care and the challenge of establishing collaborative and systemic relationships within organisations with other service providers.

Initially managed within DHS in 2005 management of the funds moved to the Centre. The Strategy is funded through an agreement between DHS and the Centre. A Senior Project Officer sits within the Centre's Training Unit, coordinates the delivery of the strategy and manages a range of programs. Key outputs have included:

Supporting sector wide training:

- Development of the Certificate IV in Community Services (Protective Care) preferred package of eight core and seven elective units of competence.
- Development of consistent training resources to meet two competencies of the Cert IV in Protective Care.
- Resources for competencies for the Certificate IV in Assessment and Workplace Training.

- Development of scholarship schemes to engage staff in training to meet the Cert IV in Protective Care.
- Development of the TAFE/DHS/CSO Network, a strategy, reference and support group which has seen most TAFE's and RTO's who deliver the Cert IV in Community Services (Protective Care) engage with the sector and agree to deliver the preferred packaging.
  It:
  - Develops and shares resources to support professional development of trainers.
  - Promotes links between residential care and training providers.
  - Supports field placements and sessional teachers.
  - Identifies and addresses emerging and ongoing issues in training for residential care.
  - Established teacher network across private RTO's and TAFE's for this qualification to develop a common learning and assessment framework.

Identifying and brokering priority training:

- Delivery of fully funded training in both rural and metropolitan areas.
- Alcohol and other drugs training to residential workers.
- Developing an LAC Care and Placement plan 'Train-the-Trainer' course.
- Delivery of Certificate IV in Assessment and Workplace Training to 60 residential supervisors and team leaders by the Salvation Army – Westcare.
- Delivery of nationally accredited Effective Conflict Management training to 150 residential staff.
- Delivery of Supervision Skills training to 80 residential supervisors.
- Professional development for TAFE and RTO trainers who deliver the Cert IV in Protective Care Preferred Package in Looking After Children, Effective Conflict Management, Recognition of Current Competency and Supervision for Residential Supervisors.

Backfill contributions to support workers attending key events such as:

- Fire safety training.
- Residential Care Worker Practice Forum.
- 'every child every chance' Resilience Congress.

Delivery of annual events:

- The Residential Care Worker Practice Forum (170 attendees in 2006).
- The RCLDS Learning and Development Forum (60 attendees in 2005).

Ongoing projects include:

- Broadening the scope of priority training in response to the ongoing training needs analysis of the sector.
- Evaluation of training already delivered with the aim of improving training delivery and effectiveness in the future.
- Participation in the Community Services Training Package review.
- Review and evaluation of the preferred package of the Cert IV Protective Care.
- Development of an RCC process which will enable experienced staff to be accredited for competencies which align to the Cert IV in Protective Care.
- Development of learning materials for the remaining six core units of the Cert IV in Protective Care.
- Development of learning materials for a unit of competence on culturally sensitive and appropriate work practices.
- Development of a further education scholarship/grant.
- Promoting the development of a learning culture in the sector through:
  - Delivering a select course of units from the new Cert IV in Training and Assessment to residential workers and supervisors

    - Keynote speakers at forums on learning organisations
    - Researching and implementing other strategies such as learning circles, action research projects and a RCLDS newsletter sharing knowledge about innovations and research in the sector.
- Continuing delivery of Effective Conflict Management and Supervision training.
- Support for TAFE's and RTO's in promoting the Cert IV in Protective Care.
- Participation and support for the implementation of the Child Wellbeing and Safety Act 2005 and Children, Youth and Families Act 2005.

