



REVIEW OF BEST PRACTICE IN RESIDENTIAL OUT OF HOME CARE

by Robyn Seth-Purdie
SEPTEMBER 2019

ISBN 978-0-6486767-1-3 (online)

ISBN 978-0-6486767-0-6 (print)

Dr Robyn Seth-Purdie
Senior Analyst, Prevention and Equity
UnitingCare Australia

42 Macquarie Street
BARTON 2600 ACT

Tel: 02 6181 1009
Email: robynS@nat.unitingcare.org.au
Website: unitingcare.org.au

Coco Liu
Graphic Designer
CoDesign Creative Studio

Tel: 0430 284 107
Email: coco@codesigncreative.com.au



CONTENTS

5	Executive Summary
5	Purpose
6	Terms of Reference
6	Background
8	The place of residential care in the formal child protection system
8	Needs of children in residential care
10	Therapeutic Interventions
10	Assessment
11	What is a model of care?
12	Which outcomes should be measured?
12	Choosing a model of care
14	Components and principles of best practice
15	Best-practice principles in Therapeutic Residential Care
17	The policy context
18	Terms of Reference
20	1. An introduction to out of home care
23	2. Child maltreatment
23	2.1 Definitions of child maltreatment
23	2.2 Child maltreatment – a public health, social and human rights issue
23	2.3 Population and individual costs of child maltreatment
25	2.4 Risk factors for maltreatment
26	2.5 Corporal punishment raises community risk level
27	2.6 Prevention and early intervention policies
29	2.7 The need to prevent exposure to risk factors in addition to maltreatment
30	2.8 Incidence of child maltreatment
36	3. Child protection systems
36	3.1 The need for a systems approach in statutory systems
37	3.2 Form and informal systems of child protection
40	3.3 Formal child protection standards
41	3.4 Australian thresholds for child protection intervention
45	4. Categories of out of home care and their use
46	4.1 International comparisons in out of home care placement types
48	4.2 The role of residential care in the development of out of home care
52	4.3 When should residential care be the first option?
56	5. The characteristics and therapeutic needs of children in out of home care
56	5.1 Characteristics of children by placement type – a Victorian study
67	5.2 Over-representation of children with a disability
58	5.3 Over-representation of parents with an intellectual disability
58	5.4 High incidence of mental health problems
60	5.5 High incidence of trauma

61	5.6 Literature synthesis on characteristics of children in different types of care
62	5.7 High incidence of complex needs in residential care
62	5.8 Emergency accommodation and large sibling groups
63	6. Assessment and workforce
63	6.1 Assessment and placement in care
65	6.2 Clinical workforce and the policy environment
66	7. Complex needs of children and young people in residential care
66	7.1 Complex needs
69	7.2 Residential care for lower needs children
69	7.3 Options for assessing and placing children or youth with complex needs
71	8. Therapeutic residential care
71	8.1 The burdens and benefits of residential care
72	8.2 'Residential care' covers a broad spectrum
72	8.3 Therapeutic residential care defined
74	8.4 Costs of therapeutic vs generic residential care
74	8.5 Principles of therapeutic residential care
78	8.6 Trauma-informed care
79	8.7 Evidence-based trauma therapies
80	8.8 There are many sources of valuable evidence
81	9. Interventions to reduce time in residential care/stabilize placements
84	10. Therapeutic care models for residential OOHC
84	10.1 What is a model of therapeutic residential care?
86	10.2 What models of therapeutic residential OOHC should be considered?
89	10.3 Alternative to standard model: core elements approach
91	11. When residential care is best
91	11.1 When children and young people prefer it
91	11.2 When children or young people with similar needs are placed together
92	11.3 When children are kept safe and feel safe
93	12. What works in residential OOHC
93	12.1 Quality of care – Narey report overview
93	12.2 Building resilience
97	13. Risk identification and management
99	13.1 The impact of risks is cumulative
99	13.2 The design of the facility itself may heighten risks of harm
99	13.3 Maltreatment risk factors may be unacceptably high in some kin or foster families' carers
99	13.4 Focus on risk reduction may come at the cost of therapeutic efficacy
100	13.5 Not-for-profits urged to return to residential OOHC provision
100	13.6 Child safe recommendations of the Royal Commission
101	14. Findings of selected reviews
101	14.1 Comparison of published quality standards for residential OOHC: Table 19
103	15. What produces the best outcomes for children in residential care
103	15.1 Salutogenic environment

104	15.2 Getting the support that they need
104	15.3 What ‘matters to them’ influences decisions concerning them
105	15.4 Relationships with staff
106	15.5 Age at entry and number of prior placements
106	15.6 Not individual vs group care but ‘quality of care’
107	15.7 Evidence-based practice
107	15.8 Instilling a sense of belonging
108	15.9 The role and varieties of social parenting
109	15.10 The desire to be ‘normal’
110	15.11 Considering dimensions of Life Space
110	15.12 Size of residential facility
111	15.13 Proximity to support networks: family, peers and community
111	15.14 Working with families
112	15.15 What adolescents need
113	16. Measuring outcomes
113	16.1 Outcomes sought by policy-makers and practitioners
115	16.2 Outcomes that reflect children’s understanding of wellbeing
120	17. OOHC carers and their careers – ‘task focused’ vs ‘family for life’
120	17.1 Ambiguity of purpose
120	17.2 Matching client and carer
121	17.3 Empathetic and challenge-ready
121	17.4 Carers’ engagement with family
122	17.5 Professional, family member, advocate
123	18. Research on variables that affect out of home care outcomes
123	18.1 Need for further research
124	19. The importance of country context in translating models
125	20. The ‘home’, ‘belonging’ and ‘permanence’ conundrums
125	20.1 Many pathways to ‘permanence’
126	20.2 There’s no place like ‘home’
127	20.3 Ways of belonging
128	21. Choosing a model of therapeutic residential care
128	21.1 Some important considerations
135	22. Conclusions
138	TABLE 21: Comparison of OOHC Models

SEPARATE APPENDICES:

APPENDIX A: History of OOHC in Australia

APPENDIX B: Jurisdictional differences in Child Protection

APPENDIX C: Evidence-based therapeutic OOHC systems and interventions

APPENDIX D: Salient recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse

ACKNOWLEDGEMENTS AND LIMITATIONS

I would like to express deep gratitude for the informative discussions held with, and suggestions made by, a number of people in the course of preparing this review, including Dr Diana Boswell, Ms Dira Horne, Dr Robyn Mildon, Dr Robyn Miller, Associate Professor Tim Moore, and current and former members of the Uniting Care Network. I would also like to thank the Griffith Institute of Criminology at Griffith University for my position as an Adjunct Research Fellow, which has enabled access to many of the research publications cited herein. Finally, the CEO of Uniting Vic.Tas, Paul Lenossier, was a driving force throughout the project and made a substantial contribution to the development of the Best Practice Principles for Therapeutic Residential Out of Home Care.

There are significant limitations on the scope of this review – in particular the lack of detailed consideration of models of therapeutic out of home care suitable for Aboriginal and Torres Strait Islander children and young people. This is in part due to the relative shortage of research on this important subject, but also because the analysis should ideally be conducted by Indigenous researchers in consultation with their communities.

Similarly, models of care for children and young people with severe disabilities, such as Foetal Alcohol Spectrum Disorder, who are over-represented in the out of home care system and cannot be easily accommodated in family group home models, have not been explored. This is another area requiring specialized research, and, as such, is beyond the scope of this review.

A further limitation relates to the time period of the literature search, which was largely completed by the end of 2018, before publication of the very useful report by McPherson et al (2019). Inter alia, it discusses a number of promising models of care (including some considered here), and considers in some detail the special needs of three groups of children who are all over-represented in out of home care: Aboriginal and Torres Strait Islander children, children with disabilities and LGBTQ children.¹

Robyn Seth-Purdie, Canberra, September 2019

1. McPherson L, Gatwiri N, Cameron N & Parmenter N (2019) [The Evidence Base for Therapeutic Group Care A systematic scoping review](#) Research Report, Australian Childhood Foundation, Southern Cross University, published 16 February 2019.

EXECUTIVE SUMMARY

Note: OOHC = Out of Home Care; Children = Children and/or Young People

PURPOSE

UNITINGCARE AUSTRALIA WAS COMMISSIONED TO UNDERTAKE THIS REVIEW OF RESIDENTIAL OUT OF HOME CARE (OOHC) SERVICES. ITS PURPOSE IS TO AID DELIBERATIONS ON WHETHER THEIR ORGANISATIONS SHOULD BE ENGAGED IN THE PROVISION OF THESE SERVICES, AND, IF SO, WHAT MODELS OF CARE AND WHAT THERAPEUTIC INTERVENTIONS WOULD BEST MEET THE NEEDS OF THE CHILDREN AND YOUNG PEOPLE LIKELY TO USE THEM.

THE UNITINGCARE NETWORK ACROSS AUSTRALIA HAS A LONG HISTORY OF THE PROVISION OF RESIDENTIAL SERVICES FOR CHILDREN AND YOUNG PEOPLE. CONTEMPORARY CHILD PROTECTION REFORMS IN EACH AUSTRALIAN JURISDICTION HAVE NARROWED THE SCOPE OF RESIDENTIAL SERVICES TO A SPECIALIST THERAPEUTIC SETTING AND/OR THE PLACEMENT OF LAST RESORT.

IT IS CRITICALLY IMPORTANT TO ENSURE THAT THESE SERVICES NOT ONLY MEET THE RELEVANT STATE OR TERRITORY STANDARDS OF QUALITY AND ACCOUNTABILITY, BUT ALSO ACHIEVE THE BEST POSSIBLE OUTCOMES FOR CHILDREN AND, ABOVE ALL, DO NO HARM.

IN UNDERTAKING THIS WORK, THE NETWORK SEES THEIR ROLE AND INTEREST AS NOT ONLY A CURRENT AND POTENTIAL FUTURE SERVICE PROVIDER OF PREFERRED MODELS, BUT AN ADVOCATE TO THE INDUSTRY AND TO GOVERNMENT TO EFFECT CHANGE SO AS TO BE CONFIDENT THAT OPTIMUM OUTCOMES FOR VULNERABLE CHILDREN AND YOUNG PEOPLE ARE ACHIEVED.

TERMS OF REFERENCE

Drawing on the findings of previous reviews of our services, on the research literature and best practice models from Australia and overseas, and using the Uniting Church Child Safe Policy Framework:

- Identify the needs of the target group of young people most likely to be allocated to residential OOHC;
- Identify evidence-based therapeutic responses to these needs and the models of residential OOHC used to provide them;
- Develop a set of best practice principles that should apply nationally to the provision of residential OOHC services by the network;
- Identify opportunities to advocate for changed models of service delivery based on the identified best practice models with industry and government; and
- Make recommendations for action.

BACKGROUND

Community standards concerning the treatment of children change over time as we increase our understanding of the type of care children need for healthy development and the conditions that place it at risk, including maltreatment or neglect at home.

International human rights law also plays a role in influencing law and policy: The Convention on the Rights of the Child articulates the conditions that children need to flourish and provides standards for assessing national performance in achieving these conditions. Over time, these standards can become recognised in the community, regardless of whether they have been integrated into domestic law.

We can identify two major systems of childcare and protection in our society². The first is the more extensive and influential customary system in which children's parents together with extended family, community, and social institutions meet the developmental needs of children. When alerted to evidence that the customary system is failing particular children, the state is empowered to intervene, offering parents support where it is safe to leave children at home, or placing them in out of home care, where it is not. State mandated care is the second major system of childcare and protection. To the extent that it removes a child or young person from a matrix of extended family and community care and does not replicate it, this system offers less robust support as well as being required to treat the trauma of maltreatment and the trauma created by removal itself for children and their families.

Children whose families experience socio-economic and housing stress, children whose parents contend with mental illness or chronic health problems, children who are exposed to family and domestic violence, are at increased risk of maltreatment.³ Children with a parent who was in care, or is suffering from untreated childhood trauma, are at substantially increased risk.⁴

2. Wulczyn F et al. (2010) [Adapting a Systems Approach to Child Protection: Key Concepts and Considerations](#) commissioned and published by UNICEF.

3. Doidge et al (2017) [Economic predictors of child maltreatment in an Australian population-based birth cohort](#). *Children and Youth Services Review* V. 72, January 2017, pp 14-25; Doidge et al (2017) [Risk factors for child maltreatment in an Australian population-based birth cohort](#). *Child Abuse Negl.* 2017 Feb;64:47-60. doi: 10.1016/j.chiabu.2016.12.002.

4. Putnam-Hornsten et al (2015) [A Population-Level and Longitudinal Study of Adolescent Mothers and Intergenerational Maltreatment](#). *American Journal of Epidemiology*, Volume 181, Issue 7, 1 April 2015, Pages 496-503, <https://doi.org/10.1093/aje/kwu321>; [The prevalence of intergenerational links in child protection and out-of-home care in NSW](#). FACSAR Report, August 2017.

Issues related to fertility control, and the timing or spacing of children can raise the risk of maltreatment.⁵

The use of corporal punishment is contrary to intentionally accepted human rights standards, is strongly associated with poor outcomes for children and with an increased incidence of physical maltreatment. It is also associated with increased risk of intimate partner violence – which constitutes maltreatment in itself and is independently associated with higher incidence of other forms of child maltreatment.

Almost all known maltreatment risk factors could be detected and addressed in advance of pregnancy by multi-disciplinary teams working with preventive investment funds.

Until the second half of the 19th century, the state had no power to intervene to protect children from their parents.⁶ Child protection was initially pursued by private child protection leagues, such as the New South Wales Society for the Prevention of Cruelty to Children (1890), the Victorian Society for the Prevention of Cruelty to Children (1894), and the Western Australian Children's Protection Society (1906) and numerous independent and faith-based Children's Homes and orphanages, such as the Scots Church Neglected Children's Aid Society, later known as Kildonan and today part of Uniting (Vic. Tas) (1881).⁷ By the end of the 19th century most Australian states had legislation to protect children from severe physical abuse, with 'boarding out' with approved families preferred to institutional care.⁸ Residential (institutional) care enjoyed a new vogue in the first part of the 20th century, and smaller group homes were favoured after the 1950's.⁹

As at 30 June 2017, there were 47,915 children and young people living in out of home care in Australia, 5.2% of whom were living in residential care. Between 30 June 2011 and 30 June 2017, the rate of children placed in out of home care increased from 7.4 to 8.7 children per 1000. All states and territories in Australia have adopted policies to reduce the rate, through provision of family support to prevent removal or to facilitate reunification, or, where safe return to family within a specified period is not possible within a specified period, through a permanent placement including open adoption.

5. For an overview and reference material see Marie Cohen's blog of April 16, 2018 [An Overlooked Approach to Child Maltreatment Prevention](#); Guterman K (2015) [Unintended pregnancy as a predictor of child maltreatment](#). *Child Abuse Negl.* 2015 Oct;48:160-9. doi: 10.1016/j.chiabu.2015.05.014.; Lukasse M et al (2015) ['Pregnancy intendedness and the association with physical, sexual and emotional abuse – a European multi-country cross-sectional study'](#), *BMC Pregnancy Childbirth*. 2015; 15: 120., May 26. doi: 10.1186/s12884-015-0558-4;

6. [History of child protection services](#) CFCA Resource Sheet— January 2015, AIFS

7. *ibid.*

8. *ibid.*

9. *ibid.*

THE PLACE OF RESIDENTIAL CARE IN THE FORMAL CHILD PROTECTION SYSTEM

The table below outlines the place of residential placement in OOHC systems. For reasons that are explained below, this review focuses on the provision of therapeutic residential care.

The system of out of home services, in order of increasing intensity and cost¹⁰

- Adoption and permanent care;
- Kinship care;
- Conventional Foster Care;
- Treatment (specialised or therapeutic) foster care;
- Parent model group care homes;
- 'Conventional' staffed group care;
- Therapeutic Residential/group care;
- Residential treatment (mental health, alcohol & other drugs); and
- Correctional facilities (centres, wilderness homes)

NEEDS OF CHILDREN IN RESIDENTIAL CARE

Residential care is a complex contemporary service type. It is a high-risk setting for residents, staff, providers and funders. In part this could be attributed to the selection process that results in placement of children in successively more intensive and expensive environments until those with the most complex needs and challenging behaviour are 'failed' into residential care.

By international standards Australia has a very high rate of child removals in the 0-4 age range (45.7%), a high proportion in relative/kinship care (47.2%), and possibly the developed world's lowest proportion in residential care (6.7%). A Victorian study¹¹ found that age was the single most influential factor in determining the chance of placement in residential age care, increasing from 3.7% among 5-9-year olds to 23.4% among 15-17-year olds.

There is little system-wide data on the needs of children in residential care, but the Victorian study just mentioned found that children and young people in residential care were assessed as having higher levels of emotional and behavioural difficulties than children in foster care or relative/kinship care. This meshes with Tarren-Sweeney's finding¹² that age of entry into OOHC acts as a proxy for cumulative exposure to maltreatment and its effects. He found that earlier entry into care was protective against the mental health problems so prevalent in children entering care at later ages.

10. Adopted from Anglin F, Holden M & Kuhn F 2014, '[The Process of Care implementation & the Managing of Complexity](#)'. Presentation, EUSARF Conference, Copenhagen, September 3-4, 2014.

11. Corrales T (2015) [Understanding differences in the outcomes of children and young people across care types](#) August 2015, Anglicare

12. Tarren-Sweeney M (2008) 'Retrospective and concurrent predictors of the mental health of children in care' *Children and Youth Services Review* 30: 1-25

The prevalence of mental health problems in OOHC children led the Royal Australian College of Psychiatrists to advocate 'comprehensive multidisciplinary mental health and developmental assessments for all children entering or placed in care'¹³.

Gallitto (2017)¹⁴ found that 59% of 13-17-year-olds in the Ontario Child Welfare system scored minimal trauma related symptoms on the Trauma Symptom Checklist, with 30% scoring moderate, and 11% severe symptoms.

A traumatic event is:

a frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity. Witnessing a traumatic event that threatens life or physical security of a loved one can also be traumatic. This is particularly important for young children as their sense of safety depends on the perceived safety of their attachment figures.¹⁵

The consequences of traumatic experiences are cumulative, continue over the life course and could include:

intense and ongoing emotional upset, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, problems relating to others or forming attachments, regression or loss of previously acquired skills, attention and academic difficulties, nightmares, difficulty sleeping and eating, and physical symptoms, such as aches and pains. Older children may use drugs or alcohol, behave in risky ways, or engage in unhealthy sexual activity.¹⁶

Disorganised attachment, which is itself associated with higher risk of mental illness, is a common effect of childhood trauma.

The consequences just listed constitute a guide to the catalogue of needs that can be found among children in residential OOHC. To them should be added the challenges presented by children and young people with inherited or acquired disabilities, including Foetal Alcohol Spectrum Disorder (FASD), autism, intellectual disability and acquired brain injury.

As the high incidence of disability, poor mental health, traumatic experience and extremely challenging behaviour of children in OOHC, especially residential care, has been recognised, so too has the need to move away from 'care as usual' to trauma-informed care (TIC) and therapeutic residential care (TRC). The scarcity of specialist care for high-needs children with disabilities has not been addressed in this review – it impacts families, foster carers and increases the numbers of children in residential OOHC. FASD creates challenging behavioural problems that are difficult to manage. It has been underdiagnosed in Australia, but an increase in incidence has occurred following the development and dissemination of diagnostic criteria.¹⁷

13. The Royal Australian and New Zealand College of Psychiatrists (RANZCP)(2015) [The mental health care needs of children in out-of-home care](#) Position Statement 59 March 2015.

14. Gallitto E et al (2017) 'Trauma-symptom profiles of adolescents in child welfare', *Child Abuse & Neglect* 68 (2017) 25-35.

15. National Child Traumatic Stress Network (US) [About Child Trauma](#) accessed 22 February 2019

16. Ibid.

17. Mutch R, Watkins R & Bower C (2015) 'Fetal alcohol spectrum disorders: Notifications to the Western Australian Register of Developmental Anomalies' *J Paediatric & Child Health*, 51,4: 433-436

Many symptoms of mental illness and of trauma overlap, so it is important that decisions on placement in care should take into account a comprehensive assessment of a child or young person's history of trauma and other adversity, of challenging behaviour that might be triggered by traumatic memories or by maladaptive response to stress, of the relationships that are important to them, as well as of their current mental health and developmental needs.

THERAPEUTIC INTERVENTIONS

There are many evidence-based therapeutic interventions for treating trauma,¹⁸ including therapies that work at a cognitive level to identify and replace maladaptive thoughts (such as Trauma-focused Cognitive Behavioural Therapy); therapies designed to promote capacity for healthy attachment, some involving the use of pets; therapies to promote the reorganisation of brain connections and the re-processing of painful memories, such as Eye Movement Desensitization and Reprocessing (EMDR), music, art and narrative therapy.

If Perry's hypothesis is correct, an effective intervention would need to engage the brain at the developmental level of function that predominated when maladaptive responses to trauma became established – ranging from the earliest stage of development when connections are made at the level of the brainstem, which controls simple reflexes, to the most advanced stage of development, involving the level of the neocortex and abstract ideas.¹⁹

Outside of trauma-informed care, there are a variety of California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated²⁰ interventions for addressing behavioural problems – such as disruptive behaviour (examples include Multi-Systemic Therapy, TFCO-A²¹, Positive Parenting Program) and for promoting placement stabilization (e.g. TFCO-A and Wraparound, CEBC 3).

ASSESSMENT

A number of validated assessment instruments are available, including the *Strengths and Difficulties Questionnaire* (SDQ: Goodman, 1997²²), which measures problematic and prosocial behaviours (parents or other significant adults in the child's life can also complete versions of these behavioural measures), the *Brief Assessment Checklist-Child and Adolescent*²³, which aims to measure mental health issues and behavioural problems not commonly captured in other rating scales, such as interpersonal, attachment-related difficulties, dysregulation, trauma-related anxiety and dissociation, abnormal responses to pain, food maintenance behaviours, sexual behaviour problems, and self-injury. The *Child and Adolescent Needs and Strengths*²⁴ instrument has been recommended as a single, brief assessment tool capable of measuring, *inter alia*, traumatic events, trauma-related symptoms and strengths.

18. See Appendix C.

19. Perry B (2006) [Applying principles of neurodevelopment to clinical work with maltreated and traumatised children](#). *The Neurosequential Model of Therapeutics* The Guildford Press, NY, p 31

20. From 1 – promising to 3 well-supported

21. Treatment Foster Care Oregon -Adolescent

22. Goodman R (1997) 'The Strengths and Difficulties Questionnaire: A Research Note' *J. Child Psychol. Psychiat.* 38, 5: 581-58

23. Tarren-Sweeney M (2013) [The Brief Assessment Checklists \(BAC-C, BAC-A\): Mental health screening measures for school-age children and adolescents in foster, kinship, residential and adoptive care](#), *Children and Youth Services Review*. 35, 771-779. Pre-print manuscript

24. Described in Milne L & Collin-Vézina D 'Assessment of Children and Youth in Child Protective Services Out-of-Home Care: An Overview of Trauma Measures' *Psychology of Violence*, April 2015, 5 (2):122-132

WHAT IS A MODEL OF CARE?

Models of care are structured approaches to the delivery of therapeutic care. They provide the framework within which therapies can be delivered in accordance with assessed needs. They may also offer staff training and accreditation, mentoring and monitoring of implementation fidelity, and evaluation of process and substantive outcomes.

The question whether a 'model of care' is more than a platform for the provision of a range of therapeutic interventions is moot: approaches such as CARE and Sanctuary argue that the care-providing organisation must provide a pervasive healing environment, reflected in the actions and reflections of all staff from the top down, a philosophy that provides an answer to the question 'What happens in the other 23 hours?'²⁵

Antonovsky's concept of the 'salutogenic' environment²⁶ describes a telling standard for assessing both the informal and formal systems of childcare: it refers to the conditions conducive to optimal health and wellbeing. They include not only the material conditions that protect against disease, but the psychological conditions that promote a sense of coherence and personal agency.

From a review of the literature on OOHC the following essential elements of an effective 'model' of therapeutic care may be derived:

- A set of values including the rationale for engaging in OOHC. Of particular importance is the worth assigned to the child or young person and their voice.
- A goal – what are the main aims of OOHC? Are these goals shared by the child, their friends and family? Are they shared by funders?
- A set of measurable outcomes relating to the goals – how do we know if we are on the right track? How will we know when our goals are achieved? Are these outcomes important to service providers, child, family and funders?
- The social context – what dynamic system(s) must we interact with as we work toward our goals? What unintended systemic consequences of our intervention might there be?
- Causal relationships affecting the goal – what has caused the condition(s) we are trying to change, and what can be done to achieve the desired goals? Check with systemic effects above.
- Resource constraints – what human, material and financial assets over what period of time are required to achieve the goal?
- How is the goal to be achieved – within the value system, within the system constraints, and with the available physical and human resources. What relationships are important for its achievement? What does the causal chain look like?
- The particular role of evidence-based therapy – what interventions, behaviour by staff, family and friends, what physical and natural environment, what purposeful and creative activities for residents, what exposure to pets, other animals and the natural world, will exert the most beneficial, therapeutic effects and contribute most to achievement of our goals?

25. That is, between one-hour-per-week therapy sessions. See Howard Bath (2016) [The Three Pillars of Transforming care: Healing in the 'other 23 hours'](#)

26. 'Salutogenesis' means 'the origin of health'. It was coined by a Professor of the Sociology of Health, Aaron Antonovsky in 1979. He wished to identify the conditions that did not merely prevent disease, but actively promoted good health. See Aronovsky A (1996) [The salutogenic model as a guide to health promotion](#) *Health International*, 11, 1:11-18.

- How will we be kept on track – what is our system of accountability? Is it proof against changes of leadership, funding or other contingencies?

WHICH OUTCOMES SHOULD BE MEASURED?

The outcomes traditionally sought by policy-makers and funders can be summed up:

- Physical, emotional, 'educational' wellbeing into adulthood (i.e. reaching developmental milestones);
- Stability – keep any moves to a minimum (Canada uses a principle of 'least disruption');
- A sense of permanence;
- Family membership (foster family and birth family);
- Continuity – links with relatives, friends and community;
- Minimum length of stay in OOHC – a key aim in USA²⁷ and UK²⁸ policy but less apparent in non-Anglophone countries²⁹. It has emerged as a key policy aim in Australia in the last few years;
- Normality – but different family forms including being part of a foster family should not be seen as conveying the stigma associated with the 'abnormal', as recounted by several of the presenters at the Siegan workshop who reported on children's views.³⁰

Starts with Fattore & Mason's (forthcoming) study³¹ of the subjective dimensions of health and wellbeing in children reveals that the achievement of developmental milestones is less important to them than achieving a sense of authentic identity, an environment of trust in which they are free to be themselves, economic and moral agency, and wellbeing that comes from living in a child-centred environment. Subjective health and wellbeing indicators need to form part of the outcomes measures for OOHC.

CHOOSING A MODEL OF CARE

The California Evidence-based Clearing House for Child Welfare (CEBC) provides a scientific ranking³² of a range of programs applicable to 'Higher Levels of Placement'.³³ Currently the only top-rated program is Treatment Foster Care Oregon – Adolescents (TFCO-A), which is not designed as a long-term residential OOHC model, but as treatment to assist children 12-18 years old with severe behavioural problems to live in lower levels of placement.

Models CARE and Sanctuary® (Sanctuary) have been rated at level 3 by the CEBC – i.e., as supported by promising research evidence. CARE was developed to improve the experience and the effects of residential OOHC care by basing it on principles derived from evidence and ensuring that these principles were fully integrated into the philosophy and practices of care providers.³⁴ The Sanctuary

27. Chapin Hall & Chadwick Center (2016) [Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare](#).

28. Thoburn J (2016) Residential care as a permanence option for young people needing longer-term care *Children and Youth Services Review* **69** (2016) 19-28.

29. Skivenes M & Thoburn J (2017) 'Citizens' views in four jurisdictions on placement policies for maltreated children' *Child & Family Social Work*, 22:1472-1479.

30. Thoburn J (2016) Achieving good outcomes in foster care: a personal perspective on research across contexts and cultures. *Social Work & Society*, Volume 14, Issue 2, 1-15, p2.

31. Fattore T & Mason Fattore, T. and Mason, J. (accepted in press) 'Constructing indicators of child wellbeing from a child standpoint.' *Developing Practice*

32. 1 – Well-Supported by Research Evidence; 2 – Supported by Research Evidence; 3 – Promising Research Evidence.

33. Defined as 'group, residential, and community treatment facilities in California with a rating classification level of 12 and above (out of 15, where the higher levels represent more therapeutic and more restrictive care -see <http://www.childsworld.ca.gov/res/pdf/OverviewClassificationLvlis.pdf>)

34. Holden M, Izzo C et al.(2010) *Child Welfare*, 89,2:131-149.

model emerged from Bloom's experience as a psychiatrist working with adults in acute mental health care who had been traumatised as children. Both approaches are trauma-informed and directed at transforming an organisation that provides services to individuals who have experienced trauma into an environment where healing can take place.

These 'off-the-shelf' programs vary in cost, according to the licensing and training requirements of the registered owners, the existing capabilities of the service provider, the conditions established by the funding authority and, of course, the needs of the children and young people who are to be placed in residential OOHC.³⁵ The cost of some models includes manuals, staff training, employment of highly qualified staff, and continuous external monitoring to ensure fidelity of implementation and measurement of outcomes. The data submitted by purchasers can contribute to on-going scientific evaluation of the program that will affect its future scientific rating.

All of these residential care models have been developed in the United States and have yet to be evaluated in an Australian setting. As noted, TFCO-A is not designed for long-term residential placements, but to facilitate placement in less intensive, less restrictive and less expensive services, primarily by bringing challenging behaviour under control. All models provide a platform for the provision of therapeutic interventions to meet the individual needs of the children and young people in care. However, they differ in the extent to which they actively facilitate a trauma-informed, child-centred, environment where children feel safe, their developmental and traumagenic needs are met, and they have the space to reflect, learn to manage their emotions, and develop a positive sense of future. They also differ in the extent to which they are culturally safe. This dimension is implicit in TFCO-A and CARE, insofar as they both require working with families, but it has been explicitly added to Sanctuary's requirements in Australia.³⁶

An alternative to the purchase of 'off-the-shelf' models of care is the customised development of models based on best practice principles as applied to a local community. This is particularly important when designing care for communities other than those in urban areas, or in designing for children from Indigenous or other culturally diverse backgrounds. These models can be co-designed with the individual communities they will serve and customised to work in harmony with the informal system of childcare operating in each place. The important function of monitoring performance can be assigned to an independent body, such as a university or specialist implementation organisation.

Custom-made models of care that incorporate core elements of established models have performed well in comparison with off-the-shelf models. However, funders are loath to underwrite programs that have not already been demonstrated to be effective, showing preference for working models even if they are being imported from a social context that differs in significant respects.

35. See Appendix for further models

36. Robyn Miller, personal communication, April 2019.

COMPONENTS AND PRINCIPLES OF BEST PRACTICE

Based on the complex needs of a high proportion of children placed in residential care, these services need to be thoroughly ‘therapeutic’ or healing in the sense intended by CARE and Sanctuary. They also need to provide trauma-informed care (TIC). Below is a list of components of trauma-informed services that were identified in a study of successful services in the UK.

Elements of TIC: from Johnson (2017)³⁷ The abbreviations are as follows: WD=Workforce Development; TFS =Trauma Focused Services; ORG = Organisational Delivery.

Level	Component
WD	1. Required staff training in the impact of trauma
WD	2. Measure staff proficiency in knowledge of impact of trauma
WD	3. Processes to prevent and help with staff secondary trauma
WD	4. Staff knowledge about when and how to access trauma focused therapy
TFS	5. Use of standardised and evidence-based assessments of trauma history and symptoms
TFS	6. Include child’s trauma history in file and care plan
TFS	7. Availability of trained, skilled clinical providers in evidence-based trauma focused therapies
ORG	8. Collaboration and information sharing <i>within</i> the agency related to trauma informed services e.g. between care and education
ORG	9. Collaboration and information sharing <i>with other</i> agencies related to trauma informed service e.g. CAMHS and social work
ORG	10. Procedures to reduce risk for re-traumatisation of children
ORG	11. Input from children and purchasers in service planning and development of a trauma informed system
ORG	12. Provide services that are strength-based and promote positive development
ORG	13. Provide a positive, safe physical environment
ORG	14. Written policies that explicitly include and support trauma informed principles
ORG	15. Presence of a defined leadership position or job function specifically related to TIC

37. Johnson D (2017) [Tangible trauma-informed care](#) *Scottish Journal of Residential Care*, 16 (1): 1-21,p5

BEST-PRACTICE PRINCIPLES IN THERAPEUTIC RESIDENTIAL CARE

There is no Australian consensus on the principles that represent best practice in Therapeutic Residential Care (TRC). However, it is clear that it must, at minimum, satisfy the recommendations of the Royal Commission on Institutional Responses to Child Sexual Abuse (RC).³⁸ The first of the RC's recommendations for institutions is that they must uphold the rights of the child recognised in the UN Convention on the Rights of the Child³⁹ and give prime consideration to the best interests of the child. The RC's Child Safe Principles place heavy weight on accommodating the voice of the child – particularly in the implementation of a child-friendly complaints mechanism. Best practice principles would need to ensure that Child Safe Principles are extended to cover prevention of all forms of maltreatment. They should also require establishment of an environment in which children can heal and become their best selves in accordance with their own dreams and aspirations.

The following set of proposed best practice principles for trauma-informed therapeutic residential care integrates principles from a number of sources, including those proposed by an International Working Group on TRC, the UnitingCare Australia Child, Young People and Family Network, and the principles of models such as CARE and Sanctuary⁴⁰.



38. See Appendix D

39. Recommendation 6.4 re Convention on Rights of the Child and Child Safe Principles

40. These are set out in section 8.5.

BEST PRACTICE PRINCIPLES FOR THERAPEUTIC RESIDENTIAL OOHc

1. **Uphold the Rights of the Child** as set out in the UN Convention;
2. **Do no harm and keep children safe:** use trauma-informed care and Child Safe Principles, including operation of a child-friendly complaints mechanism, to reduce risks to residents;
3. **Be responsive to the voice of the child** in the life and culture of the service: this means more than inviting participation in formal consultation – it means encouraging their agency in everyday life and decisions about them;
4. **Forge and maintain strong links with families, significant others, communities and culture,** fostering a strong sense of identity and belonging;
5. **Assess and monitor the developmental health and wellbeing of residents,** noting any history and ongoing consequences of trauma, and recording subjective indicators of health and wellbeing that reflect the child or young persons' aspirations for their best self;
6. **Develop, deliver and modify as necessary individually tailored, developmentally focused therapeutic treatment plans** aimed at promoting normal growth and development, including skills, knowledge and competencies, sense of (cultural) identity, agency, and the ability to form positive relationships;
7. **Identify and utilise adaptable, evidence-based models or strategies for practice** that are capable of achieving good outcomes for residents, families and staff.
8. **Recruit and retain staff with the necessary professional and personal skills to provide TRC** through provision of appropriate working conditions and personal support.
9. **Ensure that the residential facility is free of hazards and conducive to TRC;**
10. **Draw on evidence, reflection and feedback to enable continuous improvement;**
11. **Adopt systems thinking:** OOHc needs to work in harmony with a strong, community orientated family support and child protection system.
12. **Only provide residential services developed, resourced and implemented in conformity with the above principles.**

THE POLICY CONTEXT

The social policy environment at both Federal and State/Territory levels is, and has been for some decades, one of cutting back on public provision of community and welfare services and replacing block funding with competitive tendering for short-term contracts. Despite an increasing focus in policy statements on evidence-based policy, prevention and early intervention as more cost-effective than continuing to fund crisis services, the fact is that there has been little preventive investment and a history of discontinuing funding for many programs that were working.

Conditions in the informal child protection system are influenced by policy at all levels of government:

- Local Government controls access to utilities, affects community amenity, and provides grants to community bodies that foster community networks.
- State/Territory governments have sole responsibility for the formal child protection systems, and for many child and family welfare programs, including public housing, child and maternal health programs, family support, justice, subsidised public transport, urban planning etc. While the States/Territories provide education and hospital services, they rely substantially on Commonwealth funding to do so.
- The Commonwealth Government has responsibility for major policy that has a significant influence on disposable income in households, including those with children through the tax and transfer system (especially through social security and family payments), family support, job training and other community service programs, industrial relations policy, subsidised access to private rental housing, and health services.

Investment in prevention that would protect families from the significant maltreatment risks associated with poverty and social exclusion and provide timely assistance to parents who struggle with psychological, health and parenting problems cannot be made without commitments from all levels of government. The largest investment must come from the Commonwealth, but, in the long run, it has the most to gain from the improvements in human capital, economic participation and reduced longer term costs caused by early onset of chronic ill-health.

The program to prevent child maltreatment is simultaneously a program to improve the early child development of the next generation. This should not be a subject for political partisanship. The up-front costs are considerable, but the investment will produce a substantial return in financial, social and individual terms.

TERMS OF REFERENCE

Background

The Uniting Church community services network across Australia has a long history of the provision of residential services for children and young people. Contemporary child protection reforms in each jurisdiction have narrowed the scope of residential services to alternatively a specialist therapeutic setting and/or the placement of last resort.

It is critically important to ensure that our services not only meet the relevant state or territory standards of quality and accountability, but also achieve the best possible outcomes for children and, above all, do no harm.

In undertaking this work, the Uniting Church sees its role and interest as not only a current and potential future service provider of preferred models, but an advocate to the industry and to government to effect change so as to be confident that optimum outcomes for vulnerable children and young people are achieved.

Terms of Reference

Drawing on the findings of previous reviews of our services, on the research literature and best practice models from Australia and overseas, and using the Uniting Child Safe Policy Framework:

- Identify the needs of the target group of young people most likely to be allocated to residential OOHC;
- Identify evidence-based therapeutic responses to these needs and the models of residential OOHC used to provide them;
- Develop a set of best practice principles that should apply nationally to the provision of residential OOHC services by the Network;
- Identify opportunities to advocate for changed models of service delivery based on the identified best practice models with industry and government; and
- Make recommendations for action.

ABBREVIATIONS

CARE:

CEBC: California Evidence-Based Clearinghouse for Child Welfare

CROC: United Nations Convention on the Rights of the Child

EBP: Evidence-based Practice

EMDR: Eye Movement Desensitization and Reprocessing

FASD: Foetal Alcohol Spectrum Disorder

OOHC: Out of Home Care

OPCAT: Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment

ORG: Organisational Delivery

RC: Royal Commission on Institutional Responses to Child Sexual Abuse

TFCO-A: Treatment Foster Care Oregon – Adolescents

TFS: Trauma Focused Services

TIC: Trauma-informed Care

TRC: Therapeutic Residential Care

WD: Workforce Development

01

AN INTRODUCTION TO OUT OF HOME CARE

The United Nations Guidelines for the Alternative Care of Children recognize that every child and young person should ‘live in a supportive, protective, and caring environment that promotes his/her full potential.’⁴¹

The rights of the child recognized in the eponymous Convention include ‘as far as possible, the right to know and be cared for by his or her parents’.⁴² Children are not to be separated from their parents against their will:

except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents...⁴³

Placement of a child in OOHC is an attempt to provide safe and healthy living conditions for that child when perceived threats in the home environment ‘cannot be effectively addressed by appropriate outpatient support.’⁴⁴

The Guidelines for Alternative Care of Children⁴⁵ advocate top priority for supporting families to meet the needs of their children. Where children have been placed in OOHC, their emphasis is on the state’s responsibility for protecting the rights of the child, ensuring that interim care is appropriate, supporting efforts to enable safe reunification with family or close relatives, but, where this is still not possible, seeking alternative permanent placements, including adoption.⁴⁶

41. [Guidelines for the Alternative Care of Children](#), Resolution of the UN General Assembly, 64/142, 24 February 2010, para II A 4.

42. [UN Convention on the Rights of the Child](#), Article 7(1).

43. [UN Convention on the Rights of the Child](#), Article 9(1)

44. Leloux-Opmeer, H, Kuiper, C, Swaab, H, Scholte, E 2016, [Characteristics of Children in Foster Care, Family-Style Group Care, and Residential Care: A Scoping Review](#), *Journal of Child and Family Studies*, 25, 8: 2357-2371.

45. Op.cit.

46. [Guidelines for the Alternative Care of Children](#), Resolution of the UN General Assembly, 64/142, 24 February 2010

Table 1. The system of out of home services, in order of increasing intensity and cost⁴⁷

- adoption
- kinship care
- “conventional” foster care
- treatment (specialised or therapeutic) foster care
- parent model group care homes
- “conventional” staffed group care
- therapeutic residential/group care
- residential treatment (mental health) and
- correctional facilities (centres, wilderness, homes)

Table 1 above lists the types of OOHC in order of the intensity and cost. Leloux-Opmeer et al. (2016) summarised the types of OOHC and the types of intervention needed by the children placed in them as follows:

Out-of-home (24-hour) care consists of a continuum of intensive and restrictive care services, which range from lower-level family-based settings (e.g. relative foster care) to family-style group care to several types of residential treatment care Residential treatment centers in turn also reflect a continuum of services that vary from open residential to secure residential to inpatient psychiatric care Secure residential care seems to be especially preferred in juveniles with persistent aggressive behavior problems ... whereas inpatient psychiatric care is reserved for children who additionally display psychotic or suicidal behaviour In family-style group care, children live in home-like settings with live-in workers This kind of care can be viewed as an intermediate setting between foster and residential care⁴⁸

UN Guidelines for the Alternative Care of Children advocate family-type settings as those most in keeping with the best interests of the child. However, one-third to one-half of placements in foster care fail⁴⁹, necessitating further placements, which increase stress and the risk of emotional and behavioural problems, which in turn result in the need for more restrictive and intense forms of OOHC.⁵⁰ Residential care is the most intense, costly, restrictive and least family-like form of placement. The Guidelines advocate limiting its use to:

cases where such a setting is specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests.⁵¹

The Guidelines are opposed to the use of ‘large’ residential facilities – institutions – and recommend deinstitutionalisation in favour of alternatives based on ‘individualised and small group care’.⁵²

47. Anglin F, Holden M & Kuhn F 2014, ‘[The Process of Care implementation & the Managing of Complexity](#)’. Presentation, EUSARF Conference, Copenhagen, September 3-4, 2014.

48. Leloux-Opmeer et al. (2016) [Characteristics of Children in Foster Care, Family-Style Group Care, and Residential Care: A Scoping Review](#) Journal of Child and Family Studies, August 2016, 25, 8: 2357-2371, p2357. See original text for removed references.

49. Scholte (1997), Van den Bergh & Weterings (2010), Van Manen (2011) cited in Leloux- Opmeer (2016) op. cit. p. 2358. For Australian data see Osborn A & Bromfield L (2007) [Outcomes for children and young people in care](#), NCPC Brief No. 3 – October 2007.

50. *ibid*

51. [Guidelines for the Alternative Care of Children](#), Resolution of the UN General Assembly, 64/142, 24 February 2010, p. 5

52. *ibid*.

Thoburn & Courtney (2011) in their review of the international evidence on OOHC placement, note the influence of the 'historical, political and social contexts in which services are provided' and the importance of 'language/definitions [...] and socio-cultural/political differences, which result in different patterns of service delivery for different groups of children'.⁵³ Thoburn's (2010) international review showed much higher rates of children in residential care in mainland Europe, Israel and Scandinavian countries than in Anglophone countries.⁵⁴

The extent to which OOHC is state-ordered or voluntary, free or paid, time limited or open ended, can vary in response to '[d]ifferent views about the nature and role of the state, the private citizen, the private for profit and not for profit sectors and faith groups'.⁵⁵

The UK ushered in a 'mixed economy of welfare' with 'new providers of child placement services, including a 'for profit' sector alongside the voluntary sector and public providers'.⁵⁶ Australian governments at all levels have now pursued this course.

Their review prompted Thoburn & Courtney to conclude, *inter alia*, that:

- The generally negative view held in Anglophone jurisdictions about the potential for out-of-home care to benefit those children who need it is not borne out from the evidence; and
- Evidence about the effectiveness of care systems in different countries is growing, but policy makers and practitioners wishing to learn about what works in other countries must take care to understand the different contexts and care populations.⁵⁷

The conditions which give rise to placement of children in care are discussed below.

53. Thoburn, J & Courtney, M 2011, '[A guide through the knowledge base on children in out-of-home care](https://doi.org/10.1108/17466661111190910)', *Journal of Children's Services*, vol. 6, no. 4, pp. 210-227, <https://doi.org/10.1108/17466661111190910>

54. Cited in Thoburn & Courtney (2011).

55. *ibid.*

56. *ibid.*

57. *op. cit.* p. 221

02

CHILD MALTREATMENT

2.1 DEFINITIONS OF CHILD MALTREATMENT

Definitions of the four categories of child maltreatment are given in Box 1 below.

Box 1. Types of child maltreatment⁵⁸

Emotional abuse: Any act by a person having the care of a child that results in the child suffering any kind of significant emotional deprivation or trauma. Children affected by exposure to family violence are also included in this category.

Neglect: Any serious acts or omissions by a person having the care of a child that, within the bounds of cultural tradition, constitute a failure to provide conditions that are essential for the healthy physical and emotional development of a child.

Physical abuse: Any non-accidental physical act inflicted upon a child by a person having the care of a child.

Sexual abuse: Any act by a person, having the care of a child that exposes the child to, or involves the child in, sexual processes beyond his or her understanding or contrary to accepted community standards.

2.2 CHILD MALTREATMENT – A PUBLIC HEALTH, SOCIAL AND HUMAN RIGHTS ISSUE

Violence against children is a public health, social and human rights issue, with potentially devastating and costly consequences.⁵⁹ The problem of child maltreatment can be defined in terms of human rights violations and conceptualised in terms of social context, but it needs to be diagnosed and addressed as a population health issue. This means identifying and mitigating the risk factors that make it more likely and promoting the conditions that prevent it or reduce its likelihood.

2.3 POPULATION AND INDIVIDUAL COSTS OF CHILD MALTREATMENT

Child maltreatment – which includes physical, emotional and sexual abuse as well as neglect – is the single most influential known cause of preventable mental health impairment (the other high-impact causes being primarily genetic), with conservative estimates of prevalence of about 15% in high-income countries.⁶⁰

58. AIHW Child Protection 2016-17 Glossary

59. Hillis, S, Mercy, J, Amobi, A, & Kress, H 2016, . 'Global Prevalence of Past-year Violence Against Children: A Systematic Review and Minimum Estimates'. *Pediatrics*, 137, 3.

60. Constantino, J 2018, 'Prevention of child maltreatment: strategic targeting of a curvilinear relationship between adversity and psychiatric impairment', *World Psychiatry*, vol. 17, no. 1.

The causal mechanisms responsible for the ongoing effects of maltreatment in survivors are still being explored:

Empirical associations between early exposure to violence and major causes of mortality in adulthood were recognized years ago, before elucidation of their shared biological underpinnings. Recent evidence documents the biology of violence, demonstrating that traumatic stress experienced in response to violence may impair brain architecture, immune status, metabolic systems, and inflammatory responses. Early experiences of violence may confer lasting damage at the basic levels of nervous, endocrine, and immune systems, and can even influence genetic alteration of DNA.⁶¹

The impact in a particular case of maltreatment depends on its timing, duration, and intensity, as well as on the sex and genetic vulnerability of the victim. A systemic review of reviews analysing the effects of maltreatment identified the following as ‘critical findings’:

- Child maltreatment was associated with an exceptionally wide range of physical health problems and a pro-inflammatory state associated with reduced immune system efficiency which may underpin many of these difficulties;
- Adult survivors of child maltreatment had significant abnormalities in the structure and functioning of the brain and endocrine system, possibly associated with mental health problems;
- Child maltreatment was associated with an exceptionally wide range of mental health problems in adolescents and adults;
- Child maltreatment was associated with a wide range of negative psychosocial outcomes across the life span including difficulties in making and maintaining relationships, managing sexual and aggressive impulses, adjustment in school and at work, and maintaining a satisfying quality of life;
- Surviving multiple forms of severe maltreatment was associated with more adverse outcomes;
- Specific forms of maltreatment were associated with specific outcomes, for example, physical abuse with aggression, sexual abuse with sexuality problems, and emotional abuse with severe mental health problems.⁶²

The population cost of maltreatment is predictably high. In Australia the lifetime economic costs of child maltreatment have been estimated at \$9.3 billion and the lifetime costs in terms of reduced quality of life and premature mortality at \$17.4 billion.⁶³

A recent (conservative) estimate of average lifetime economic costs to the individual victim of child maltreatment by a primary carer in the UK was £89,390.⁶⁴ The largest components of this came from the costs of social care, short-term health-related costs, and the costs resulting from a lower probability of employment.⁶⁵

61. Hillis S, Mercy J, Amobi, A & Kress, H (2016). ‘[Global Prevalence of Past-year Violence Against Children: A Systematic Review and Minimum Estimates](#)’. *Pediatrics*, 137, 3: March 2016. See original article for further references.

62. Carr A, Duff H & Craddock F (2018) ‘A Systematic Review of Reviews of the Outcome of Noninstitutional Child Maltreatment’ *Trauma, Violence and Abuse*, First Published September 24, <https://doi.org/10.1177/1524838018801334>, p6

63. McCarthy M et al. 2016 ‘[The lifetime economic and social costs of child maltreatment in Australia](#)’ *Children and Youth Services Review* v. 71 Dec 2016: 217-226.

64. AU\$157,094 as at 18/12/18

65. Conti et al (2017) [The economic cost of child maltreatment in the UK. Preliminary study estimating the lifetime costs of child abuse and neglect](#) National Society for the Prevention of Cruelty to Children (NSPCC), UK. The authors gave the 95% confidence limits as £44,896 and £145, 508.

Constantino⁶⁶ estimated that maltreatment accounts for at least 25% of the population-attributable risk for child psychopathology, and maltreatment has a strong association with the likelihood that victims will themselves become perpetrators in adulthood (Shaley et al 2016, cited in Constantino 2018). In a survey for the World Health Organisation (WHO), Kessler et al. (2010)⁶⁷ reported that childhood adversities accounted for 28.9% of adult psychopathology in a range of high, middle and low-income countries.