13. Future Directions

Key Challenges/Current Practice Issues	Actions
Systems Change ▪ Begin strategic change strategies then institutionalising in organisations falters; strategies fall off and disappear without knowing their impact ▪ Need to move beyond "being stuck" and implement solutions ▪ Protective staff are not completing LAC information	Ongoing commitment and Investment in system's change: ▪ LAC ▪ CRISP ▪ ZOOM (leaving care resources) ▪ Develop a sector base learning strategy with leaders to tackle inability to adopt best practice tools that inform service delivery and sustain them to become "core practice"
Care & Accommodation Paradigm ▪ Majority of services provide care and accommodation and not therapeutic/treatment oriented approaches ▪ Lack of statewide understanding of what residential care is and it's therapeutic purpose? ▪ Residential Services are not "needs based" but instead respond to need for placement ▪ Issue of under 12's in residential care ▪ If have an empty bed, compelled to fill it therefore no flexibility to mix and match placements	Explore new therapeutic/treatment approaches: ▪ Develop a "treatment paradigm" culture ▪ Clinically significant outcomes ▪ Flexibility in models – meet the assessed needs of children and young people (eg. trauma and conduct disorder) ▪ Develop a range of specialised service responses ▪ Need to involve young people in decision-making and development of options ▪ Host a training event with Professor Anglin – culture change ▪ Pilot "therapeutic" treatment approaches and research the implementation process (action-research learning) and outcomes ▪ Development of leadership to lead new approaches ▪ Skill up staff with specialised training ▪ Access to specialist, multi-disciplinary, secondary consultancy and on-going training
Lack of "inclusive" approach and involvement of parents/family work in residential placement	▪ Develop a culture of work with families ▪ Professional development on family centered/child-youth focused approaches – skill up staff ▪ Adequate resources
Lack of an Assessment Tool ▪ Impact of currently not being able to "match" placements that are compatible and consequences of contagion ▪ Limited knowledge of "needs" and tailored responses/placement options in best interest of child/youth ▪ Limited knowledge of best practice interventions	▪ Explore the development of a common assessment tool/s that can be utilised Statewide in partnerships with Take Two and University ▪ Assessment informs placement preference and interventions ▪ Need for multi-disciplinary teams – including psychologist ▪ Evidence-based practice and research interventions/outcomes

Key Challenges/Current Practice Issues	Actions
Placement Diversion ▪ Limited capacity to work preventatively and intensively with families to prevent unnecessary placements of youth	▪ Explore models of intensive community-based support to prevent placements ▪ Availability of respite placements for families in crisis within the context a therapeutic approach (rather than placement in a vacuum and no family work to address protective concerns) ▪ Shared-care models
Intensive Case Management ▪ Differences between metro and rural/regional models ▪ Residential Services case managers and ICMS case management issues	▪ CSO's (if desire) to be funded to take on additional case management function (beyond capping) with ICMS support
Lack of opportunity to showcase local best practice or promote conceptual thinking/treatment models on residential services	Sector professional development and knowledge sharing: ▪ Establish a Statewide residential services practice conference ▪ Establish Learning Circles ▪ Host experts in residential care for training/consultancy ▪ Seek resources from DHS to reestablish development of Best Practice documentation as previously resourced in the '90's ▪ Show-case best practice resources within residential services ▪ Culture change opportunities
Needs of Indigenous Children & Youth ▪ Limited access to specialist resources ▪ Need resources to respond the APP's ▪ Children from the bush and interstate going into residential care – they do not identify and want to be with their cultural group ▪ Homeless issues for youth who are 18 years	▪ Develop strategies with Indigenous organisations
Children/Youth with Disabilities	▪ Develop strategies with disability organisations and sector
Kith & Kin Placements ▪ Lack of systemic support to the placement to prevent breakdown	▪ Invest in placement prevention services to prevent breakdowns
Purpose Built Units ▪ Maintenance issue-whose responsibility? ▪ Created ghettos – locked into location (issue of neighbours) ▪ Limitations in use of units – inflexible design ▪ Not good for client mixes ▪ Big verses small units	Establish a review process of units: ▪ Identify and develop strategies to work with unit strengths