2.4 RISK FACTORS FOR MALTREATMENT

Research has identified the following as risk factors for child maltreatment:

- Issues related to fertility control, the timing or spacing of children can raise the risk of maltreatment.⁶⁸
- Children with a disability (10.4% of the population) are over-represented in child protection notifications (25.9%) and substantiations (29.0%), but only children with an intellectual disability, mental or behavioural problems, or conduct disorder (Australian data).⁶⁹
- Economic disadvantage – accounts for an estimated 27.3% of maltreatment, with poverty and parental unemployment the strongest predictors (Australian data).⁷⁰
- Poor parental mental health, parental substance abuse, and social instability (as well as higher levels of economic disadvantage) were strongly associated with increased risk of child maltreatment. Nine independent factors were identified in an Australian data set – the risk of maltreatment increased exponentially as risk factors accumulated and exceeded 80% in the highest risk groups (Australian data).⁷¹
- Parental experience of abuse in childhood. After adjustment for other risk factors, a maternal history of either unsubstantiated (hazard ratio = 2.19, 95% confidence interval: 2.06, 2.33) or substantiated (hazard ratio = 3.19, 95% confidence interval: 3.00, 3.39) maltreatment emerged as a strong predictor of maltreatment and child protection involvement in the next generation (US data).⁷²
- Parental experience of out of home care. Almost one-third of children and young people involved with the NSW statutory child protection system in 2014-15 had at least one parent who had either been reported or were in OOHC when they were a child. The intergenerational link was strongest for children and young people in OOHC with almost one-half having a parent who had either been reported or were in OOHC when they were a child.⁷³

66. Constantino J (2018) [Prevention of child maltreatment: strategic targeting of a curvilinear relationship between adversity and psychiatric impairment](#) *World Psychiatry* 17:1 – February 2018.

67. Kessler et al (2010) [Childhood adversities and adult psychopathologies in the WHO World Mental Health Surveys](#) *Br J Psychiatry*. 2010 Nov; 197(5): 378-385. doi: 10.1192/bjp.bp.110.080499

68. For an overview and reference material see Marie Cohen's blog of April 16, 2018 [An Overlooked Approach to Child Maltreatment Prevention](#); Guterman K (2015) [Unintended pregnancy as a predictor of child maltreatment](#). *Child Abuse Negl.* 2015 Oct;48:160-9. doi: 10.1016/j.chiabu.2015.05.014.; Lukasse M et al (2015) ['Pregnancy intendedness and the association with physical, sexual and emotional abuse – a European multi-country cross-sectional study'](#), *BMC Pregnancy Childbirth*. 2015; 15: 120., May 26. doi: 10.1186/s12884-015-0558-4;

69. Maclean M, Sims S et al (2017) 'Maltreatment Risk Among Children With Disabilities' *Pediatrics*, April 2017, 139,4

70. Doidge et al (2017) [Economic predictors of child maltreatment in an Australian population-based birth cohort](#). *Children and Youth Services Review* V. 72, January 2017, pp 14-25

71. Doidge et al (2017) [Risk factors for child maltreatment in an Australian population-based birth cohort](#). *Child Abuse Negl.* 2017 Feb;64:47-60. doi: 10.1016/j.chiabu.2016.12.002.

72. Putnam-Hornsten et al (2015) [A Population-Level and Longitudinal Study of Adolescent Mothers and Intergenerational Maltreatment](#). *American Journal of Epidemiology*, Volume 181, Issue 7, 1 April 2015, Pages 496-503, <https://doi.org/10.1093/aje/kwu321>

73. [The prevalence of intergenerational links in child protection and out-of-home care in NSW](#). FACSAR Report, August 2017.

- Exposure to domestic violence. Exposure to Domestic violence constitutes maltreatment even in the absence of other forms of maltreatment.⁷⁴ Exposure to Domestic violence in the family (US data) was 'very closely associated with several forms of maltreatment and exposure to other forms of family violence [...] with adjusted OR⁷⁵ ranging from 3.88 to 9.15.'⁷⁶

The reasons for the significant over-representation of Indigenous children in child protection notifications and OOHC are:

complex and are connected to past policies and the legacy of colonisation. Poverty, assimilation policies, intergenerational trauma and discrimination, and forced child removals⁷⁷ have all contributed to the over-representation of Aboriginal and Torres Strait Islander children in care, as have cultural differences in child-rearing practices and family structure (Human Rights and Equal Opportunity Commission [HREOC], 1997; SNAICC, 2016a; Titterton, 2017).⁷⁸

Newton (2017) reports research on the possibility that cultural differences in the understanding of 'neglect' that might account for the higher proportion of substantiated cases of neglect amongst Indigenous children (see Table 4 below). She found no evidence of such a cultural difference:

Instead, it is the difficult circumstances experienced by Aboriginal families that keep parents from actualising their parenting expectations.⁷⁹

2.5 CORPORAL PUNISHMENT RAISES COMMUNITY RISK LEVEL

Corporal punishment is proscribed by the UN Convention on the Rights of the Child:

Art. 19: (1) States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child....

It has not been prohibited in Australia, although what constitutes 'reasonable' punishment has been defined in some jurisdictions.⁸⁰

Researchers have found strong associations between corporal punishment, poor outcomes for children and higher incidence of violence in families:

74. See for example Wathen CN & MacMillan H (2013) [Children's exposure to intimate partner violence: Impacts and interventions](#). *Paediatr Child Health*. 2013 Oct; 18(8): 419-422.

75. OR – Odds Ratio – or hazard ratio, which reflects how much more likely a particular outcome is after exposure to a given risk factor.

76. Hamby et al (2010) [The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth](#). *Child Abuse Negl*. 2010 Oct;34(10):734-41. doi: 10.1016/j.chiabu.2010.03.001.

77. The so-called Stolen Generation refers to the removal of Indigenous children from their parents between 1910 and 1970 in accordance with policies motivated more by assimilationist aims than child protection. See the Australian Human Rights Commission 1997 Report [Bringing Them Home](#).

78. [Child protection and Aboriginal and Torres Strait Islander children](#), CFCA Resource Sheet — January 2019, Australian Institute of Family Studies.

79. Newton B (2017) 'An Aboriginal community's perceptions and experiences of child neglect in a rural town' *Aust J Soc Issues* 52:262-277

80. [Corporal punishment: Key issues](#), CFCA Resource Sheet — March 2017, Australian Institute of Family Studies

Virtually without exception, these studies found that physical punishment was associated with higher levels of aggression against parents, siblings, peers and spouses.⁸¹

Meta-analysis of research comparing the effects of corporal punishment and physical abuse found that corporal punishment had a significant association with 13 out of 17 negative outcome measures, including:

antisocial behaviour, external behaviour problems, low moral internalisation, aggression, mental health problems, negative parent-child relationships, impaired cognitive ability, low self-esteem and risk of physical abuse from parents.⁸²

Evidence of the link between the practice of corporal punishment and the incidence of physical injury to a child has been accumulating for some time:

Although research began to accumulate in the 1970s that showed that most physical abuse is physical punishment (in intent, form and effect), studies of child maltreatment have since clarified this finding. For example, the first cycle of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS 1998) showed that 75% of substantiated physical abuse of children occurred during episodes of physical punishment. This finding was replicated in the second cycle of the study (CIS 2003). Another large Canadian study found that children who were spanked by their parents were seven times more likely to be severely assaulted by their parents (e.g., punched or kicked) than children who were not spanked. In an American study, infants in their first year of life who had been spanked by their parents in the previous month were 2.3 times more likely to suffer an injury requiring medical attention than infants who had not been spanked. Studies of the dynamics of child physical abuse have shed light on this process, which involves parents attributing conflict to child wilfulness and/or rejection, as well as coercive family dynamics and conditioned emotional responses.⁸³

In summary, the use of corporal punishment is contrary to intentionally accepted human rights standards, is strongly associated with poor outcomes for children and with an increased incidence of physical maltreatment. It is also associated with increased risk of domestic and family violence – which constitutes maltreatment in itself and is independently associated with higher incidence of other forms of child maltreatment.

2.6 PREVENTION AND EARLY INTERVENTION POLICIES

A public health approach aimed at reducing the prevalence of risk factors, and providing support for families in high-risk categories, would be expected to reduce the incidence of harm and reduce the need for child removal.

81. Durrant J & Ensom R (2012) 'Physical punishment of children: lessons from 20 years of research' *CMAJ* September 04, 184 (12) 1373-1377

82. Gershoff E & Grogan-Kaylor A (2016) 'Spanking and child outcomes: Old controversies and new meta-analyses' *Family Psychology*, 30(4), 453-469 cited in Corporal punishment: Key issues, CFCA Resource Sheet — March 2017, Australian Institute of Family Studies.

83. Durrant J & Ensom R (2012) [Physical punishment of children: lessons from 20 years of research](#) *CMAJ* September 04, 184 (12) 1373-1377 See paper for deleted additional references.

Constantino sums up the evidence concerning risk, how it might be ascertained, and how it might be addressed:

Our ability to predict child maltreatment on the basis of risk indicators that can be feasibly ascertained on the first day of an infant's life (including indices of parental mental health or substance use impairment, concentrated poverty, and a range of socio-economic stress indicators) has considerably advanced, and specific risk profiles can be delineated identifying a subgroup of children who have an up to 70% likelihood of ultimately being detected in official governmental records for child abuse/neglect. In spite of this, hospitals and health agencies rarely systematically screen for child maltreatment risk.

Child maltreatment is preventable. Its prevention requires the coordinated application of interventions that address key lapses in "species-typical" mechanisms of protection of the young: caregiving knowledge and competence, resource acquisition, surrogacy (i.e., the family or adult "village" surrounding a child to assist when a parent needs help), and close surveillance of the child.

A prototypic, yet remarkably common risk scenario is that of a single parent with multiple young children, isolated by poverty, under-educated in the modelling of appropriate caregiving (or whose own experience in being parented was traumatic or deficient) and with either an untreated mental health impairment or substance use disorder.

An effective, evidence-informed approach to reduce the risk of child maltreatment imposed by this set of circumstances would include nurse (or paraprofessional) home visitation, parenting education, parental mental health care, a support resource for times of crisis, and reproductive health planning. This is analogous to the level of comprehensive intervention that is afforded to patients with complex medical disorders in most health systems, encompassing cost-efficient, evidence-based interventions that could be prioritized for families at risk and coordinated by efficient, targeted case management.⁸⁴

The suffering of so many maltreated children, including Indigenous children, is preventable, just as the suffering endured by so many of their parents was preventable. We need to stop the intergenerational transfer of maltreatment by taking note of the relevant risk factors and limiting exposure to them or mitigating their impact.

Carr et al (2018) identified the following implications for policy from their review of child maltreatment reviews:

- Evidence-based child protection policies and practices are required to prevent maltreatment and treat child abuse survivors;
- Primary, secondary, and tertiary child maltreatment prevention programs should be established;

84. Constantino J (2018) [Prevention of child maltreatment: strategic targeting of a curvilinear relationship between adversity and psychiatric impairment](#) *World Psychiatry*17:1 – February 2018.

- For primary prevention of physical abuse and neglect, universal, community-wide parent training programs are the most effective interventions;
- Effective secondary prevention programs, which target families where there is a high-risk of child maltreatment, include intensive home visiting, parenting skills training, and life skills, stress management, and anger management training for parents;
- Effective tertiary prevention programs to prevent recurrence of abuse or neglect in families where children have been maltreated, involve intensive intervention for children to facilitate recovery from trauma; for parents to develop childcare, parenting, and self-regulation skills; and for families to become more cohesive. For cases where it is unsafe for children to live with parents, treatment foster care⁸⁵ is the best available evidence-based intervention;
- For adult survivors of child abuse with physical and mental health problems, a universal trauma-informed approach to the provision of health care is required, and for those who engage in abusive sexual behavior, evidence-based group therapy programs should be provided;
- There is a need for more longitudinal studies on both the psychosocial and physiological mechanisms that link maltreatment in childhood to physical and mental health problems and psychosocial adjustment difficulties across the life span.⁸⁶

2.7 THE NEED TO PREVENT EXPOSURE TO RISK FACTORS IN ADDITION TO MALTREATMENT

Research has revealed that the experience of adversity is biologically embedded and the cumulative experience of adversity from conception across the early years of childhood can exert harmful effects over a lifetime. The latter can be seen, *inter alia*, in physiological systems and brain structure and function that are poorly adapted to cope with stress, in changes in the levels of inflammation that may predispose individuals to later disease, in changes in gene expression (epigenetic changes) that affect lifetime vulnerability to problems with physical health, mental health, learning, and behaviour. Adversity-linked epigenetic changes may even be transmitted across generations who have not themselves been exposed to adversity. The impact of adversity is determined by its timing, duration, intensity, cumulative risk exposure, as well as the sex, genetic, and epigenetic susceptibility of the individual.⁸⁷

Exposure to adversity in early childhood affects learning, memory and executive function as well as lifelong health.⁸⁸

Some risk factors, such as maltreatment, are well known, others are not. Many of these constitute risk factors for parental maltreatment. They include: parental mental health problems; poverty and financial stress; unemployment; housing stress (more than two people per bedroom⁸⁹); housing insecurity (frequent moves); being teen parent(s); low parental education (particularly maternal); more than three siblings; siblings born less than two years apart; low birthweight; short or no breast-feeding etc.⁹⁰

85. 'Foster care' is used here as a synonym for OOHC. So 'treatment foster care' can be interpreted as therapeutic OOHC.

86. Carr A, Duff H & Craddock F (2018) 'A Systematic Review of Reviews of the Outcome of Noninstitutional Child Maltreatment' *Trauma, Violence and Abuse*, First Published September 24, <https://doi.org/10.1177/1524838018801334>, p6

87. *ibid*.

88. Shonkoff J et al. [The Lifelong Effects of Early Childhood Adversity and Toxic Stress](#) *Pediatrics*, V 129, No. 1, January 2012. doi: 10.1542/peds.2011-2663

89. Housing rental stress - household in the bottom 40% of incomes has to spend more than 30% of its income on rent – can contribute to financial stress.

90. For a list of risk factors and sources of evidence see pp 16-22 of Biddle N & Seth-Purdie R (2013) [Relationship between development risk and participation in early childhood education: How can we reach the most vulnerable children?](#) Crawford School, ANU

Intergenerational poverty can be seen as the result of processes that transmit patterns of social behaviour and biological processes that result from toxic stress – i.e. from exposure to a high level of adversity or risk.⁹¹

Given the problems in achieving *Close the Gap* targets in Australia, it is of interest to note that when exposure to risk factors is taken into account, there is no significant difference in the performance of Indigenous and non-Indigenous children on measures of cognitive and non-cognitive development in the first year of school.⁹²

Secondary and tertiary interventions in response to the harms caused by exposure to toxic stress/ high-risk burden are expensive and limited in effectiveness. A public health approach that prioritised primary prevention would mean substantial additional investment in policies to prevent exposure to risk, but would predictably result in substantially reduced net expenditure on social problems and the secondary and tertiary interventions to address them. It would also lead to increased revenue from economic activity as the next generation of children matured into productive adulthood.

2.8 INCIDENCE OF CHILD MALTREATMENT

It is extremely difficult to establish the real incidence of child maltreatment in a population. Official statistics report only those cases that have been the subject of an official report or investigation and must be treated as understatements of prevalence. If reporting a concern is more likely to lead to child removal than support for a struggling family, members of a community may be reluctant to communicate with officials. In groups with a traumatic history of child removal, such as Australia's Indigenous community, under-reporting may be even higher.⁹³

International

From a review of a series of meta-analyses Stoltenborgh et al (2015) calculated worldwide incidence of child maltreatment, using self- and informant-reports respectively:

The overall estimated prevalence rates for self-report studies (mainly assessing maltreatment ever during childhood) were 127/1000 for sexual abuse (76/1000 among boys and 180/1000 among girls), 226/1000 for physical abuse, 363/1000 for emotional abuse, 163/1000 for physical neglect and 184/1000 for emotional neglect. The overall estimated prevalence rates for studies using informants (mainly assessing the 1-year prevalence of maltreatment) were four per 1000 for sexual abuse and three per 1000, respectively, for physical abuse and emotional abuse.⁹⁴

91. McEwen C & McEwen B (2017) [Social Structure, Adversity, Toxic Stress, and Intergenerational Poverty: An Early Childhood Model](#) *Annual Review of Sociology* Vol. 43:445-472. <https://doi.org/10.1146/annurev-soc-060116-053252>

92. Biddle N & Seth-Purdie R (2013) [Relationship between development risk and participation in early childhood education: How can we reach the most vulnerable children?](#) Crawford School, ANU

93. [Child protection and Aboriginal and Torres Strait Islander children](#), CFCA Resource Sheet— January 2019, Australian Institute of Family Studies.

94. Stoltenborgh M et al. (2015) [The Prevalence of Child Maltreatment across the Globe: Review of a Series of Meta-Analyses](#) *Child Abuse Review* 24: 27-50, doi:10.1002/car.2353

Australia

Below is a summary of trends in Australian child protection data taken from AIHW's Child Protection 2016-2017. Of particular note is that:

- the growth in rates of notification, substantiation and children in OOHC continued long-standing trends
- the extent of the over-representation of Aboriginal and Torres Strait Islander children in the child protection data continued to rise.

Box 2. Summary of Australian child protection statistics 2016-2017⁹⁵

- **One in 32** children received child protection services, with **74%** being repeat clients
- Aboriginal and Torres Strait Islander children continued to be over-represented: in 2016-17, they were **7 times** as likely as non-Indigenous children to have received child protection services.
- Children from Very Remote areas were **4 times** as likely as those from major cities to be the subject of a substantiation.
- In 2016-17, 168,352 **(1 in 32)** children had an investigation, care and protection order and/or were placed in out-of-home care.
- Rates for children who were the subject of substantiations, on care and protection orders, and in out-of-home care **continued to rise**.
- Between 2012-13 and 2016-17, rates of children:
 - who were the subject of a substantiation **rose from 7.8 to 9.0** per 1,000 children
 - on care and protection orders **rose from 8.2 to 9.9** per 1,000, and
 - in out-of-home care **rose from 7.7 to 8.7** per 1,000.
- At 30 June 2017, more than half **(52%)** of children in relative/kinship placements were placed with grandparents.
- Of children who were in long-term out-of-home care in 2016-17:
 - **24%** lived with a third-party carer who had long-term legal responsibility for them; and
 - **62%** were under the long-term legal responsibility of the state or territory.

95. [Child Protection Australia 2016-2017](#), Australian Institute of Health & Welfare, 2018.

Table 2. Child protection trend data, number of children in the child protection system, states and territories, 2012-2013 to 2016-17⁹⁶

Year	NSW ^{(a)(b)}	Vic	Qld ^(c)	WA ^(d)	SA ^(e)	Tas ^{(f)(g)}	ACT ^(h)	NT	Total
Number									
Children receiving child protection services⁽ⁱ⁾									
2012–13	48,399	27,272	30,389	13,657	6,380	2,947	2,215	3,880	135,139
2013–14	53,250	28,949	29,585	15,385	7,083	2,609	1,635	4,527	143,023
2014–15	59,092	33,430	27,163	15,909	6,309	2,560	1,703	5,814	151,980
2015–16	64,330	37,357	27,842	15,375	6,204	2,579	2,388	6,100	162,175
2016–17	66,689	40,415	28,634	15,282	6,194	2,605	2,008	6,525	168,352
Children who were the subject of substantiations⁽ⁱ⁾									
2012–13	16,236	10,048	7,149	2,686	1,836	918	494	1,204	40,571
2013–14	15,074	11,395	6,685	3,053	2,190	712	341	1,394	40,844
2014–15	15,022	13,300	5,869	3,382	1,908	833	386	1,757	42,457
2015–16	17,282	14,154	5,621	4,198	1,641	795	449	1,574	45,714
2016–17	18,919	15,488	5,767	4,633	1,526	755	317	1,910	49,315
Children on care and protection orders⁽ⁱ⁾									
2012–13	16,373	7,751	9,211	4,260	2,798	1,253	674	816	43,136
2013–14	17,242	9,233	9,131	4,471	2,786	1,188	705	990	45,746
2014–15	18,496	10,135	9,269	4,808	3,019	1,183	747	1,073	48,730
2015–16	19,876	10,962	9,580	4,946	3,448	1,248	823	1,089	51,972
2016–17	20,453	12,354	9,716	5,138	3,686	1,316	889	1,114	54,666
Children in out-of-home care⁽ⁱ⁾									
2012–13	17,422	6,542	8,136	3,425	2,657	1,067	558	742	40,549
2013–14	18,192	7,710	8,185	3,723	2,631	1,054	606	908	43,009
2014–15	16,843	8,567	8,448	3,954	2,838	1,061	671	1,017	43,399
2015–16	17,800	9,705	8,670	4,100	3,243	1,150	748	1,032	46,448
2016–17	17,879	10,312	8,941	4,232	3,484	1,205	803	1,059	47,915

(a) NSW care and protection orders data do not include children on finalised supervisory orders.

(b) NSW out-of-home care data at 30 June 2015 onwards are not comparable with previous years' data. NSW Safe Home for Life (SHFL) legislative reforms, effective 29 October 2014, transitioned eligible children/young people to the independent care of their guardian. These children/young people exited and were no longer counted in out-of-home care.

(c) Data produced from the CP NMDS based on nationally agreed specifications may not match Qld figures published elsewhere. Qld data for 2014–15 onward are not comparable with data for previous years.

(d) WA out-of-home care data exclude children on third-party parental responsibility orders and from 2015–16 includes children placed in boarding schools.

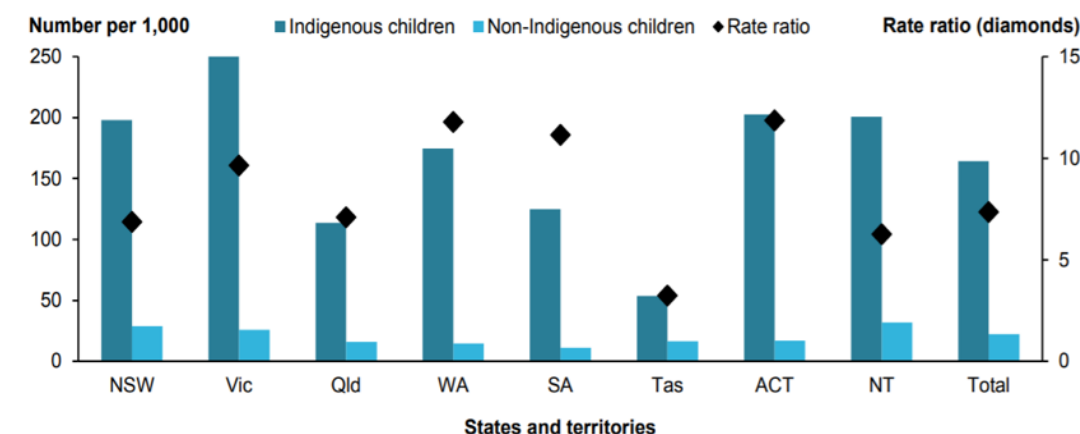
(e) SA could provide the number of children in out-of-home care only where the department is making a financial contribution to the care of a child (this excludes cases where financial payment was offered and declined).

(f) Tas care and protection data may not be comparable year to year due to considerable data lag with the recording of order status.

(g) Tas out-of-home care data exclude children not under care and protection orders placed with relatives for whom a financial contribution is made under the Supported Extended Family or Relatives Allowance programs.

96. [Child Protection Australia 2016-2017](#), Australian Institute of Health & Welfare, 2018, p63.

Table 3. The ratio of Indigenous to non-Indigenous children by State/Territory, 2016-2017⁹⁷

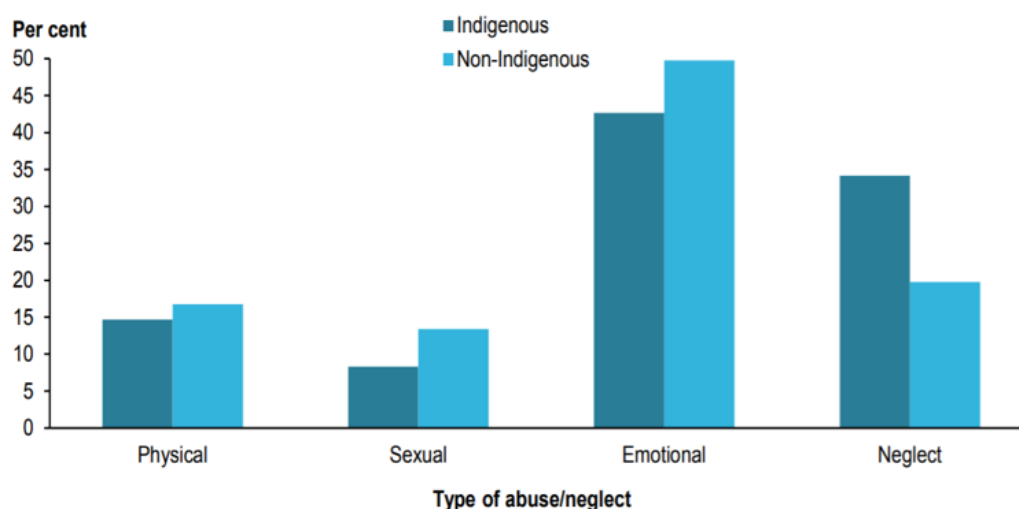


Notes

1. In Tas, the higher proportion of children with unknown Indigenous status might affect the reliability of the rate ratio calculation. Rate ratios should therefore be interpreted with caution.

Indigenous children received child protection services at a rate seven times that of non-Indigenous children.

Table 4. Types of substantiated maltreatment by Indigenous Status 2016-17⁹⁸



Note: For each child, the type of abuse/neglect reported is the type identified for their first substantiation in the year. Where multiple types of abuse were reported in the same substantiation, the data reflect the abuse type that is most likely to place the child at risk, or be most severe in the short term.

Source: Table S14.

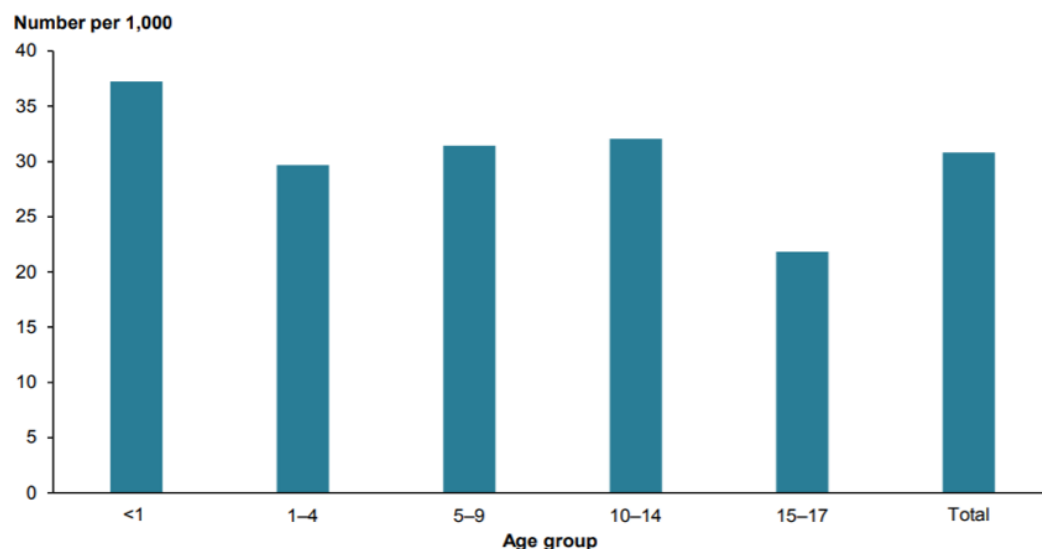
Emotional abuse and neglect constituted the highest proportions of substantiated cases overall, whereas Indigenous children (34%) had a higher percentage of substantiations for neglect than non-Indigenous children (20%), and a lower percentage of substantiations for emotional, physical, and sexual abuse.⁹⁹

97. op.cit. p15

98. op. cit. p27

99. *ibid.*

Table 5. Rates of children receiving child protection services by Age Group 2016-2017¹⁰⁰

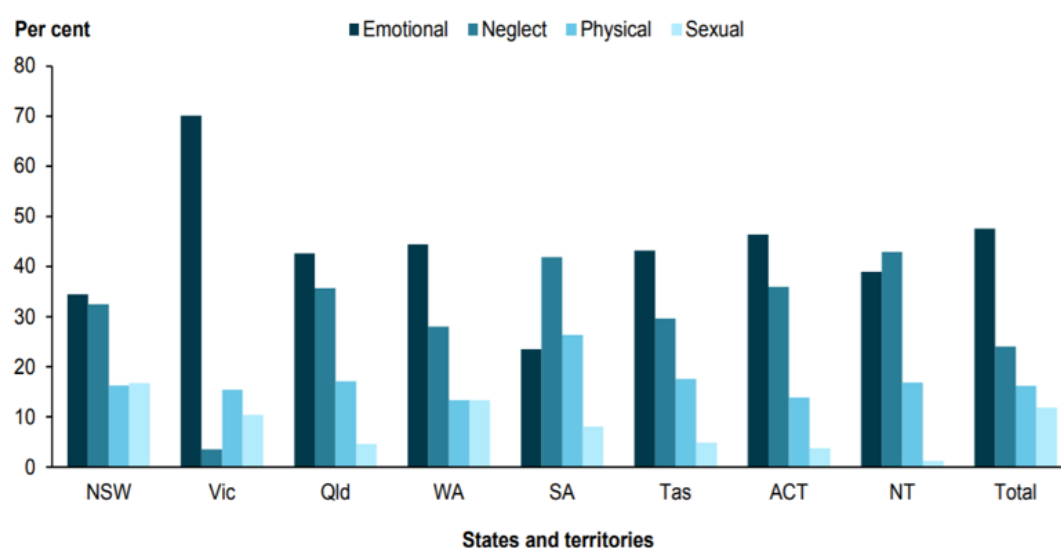


Notes

1. Unborn children may be covered under child protection legislation and are therefore included in this report. However, they are excluded in rate calculations for the 'less than 1' and '0-17' age categories. Unborn children are included in the 'All children' rates.
2. 'All children' includes children of unknown age.

The higher rate of child protection services for younger children may reflect greater emphasis on the need for early intervention.¹⁰¹

Table 6. Substantiated maltreatment type by jurisdiction 2016-17¹⁰²



Note: Only the abuse type that is most likely to place the child at risk, or be most severe in the short term is reported for the first substantiation in the year.

100. [Child Protection Australia 2016-2017](#), Australian Institute of Health & Welfare, 2018, p14.

101. op. cit. p6

102. op. cit. p27

Emotional abuse was the most commonly substantiated form of maltreatment in all jurisdictions except SA and the NT, where neglect was most common. The comparatively high rate of emotional maltreatment and low rate of neglect amongst Victorian cases beg for explanation.

Table 7. Co-occurrence of maltreatment type 2017¹⁰³

Primary type of abuse or neglect	Co-occurring type of abuse or neglect ^{(a)(b)}				Total number of substantiations ^(c)
	Physical abuse	Sexual abuse	Emotional abuse	Neglect	
Physical abuse	..	2.0	44.6	25.1	11,043
Sexual abuse	6.3	..	22.8	12.7	7,863
Emotional abuse	22.5	1.8	..	32.5	30,745
Neglect	6.4	1.0	23.4	..	18,149
Average co-occurrence^(d)	15.1	1.6	29.6	27.7	67,800

(a) Excludes 3,955 cases for Qld where the same type of abuse/neglect was recorded as both a primary and co-occurring type of abuse/neglect.

(b) Not all jurisdictions were able to provide data for all types of co-occurring abuse or neglect—some jurisdictions were able to report only primary and secondary types. Therefore, the proportion of co-occurring abuse types may be understated.

(c) Excludes 168 cases where the primary type of abuse was unknown.

(d) 'Average co-occurrence' is equal to the total number of cases where the type of abuse or neglect of interest was identified as co-occurring, divided by the total number of substantiations where the given type of abuse or neglect was not the primary type.

Source: AIHW Child Protection Collection 2017.

Table 7 above shows the percentage of substantiated cases of each maltreatment type with co-occurring maltreatment. Emotional abuse had the highest average rate of occurrence followed by neglect and physical abuse. Table 6 showed sexual abuse to be the least prevalent form of substantiated maltreatment; it was also by far the least common co-occurring form.

103. [Child Protection Australia 2016–2017](#), Australian Institute of Health & Welfare, 2018, p22.

03

CHILD PROTECTION SYSTEMS

3.1 THE NEED FOR A SYSTEMS APPROACH IN STATUTORY SYSTEMS

A critical incident, such as the death or grave injury of a child in care or otherwise known to the child protection system, prompts investigations to identify how the system failed and what needs to be done to prevent recurrence.

Monro (2005) found that ‘traditional’ responses to such failures in the UK and the USA resulted in one or more of the following conclusions:

- ‘Blame culture’ – punish the culprits and so encourage the others to be more diligent;
- Reduce the role of individual human reasoning (and hence fallibility) as much as possible, formalising this with increasingly precise instructions to the human operators; and
- Increase the monitoring of practice to ensure compliance with the instructions.¹⁰⁴

Although the ‘traditional responses’ were intended to improve efficiency and effectiveness, Monro concluded that they had not improved child protection outcomes, particularly when adopted in combination with policies focusing on market mechanisms: increased levels of child poverty had been the result.¹⁰⁵ Such responses could impact staff by increasing stress and risk aversion and by placing greater emphasis on crisis reaction than on preventive work to support families, while lowering staff morale, decreasing ‘professionalism’ as automated decision-making tools became more prevalent, and raising workloads as a result of increased accountability and reporting requirements.

Systems thinking used by engineers and some branches of medicine, led to the design of integrated structures and processes that provided an environment more conducive to robust decision-making. When the ‘standard solutions of providing more tools, more detailed manuals, and closer management scrutiny’ failed to reduce, and sometimes increased human error:

104. Monro E (2005) ‘Improving practice: Child protection as a systems problem’ *Children & Youth Services Review* 27:375-391, p378.

105. *op.cit.* p380

Engineers radically reframed the way they were looking at the problem. Instead of regarding human error as a satisfactory explanation of an accident and therefore concluding the investigation at that point, they treated it as the start of the inquiry: why did the front line worker misread the dial, omit critical steps in the procedures, or overlook signs of trouble? This led them to investigate the total system within which a person was operating so that they could better understand why the faulty action had looked the sensible thing to do at the time or why it might have been difficult for humans to perform well.¹⁰⁶

The implications for child protection are these:

Judgement and decision-making in child protection are best not seen as discrete acts performed by individuals, but as part of a constant stream of activity, often spread across groups, and located within an organizational culture that limits their activities, sets up rewards and punishments, provides resources and defines goals that are sometimes inconsistent (Woods et al., 1994). Human errors are, in general, not random and individual but follow predictable patterns that can be understood by seeing them in their context.¹⁰⁷

3.2 FORM AND INFORMAL SYSTEMS OF CHILD PROTECTION

A report prepared by Chapin Hall for UNICEF sets out the elements of child protection. As set out in Box 3 below, they imply that a child protection system needs to be conceptualised as much more than the statutory framework for intervention by the state when healthy child development is threatened. In fact, it encompasses all the customary ways of meeting the needs of children as well as the feedback mechanisms and built-in redundancy that will ensure children continue to receive the responsive care they need even if first-line resources fail. From this perspective, social policies that underpin the ability of parents, extended families and communities to meet the needs of children form the foundation of child protection in our society.

¹⁰⁶. op.cit,p376

¹⁰⁷. op.cit. p382

Box 3. Systems thinking in child protection – UNICEF/Chapin Hall (2010)¹⁰⁸

- Any system involves a collection of components or parts that are organized around a common purpose or goal—this goal provides the glue that holds the system together.
- All systems reflect a nested structure—in the case of child protection, children are embedded in families or kin, who live in communities, which exist within a wider societal system.
- Given the nested nature of systems, specific attention needs to be paid to coordinating the interaction of these subsystems such that the work of each system is mutually reinforcing to the purpose, goals, and boundaries of related systems.
- All systems accomplish their work through a specific set of functions, structures, and capacities. However, the characteristics of these functions, structures, and capacities will be determined by the context in which the system operates.
- All change within a system framework is bi-directional—changes to any system, for whatever reason, will change the context and changes in the context will alter the system.
- Well-functioning systems pay particular attention to nurturing and sustaining acts of cooperation, coordination, and collaboration among all levels of stakeholders, including those managing key activities as well as those performing key functions.
- Systems will achieve their desired outcomes when they design, implement, and sustain an effective and efficient process of care in which stakeholders are held accountable for both their individual performance as well as the performance of the overall system.
- Effective governance structures in any system must be flexible and robust in the face of uncertainty, change, and diversity.

The dynamic and interactive nature of complex systems is noteworthy: you change one part and related parts start behaving differently. Except within the tolerance levels of individual components, it is not possible to change one part of a dynamic, complex system without changing another part.

Formal child protection systems arise in response to the perceived failure of informal systems in which normative roles and responsibilities are customarily assigned to families, kin and community.

The Chapin Hall researchers offered views about the elements of a child protection system, which would depend on ‘local preferences, customs, pre-existing structures, laws, and the will of the actors who take on the challenge of protecting children’.¹⁰⁹ Box 4 below, sets out their thinking about the ‘planning parameters’ of child protection systems, which include consideration of social context and operating dynamics.

108. Wulczyn F et al. (2010) [Adapting a Systems Approach to Child Protection: Key Concepts and Considerations](#) commissioned and published by UNICEF.

109. op. cit. p4

Box 4. ‘Planning parameters of child protection systems’ UNICEF/Chapin Hall (2010)¹¹⁰

- The boundary (i.e., the structural relationship or embeddedness) between a child protection system and other formal systems (e.g., education, health, mental health) or informal systems (e.g., family, kin, community) is an important feature of the child protection system that has implications for how one defines functions, capacities, the process of care, governance, and accountability.
- Externalities and emergencies can have notable impacts on the capacity of any child protection system. Well-designed systems (i.e., those with strong infrastructure) will be better prepared to manage externalities and emergencies; externalities and emergencies may lead to stronger systems in the long run, provided the actors involved respond in a cooperative manner.
- To the extent that systems take shape around the goals of the system, the impact of the child protection system on the status of children (i.e., the wellbeing of children) is a central dynamic that affects how the system evolves through time. Ideally, where there is a gap between the goals of the system and whether children are being protected, efforts within the system will turn to bringing what the system accomplishes into line with system goals.
- With respect to the process, all child protection systems have to have a means to identify children whose rights have been violated. If the normative framework establishes a boundary around the notion of who is in need of protection, the process of care clarifies the myriad ways children and families may come to the system’s attention, including those ways that rely on voluntary engagement and those that rely on some type of reporting mechanisms. The process of care also incorporates assessment strategies, case planning, treatment, and follow up, with the specific processes shaped by whether the underlying services are promotion, prevention, or response.
- Because the child protection system serves children coming from diverse circumstances presenting equally diverse protection needs, it needs a service continuum matched to this diversity. The holistic view of children, families, and communities that is one hallmark of the systems approach to child protection expands what it means to respond to protection needs by adding promotion and prevention as points along the service continuum depending on how other systems with potentially overlapping mandates are structured in relationship to the child protection system.
- When it exists as an organization, the child protection system has to maintain a level of capacity commensurate with what the system requires. Capacity refers to human resources, funding, and infrastructure. A coherent child protection system has the means by which to compel the use of resources towards the goals of the system.

110. op. cit. p3-4

3.3 FORMAL CHILD PROTECTION STANDARDS

UN Convention on the Rights of the Child

Like other international human rights instruments that emerged in the second half of the 20th century, the UN Convention on the Rights of the Child¹¹¹, which came into force in September 1990, articulates the conditions that its subjects – in this case children – need to flourish. *Inter alia*, it turns its back on traditions that considered events behind the domestic curtain as out of bounds for outside scrutiny. It depicts children as rights bearers and undercuts the maxim that ‘children should be seen and not heard’.

The rights of the child to protection against all forms of violence and to protective measures to support them and their carers in cases of maltreatment are set out in Article 19:

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

The rights of the removed child to maintain family contact and cultural identity are set out in Article 20:

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.
2. States Parties shall in accordance with their national laws ensure alternative care for such a child.
3. Such care could include, *inter alia*, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child’s upbringing and to the child’s ethnic, religious, cultural and linguistic background.

Article 12 provides for the voice of the child to be heard and given due weight:

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

111. [Convention on the Rights of the Child](#)

Other Articles of the Convention apply to the environment and services that should be afforded the child in OOHC.

The Convention as a whole has not been incorporated into Australia's domestic law which would provide a statutory basis for asserting the rights of children in this country. Australia as a signatory to the Convention is obliged to give it effect in this way.

3.4 AUSTRALIAN THRESHOLDS FOR CHILD PROTECTION INTERVENTION

The Australian Institute for Health and Welfare definitions of child maltreatment (in Box 1 supra) reflect cultural and community standards of acceptable child treatment. In practice, each jurisdiction's administration of its statutory child protection legislation differs – see Appendix B.

National Policy on Child Protection

The Federal policy agreed by state and territory governments is expressed in the National Framework for the Protection of Australia's Children 2009-2020.

The National Framework outlines six supporting outcomes and provides details about how each of these outcomes will be achieved. The six supporting outcomes are:

- children live in safe and supportive families and communities;
- children and families access adequate support to promote safety and intervene early;
- risk factors for child abuse and neglect are addressed;
- children who have been abused or neglected receive the support and care they need for their safety and wellbeing;
- Indigenous children are supported and safe in their families and communities;
- child sexual abuse and exploitation is prevented, and survivors receive adequate support.

Each state/territory approach toward child protection should operate within this framework.

Given that rates of child maltreatment are increasing, the gap in rates of maltreatment amongst Aboriginal and Torres Strait Islander and other children is growing, and rates of developmental vulnerability are increasing across some domains¹¹², implementation of the National Framework could not be described as successful. It would be valuable to see how the partners to this agreement see their respective responsibilities and how they would report on their individual progress in achieving the supporting outcomes.

Jurisdictional differences in child protection are outlined in Appendix B.

On 1 June 2018 Community Services Ministers released a post-meeting communique concerning the Fourth Action Plan on the National Framework. They named four priorities:

- to improve outcomes for Aboriginal and Torres Strait Islander children at risk of entering, or in, child protection systems;

112. [Australian Early Development Census 2015](#)

- to improve prevention and early intervention responses through joint service planning to improve access for children and families, and provide more targeted, coordinated investment by governments;
- to improve outcomes for children in OOHC by enhancing placement stability through reunification and other permanent care options; and
- to improve organisations' and governments' ability to keep children and young people safe from abuse in recognition of the recommendations of the *Royal Commission into Institutional Responses to Child Sexual Abuse* (Royal Commission).

The Ministers noted the National Principles for Child Safe Organisations (see below), which incorporate the Child Safe Standards recommended by the Royal Commission. Ministers reaffirmed their commitment to finalise the National Principles and progress them to COAG for endorsement following all governments' responses to the Royal Commission's report.

Although the Ministers emphasised that the interests of the child would be paramount in all decisions concerning permanency, it is not yet clear that the voice of the child and rights of cultural and family connection will be given due weight when balanced against the perceived imperative to achieve permanency 'in a reasonable time.' OOHC is expensive, risky, and associated on the whole with poorer outcomes for children, but adoption too has its own risks – not a subject which can be explored here.

National principles for child safe organisations

The Draft National Principles reflect ten child safe standards recommended by the Royal Commission, but their scope extends beyond sexual abuse to cover other forms of potential harm. The final National Principles will be considered by Community Services Ministers before being submitted to COAG for endorsement in late-2018.¹¹³

113. [National Principles for Child Safe Organisations](#) Australian Human Rights Commission

Box 5. Draft National principles for child safe organisations

1. Child safety and wellbeing is embedded in organisational leadership, governance and culture.
2. Children and young people are informed about their rights, participate in decisions affecting them and are taken seriously.
3. Families and communities are informed and involved in promoting child safety and wellbeing.
4. Equity is upheld and diverse needs respected in policy and practice.
5. People international with children and young people are suitable and supported to reflect child safety and wellbeing values in practice.
6. Processes for complaints and concerns are child focused.
7. Staff and volunteers are equipped with the knowledge, skills and awareness to keep children and young people safe through ongoing education and training.
8. Physical and online environments promote safety and wellbeing while minimising the opportunity for children and young people to be harmed.
9. Implementation of the national child safe principles is regularly reviewed and improved.
10. Policies and procedures document how the organisation is safe for children and young people.

Table 8. below contains Australian Human Rights Commission guidance on implementing and monitoring Principle 1 – the organisational embedding of child safety and wellbeing.¹¹⁴

Key action areas for Principle 1	Indicators that Principle 1 upheld
<ul style="list-style-type: none"> The organisation makes a public commitment to child safety. A child safe culture is championed and modelled at all levels of the organisation from the top down and the bottom up. Governance arrangements facilitate implementation of the child safety and wellbeing policy at all levels. A Code of Conduct provides guidelines for staff and volunteers on expected behavioural standards and responsibilities. Risk management strategies focus on preventing, identifying and mitigating risks to children and young people. Staff and volunteers understand their obligations on information sharing and recordkeeping. 	<ul style="list-style-type: none"> The organisation can demonstrate they have publicly available and current documents such as a child safety and wellbeing policy, practice guidance, information sharing protocols, staff and volunteer codes of conduct and risk management strategies. The organisational leadership models and regularly reinforces attitudes and behaviours that value children and young people and a commitment to child safety, child wellbeing and cultural safety. This commitment is clear in duty statements, performance agreements and staff and volunteer review processes. Staff, volunteers, children and young people have a sound knowledge of children's rights, including their rights to feel safe and be heard, and the accountabilities that accompany these rights. Leaders promote sharing good practice and learnings about child safety and wellbeing.

114. *ibid.*

Elements of a child safe church – Uniting Church

The Principles below were developed by a Working Group led by Rev John Cox. They, together with a National Child Safe Policy Framework incorporating them were formally adopted by the Uniting Church in March 2017. A program for implementation of the recommendations of the Royal Commission is now underway.

Child Safe Church Principles

1. Promote strong leadership and governance and a culture of child safety
2. Enable children and families to participate in decision-making
3. Provide an open environment
4. Respect diversity and promote equity
5. Have clear codes of conduct
6. Adopt clear evidence-based policies and procedures
7. Recruit well
8. Provide child safe focused orientation and training
9. Undertake strong planning and supervision
10. Provide support
11. Comprehensive investigation and reporting
12. Keep good records
13. Review

Recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse

The OOHC Recommendations of the Royal Commission into Institutional Response to the Sexual Abuse of Children are set out in Appendix D.

Australia's ratification of Optional Protocol to the Convention Against Torture

On 17 December 2017 Australia ratified the Optional protocol to the Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (OPCAT).¹¹⁵ The Government has three years from the date of ratification to put in place a national system of independent, unannounced inspections and prepare for inspections by the United Nations Subcommittee on the Prevention of Torture to monitor compliance with the Convention in places of detention and other closed environments.¹¹⁶

It seems reasonable to expect that residential facilities providing OOHC will be subject to this regime.

¹¹⁵. [Australia ratifies major anti-torture treaty OPCAT](#), Australian Human Rights Commission, Friday 15 December 2017.

¹¹⁶. [OPCAT: Optional Protocol to the Convention against Torture](#), Australian Human Rights Commission, Tuesday 19 June 2018.

04

CATEGORIES OF OUT OF HOME CARE AND THEIR USE

*Out-of-home care is overnight care for children aged 0-17, where financial support from state or territory departments responsible for child protection is given or offered to the carer. It can include kinship care (provided by relatives of the child), foster care, family group homes and residential care.*¹¹⁷

The United Nations Convention on the Rights of the Child (CROC) recognises the right of every child ‘to grow up in a supportive, protective, and caring environment that promotes his or her full potential.’¹¹⁸

Placement of a child in OOHC can be viewed as an attempt to promote that child’s right to positive development when perceived developmental threats ‘cannot be effectively addressed by appropriate outpatient support.’¹¹⁹

Influential research published by Jane Rowe in 1989 suggested the following list of ‘foster care’ functions and tasks, which seem applicable to all forms of OOHC:

- Emergency care;
- Planned temporary care / strengthening families/ preparation for reunification;
- Regular series of placements with the same family (‘respite’ or ‘support’ foster care, often for disabled children);
- Assessment (of child, of parents, of whole family);
- Therapy (of child, of parents, of whole family);
- Preparation for long-term placement, usually of young children and usually with an adoptive family not previously known to the child;
- Care and upbringing (‘long-term’ ‘permanent’ foster family care);
- A bridge to independence for teenagers entering care following family breakdown or following an adoptive or long-term foster family breakdown.¹²⁰

117. [A stable and secure home for children in out-of-home care](#), Australia’s Welfare 2017, AIHW

118. Summarised by Leloux-Opmeer et al. (2016) [Characteristics of Children in Foster Care, Family-Style Group Care, and Residential Care: A Scoping Review](#) Journal of Child and Family Studies, August 2016, Volume 25, Issue 8, pp 2357–2371, p2357. See original text for removed references.

119. *ibid.*

120. Cited in Thoburn J (2016) [Achieving good outcomes in foster care: a personal perspective on research across contexts and cultures](#). Social Work & Society, International Online Journal V14, No.2

Regardless of the reasons for being there, all children in OOHC have been subjected to the trauma and uncertainty created by removal and placement in a new and unfamiliar setting. Even removal from a situation of maltreatment re-traumatizes children. All types of OOHC need to establish an environment which not only prevents further harm (caused for example by placement instability and staff turnover) but also addresses the therapeutic needs arising from past trauma and removal.