14. Contacts

Contact	Resource	Contact
Menzies Inc	Residential Care Unit Practice Documentation Sages Cottage Farm Animal Assisted Therapy & Creative Arts Therapy Aggression Replacement Training	Marie Baird ☏ 9784 9700 ✉ bairdm@menzies.org.au Manager ☏ 5971 5964
Westcare The Salvation Army	Organisation Holistic Model of Practice (2005) Crisis Plan Tool Going Places, Creating Memories Program Creating Dreams Project Education Program	Glenys Bristow ☏ 9312 3544 ✉ glenys.bristow@aus.salvationarmy.org
Berry Street Victoria	Rover Support Team Health Team Leaving Care Project BEST Centre Best @The Shed Take Two	Jenny Cummings ☏ 9359 1900 ✉ jcummings@berrystreet.org.au Pat Clinton ☏ 9359 1900 ✉ pclinton@berrystreet.org.au Ric Pawsey ☏ 9359 1900 ✉ rpawsey@berrystreet.org.au
Lisa Lodge	Welcome Booklet to Clarkson Street – Adolescent House Charter of Rights for Children in Care Residential Unit Admission Procedure and Behavioural Checklist Young Person's Behaviour Plan - Response Plan to Self-Harming Behaviour Optimal Learning Champions Mentoring Program	Sarah Buter ☏ 5331 3838 ✉ sarahb@lisalodge.com.au Di Noyce ☏ 5331 3838 ✉ diannen@lisalodge.com.au

South Eastern Services Network (SESN) Peninsula Youth & Family Services The Salvation Army	Coming of Age Guide – Independent Living Skills Training Manual	Sheryl Bayliss ☏ 9784 5000 ✉ sheryl.bayliss@aus.salvationarmy.org
MacKillop Family Services	Adolescent Practice Framework for Out-of-Home Care Working with Aboriginal & Torres Strait Islander Children Manual Aboriginal Resource Information Kit Leaving Care Handbook (2004) Journeys Program Parent Support Group Rice Education and Youth Services	Bruce Tucker ☏ 9376 3555 ✉ bruce.tucker@mackillop.org.au Joleen Ryan ☏ 5278 9211 ✉ joleen.ryan@mackillop.org.au Practice & Policy Unit ☏ 9699 9177 Colin Charles ☏ 9376 3555 ✉ journeys@mackillop.org.au Marija Joyce ☏ 9317 6200 ✉ marija.joyce@mackillop.org.au
Glastonbury Child & Family Services	Family Reunification Unit My "Family First" Groupwork Program	Lyn Edwards ☏ 5222 6911 ✉ ledwards@glastonbury.org.au
Anglicare Victoria	Redevelopment of Residential Services	Sue Sealey ☏ 9890 6322 ✉ sue.sealey@anglicarevic.org.au
Victorian Aboriginal Child Care Association	VACCA Educational Support Program	Gwen Rogers ☏ 8388 1855 ✉ vacca@vacca.org
Eastcare – Youth Services The Salvation Army	WARPed	Jim Mosdall ☏ 9890 7144 ✉ jim.mosdall@aus.salvation army.org
CREATE Foundation	CREATE	Caitlin Telford ☏ 9614 0439 ✉ caitlin.telford@create.org.au

The Centre for Excellence in Child & Family Welfare	Occupational Health & Safety in Residential Care Services to Children & Young People Investing for success: The economics of supporting young people leaving care Leaving Care: A Model for Victoria Residential Care Learning & Development Strategy (RCLDS)	Sunitha Raman or Michael White ☏ 9614 1577 policy@cwav.asn.au Michael White or David Rackham ☏ 9614 1577 michael.white@cwav.asn.au
Save the Children Fund (Queensland Division)	Lisa Hillan – Churchill Fellowship Report	Lisa Hillan ☏ 07 38442699 lisah@scfq.org.au

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This references and further reading list is a consolidation of references provided to the Think Tank, the bibliography from What Works in Residential Child Care[124] and the MacKillop Family Services Literature Review.

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