Although UN Guidelines on Alternative Placement of Children advocate family type settings as those most in keeping with the best interests of the child, placements in foster care are most likely to fail, necessitating further placements, which increase stress and the risk of emotional and behavioural problems.¹²¹ The Guidelines advise limiting residential OOHC to certain cases:

The use of residential care should be limited to cases where such a setting is specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests.¹²²

4.1 INTERNATIONAL COMPARISONS IN OUT OF HOME CARE PLACEMENT TYPES

Thoburn (2016) notes that the rate of usage of different placement types depends on a number of factors that vary among countries:

- the extent of use of foster care compared with other placement options such as residential care;
- the proportion of children entering care via the courts, administrative procedures or through agreement with parents;
- the ages of children entering care, which is linked to the availability of family support provision for the different age groups.¹²³

It may be quite complex to explain cross-country difference in the relevant legal and administrative processes that precede placement; they may be:

more a factor of 'custom and practice' (see especially the edited book by Fernandez and Barth, 2010). Norway, Sweden and Denmark have much in common but in Sweden and Denmark more children come into care as a result of social work discretion and with parental agreement than is the case in Norway.¹²⁴

Table 9 below shows the jurisdiction by age of placement into OOHC of Australian children in 2016-2017. The allocation among placement types was:

- 93.2% of all children living in OOHC in Australia are in home-based care
 - 47.2% are in relative/kinship care
 - 37.8% are in foster care

121. *ibid.*

122. [Guidelines for the Alternative Care of Children](#), Resolution of the UN General Assembly, 64/142, 24 February 2010, p. 5

123. Thoburn J (2016) [Achieving good outcomes in foster care: a personal perspective on research across contexts and cultures](#). Social Work & Society, International Online Journal V14, No. 2

124. *ibid.*

- 7% are in third-party parental care
- 1.2% are in other forms of home-based care.
- 6.7% of children are placed in alternative living arrangements such as residential care or group homes.¹²⁵

The Tables below shows the latest statistics on age of entry into OOHC by Australian jurisdiction. Tables 10 and 11 show the strong relationship between age of entry into care and placement type. The proportion of children entering care under the age of 4 (45.7%) in Australia is high even in relation to other Anglophone countries. This may contribute to Australia's comparatively high proportion of children in relative/kinship care (47.2%) and its very low proportion of children in residential care (6.7%), which has been described as the lowest in the developed world.¹²⁶

Table 9. Age of entry into OOHC by jurisdiction¹²⁷

Age (years)	NSW	Vic.	Qld	WA	SA	Tas.	ACT	NT	Total
< 1	657	601	456	224	185	44	32	52	2,251
1–4	785	1,007	595	291	177	65	43	69	3,032
5–9	678	918	582	265	174	47	53	78	2,795
10–14	534	899	517	213	132	42	49	80	2,466
15–17	193	355	272	90	56	10	19	17	1,012
Unknown	1	0	0	0	0	0	0	0	1
Total	2,848	3,780	2,422	1,083	724	208	196	296	11,557
Percentage									
< 1	23.1	15.9	18.8	20.7	25.5	21.1	16.3	17.6	19.5
1–4	27.6	26.6	24.6	26.9	24.4	31.2	21.9	23.3	26.2
5–9	23.8	24.3	24.0	24.5	24.0	22.6	27.0	26.3	24.2
10–14	18.8	23.8	21.3	19.7	18.2	20.2	25.0	27.0	21.3
15–17	6.8	9.4	11.2	8.3	7.7	4.8	9.7	5.7	8.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Notes: The table includes all children admitted to OOHC for the first time, as well as those children returning to care who had exited care 60 days or more previously. Children admitted to OOHC more than once during the year were only counted at the first admission. Percentages in the table may not add exactly to 100.0% due to rounding. Source: AIHW, 2018b, Table S52.									

125. The 2016/17 AIHW statistics show that 93.2% of all children living in OOHC in Australia are in home-based care (see Table 3) (AIHW, 2018a).

Taken from [Children in Care](#), CFCA Resource Sheet— September 2018

126. Hart D, La Valle I, & Holmes L. (2015). [The place of residential care in the English child welfare system](#). London, England: Department for Education, p 29

127. *ibid*.

Table 10. Percentages of children entering care by age group & country * **128

Country	0-4 (<12 months)	5-9	10+
England	35% (17%)	18%	47%
Denmark	12% (5%)	12%	76%
Germany	15% (0-5 yrs) (4%)	28% (6-11 yrs)	56% (aged 12+)
Sweden	12% (0-3 yrs)	15% (4-9 yrs)	79%
USA	38% (15%)	20%	43%

*years for these data range from 2010-2013 **Data on entrants to care during a given year are not available from some countries, although data on children in care on a given date are usually available. It is data on entrants which more clearly indicate how the foster care service is being used.

Table 11. Percentage of children in different placement types by country¹²⁹

	England	Norway	Denmark	Sweden	USA
Non-kin foster care	63%	55%	60%	65%	46%
Kinship foster care	11%	17%	Included in above	12%	23%
Adoption	5%				5%
Residential care	12%	14%	39%	21%	19%
Other	9%	14%	1%	3%	4%

4.2 THE ROLE OF RESIDENTIAL CARE IN THE DEVELOPMENT OF OUT OF HOME CARE

A condensed version of a paper on the history of OOHC in Australia, that was prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, appears at Appendix A.

In Australia, as elsewhere, the role of residential care within the spectrum of OOHC alternatives has waxed and waned in popularity, sometimes being seen as a viable alternative for meeting the needs of some children, sometimes being seen as a last resort, to be used when all else has failed or no more family-like placement is feasible.

History of out of home care in the US

How OOHC is characterised can be linked to views about how maltreated children should be handled – whether their primary deficits are moral, behavioural or psycho-social, as seen in Sandra Bloom's description of the changing influences on OOHC in the United States:

128. Thoburn J (2016) [Achieving good outcomes in foster care: a personal perspective on research across contexts and cultures](#). *Social Work & Society, International Online Journal* V14, No.2

129. *ibid.*

Throughout the last two centuries the care of children who have fallen on hard times has passed through a number of phases in the United States. Many of the debates related to these phases persist in influencing the present care of children within residential treatment centers in the United States (Abramovitz and Bloom 2003). In the early part of the nineteenth century it was considered a social responsibility to remove children from the evil moral influences in their homes and communities and to place them in reformatories and orphanages that stressed precision, regularity, and obedience to authority that was strictly enforced through the use of physical punishment (Rothman 1990). By the late 1800's, individual biological explanations of bad behavior dominated the approach to children in institutional settings and care centered on containment and protection from the community (Brace 1872).

At the beginning of the 20th century, when larger social problems like poor childrearing and poverty entered social discourse, environmental theories dominated the explanations of why children ended up having behavioral problems. From around 1915-1960, individual psychoanalytic explanations powerfully influenced the growth and development of psychoanalytically oriented intensive individual treatment within residential settings as well as treatment programs and special schools guided by therapeutic community principles (Bettelheim and Sanders; Aichorn 1939; Redl and Wineman 1952; Bridgeland 1971; Kennard 1998). The social turmoil of the 1960's and 70's lent credibility once again to explanations that focused on negative social influences, poverty, poor education, poor parenting, racism and discrimination. But from the 1970's through today, treatment in many places has once again shifted to attempts to control maladapted children through behavioral and biochemical controls.¹³⁰

History of out of home care in England

This brief account of OOHC in England is from Holmes et al. (2018):

Children's homes in England began in the early nineteenth century as reformatory schools which were introduced as an alternative to prison. There were separate provisions (industrial schools) for those in need of "care and protection" and the concept of two groups of young people, either "troubled or troublesome", was developed (Whittaker, 1979). The idea of more focused individual homes developed in the early 1940s, with the concept of house parents and a family style approach, becoming the dominant model. However, this approach was criticized for lacking separation of the professional and personal. In England, the use of children's residential care peaked during the 1970s and accounted for approximately 40% of all placements for children in out-of-home care (Narey, 2016). Throughout the past 30 years, the debate of how to provide therapeutic interventions or therapy for these children and young people has continued; the therapeutic milieu of the

130. Bloom, S. L. (2005) Introduction to Special Section- [Creating Sanctuary for Kids: Helping Children to Heal From Violence](#). Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations 26(1): 57-63.

placement seen as the treatment agent by some, while others viewing the clinic setting as necessary for therapeutic change. Throughout the past 30 years, the debate of how to provide therapeutic interventions or therapy for these children and young people has continued; the therapeutic milieu of the placement seen as the treatment agent by some, while others viewing the clinic setting as necessary for therapeutic change.[...]

Further developments ensued in the role and purpose of these placements during the 1990s with a shift to the declining use of children's homes and foster homes being favored for young people (Clough, Bullock, & Ward, 2006). During this time frame, the negative perspective of residential children's homes was highlighted by Sir William Utting in his 1997 review of residential care. The report indicated that many children were placed in homes unsuited to their particular needs and experienced repeated placement moves. Furthermore, Utting (1997) questioned the risks associated with placing children and young people in small unregistered homes and the lack of access to education: with over a third of children placed in residential care not receiving an education. Utting (1997) further described children absconding from residential care and becoming homeless and highlighted abuse by care staff. This history no doubt influenced the closure of residential homes and led to a favoring of foster families as a first-choice placement.¹³¹

Current US policy to reduce residential care

Current policy in the US is to reduce the number of children in congregate (residential) care and the time they spend there:

The child welfare system's use of congregate care is in a period of rapid transition. Building on years of professional interest in offering more home-like placement options, legislative and administrative pressure at the state and federal levels is accelerating the pace of change. Congregate care has long been viewed as a viable placement alternative for children and adolescents, especially those whose histories, mental health needs, and current behavior render them difficult to manage in home-based settings. In our current fiscal and cultural climate, the appropriateness and effectiveness of congregate care is increasingly being called into question. Changing federal and state policies, as well as clinical guidelines, now suggest that congregate care be reserved for the short-term treatment of acute mental health problems to enable stability in subsequent community-based settings (Blau et al., 2010). In response to these changing expectations, the demand for congregate care will likely decline. From a public policy perspective, it is vital that we establish the infrastructure necessary to support the type of children and youth often served in group and residential care in more home-like environments.¹³²

131. Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth*, 35:3, 209-224, pp211-212

132. Chapin Hall & Chadwick Center (2016) [Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare](#).

Australian policy to reduce residential care

Policy to reduce the proportion of children in residential care has been in the ascendency throughout Australian jurisdictions at least since the early 1990s.¹³³ Ainsworth & Hensen (2005) attribute the decline in popularity partly to the stigma of the Stolen Generation and of forced child migration from Britain in the post war period up to the 1960s, particularly the accounts that emerged of physical and sexual abuse in a range of residential institutions for children.¹³⁴ The international movement towards deinstitutionalisation that gathered force in the 1960s also played a role in closing residential care programs:

...regardless of whether these programmes could demonstrate that they had an ethical, safe and sensible programme that was likely to generate positive out-comes, or not. Indeed, residential programmes were all viewed as unsafe places incapable of reform.¹³⁵

The upfront economic costs of residential care added to the weight of arguments against them.

The major social policy ideologies of the last two decades or more, deinstitutionalisation, normalisation, least restrictive environment, mainstreaming and diversion, supported this thrust (toward reduction of residential care) a development that ultimately was revealed as self-defeating:

...given that in the 2003/04 financial year the NSW Department of Community Services, the statutory authority for childcare and protection services in that State, spent Au\$58.5m on 169 children and youth (about Au\$346,000 per child) for whom foster care placements could not be found (Horin, 2004). During that time these young people were accommodated individually for significant periods of time in specially rented houses, hotel and motel rooms where they were supervised 24 hours a day, 7 days a week, by mainly untrained youth workers.¹³⁶

Reduction in residential care also seems to have been associated with growth in the numbers of homeless youth.¹³⁷

Thoburn & Courtney (2011) in their review of the international evidence on OOHC placement, note the influence of the 'historical, political and social contexts in which services are provided' and the importance of 'language/definitions... and socio-cultural/political differences, which result in different patterns of service delivery for different groups of children'.¹³⁸ Thoburn's (2010) international review showed much higher rates of children in residential care in mainland Europe, Israel and Scandinavian countries than in Anglophone countries.¹³⁹

133. Ainsworth, F., & Hansen, P. (2005). A dream come true: No more residential care. A corrective note. *International Journal of Social Welfare*, 14(3), 195-199. doi:10.1111/ijsw.2005.14.issue-3

134. Ainsworth & Hansen (2005) op. cit. p196, and see too Report of the Royal Commission into Institutional Responses to the Sexual Abuse of Children (2017)

135. Ainsworth & Hansen (2005) op. cit. p196

136. *ibid.*

137. *ibid.*

138. Thoburn J & Courtney M (2011) [A guide through the knowledge base on children in out-of-home care](https://doi.org/10.1108/17466661111190910) *Journal of Children's Services*, 6(44) 210-227, <https://doi.org/10.1108/17466661111190910>

139. Cited in Thoburn & Courtney(2011).

Thoburn (2016) reported that in the early 2000s the rate of children aged 0-17 in residential care on a given date was less than 10 per 10,000 in Anglophone countries¹⁴⁰ compared with over 40 per 10,000 in Denmark, France and Germany.¹⁴¹

The extent to which OOHC is state-ordered or voluntary, free or paid, time limited or open ended, can vary in response to '[d]ifferent views about the nature and role of the state, the private citizen, the private for profit and not for profit sectors and faith groups'.¹⁴²

In the UK the State ushered in the 'mixed economy of welfare' with 'new providers of child placement services, including a 'for profit' sector alongside the voluntary sector and public providers'.¹⁴³ Australian governments at all levels have now pursued this course.

Their review prompted Thoburn & Courtney (2011) to conclude, *inter alia*, that:

- The generally negative view held in Anglophone jurisdictions about the potential for OOHC to benefit those children who need it, is not borne out from the evidence; and
- Evidence about the effectiveness of care systems in different countries is growing, but policy makers and practitioners wishing to learn about what works in other countries must take care to understand the different contexts and care populations.¹⁴⁴

4.3 WHEN SHOULD RESIDENTIAL CARE BE THE FIRST OPTION?

..in all cultural contexts, there are questions about the extent to which residential care environments can provide an experience for young people from high-risk backgrounds that helps them to overcome adversity and meets their need to develop security, resilience and a sense of belonging.¹⁴⁵

Data from England reveal a steep decline in the use of residential care as a first placement – from 46% to 2% between the 1980's and the 2000s.¹⁴⁶ In 2012 only 25% of children in residential care were there as a first placement (at an average age of 14.5 years)¹⁴⁷, and 31% had had six or more placements (usually foster care, pre-adoption placements interspersed with short spells in emergency residential care).¹⁴⁸ The reduction in the use of residential care placements in Australia has already been noted above.¹⁴⁹

140. Thoburn J (2016) 'Residential care as a permanence option for young people needing longer-term care' *Children & Youth Services Review* 69:19-28, p 19

141. Thoburn J & Ainsworth F (2015) 'Making sense of differential cross-national placement rates for therapeutic residential care' in Whittaker, J. K., del Valle J, Holmes L (eds) (2014) *Therapeutic residential care for children and youth*. London: Jessica Kingsley. pp 31-46

142. Thoburn J & Courtney M (2011) [A guide through the knowledge base on children in out-of-home care](https://doi.org/10.1108/17466661111190910) *Journal of Children's Services* 6(4):210-227, <https://doi.org/10.1108/17466661111190910>.

143. *ibid.*

144. *op.cit.* p 221

145. Schofield, G., Larsson, B., & Ward, E. (2017) 'Risk, resilience and identity construction in the life narratives of young people leaving residential care' *Child & Family Social Work*, 22(2): 782-791. doi:10.1111/cfs.12295, p 782

146. Bullock, R., & Blower, S. (2013). 'Changes in the nature and sequence of placements experienced by children in care, 1980-2010' *Adoption and Fostering*, 37(3): 268-283, cited in Thoburn J (2016) 'Residential care as a permanence option for young people needing longer-term care' *Children & Youth Services Review* 69: 19-28, p19.

147. Hart D, La Valle I & Holmes L. (2015) '[The place of residential care in the English child welfare system](#)' Department for Education, UK cited in Thoburn J (2016) 'Residential care as a permanence option for young people needing longer-term care' *Children & Youth Services Review* 69: 19-28, p20

148. *op. cit.* p 19

149. See for example: Ainsworth, F., & Hansen, P. (2005) 'A dream come true: No more residential care. A corrective note' *International Journal of Social Welfare*, 14(3): 195-199. doi:10.1111/

Although there have been many reviews of residential care over the last two decades, there is no clear consensus on when residential care might be the first placement of choice. England's Narey Review cites positive personal experience of some residential care leavers, for example:

Many believe a family environment is a more suitable placement for a young person to grow up in. That may be the case for lots of young people and children in care, but not for all. Unfortunately, there seems to be a big push for foster care as residential care isn't viewed as an ideal option, more of a last resort if they can't find another suitable placement. That attitude needs to change, residential care homes work for a number of young people for reasons that are probably far too complicated than I can ever fully explain. But I do know that for me and a number of other young people, care homes were the BEST option, not the last resort option and they did some amazing work with us during our time there.¹⁵⁰

The Narey Review nevertheless concluded that:

... fostering is the right choice for most children who cannot return home, enter special guardianship, or who are unsuitable for adoption. And local authorities must treat it as the first option, not least because it is much less expensive than residential care. According to DfE, the average cost of foster care has been estimated at around £600 per child per week compared to around £3,000 per week for a child living in a children's home. It would be ridiculous to pretend that such a cost differential can be ignored. So I entirely accept that local authorities will generally need to try fostering first.¹⁵¹

whilst noting:

But, particularly with adolescents, the possibility that residential care might be the better option and offer greater permanence – not least because some older children will steadfastly resist being fostered – must not be ignored.¹⁵²

It is not uncommon for older children – adolescents – to express the view that they have a family already and, having no desire for a new one, do not want to be fostered.¹⁵³

What is clear from the research on OOHC is that the most traumatised children have the highest likelihood of disrupted placements, and that disruption itself can contribute to poorer outcomes.¹⁵⁴

Lok & Tzioumi (2015) found that the incidence of mental health problems (mostly of attachment and behaviour) in young children (6 years and under) increased by 18% for each additional year of age of entry into care, and that each additional placement increased the rate by 15%.¹⁵⁵

150. Care leaver quoted in Narey, M (2016) [Residential Care in England](#) Report of Sir Martin Narey's independent review of children's residential care, July 2016, p. 5

151. Narey op. cit. p 21

152. *ibid.*

153. *ibid.*

154. Newton R, Litrownik A & Landsverk J (2000) [Children and youth in foster care: disentangling the relationship between problem behaviors and number of placements](#) *Child Abuse Negl.* 24(10):1363-74.

155. Lok L & Tzioumi D (2015) Mental health needs of children in out-of-home-care. *Journal of Paediatrics and Child Health*, 51(S2): 7-8

Young people in need of placement, whether after one or more failed foster or kinship placements, or after being removed from their families after a protracted period of maltreatment, are likely to be highly traumatised and at highest risk of placement instability.

In England¹⁵⁶, and increasingly in Australia, permanency planning has emerged as an important objective of OOHC decisions. Where residential care is considered at best a short-term option, then priority will be given to expediting a move to a preferred type of placement.

However, official guidance recognises that:

It is also important to think about the needs of older children and young people in relation to achieving permanence in their lives. They may not be able to live with birth parents for a variety of reasons nor wish to be in a foster home or to be adopted but prefer to live in a children's home where they can also achieve a sense of security and belonging.¹⁵⁷

Where 'care and upbringing' forms the major purpose of residential care, its intent is to provide stability, a 'sense of permanence' and community membership,¹⁵⁸ through subsidiary aims:

(sometimes achieved, but often not) [...] to provide trusting relationships with staff who care about as well as for them, are available and provide good quality 'parenting', which includes skills in addressing the impact of loss and maltreatment suffered in their early lives. Appropriate links with family members and support through the transition to adulthood, with access to therapy and specialist services when needed will also be part of a successful 'care and upbringing' regime.¹⁵⁹

Thoburn (2016) reported a study of English children who had lived in charity run residential homes for 4-5 children, having entered at an average age of just over 13.

Just over half entered care as younger children (pre-adolescence) because of maltreatment associated with parental relationship difficulties including family and domestic abuse, mental health, criminality or addiction problems. However, since the majority of the youngest entrants to OOHC either go home, are adopted, or settle well in long-term kin or non-kin foster families, most of these younger entrants to care who eventually were placed at one of these children's homes will have been aged four or over at the time they came into care. The most frequent form of maltreatment the children had suffered was neglect, but important minorities had experience serious physical and sexual assaults by parents or people known to the family.¹⁶⁰

156. Thoburn J (2016) 'Residential care as a permanence option for young people needing longer-term care' *Children & Youth Services Review* 69: 19-28, p 19

157. Department for Education (2015). The Children Act 1989 guidance and regulations volume 2: Care planning, placement and case review. London, (Para 2.6) cited in Thoburn (2016) p 19

158. Thoburn, op. cit. p 20.

159. *ibid.*

160. *ibid*

The fact that the median number of placements between starting to be looked after and coming to their planned long-term group care placement was between three and four (with a small number who had experienced 6 or 7 placements) led Thoburn to conclude that residential care, despite the 'permanence aims' of the service-providing charity was substantially being treated as a placement of last resort. Just over half left in a planned move towards independence around 18 years. For these children residential care had succeeded in providing placement stability. The outcomes recorded for this small sample were also better than those usually associated with residential care.

Studies of children in care from across the world most often conclude that longer stays in stable placements result (on average) in better outcomes for the young adults. The important emphasis here is on the word 'stable' although stability and the experience of positive relationships with at least one carer achieved in the later stages of care, even after much instability, can be associated with positive outcomes (Schofield, 2003; Stein, 2007; Pecora et al., 2006; Sinclair et al., 2007). Outcomes for care leavers who enter care because of maltreatment, or as adolescents, are recognised as being worse than for general populations (Vinnerljung & Sallnas, 2008). However some studies conclude that children placed in care do as well or better than children from similar backgrounds where family problems are identified but who do not come into care (Bullock, Courtney, Parker, Sinclair, & Thoburn, 2006; Thoburn & Courtney, 2011; Boddy, 2013; Sebba et al., 2015).¹⁶¹

Thoburn's extensive experience in the field together with her review of the literature and data from her study of OOHc leavers provided the basis for her conclusion:

Although the outcome of research on residential care is still far from robust, there are indications (mainly from Europe, see Petrie, Boddy, Cameron, Wigfall, & Simon, 2006, Hart et al., 2015, where such placements are more frequent) that variables associated with more positive outcomes for family foster care leavers also apply to stable placements that last for a period of years in planned residential care. What this study, combined with the findings of Schofield et al. (2015), shows, is that stability in residential care can be associated with feelings of family and belonging, more commonly associated with permanence in family placements, when close relationships with staff and continuity of care into early adulthood are available.¹⁶²

161. Thoburn J (2016) 'Residential care as a permanence option for young people needing longer-term care' *Children & Youth Services Review* 69: 19-28, p 27

162. *ibid.*

05

THE CHARACTERISTICS AND THERAPEUTIC NEEDS OF CHILDREN IN OUT OF HOME CARE

A combination of local demographic characteristics and decision-rules concerning the placement of children, will determine the characteristics of the children and their patterns of clinical need in each type of OOHC placement. The assessment of the child's needs on entry to OOHC will determine the type of care best suited to meet those needs as well as specific therapeutic interventions required. The studies listed below records some of the needs more commonly found in children in OOHC than in the general population, and those found more commonly among particular types of OOHC.

5.1 CHARACTERISTICS OF CHILDREN BY PLACEMENT TYPE – A VICTORIAN STUDY

A 2015 paper by Corrales¹⁶³ provides rare analysis of the characteristics of children and young people in care in Australia. She describes 'the different profiles of children and young people in care, and their attendant short and medium-term outcomes.'¹⁶⁴ Age was the single most significant factor in determining the chance of being placed in residential OOHC increasing from 3.7% amongst the 5-9 age group to 23.4% amongst the 15-17's – see Table 12 below.¹⁶⁵

Table 12. Proportion of residential care placements by age group

Comparison	% (n)		χ^2	Odds ratio
10-14 years old vs 0-2 years old	0% (53)	21.3% (89)	13.06	15
10-14 years old vs 5-9 years old	3.7% (109)	21.3% (89)	14.92	7.11
15-17 years old vs 0-2 years old	0% (53)	23.4% (47)	13.94	16.9
15-17 years old vs 3-4 years old	0% (47)	23.4% (47)	12.46	15.3
15-17 years old vs 5-9 years old	3.7% (109)	23.4% (47)	14.72	8.03

Note: all comparisons are significant at $p < .000$

Developmental stage comparisons were also conducted for kinship care placement, although no statistically significant differences were identified. This may be a function of the small number of children and young people, across all age groups, who were placed in kinship care settings in this sample.

163. Corrales T (2015) [Understanding differences in the outcomes of children and young people across care types](#) August 2015, Anglicare

164. op. cit. p1

165. op. cit. p9

Table 13 below summarises the main differences in the characteristics of residents by OOHC placement type. Note that the sample size¹⁶⁶, is small, with 181 (62%) children and young people in foster care, 34 (11.6%) children and young people in residential care, and 77 (26.4%) children and young people in kinship care.

Table 13. Characteristics of children in OOHC by placement type¹⁶⁷

Indicator	Placement type		
	Foster care % (n)	Residential care % (n)	Kinship care % (n)
<i>Physical health</i>			
Disabilities	29.3% (63)	12.5% (4)	20.8% (16)
Physical activity	56.5% (39)	16.7% (4)	52.9% (9)
Alcohol use	20% (11)	59.1% (13)	27.3% (3)
Illicit drug use	8.5% (5)	31.8% (7)	0
Tobacco/ smoking	15.3% (9)	47.8% (11)	15.4% (2)
<i>Emotional and social development</i>			
Risk behaviour	19% (12)	66.7% (20)	25% (5)
Self-care	40.9% (9)	50% (5)	40% (2)
<i>Education</i>			
Full-time attendance	87.1% (122)	48.5% (16)	88.7% (47)
Academic aspirations	59.6% (28)	57.1% (8)	42.9% (6)
<i>Placements and stability</i>			
Continuity of care	29.1% (44)	50% (2)	30.4% (14)
Placement stability	11.1% (7)	36% (9)	9.1% (2)
<i>Relationships</i>			
Contact with siblings	13.7% (20)	15.2% (5)	30.6% (15)
Trusted adult	93.7% (59)	77.8% (14)	88.9% (16)
<i>Identity and belonging</i>			
Positive self-view	61.4% (116)	42.9% (12)	54% (34)

The small sample size meant that only two of the apparent differences in characteristics across the three placement types reached statistical significance:

- children and young people in foster care were 4.8 times less likely to engage in risk-taking behaviour, compared to children and young people in residential and kinship care ($\chi^2 (1) = 15.72$)
- children and young people in residential care were 6.3 times less likely to be attending school on a full-time basis, compared to children and young people in foster and kinship care ($\chi^2 (1) = 24.21$)¹⁶⁸

There were no significant differences in the bivariate analyses of indicators by sex.¹⁶⁹

5.2 OVER-REPRESENTATION OF CHILDREN WITH A DISABILITY

A 2002 Victorian government audit of children and young people in home-based care reported that a mental health problem was diagnosed in 18% of the sample, a disability in 20%, and an intellectual disability in 14%, whilst 14% of the sample had threatened suicide.¹⁷⁰

166. Drawn from the Looking After Children (LAC) records of 353 children and young people placed in OOHC with Anglicare Victoria.

167. Corrales T (2015) [Understanding differences in the outcomes of children and young people across care types](#) August, 2015 Anglicare, p12

168. op. cit. p13

169. op. cit. p14

170. Victorian Department of Human Services, 2002, cited in Osborn A & Bronfield L (2007) [Outcomes for children and young people in care](#), NCPC Brief No. 3 – October 2007, AIFS

The most recent figures on the incidence of disability among Australian children are from 2009, when 7.0% of children 0-14 had a disability (8.8% of boys and 5.0% of girls). Rates increased with age, ranging from 3.4% of children aged 0-4 years to 8.8% of those aged 5-14 (11.4% for boys aged 5-14 years and 6.1% for girls aged 5-14 years). Of children with a disability, 61% of children aged 5-14 years had an intellectual disability, more than twice the proportion of children aged 0-4 years (29%).¹⁷¹

Older children were much more likely to be placed in residential care, and were much more likely to exhibit emotional and behavioural problems:

Children and young people in residential care scored significantly higher on conduct problems and peer problems than children in foster or kinship care. Interestingly, children and young people in kinship care also scored higher than their foster care counterparts on this scale. Children and young people in residential care also had significantly higher Total Difficulties Scores than children and young people in foster care, and this pattern was also found for children in kinship care. Put simply, children and young people in foster care scored consistently lower on all measures of emotional and behavioural difficulties relative to children and young people in kinship and residential care, with the residential care group scoring the highest across all measures.¹⁷²

5.3 OVER-REPRESENTATION OF PARENTS WITH AN INTELLECTUAL DISABILITY

A 2015 Senate Inquiry into OOHC was told by Ms Marissa Sandler, a witness from the Intellectual Disability Rights Service, that although families with an intellectual disability make up just one to two per cent of all families with children aged 0-17, they constitute nine per cent of child protection cases before the NSW Family Court; she estimated that one in six children in care has a parent with an intellectual disability.¹⁷³

5.4 HIGH INCIDENCE OF MENTAL HEALTH PROBLEMS

In a 2015 position statement, the Royal Australian and New Zealand College of Psychiatrists stated that:

The high rates of psychosocial and developmental difficulties seen in children in OOHC indicate that all children entering or within these placements require a comprehensive multidisciplinary mental health and developmental assessment.¹⁷⁴

Hodges et al (2013) found through path analysis of clinical level symptoms in a sample of 8 to 12-year-old Californian children in OOHC that:

Accumulated exposure to multiple different trauma types predicts symptom complexity as reported by both children and their caretakers.¹⁷⁵

171. ABS, [Children with a disability](#), Australian Social Trends, 4102.0 – Australian Social Trends, Jun 2012. Diagnostic difficulty may contribute to the higher proportion of older children with an intellectual disability.

172. Corrales T (2015) [Understanding differences in the outcomes of children and young people across care types](#) August, 2015 Anglicare, p 18

173. Senate Standing Committee on Community Affairs, [Out of Home Care Report](#), August 2015, chapter 9 para 9.7.

174. Royal Australian & New Zealand College of Psychiatrists, [The mental health needs of children in out of home care](#), Position Statement 59, March 2015.

175. Hodges M et al. (2013) 'Cumulative trauma and symptom complexity in children: A path analysis' *Child Abuse & Neglect* 37 (11): 891-898

This is consistent with findings of a strong association between the extent of developmental and mental health problems amongst children and young people in care and the age at first placement.

Tarren-Sweeney (2006, 2013) conducted an epidemiological study – the Children in Care Study – of children in court-ordered foster and kinship care in NSW between October 1999 and October 2001. It was designed to provide baseline measures of mental health, use assessment tools that do not neglect problems manifested by children in care – ‘attachment and peer relationship difficulties, anxiety and dissociative responses to trauma, sexual behaviour and self-injury,’¹⁷⁶ address questions about the development of siblings in care, as well elucidating relationships between a range of prospective and retrospective risk and protection factors. The study was large, consisting of 619 children between the ages of 4-9.¹⁷⁷

The study revealed that the mental health profiles of children in OOHC more closely resembled those of children referred for clinical care than those of children in the population at large.¹⁷⁸ His analysis of the factors associated with higher incidence of mental health problems in children in OOHC provided:

partial support for a cumulative risk model of developmental psychopathology. The strongest and least ambiguous pre-care predictors of children’s mental health were “age at entry into care” and the inversely correlated “time in care”, which are indicators of overall exposure to pre-care adversity. Furthermore, encountering more types of maltreatment was less influential than the estimated length of exposure to maltreatment. Whereas a single harmful event may have life-altering developmental consequences for children at large, the impact of individual events is tempered among children exposed to chronic and multiple adversities.¹⁷⁹

The principal findings from Tarren-Sweeney’s study were that:

- ‘entry into care at younger ages protects chronically maltreated children who are in need of care from developing mental health problems’; and
- appropriate permanency planning and decision-making can improve outcomes for children in care by removing insecurity on the part of both carers and children that can act as a barrier to the development of healthy attachment.¹⁸⁰

176. Tarren-Sweeney M, Hazell P (2006) ‘The mental health of children in foster and kinship care in New South Wales, Australia’ *J Paediatr Child Health* 42:91-99, p 89.

177. op.cit. p 90.

178. Tarren-Sweeney M, Hazell P (2006) ‘The mental health of children in foster and kinship care in New South Wales, Australia’ *J Paediatr Child Health* 42:91-99; Tarren-Sweeney M (2013) ‘The Brief Assessment Checklists (BAC-C, BAC-A): Mental health screening measures for school-aged children and adolescents in foster, kinship, residential and adoptive care’ *Children & Youth Services Review*, 35: 771-779, p 771

179. Tarren-Sweeney M (2008) ‘Retrospective and concurrent predictors of the mental health of children in care’ *Children and Youth Services Review* 30: 1-25 p 17

180. op. cit. p 22

5.5 HIGH INCIDENCE OF TRAUMA

Trauma is the after-effect of exposure to at least one traumatic event:

A traumatic event is a frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity. Witnessing a traumatic event that threatens life or physical security of a loved one can also be traumatic. This is particularly important for young children as their sense of safety depends on the perceived safety of their attachment figures.

Traumatic experiences can initiate strong emotions and physical reactions that can persist long after the event. Children may feel terror, helplessness, or fear, as well as physiological reactions such as heart pounding, vomiting, or loss of bowel or bladder control. Children who experience an inability to protect themselves or who lacked protection from others to avoid the consequences of the traumatic experience may also feel overwhelmed by the intensity of physical and emotional responses.¹⁸¹

Events which might be experienced as traumatic by a child include:

- Physical, sexual, or psychological abuse and neglect (including trafficking);
- Natural and technological disasters or terrorism;
- Family or community violence Sudden or violent loss of a loved one;
- Substance use disorder (personal or familial);
- Refugee and war experiences (including torture);
- Serious accidents or life-threatening illness;
- Military family-related stressors (e.g., deployment, parental loss or injury)¹⁸²

Consequences of traumatic experiences are cumulative, continue over the life course and could include:

intense and ongoing emotional upset, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, problems relating to others or forming attachments, regression or loss of previously acquired skills, attention and academic difficulties, nightmares, difficulty sleeping and eating, and physical symptoms, such as aches and pains. Older children may use drugs or alcohol, behave in risky ways, or engage in unhealthy sexual activity.¹⁸³

Children in OOHC might manifest some of the challenging symptoms above as a result of exposure to person, places, or events that 'triggered' traumatic memories:

Children may be reminded by persons, places, things, situations, anniversaries, or by feelings such as renewed fear or sadness. Physical reactions can also serve as reminders, for example, increased heart rate or bodily sensations. Identifying children's responses to

181. National Child Traumatic Stress Network (US) [About Child Trauma](#) accessed 22 February 2019

182. *ibid*

183. *ibid*

trauma and loss reminders is an important tool for understanding how and why children's distress, behavior, and functioning often fluctuate over time. Trauma and loss reminders can reverberate within families, among friends, in schools, and across communities in ways that can powerfully influence the ability of children, families, and communities to recover. Addressing trauma and loss reminders is critical to enhancing ongoing adjustment.¹⁸⁴

Gallito et al. (2017) examined the trauma symptom profiles of young people (13-17 years) in the Ontario province child welfare system. Using self-report data from the Trauma Symptom Checklist for Children they found that 59% (n = 281) manifested minimal trauma-related symptoms, 30% (n = 144) moderate trauma-related symptoms, and 11% (n = 54) severe trauma-related symptoms. Greater severity of sexual abuse and female sex were associated with a greater likelihood of belonging to the severe trauma symptom profile than both the moderate and the minimal trauma symptom profiles.¹⁸⁵

5.6 LITERATURE SYNTHESIS ON CHARACTERISTICS OF CHILDREN IN DIFFERENT TYPES OF CARE

Netherlands based researchers, Leloux-Opmeer et al. (2016), drew on a wide range of published studies (including some from Australia) to develop broad characterisations of child and family background placed in three types of OOHC. It should be noted that their findings represent generalisations about observed differences at a point in time and do not necessarily represent best practice in assessment and placement:

Foster care

Normally intelligent foster children could be characterized as young school-aged children whose most notable individual problems include chronic health problems as well as behavioral problems. They usually come from broken, poor families that frequently have histories of neglect and family and domestic violence. Many parents appear to suffer from mental illness, addiction problems, or both, and one of them would commonly be incarcerated.¹⁸⁶

Family style group homes

For children in family-style group care with average intelligence, the most common finding was that data concerning their individual problems were insufficient. However, the few studies available suggest that attachment and behavioural problems occur particularly frequently and that the children would mostly have a Caucasian ethnic background. With regard to family issues, many children appear to suffer from physical or emotional abuse and are mainly under civil law family supervision. Children placed in family style group care usually come from another type of care.¹⁸⁷

184. *ibid*

185. Gallitto E et al (2017) 'Trauma-symptom profiles of adolescents in child welfare', *Child Abuse & Neglect* 68 (2017) 25-35.

186. Leloux-Opmeer et al. (2016) [Characteristics of Children in Foster Care, Family-Style Group Care, and Residential Care: A Scoping Review](#) *Journal of Child and Family Studies*, August 2016, Volume 25, Issue 8, pp 2357-2371, p2367.

187. *ibid*.

Residential care

Finally, residentially placed children may be [mainly] characterized as older school-aged male children with lower than average IQs. Many of them seem to suffer from chronic health problems and the reported figures indicate that many of them are on prescribed medication. Difficulties in peer relations and cognitive problems appear to be the most notable characteristics of residentially placed children, who also seem to frequently display severe emotional and behavioural problems. The extent to which these social emotional problems relate to attachment problems remains unknown. Furthermore, residentially placed children tend to come from broken, poor families that chiefly have histories of child abuse, neglect, and sexual abuse. Many parents in these families seem to suffer from mental illness and addiction. Literature data suggest that these children are usually under permanent legal guardianship and have experienced an average of at least four placements before they enter residential care.¹⁸⁸

5.7 HIGH INCIDENCE OF COMPLEX NEEDS IN RESIDENTIAL CARE

The Victorian Auditor General made the following finding about children in residential care:

Children in residential care have generally been exposed to multiple traumas in the form of family violence, alcohol and drug abuse, or sexual, physical and emotional abuse since they were very young. They may have a parent who is in prison or a struggling single parent with mental health issues. Some have been born to mothers who were very young, often with a violent partner. They usually have other siblings in care, and one of their parents may also have been in care as a child. They are usually known to child protection at an early age. They come to residential care typically as a young adolescent, having experienced a number of placements in home-based care that have since broken down or were only available for short periods of time. They often come to residential care with little warning and with few belongings. On their 18th birthdays, if not before, they leave the protection of the state.¹⁸⁹

Meeting the complex needs of children in OOHC is considered further in Section 7 below.

5.8 EMERGENCY ACCOMMODATION AND LARGE SIBLING GROUPS

Children may enter residential care because family type care is not available at short notice or cannot accommodate a large sibling group that should be kept together. Not all of these children will present with complex needs.

188. *ibid*

189. Victorian Auditor General 's Report (2014) [Residential Care Services for Children](#) p ix

06

ASSESSMENT AND WORKFORCE

6.1 ASSESSMENT AND PLACEMENT IN CARE

Tarran-Sweeney (2013) used new assessment tools¹⁹⁰ to ascertain the mental health status of children in OOHC in NSW. He found:

- More than half of children and young people in foster, kinship, and residential care, as well as those subsequently adopted from care, have mental health difficulties that require clinical formulation and intervention.
- A range of attachment- and trauma-related mental health difficulties are prevalent in the OOHC populations
- Almost all children in care are exposed to systemic, adverse pressures on their development and wellbeing, and they have vulnerabilities that are not necessarily revealed by their mental health presentations.¹⁹¹

He argued that the common '*clinical/psychosocial-developmental*' approach to assessing the needs of children in OOHC — which depends upon 'a relatively narrow, "mechanical" focus on identifying [their] symptoms and disorders'¹⁹² — may not be sufficient to 'screen for a range of attachment- and trauma-related mental health difficulties observed among these populations' and should be replaced by a 'universal, comprehensive assessment' (which includes screening for immediate risk of harm). By gaining 'a comprehensive understanding of their felt experience, their relationships, family/ placement processes, and systemic and care-related pressures on their development' a greater proportion of trauma and attachment-related risk 'can be identified and intercepted, and their effects prevented and remediated.'¹⁹³

Despite finding that the Brief Assessment Checklists (BAC-C and BAC-A) were 'likely to provide accurate mental health screening for children and young people in various types of care,' Tarren-Sweeney warned that further studies to benchmark their value as screening tools against clinical data were required. Except for screening for the risk of self-harm (and presumably harm to others) he was not in favour of routine mental health screening in isolation from comprehensive assessment:

190. The BAC-C and the BAC-A are '20-item caregiver-report psychiatric rating scales designed to: 1. Screen for and monitor clinically-meaningful mental health difficulties experienced by children and adolescents in various types of care; and 2. Be safely administered and interpreted by health and social care professionals other than child and adolescent mental health clinicians.' See Op. cit. supra.

191. Tarren-Sweeney M (2013) 'The Brief Assessment Checklists (BAC-C, BAC-A): Mental health screening measures for school-age children and adolescents in foster, kinship, residential and adoptive care', *Children and Youth Services Review*. 35, 771-779. Pre-print manuscript

192. Tarren-Sweeney (2013) Op. cit.

193. op. cit.

There is compelling evidence to support the argument that, given the availability of an adequately trained and specialised workforce, children in care would be better served by universal, comprehensive assessment — bypassing the need for mental health screening (with the exception of screening for immediate risk of harm). Almost all children in care are exposed to systemic, adverse pressures on their development and wellbeing, and they have vulnerabilities that are not necessarily revealed by their mental health presentations. Many of these pressures can be profoundly distressing and undermine children's felt security. Much of this risk can be identified and intercepted, and their effects prevented and remediated, through thorough assessment. I would argue that we need to shift towards a new standard of psychological practice, informed by more detailed assessment of attachment- and trauma-related problems, and a wider developmental and contextual focus than that typically employed in mental health clinical assessments, within what might be termed a clinical/psychosocial–developmental scope of practice. In essence, specialised assessment of these children requires a shift from a relatively narrow, 'mechanical' focus on identifying children's symptoms and disorders — to seeking a comprehensive understanding of their felt experience, their relationships, family/placement processes, and systemic and care-related pressures on their development.¹⁹⁴

Milne and Collin-Vézina (2015) also emphasise that trauma and mental health problems may give rise to common symptoms:

In assessing a child's symptomatology, it is important to consider that trauma-related symptoms and mental health symptoms are not always mutually exclusive (e.g., avoidance of feared stimuli, hyperarousal, and sleep problems may be a symptom of exposure to a traumatic event or an anxiety disorder)[...] In addition, a child may experience a mental health problem without having experienced a traumatic event, just as a child may have experienced a traumatic event without developing a mental health problem. This lack of distinction is complicated by the fact that a traumatic event can aggravate an existing mental health condition.¹⁹⁵

They offer practitioners a selection of six established assessment instruments:

- *Trauma Symptom Checklist for Children* (TSCC; Briere, 1996), which assesses for symptoms of anger, depression, anxiety, posttraumatic stress, dissociation, and sexual concerns;
- *Adolescent Dissociative Experiences Scale* (A-DES; Armstrong, Putnam, Carlson, Libero, & Smith, 1997) [which] is a self-report questionnaire to assess for normative and pathological forms of dissociation;
- *Behaviour Assessment System for Children-Self-Report of Personality* (BASC-SRP; Reynolds & Kamphaus, 2004), which measures behaviour problems, academic problems and adaptive functioning;

194. Tarren-Sweeney M (2013) 'The Brief Assessment Checklists (BAC-C, BAC-A): Mental health screening measures for school-age children and adolescents in foster, kinship, residential and adoptive care', *Children and Youth Services Review* 35: 771-779, p778

195. Milne Lise & Collin-Vézina D 'Assessment of Children and Youth in Child Protective Services Out-of-Home Care: An Overview of Trauma Measures' *Psychology of Violence*, April 2015, 5 (2):122-132,p 123

- *Strengths and Difficulties Questionnaire* (SDQ; Goodman, 1997), which measures problematic and prosocial behaviours (parents or other significant adults in the child's life can also complete versions of these behavioural measures);
- *Child Behaviour Checklist for Children and Youth Self-Report* (CBCL; Achenbach, 1991), which provides measures of internalizing and externalizing symptoms.
- *Brief Assessment Checklist-Child and Adolescent* (BAC-C; BAC-A; Tarren-Sweeney, 2013) aims to measure mental health issues and behavioural problems not commonly captured in other rating scales, such as interpersonal, attachment-related difficulties, dysregulation, trauma-related anxiety and dissociation, abnormal responses to pain, food maintenance behaviours, sexual behaviour problems, and self-injury.¹⁹⁶

The authors noted that few instruments allow simultaneous measurement of trauma events as well as their clinical consequences, so added to their list the Child and Adolescent Needs and Strengths (CANS; Lyons, Griffin, Fazio, & Lyons, 1999; Lyons, Small, Weiner, & Kisiel, 2008), which they recommended as a single 'comprehensive instrument to capture traumatic events, trauma-related symptoms, strengths, and a host of other important features, CANS is recommended due to its brevity, as well as the multitude of different problem-specific modules.'¹⁹⁷

6.2 CLINICAL WORKFORCE AND THE POLICY ENVIRONMENT

Based on his understanding of the needs of children in, or adopted from, OOHC, Tarren-Sweeney (2010) proposed principles to underpin '[e]ffective specialization in child welfare work by clinical child psychologists, psychotherapists and psychiatrists', namely:

1. specialized knowledge and skills;
2. a shift from traditional clinical practice to a clinical psychosocial-developmental scope of practice; and
3. a strong advocacy role, with supportive service design guided by
4. a primary—specialist care nexus, that includes universal, comprehensive assessments;
5. a shift from acute care to preventative, long-term engagement and monitoring;
6. integration within the social care milieu;
7. a shift from exclusion to active ownership of these client groups;
8. normalization strategies; and
9. alignment of services for these client groups, and
10. mental health service provision [...] strengthened by policy that promotes "whole of government" accountability for their mental health needs.¹⁹⁸

196. op.cit. pp 126-127. Note that fees were reported for use of the Trauma Symptom Checklist for Children and the Behavior Assessment System for Children-Self-Report of Personality.

197. op.cit. p 128.

198. Tarren-Sweeney M (2010) 'It's time to re-think mental health services for children in care, and those adopted from care' *Clinical Child Psychology and Psychiatry* First Published October 5, 2010 <https://doi.org/10.1177/1359104510377702>

07

COMPLEX NEEDS OF CHILDREN AND YOUNG PEOPLE IN RESIDENTIAL CARE

7.1 COMPLEX NEEDS

High or complex needs refer to the needs of a child or young person who:

- exhibits challenging and/or risk-taking behaviours of such intensity, frequency, and duration that they place themselves or others at serious risk of harm, and/or
- has mental health presentations which impair their ability to participate in an ordinary life and which reduce access to services, activities and experiences, and/or
- has a disability with high level challenging behaviours or complex health issues which are life threatening or require continuous monitoring and intervention.¹⁹⁹

Such children and young people are typically involved with multiple sectors (e.g. health, welfare, criminal justice) and absorb a high level of system resources over a prolonged period. They are at exceedingly high-risk of failed OOHC placements and poor outcomes on leaving care.

Burns' 2012 report 'Youth in Care with Complex Needs', provides the three case studies below²⁰⁰; they illustrate how complex needs affect the lives of children in residential OOHC in Canada.

199. Schmied V, Brownhill, S & Walsh P (2006). [Models of service delivery and interventions for children and young people with high needs](#). Ashfield, New South Wales: Centre for Parenting & Research.

200. Burns L (2012) [Youth in Care with Complex Needs](#), Special Report for the Office of the Children's Advocate, Alberta, March 2012.

COMPLEX NEEDS CASE STUDY:

IAN

Ian, age 16, has been known to child welfare agencies throughout his childhood, related to a series of incidents of physical and sexual abuse perpetrated by his mother's series of partners. His mother has struggled with chronic depression and low self-esteem throughout her life; her own childhood was marked by severe abuse and neglect. Ian was referred to child and adolescent mental health services when he was 11 because of behaviour problems at school. By 13, he had entered child welfare care as his mother could no longer manage his behaviour. As adolescence emerged, the effects of years of abuse and inconsistent parenting were evident: Ian was aggressive, disengaged from peers, suspended from school for physically assaulting a teacher, frequently ran away, and was misusing drugs and alcohol. He has been through 10 placements in 4 years, including a specialized treatment facility that was unable to manage his behaviour.

COMPLEX NEEDS CASE STUDY:

JASMINE

Indications of Jasmine's compromised mental health were evident in early childhood. Her parents sought services from mental health services, psychologists, mobile crisis teams, and psychiatrists, with a diagnosis of Psychosis (Not Otherwise Specified) finally being levied when she was 12 years old. The diagnosis, and corresponding prescribed medication, did little to facilitate access to services. Jasmine drifted from foster home to psychiatric ward, from group home to youth correctional facility, from home with her parents to a hospital where she would be placed with adults, although she was only 14 years old. She has not received a consistent educational program for several years.

COMPLEX NEEDS CASE STUDY:

CAROL

Carol is a 17-year-old with a degenerative brain condition. She is developmentally delayed and has an IQ of 40. She is impulsive and her behaviour can be violent and out of control. She has had numerous medical and other assessments and has been hospitalized many times. Carol lived with her parents until age 14 when they could no longer manage the level of care she needed at home. She now resides in a residential facility with up to three staff caring for her at all times. Carol has complex needs and her family expresses frustration in trying to get services from three ministries – Children's Services for 24-hour residential care; Health and Wellness for hospital placements, professional services of neurologists and psychiatrists, and medications; Learning for the provision of special education services.

Burns distilled the major themes emerging in the profiles of 12 cases of complex needs referred to the Office of the Child Advocate in Alberta as these:

- Mental health concerns
- Physical disabilities
- Developmental disability
- Foetal Alcohol Spectrum Disorder (FASD)
- Criminal justice system involvement
- Behavioural issues

- Sexual exploitation
- Self-harming behaviours
- Harm towards others
- Complex health conditions
- Communication barriers
- Attachment issues²⁰¹

Locating a suitable placement for these children and young people, even in residential care, had been difficult, and in some cases impossible – not always because of the range of needs, but in some cases because of the severity of one particular need:

Most often cited as major barriers to placement for youth (in foster homes, groups homes, and residential care facilities) were violent or aggressive behaviour issues, suicidal and self-harming behaviours, and cognitive impairment.²⁰²

201. op. cit. p15
202. ibid.

A major aim of this report is to identify evidence-based models of care that are capable of meeting the most complex needs of children in the care system – those found amongst children and young people in residential care. The increased emphasis on early intervention and permanent placement in many jurisdictions can be seen in part as a desire to prevent development of the most intractable challenges presented by children in residential care. Approaches to the assessment, placement and treatment interventions in such cases are described below.

7.2 RESIDENTIAL CARE FOR LOWER NEEDS CHILDREN

Children who do not necessarily present with complex needs may also be placed in residential care because of a family emergency and/or because of the need to accommodate a sibling group that needs to be kept together but cannot be accommodated in foster or kinship care.

7.3 OPTIONS FOR ASSESSING AND PLACING CHILDREN OR YOUTH WITH COMPLEX NEEDS

Burns (2012) describes the need for innovative approaches to address the most complex needs of youth in OOHC:

While the literature makes it clear that there will always be a very small proportion of youth with complex needs who will require the creation of individualized placements, the majority of youth with complex needs can be cared for within a comprehensive range of placement options, supplemented by treatment services across many service sectors. A number of innovative placement models were identified in this report to augment the current system: a continuum of one bed, two-bed, three-bed and four-bed placement options, alternative caregiver models that build teams of foster parents and respite staff (supported by professional consultation in mental health and behaviour management), in-patient and out-patient trauma services, and expanded crisis stabilization services. Such models will require a review of policies, staffing formulas and funding models in order to create the placement resources that best meet the needs of youth with complex needs. It will also be an opportunity to update these aspects of the alternative care system that may be outdated and no longer fits the needs or realities of providing care to youth with complex needs in today's society.²⁰³

203. Burns L (2012) [Youth in Care with Complex Needs](#), Special Report for the Office of the Children's Advocate, Alberta, March 2012, p121

Figure 1. Prioritizing youth with complex needs for assessment and placement²⁰⁴

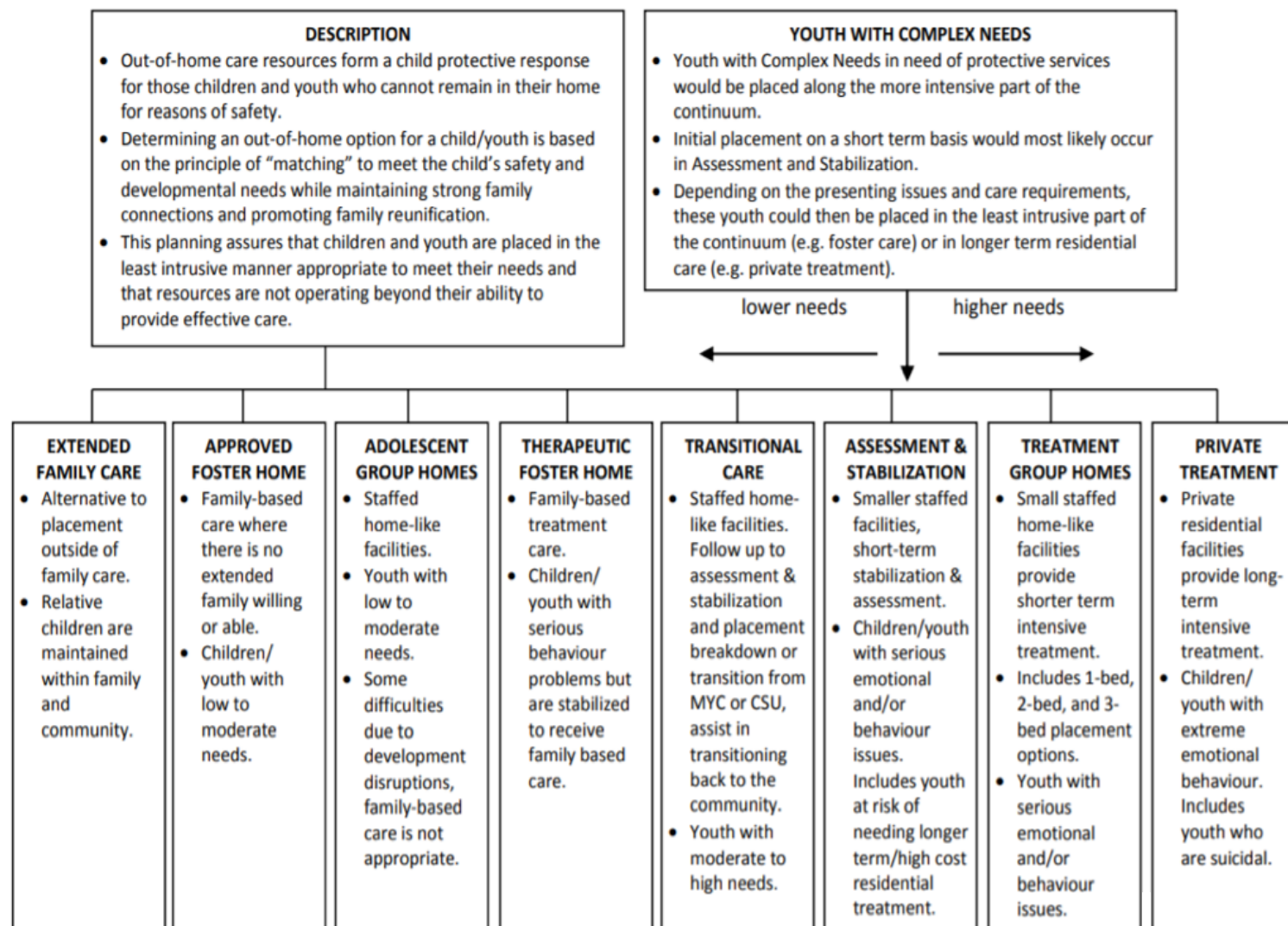


Figure 1 above provides an outline of the steps to be taken in order to place young people with complex needs in the least restrictive form of OOH that can be expected to meet those needs.

204. op. cit. This diagram is adapted from a model proposed by Saskatchewan to respond to the high needs of sexually exploited youth.

08

THERAPEUTIC RESIDENTIAL CARE

8.1 THE BURDENS AND BENEFITS OF RESIDENTIAL CARE

As Bloom (2005) points out:

...residential care has long been a subject of concern related to: criteria for admission; inconsistency of community based treatment; the costliness of such services; the risks of treatment, including failure to learn behaviour needed in the community; the possibility of trauma associated with separation from family; difficulty re-entering family or abandonment by family; victimisation by staff; and learning of anti-social or bizarre behaviour from intensive exposure to other children.²⁰⁵

Failures are well-publicised and costly to the provider and to the commissioner of services, whether they are one and the same, in the case of state provided residential care, or different, as in the case of care provided by or under the auspices of UnitingCare. But the need for such care persists.

Furthermore, determining whether residential care is responsible for iatrogenic effects on its client population, requires the use comparison groups who have comparable characteristics before being placed in different forms of care.

Trials of therapeutic residential care compared with 'care as usual' were funded by the Victorian Government from June 2007 and evaluated by Verso Consulting between August 2009 and July 2011. A 5-day training session in a common approach that drew on various models and approaches including the Sanctuary model, attachment theory, resilience, trauma, child brain development, organisational learning and congruence was given to all staff. The evaluation found that the additional cost of \$65,000 per child was warranted in the light of the improved outcomes for those in the TRC pilots, including 'reduced demand for crisis services and intensive intervention services such as secure welfare, youth justice, police and the courts.'²⁰⁶

205. Bloom, S. L. (2005) Introduction to Special Section- [Creating Sanctuary for Kids: Helping Children to Heal From Violence](#). Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations 26(1): 57-63.

206. [Evaluation of the Therapeutic Residential Care Pilot Programs. Final Summary & Technical Report](#), 4 November 2011, Verso Consulting Pty Ltd, Department of Human Services, Victoria, p 5.

8.2 'RESIDENTIAL CARE' COVERS A BROAD SPECTRUM

Whittaker et al (2016) note that the broad application of 'residential care' limits its usefulness as a term in the development of evidence-based practice.

..“therapeutic group residential care” as an umbrella term masks individual differences within and between program exemplars: to say “residential care” or “residential services” communicates little beyond minimal setting information. The sheer range and variability of service components, change theories, frequency, intensity and duration of specific intervention strategies, organizational arrangements (size of living units, lengths of stay, staffing arrangements, for example) to say nothing of protocols for staff training and development and the integration of ongoing, systematic evaluation, all argue for increasing precision and specificity in both description and analysis.²⁰⁷

Further, they note that strategies for intervention that seem well-defined by comparison can be very appealing to policy-makers:

If residential services have fallen from favor as many of our contributors have noted, at least a partial reason must surely be that the term can mean so many different things in different contexts. This masking of differences in the use of umbrella terms such as “residential care” contrasts ever-more sharply with the conceptual and empirical precision that characterize many newer evidence-informed and evidence-based approaches to work with troubled youth such as Multi-Systemic Treatment (MST) and Multi-Dimensional Treatment Foster Care (MTFC) referenced in several earlier chapters. Proponents of these promising and innovative stratagems can speak with clarity and precision about intervention components, lengths of service, costs and organizational characteristics in ways that are compelling to policymakers. In a head-to-head comparison with a largely unspecified and variable “residential” comparison, they will almost certainly win the rhetorical as well as the empirical battle.²⁰⁸

8.3 THERAPEUTIC RESIDENTIAL CARE DEFINED

An Australian National Therapeutic Residential Care (NTRCA) Working Group proposed the following interim definition of therapeutic residential care in 2011:

Therapeutic residential care is intensive and time limited for a child or young person in statutory care that responds to complex impacts of abuse, neglect, and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by sound understanding of trauma, damaged attachment and developmental needs.²⁰⁹

207. Whittaker, Del Valle, and Holmes (2014: 329) cited in Whittaker et al. [Therapeutic Residential Care for Children and Youth: A Consensus Statement of the International Work Group on Therapeutic Residential Care](#), *Residential Treatment for Children & Youth*, 33:2, 89-106.p

208. *ibid.*

209. Association of Children's Welfare Agencies/NSW Department of Family and Community Services, 2016, p. 9, cited in Ainsworth F (2017) For the Few Not the Many: An Australian Perspective on the Use of Therapeutic Residential Care for Children and Young People, *Residential Treatment for Children & Youth*, 34:3-4, 325-338, DOI: 10.1080/0886571X.2017.1383868

Ainsworth (2017) criticised this definition for its inclusion of elements that have no relevance to service provision – statutory care and time limitation.²¹⁰ Instead, he supported the definition endorsed by an international group of 32 participants from 11 countries that met in April 2016, and issued a Consensus Statement about therapeutic residential care for children and youth, which offered this definition as a useful starting point:

Therapeutic residential care involves the planful use of a purposefully constructed multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support and protection to children and youth with identified mental health or behavioural needs.²¹¹

The group noted the variety of settings in which it can be delivered, including:

community-based centers (e.g., children's homes) utilizing community schools, or through campus-based programs which provide on-site school programs.²¹²

Notwithstanding the authority of the international consensus definition above, Ainsworth noted that there is 'no there is no agreed upon Australia-wide definition of TRC and that agreement about a definition of TRC is unlikely to be achieved any time soon' – a situation he attributed to its falling under State and Territory responsibilities.²¹³ A new definition proposed by the NTRCA in 2016 responds to some of the limitations of the 2011 version, but has yet to achieve consensus in Australia, with many preferring the International consensus definition's reference to a developmental needs that extend beyond healing relationships.

Therapeutic residential care is an intensive intervention for children and young people, which, in Australia, is a part of the out-of-home care system. It is a purposefully constructed living environment which creates a therapeutic milieu that is the basis of positive, safe, healing relationships and experiences designed to address complex needs arising from the impacts of abuse, neglect, adversity and separation from family, community and culture. Therapeutic care is informed by current understandings of trauma, attachment, socialisation and child development theories; which are translated into practice and embedded in the therapeutic care program.²¹⁴

210. Ainsworth, op. cit.

211. Whittaker, del Valle, & Holmes, 2015, p. 24 cited in Whittaker et al. [Therapeutic Residential Care for Children and Youth: A Consensus Statement of the International Work Group on Therapeutic Residential Care*](#), *Residential Treatment for Children & Youth*, 33:2, 89-106, p 94

212. *ibid.*

213. Ainsworth F (2017) For the Few Not the Many: An Australian Perspective on the Use of Therapeutic Residential Care for Children and Young People, *Residential Treatment for Children & Youth*, 34:3-4, 325-338, DOI: 10.1080/0886571X.2017.1383868

214. National Therapeutic Residential Care Alliance, 2016 cited in McLean S (2018) [Therapeutic residential care: An update on current issues in Australia](#) CFCA paper no. 49, Australian Institute for Family Studies.

8.4 COSTS OF THERAPEUTIC VS GENERIC RESIDENTIAL CARE

Table 14 below, from Ainsworth (2017), shows the per annum dollar costs of Generic versus Therapeutic Residential Care, noting that the cost comparisons ‘confirm the view that TRC will of necessity be for the few not the many.’²¹⁵

Table 14. A State by State cost comparison of Standard/Generic Residential care and Therapeutic Residential Care Programs

State	Dollar cost per annum—Standard/generic	Dollar cost per annum—TRC
Victoria	162,880	306,026
NSW	189,532	310,144
Queensland	216,017	337,285

Sources: NSW FaCS, 2014; QCPCI, 2013; VA-G, 2014.

Frank Anglin et al²¹⁶ suggested that the role of residential care could be likened to that of Hospital Intensive Care wards:

Calculating the costs for therapeutic residential care

- Residential care is an expensive service when compared with various forms of foster care, kinship care or adoption.
- Therapeutic residential care is more expensive than “regular” group care, however, it is less costly than secure care, juvenile detention centres or psychiatric wards in hospitals., and it can reduce significantly services required by care leavers(Department of Youth Safety, 2011).
- One can think of therapeutic residential care as like the “intensive care service” of child welfare; no one seriously considers eliminating intensive care in hospitals because it is too expensive. It is an important part of the medical system.

8.5 PRINCIPLES OF THERAPEUTIC RESIDENTIAL CARE

Children Young People & Families Network

Members of the Uniting Network’s Children, Young People & Families Network attended a Workshop on 26 June 2018 at which they proposed the following set of principles for OOHc services, that are drawn from an understanding of both theory and practice.

215. Ainsworth F (2017) For the Few Not the Many: An Australian Perspective on the Use of Therapeutic Residential Care for Children and Young People, *Residential Treatment for Children & Youth*, 34:3-4, 325-338.

216. James Anglin, Martha Holden, Frank Kuhn, The Process of Care implementation & the Managing of Complexity. Presentation, EUSARF Conference, Copenhagen, September 3-4, 2014.

Principles for (residential and other) OOHC

1. Children and young people are safe and feel safe enough to dream
2. Shaped by the voice of children and young people
3. Individually tailored to support children and young people to become the best version of themselves
4. Draw on evidence, reflection and feedback to enable continuous improvement
5. Recognise and value families, carers and significant others
6. Are fully anchored in community and culture
7. Build strong, healthy, long term relationships

Children and residential experience (CARE)

Martha Holden developed an approach to the provision of OOHC that commences with principles, based on published research, that are intended to pervade organizational thinking and all aspects of practice:²¹⁷

- Developmentally focussed – promoting normal growth and development as well as healing;
- Family involved – involving a family member or other concerned adult to support all aspects of identity;
- Relationship based – promoting normal attachment and ability to form positive relationships;
- Competence centred – fostering skills, knowledge and attitudes needed to negotiate life's challenges;
- Trauma-informed – creating a safe and non-violent culture (rather than one of control and compliance) to address the impact of trauma and aid the development of new responses to stress; and
- Ecologically oriented – ensuring that the environment provides the child with opportunities to grow (modifying the environment rather than expecting the child to make a change that may be beyond his or her capacity).

International work group

The International Summit Work Group which met in 2016 was strong in its recommendation that TRC in any of its particular expressions be defined not simply by a completed checklist of certain attributes or strategies, but instead by a solid foundation of shared values. Their statement of the key principles for arriving at best practice in TRC appears below.

217. Holden M et al. (2010) Children and residential experiences: a comprehensive strategy for implementing a research-informed program model for residential care *Child Welfare* 89.2 (March-April 2010): p131+

International Summit Work Group: Principles for developing best practice in Therapeutic Residential Care

1. We are acutely mindful that the first principle undergirding therapeutic residential care must be 'primum non nocere': to first, do no harm. Thus, our strong consensus is that 'Safety First' be the guiding principle in the design and implementation of all TRC programs.
2. Our vision of therapeutic residential care is integrally linked with the spirit of partnership between the families we seek to serve and our total staff complement – whether as social pedagogues, child or youth care workers, family teachers or mental health professionals. Thus, the hallmark of TRC programs – in whatever particular cultural expression they assume – is to strive constantly to forge and maintain strong and vital family linkages.
3. Our view of therapeutic residential care is one in which services are fully anchored in the communities, cultures and web of social relationships that define and inform the children and families we serve. We view TRC programs not as isolated and self-contained islands, but in every sense as contextually grounded.
4. We view therapeutic residential care as something more than simply a platform for collecting evidence-based interventions or promising techniques or strategies. TRC is at its core informed by a culture that stresses learning through living and where the heart of teaching occurs in a series of deeply personal, human relationships.
5. We view an ultimate epistemological goal for therapeutic residential care as the identification of a group of evidence-based models or strategies for practice that are effective in achieving desired outcomes for youth and families, reliable from one site to another, and scalable, i.e., sufficiently clear in procedures, structures and protocols to provide for full access to service in a given locality, region or jurisdiction.²¹⁸

However, the Work Group noted:

the challenges involved in mounting rigorous research in a service context where contracts are increasingly focused, time-limited, and specific with respect to desired outcomes. It is unlikely that identification of evidence-based models of therapeutic residential care will emerge from service contracts alone.²¹⁹

Adopting an effective set of guiding principles for OOHC

As the International Summit Work Group found – the ultimate aim of TRC is to find evidence-based models of practice that reliably produce good outcomes for children and young people. Accordingly, any set of principles needs to promote openness, new research, and feedback from practice as much as it needs to provide child-centred, safe and healing care. Principles should also recognise the critical

218. Whittaker et al.(2016) [Therapeutic Residential Care for Children and Youth: A Consensus Statement of the International Work Group on Therapeutic Residential Care*](#), *Residential Treatment for Children & Youth*, 33:2, 89-106, pp96-98.

219. *ibid.*

contribution of the informal system of child protection and the need to strengthen the supports and the network of sustaining relationships available to a child exiting care. All the principles cited above are worth consideration – and, in being expressed differently, offer useful differences in perspective.

The following set of best practice principles for trauma-informed therapeutic residential care integrates principles from a number of sources, including those proposed by the International Working Group on TRC, the UnitingCare Australia Child, Young People and Family Network, and the principles of models such as CARE and Sanctuary outlined above.

Best Practice Principles for Therapeutic Residential OOH

1. **Uphold the Rights of the Child** as set out in the UN Convention.
2. **Do no harm and keep children safe:** use trauma-informed care and Child Safe Principles, including operation of a child-friendly complaints mechanism, to reduce risks to residents;
3. **Be responsive to the voice of the child** in the life and culture of the service: this means more than inviting participation in formal consultation – it means encouraging their agency in everyday life and decisions about them;
4. **Forge and maintain strong links with families, significant others, communities and culture,** fostering a strong sense of identity and belonging;
5. **Assess and monitor the developmental health and wellbeing of residents,** noting any history and ongoing consequences of trauma, and recording subjective indicators of health and wellbeing that reflect the child or young persons' aspirations for their best self;
6. **Develop, deliver and modify as necessary individually tailored, developmentally focused therapeutic treatment plans** aimed at promoting normal growth and development, including skills, knowledge and competencies, sense of (cultural) identity, agency, and the ability to form positive relationships;
7. **Identify and utilise adaptable, evidence-based models or strategies for practice** that are capable of achieving good outcomes for residents, families and staff.
8. **Recruit and retain staff with the necessary professional and personal skills to provide TRC** through provision of appropriate working conditions and personal support.
9. **Ensure that the residential facility is free of hazards and conducive to TRC;**
10. **Draw on evidence, reflection and feedback to enable continuous improvement;**
11. **Adopt systems thinking:** OOH needs to work in harmony with a strong, community orientated family support and child protection system.
12. **Only provide residential services developed, resourced and implemented in conformity with the above principles.**

8.6 TRAUMA-INFORMED CARE

A high proportion of children in OOHC, and an even higher proportion of those in residential OOHC, manifest mental health problems, including problems related to the experience of trauma (see Section 5.5 above). The provision of trauma-informed care (TIC) is a major principle of models of OOHC such as CARE and Sanctuary, but the concept has multiple definitions, leading to difficulty in determining when TIC has been used in practice and in evaluating its effects. Hanson & Lang (2016) combined the definitions used in a number of rigorous, published studies with information from a survey of practitioners to zero in on the essential components of TIC.²²⁰ Their results are summarised in Table 15 below, taken from Johnson (2017). The fifteen components, which can be grouped into 3 categories are: workforce development (WD), trauma focused services (TFS) and organisational delivery (ORG), can be used to organise a service's implementation of TIC.

Table 15. Components of trauma-informed care services from Hanson & Lang (2016)²²¹

Level	Component
WD	1. Required staff training in the impact of trauma
WD	2. Measure staff proficiency in knowledge of impact of trauma
WD	3. Processes to prevent and help with staff secondary trauma
WD	4. Staff knowledge about when and how to access trauma focused therapy
TFS	5. Use of standardised and evidence-based assessments of trauma history and symptoms
TFS	6. Include child's trauma history in file and care plan
TFS	7. Availability of trained, skilled clinical providers in evidence-based trauma focused therapies
ORG	8. Collaboration and information sharing <i>within</i> the agency related to trauma informed services e.g. between care and education
ORG	9. Collaboration and information sharing <i>with other</i> agencies related to trauma informed service e.g. CAMHS and social work
ORG	10. Procedures to reduce risk for re-traumatisation of children
ORG	11. Input from children and purchasers in service planning and development of a trauma informed system
ORG	12. Provide services that are strength-based and promote positive development
ORG	13. Provide a positive, safe physical environment
ORG	14. Written policies that explicitly include and support trauma informed principles
ORG	15. Presence of a defined leadership position or job function specifically related to TIC

220. Hanson R & Lang J (2016) 'A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families' *Child Maltreatment* 21(2) 95-100

221. In Johnson D (2017) [Tangible trauma-informed care](#) *Scottish Journal of Residential Care*, 16 (1): 1-21,p5

8.7 EVIDENCE-BASED TRAUMA THERAPIES

Johnson (2017) reviewed literature on several promising ‘models’ of therapeutic care including:

- **Neurosequential Model of Therapeutics**²²², which holds that brain development occurs in an hierarchical fashion commencing with the ‘simple and reflexive’ (brain stem) and culminating in the most complex – language and abstract thought (neocortex). Trauma therapy needs to address the functional areas of the brain that correspond to the developmental stage at which traumatic experience occurred;
- **Sanctuary**²²³, which places a premium on creating a whole-of-organisation environment of non-violence and safety within which traumatised children can heal; and
- **Neurological Reparative Therapy**²²⁴, which attempts to deal with conditioned maladaptive brain responses to threat, by providing a safe and supportive environmental for learning and encouraging ‘neuro-integration’ – eg communication of right and left hemispheres through requiring child to describe the images stimulated by the experience of music.

After observing implementation of these ‘models’ in various sites in Scotland, Johnson concluded that there was no one approach that met all the requirements of OOHC:

The best-fit model appears to be a strategy whereby a residential service utilises the guidance and tools from a range of approaches, one that takes the most useful and salient of these for their own specific service.²²⁵

However, he urged practitioners to adopt ‘an overarching framework’ containing the elements of trauma-informed care – set out in Table 15 above.

It should be noted that of the models named by Johnson, only one, Sanctuary, has been rated by the CBEC. However, the Neurosequential Model’s insistence that therapies can only be effective if they engage with the stress response system in the brain that has been maladaptively activated by trauma seems plausible. This may help explain, the otherwise improbable clinical success of a trauma therapy such as Eye Movement Desensitization and Reprocessing (EMDR)²²⁶.

Perry (2006) summed up the clinical implications of a child’s developmental history thus:

A child exposed to consistent, predictable, nurturing, enriched experiences will develop neurobiological capabilities that will increase the child’s chance for health, happiness, productivity and creativity. Conversely, neglect, chaotic and terrorizing environments will

222. Perry B (2006) Applying principles of neurodevelopment to clinical work with maltreated and traumatised children. *The Neurosequential Model of Therapeutics* The Guildford Press, NY

223. Bloom S (2013) [The Sanctuary Model](#) in Ford J and Cortois C, Eds, *Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models*. The Guildford Press, NY, pp 277-294.

224. Ziegler D (2011) *Neurological Reparative Therapy: A roadmap to healing, resiliency and wellbeing*. Jasper Mountain.

225. Johnson D (2017) [Tangible trauma-informed care](#) *Scottish Journal of Residential Care*, 16 (1): 1-21, p 4

226. Shapiro F (1989) ‘Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories’ *Journal of Traumatic Stress*, 2 (2): 199-223.

increase a child's risk for significant problems in all domains of functioning. The specific symptoms or physical signs a child develops following maltreatment or trauma will reflect the history of neural activation – or, in the case of neglect, the history of inactivation. Neuropsychiatric symptoms and signs present in maltreated or traumatised children are related to the nature, timing, pattern and duration of their developmental experiences – both adverse and protective.²²⁷

8.8 THERE ARE MANY SOURCES OF VALUABLE EVIDENCE

Practitioners who are keen to expand their perspective and improve the effectiveness of their services are always on the lookout for new evidence on which to base their practice. Thoburn (2016) notes that they need not limit their search to the results of random controlled trials, as there are many other sources of valuable evidence. The remarks below are made about foster care but apply equally to other forms of OOHC.

Given the complexity of the foster care service and the diversity (in every sense of the word) of foster families, it is unsurprising and appropriate that [...] the full range of research methodologies is used. It is to be welcomed that [...] we have moved on from a hierarchy of research methodologies (with systematic reviews and randomised control trials as the gold standards), both for scoping the relevant literature and for the research process itself. Practitioner and action research, the involvement of peer researchers, the satisfaction of children or adults as outcome measures (all in evidence in this volume or at the workshop), do not fit easily into 'pure model' methodologies. The resulting reports do not always appear in web-based searches and may require some detective work and lead-following before they come to light. There is a space for soundly conducted randomised control trials when there is a clearly identified group of children with similar needs and a specific intervention, with outputs and outcomes that can be robustly identified and measured within a reasonably short time frame. Advances in statistical techniques have also been important for the more rigorous analysis of routinely collected administrative data as with the Sebba et al. (2015) study²²⁸ comparing educational outcomes for children in care with similar children not in care. When these results are combined with robustly conducted prospective longitudinal studies (using mixed quantitative and some increasingly imaginative qualitative methodologies) the combined analysis can be particularly valuable. But for some of the questions for which we need answers a range of qualitative methodologies, and some exciting new techniques to engage children, carers and birth parents (texting, use of cameras) are being developed to capture the experience of foster family life.²²⁹

227. Perry B (2006) Applying principles of neurodevelopment to clinical work with maltreated and traumatised children. *The Neurosequential Model of Therapeutics* The Guildford Press, NY. p 36

228. Sebba J, Berridge D et al. (2015) The educational progress of looked after children in England. Oxford: Rees Centre

229. Thoburn J (2016) Achieving good outcomes in foster care: a personal perspective on research across contexts and cultures. *Social Work & Society*, 14 (2): 1-15, p9

09

INTERVENTIONS TO REDUCE TIME IN RESIDENTIAL CARE/STABILIZE PLACEMENTS

Evidence from a longitudinal study in the US (the National Survey of Child and Adolescent Wellbeing, NSCAW II) shows that youth in residential care and in therapeutic foster care had higher rates of externalizing behaviours as measured by the Child Behaviour Checklist (Achenbach & Rescoria, 2001) than their peers in home-based care and those placed in emergency shelter care:

These data suggest that interventions focused on stabilizing affect and behavior, de-escalating conflict, and promoting mindfulness and stress reduction could be used to make more home-based placements available to youth with externalizing behaviors currently served in congregate care as they are clinically similar to youth in therapeutic foster care settings.²³⁰

Chapin Hall & the Chadwick Center found that youth placed in care were likely to be older, with more challenging behavioural problems than those placed in other forms of care:

Like youth placed in therapeutic foster care youth residing in group homes or residential treatment centers are predominantly older (ages 11+) and likely to exhibit externalizing behaviors (51-57%). However, several NSCAW II findings underscore the idea that youth with comparable clinical characteristics are more likely to be placed in congregate care than therapeutic foster care to manage their behavioral risk. These youth are more likely to exhibit externalizing behaviors (such as aggressive behavior, oppositionality, and conduct problems). Among those youth requiring higher levels of care, those with internalizing problems (e.g. depression & anxiety) are more likely to be placed in therapeutic foster homes than congregate care settings.²³¹

230. Chapin Hall & Chadwick Center (2016) : [Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare](#).

231. op. cit.

They concluded that:

investments in interventions focused on stabilizing affect and behavior, de-escalating conflict, and promoting mindfulness and stress reduction could be used to make more home-based placements available to youth with externalizing behaviors.²³²

In order to achieve the commonly supported goal of reducing the use of congregate (residential) care, they recommended a two-pronged approach:

- I. Evidence-based interventions to target the needs of youth, and
- II. Services and supports for their home-based caregivers.

Table 16 below provides a list of interventions for disruptive behaviour rated by California Evidence-Based Clearing House for Child Welfare as well-supported by evidence.

Table 16. Evidence-based interventions to deal with disruptive behaviour ²³³

DISRUPTIVE BEHAVIOR TREATMENTS
CEBC Rating of: 1 Well Supported by Research Evidence
Coping Power Program <i>ages 8–14 child and parent components</i>
Multi-Systemic Therapy (MST) <i>ages 12–17 family-focused intervention</i>
Parent-Child Interaction Therapy (PCIT) <i>ages 2–7 parent-focused intervention</i>
Parent Management Training, Oregon Model (PMTO) <i>ages 2–18 parent-focused intervention</i>
Positive Parenting Program® (Triple P) Level 4 <i>ages birth–12 parent-focused intervention</i>
Problem Solving Skills Training (PSST) <i>ages 7–14 child-focused intervention with some parent involvement</i>
Promoting Alternative Thinking Strategies (PATHS) <i>ages 4–12 often conducted in a school setting</i>
The Incredible Years (IY) <i>ages 4–8 parent-focused intervention with child component</i>
Treatment Foster Care Oregon – Adolescents (TFCO-A) <i>ages 12–18 parent and child components</i>

232. op.cit.

233. ibid.

Table 17. Evidence supported interventions to stabilize OOHC placements²³⁴

PLACEMENT STABILIZATION PROGRAMS
CEBC Rating of: 1 Well Supported by Research Evidence
<p>Treatment Foster Care Oregon – Adolescents (TFCO-A) <i>at least two randomized controlled trials have shown the practice to be effective and that sustained effect has been seen 12 months after the end of services, as compared to a control group.</i></p>
CEBC Rating of: 3 Promising Research Evidence
<p>Family Group Decision Making (FGDM) <i>several controlled studies have shown effect on placement stability</i></p>
<p>KEEP Keeping Foster and Kin Parents Supported and Trained <i>several randomized controlled trials have been conducted and shown effect on placement stability.</i></p>
<p>Neighbor to Family Sibling Foster Care Model <i>one comparison study showed effects on placement stability</i></p>
<p>Wraparound <i>one randomized controlled trial, with no post-intervention follow-up, showed effect on the rate of placement change</i></p>

234. *ibid.*

10

THERAPEUTIC CARE MODELS FOR RESIDENTIAL OOHC

What is clear from this research is that all jurisdictions need a range of options in alternative care to best meet the needs of children and young people in care. Systems that have tried to exist without residential care have failed to provide stability and continuity for children and young people in care.

[...] Residential care cannot be seen as a last resort as this is a grossly unfair message to young people. It indicates that it is their fault they are in care [...] and does not provide a sense that residential care is a positive option for them, a decision they made in the best interest of their life chances.²³⁵

What is apparent is that we need to continue to strive to make residential care of the highest quality so that young people in care claim a life due them, not half a life or a good enough life but a life as active citizens of society with an ability to reach their full potential.²³⁶

10.1 WHAT IS A MODEL OF THERAPEUTIC RESIDENTIAL CARE?

Models of therapeutic care vs therapies

Residential care is not simply a platform to which various individual treatment modalities can be anchored.²³⁷ Before any gain can be made by a child from an individual treatment hour, the environment in which the child lives must be stable, warm and nurturing, to allow the child to engage in treatment or social learning or other functions. Without the existence of a living environment that displays these attributes, the individual treatment hour is unlikely to result in any gains for a child or positively contribute to the aim of TRC, namely, behaviour change.²³⁸

Whilst behaviour change may be the main or only 'aim' of a particular therapeutic intervention, it does not sum up the goals of TRC. However, the main point being made by Ainsworth & Hansen above, is that provision of the pervasively therapeutic environment in TRC, unlike the provision of individual therapeutic interventions, is a 24/7

235. Hillan L (2006) [Reclaiming residential care: a positive choice for children and young people in care](#). Report of 2005 Churchill Fellow, The Winston Churchill Memorial Trust of Australia, p4.

236. op.cit. p28

237. Pecora P & English D (2016). Elements of effective practice for children and youth served by therapeutic residential treatment and group care. Seattle, WA: Casey Family Programs. Note that the reference to platforms was not found in this paper.

238. Ainsworth F & Hansen P (2018) Group Homes for Children and Young People: The Problem Not the Solution, Opinion, *Child Australia*, V43 No. 1 pp. 42-46, p44.

exercise. This issue is explored in the book *The Other 23 Hours: child-care work with emotionally disturbed children in a therapeutic milieu* which 'explores in detail the relationships and non-verbal behaviour needed by staff who have not been professionally trained in childcare to provide a therapeutic milieu for children'.²³⁹

Models of care are structured approaches to the delivery of therapeutic care. They provide the framework within which therapies can be delivered in accordance with assessed needs. They may also offer staff training and accreditation, mentoring and monitoring of implementation fidelity, and evaluation of process and substantive outcomes.

In the case of children in residential OOHC the model of care helps service providers establish and maintain an environment which helps children address the physical, emotional and behavioural sequelae of abuse or neglect.

In some ways, purchasing a model for the delivery of care is like buying a franchise, where the purchaser buys in the expertise and experience of the franchisor.

The service provider who has expertise, a sound understanding of the environment in which services will be provided and client population and their families, may not need the support of an off-the-shelf system or platform. Effective delivery of indicated therapies (i.e. as assessed by a qualified professional) could occur in any care setting in which children really were, and felt, safe, valued, respected, and heard by skilled carers who had their interests at heart, used evidence-based practice to handle behavioural and emotional problems and to strengthen their sense of self, purpose, and ability to form trusting relationships with the children and young people in their charge.

It is worth noting that no scientifically rated 'model' of care has been developed in Australia, although programs such as Parents under Pressure and Triple P Parenting, have been. Spiral to Recovery was developed in Australia, however, and is reportedly achieving promising results with the Indigenous children for whom it was primarily developed.

Elements of models of Therapeutic Residential Care

From consideration of the published models of care and the literature on OOHC, the following elements of a model of TRC are proposed:

- A set of values – why do we do it? Of particular importance is the worth assigned to the child or young person and their voice.
- A goal – what are we trying to do? Is this goal shared by the child, their friends and family? Is it shared by funders?
- A set of measurable outcomes – how will we know we are on the right track? How will we know when our goal is achieved?

239. Albert E, Trieschman, J et al. (1969) *The Other 23 Hours: child-care work with emotionally disturbed children in a therapeutic milieu* Chicago: Aldine. See [outline](#)

- The social context – what dynamic system must we interact with as we work toward our goal?
- Causal relationships affecting the goal – what has caused the condition we are trying to change, and what can be done to achieve the desired goal?
- Resource constraints – what human, material and financial assets over what period of time are required to achieve the goal?
- How is the goal to be achieved – within the value system, within the system constraints, with the physical and human resources, and the relationships important for its achievement? What does the causal chain look like?
- The particular role of evidence-based therapy – what interventions, behaviour by staff, family and friends, what physical and natural environment, what purposeful and creative activities for residents, what exposure to pets, other animals and the natural world, will exert the most beneficial, therapeutic effect and contribute most to achievement of our goal?
- How will we be kept on track – what is our system of accountability – is it proof against changes of leadership or funding?

10.2 WHAT MODELS OF THERAPEUTIC RESIDENTIAL OOHc SHOULD BE CONSIDERED?

There are few models of evidence-based TRC that have been specifically developed for that purpose; most have been adapted from therapeutic interventions used to stabilise behaviour and facilitate exit from residential to family based OOHc or reunification.

Echoing observations already cited above,²⁴⁰ a paper about the Australian-developed Spiral to Recovery model questions whether the mere addition of therapeutic interventions to residential care results in TRC:

This philosophy of deeply embedded therapeutic care is found in other models of TRC, including CARE, Sanctuary, and Wraparound.²⁴¹

Models of evidence-based treatment provide a systematic approach to intervening in the psychosocial environment of the maltreated child in residential care – although they might not amount to embedded TRC, as specified above. There are common elements in many of these models. Evidence-based or supported therapies that might be appropriate for the treatment of individuals in care may be brought in as needed.

Summarised in Appendix B are evidence-based models of residential care and specific therapies that have been rated by the California Evidence-Based Clearinghouse for Child Welfare (CEBC) using this scale: 1 – Well supported by research evidence; 2 – Supported by research evidence; 3 – Promising. They include – with CEBC rating in brackets:

- **Treatment Foster Care Oregon – Adolescent** (TFCO-A) (1) – previously called Multi- Dimensional Treatment Foster Care. Oz Child are franchised to run this model in Australia and are implementing it in conjunction with Anglicare in Victoria and have just secured a valuable two-year contract to provide it in NSW. It is promoted as a model for reducing time spent in residential care.

240. EG Whittaker et al.(2016) [Therapeutic Residential Care for Children and Youth: A Consensus Statement of the International Work Group on Therapeutic Residential Care*](#), *Residential Treatment for Children & Youth*, 33:2, 89-106, pp. 96-98, Principle 4.

241. Although Ainsworth & Hansen (2018) call these platforms, as they do not contain programs of treatment.

- **Children and Residential Experiences (CARE)** (3) – used by UnitingCare Community, Qld. This is not specifically a model of residential care, but an approach to embedding a therapeutic environment throughout an entire organisation. UnitingCare is an accredited provider and trainer.
- **Sanctuary** (3) – which is also a model primarily concerned with creating change in organisations to enable them to respond more effectively to the complex needs of children who have experienced trauma. It is used by the Victorian and Western Australian Governments, with Mackillop having the franchise in Australia.
- **Positive Peer Culture** (3) – a technique for teaching empathy and caring behaviour rather than a model of residential care. It is not in use in Australia.
- **Phoenix House Academy** (3) – not in use in Australia. A residential program for children and young people with addiction problems.
- **Stop Gap** (3) – designed as a residential model for 25-35 residents
- **Teaching Family** (3) – used by Berry Street in Victoria. Can be delivered at home or various OOHC placement types.

Note that it seems appropriate to consider Sanctuary and CARE as ‘platforms’ or ‘frameworks’ for creating and maintaining organisational climates conducive to healing. Although essential components of each are intended to have therapeutic effects, both models require professional therapeutic interventions to address the complex needs of most children and young people in residential OOHC.²⁴² For example, staff in organisations accredited to use these models still required training in Therapeutic Crisis Intervention.²⁴³ Bailey et al (2018) considered that assisting the efficacy of such models was difficult, that there was at present ‘limited’ evidence to support trauma-informed care models, although they remained hopeful that ‘the application of trauma-informed such models may have significantly positive outcomes for children in OOHC.’²⁴⁴

Other off-the shelf programs rated by CEBC are intended as alternatives to residential care, including:

- **Multi-dimensional Family Therapy (MDFT)** (1) – this program addresses problem behaviours and improves parenting skills, and is not used in Australia.
- **Multi-systemic Therapy for Child Abuse and Neglect (MST-CAN)** (1) – for use with juvenile offenders and their families. It is used by the NSW Government to reduce the need for OOHC.
- **Functional Family Therapy (FFT – Child Welfare)** (2) – is a family reunification or preservation program used by the NSW Government.

Models of OOHC not rated by the CEBC, and not considered in detail here for that reason, include

- **Spiral to Recovery** – an evidence informed TRC developed by Catalyst child and family services in far north Queensland.²⁴⁵

242. See for example Ainsworth F & Holden J (2018) Letter to the Editor: A Response to ‘Weighing Up the Evidence and Local Experience of Residential Care’ *Children Australia* **43**,3, pp 169-172, p 170.

243. See [Therapeutic Crisis Intervention System](#), like CARE developed by Cornell University.

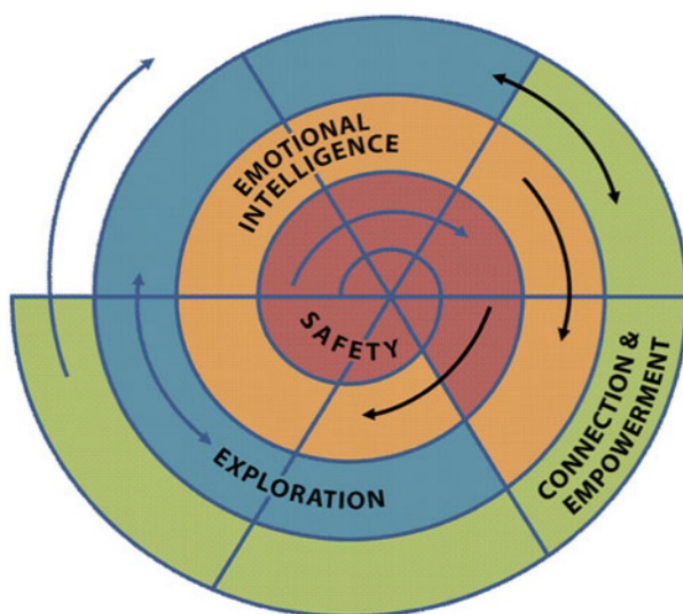
244. Bailey C, Klas A, Cox R et al (2018) ‘Systematic review of organisation wide, trauma-informed care models in out-of-home care (OOHC) settings’. *Health and Social Care in the Community* 23 July 2018, <https://doi.org/10.1111/hsc.12621>, p 11.

245. Downey, L et al (2015) ‘The Spiral to Recovery: An Australian Model for Therapeutic Residential Care.’ V40, No. 4, pp 351-360, doi:10.1017/cha.2015.31, pp 353-4

- **Social Pedagogy** – an approach to improving the social integration of children in care and educational settings. It is holistic, humanistic and directed at cultivating community norms and shared responsibility for children’s wellbeing. It originated in Europe, where it is closely linked to the norms and practices of social work, but has been introduced to the UK, the US and some Scandinavian countries.
- **Multifunctional Treatment in Residential and Community Settings (MultifunC)**²⁴⁶ – this was developed for youth with challenging behaviour that threatens to result in involvement with the criminal justice system. It was developed in Norway but is being trialled throughout Scandinavia.

Spiral to Recovery is based on a conceptualisation of the healing process which traumatised children undergo as a spiral, with the process of achieving actual and perceived safety at its centre – see Figure 2 below.

Figure 2. The Spiral to Recovery²⁴⁷



As noted above, it also places great weight on the deep embedding of the therapeutic approach into every aspect of the organisation’s structures, functions and practices. Cultural competence forms an important part of model, which has been applied predominantly in work with Indigenous children.

This spiral graphic of the road to recovery seems like a valuable heuristic that could be applied to many models of care.

Social pedagogy also seems to have useful features that could motivate improvements in the development of systems of care that can draw from and contribute to communities and promote social integration of children who experience high levels of social exclusion.²⁴⁸ The list of key principles of Social Pedagogy in Table 17 is worth consideration, despite the fact that the pilot testing the introduction of social

246. [Multifunctional Treatment in Residential and Community Settings](#) (MultifunC)

247. *ibid.*

248. Campo M & Commerford J (2016) [Supporting young people leaving out-of-home care](#) CFCA Paper No. 41, 2016. AIFS

pedagogy with a sample of residential homes containing ‘troubled and troublesome’ residents did not demonstrate improved wellbeing in comparison with the controls. Fidelity of implementation and the complex nature of residents’ needs are twin problems that are always hard to address.

TABLE 18. THE KEY PRINCIPLES OF SOCIAL PEDAGOGY²⁴⁹

- focus on the child as a whole person;
- the practitioner sees her-/himself as a person and uses their individual attributes and skills in the relationship with the child;
- children and staff occupy the same life-space, not separate hierarchical domains;
- pedagogues adopt a reflexive approach to their practice and apply theoretical understanding and self-knowledge to their relationships;
- practical skills are important and pedagogues become involved in children’s daily lives and activities;
- the group is a useful resource;
- there is a genuine interest in children’s rights beyond narrow legal and procedural requirements;
- teamwork is important with parents, other professionals and the local community;
- the relationship is central, together with the importance of listening and communicating.

10.3 ALTERNATIVE TO STANDARD MODEL: CORE ELEMENTS APPROACH

Lee & McMillan (2017) noted that evidence-based practice (EBP) was originally used to describe the process of using research evidence, along with clinician experience and client preferences, to select and implement a specific technique or intervention.²⁵⁰ They noted that, in general, manualised EBPs had not been developed for and tested on youth in residential care. Strategies to address this shortcoming have included:

Implementing manualised EBPs in-house, infusing and evidence-based treatment model throughout the milieu, and making better informed referrals to community clinicians who can provide specific EBPs to group care residents.²⁵¹

Lee and McMillan compared three strategies:

- Using the common elements of evidence-based interventions;
- Creating a home-grown intervention and its evidence base;
- Adapting an established EBP for use in a group care setting; and
- Adapting a group care setting to better facilitate the delivery of EBPs.²⁵²

249. Petrie et al, cited in Berridge D et al (2010) [Raising the bar? Evaluation of the Social Pedagogy Pilot Programme in residential children’s homes](#) Department of Education UK, p5

250. Gibbs & Gambrill (2002), Sackett et al. (1997) cited in Lee B & McMillan J (2017) ‘Pathways Forward for Embracing Evidence-Based Practice in Group Care Settings’ *Journal of Emotional and Behavioral Disorders* 25(1) 19-27, p19

251. American Association of Children’s Residential Centres (2009), p250 in Lee & McMillan, op. cit. p20).

252. Lee & McMillan op. cit. p 20

They reported certain advantages of the common elements approach, as exemplified in the area of child mental health:

Instead of focusing on an evidence-based intervention's treatment manual as the unit of analysis, the common elements approach unbundles manualized treatments into actual practice techniques or building blocks frequently found across interventions with known effectiveness (Chorpita, Daleiden, & Weisz, 2005). The common elements of child mental health practice were initially identified through a review of 322 randomized clinical trials of interventions to treat key child disorders (e.g., depression, anxiety, disruptive behaviour, trauma). For each of these studies, the treatment conditions with significantly better outcomes were distilled to understand the components or practices embedded within (Chorpita & Daleiden, 2009). Then, across all the winning treatments, the most frequently included practices were labelled as common elements. For example, in managing disruptive behaviours of young children, several EBPs include teaching parents about time out, so time out is one of the common elements of effective practice. The process of reviewing 322 studies yielded approximately 41 practice elements (Chorpita & Daleiden, 2009).²⁵³

By contrast with the task of mastering a single manualised treatment, achieving competence in the common elements of practice:

- allows a practitioner to work with a larger proportion of youth;
- minimizes the cost and time of training staff to gain and retain certification, as practitioners can be taught practice elements that can be applied across a number of clients;
- provides inherent flexibility in selection, sequencing or setting (e.g. duration & structure of treatment).²⁵⁴

A modularised framework, as exemplified in 'Managing and Adapting Practice' can be used to govern 'decision-making based on research evidence, client characteristics, and on-going outcomes monitoring.'²⁵⁵

James et al. (2015) reported successful use of MAP in residential care to treat common problems of: anxiety, depression, trauma & disruptive behaviours (Lee & McMillan 2017, p21). The technique has been used successfully with a large-scale provider in Los Angeles (Southam-Gerow et al. 2014).²⁵⁶

MAP has not only produced 'faster and greater youth behaviour improvements' but was also associated with 'high rates of satisfaction by providers'²⁵⁷, whilst potential fidelity problems posed by flexibility could be controlled through application of 'the MAP resources and tools for outcome monitoring and benchmarking...'.²⁵⁸

253. *ibid.*

254. *ibid.*

255. Lee & Mc Millan, *op. cit.*

256. *op. cit.* p21

257. *ibid.*

258. *ibid.*

11

WHEN RESIDENTIAL CARE IS BEST

The evidence on ‘for whom’ in relation to residential care is not sufficient to draw even tentative conclusions. (Hart et al. 2015²⁵⁹)

11.1 WHEN CHILDREN AND YOUNG PEOPLE PREFER IT

Narey Report on Residential Care in England

Individuals and organisations responding to the call for evidence were keen to identify and share their own perspectives on what works to secure positive outcomes for children in residential care. Views on what works were often inherently linked to the role and purpose of residential care. Whilst many responses expressed that ideally children should be placed with their families or in foster care, a consistent message was that residential (sic) works for children and young people who simply do not wish to live in another person’s family.²⁶⁰

11.2 WHEN CHILDREN OR YOUNG PEOPLE WITH SIMILAR NEEDS ARE PLACED TOGETHER

The Narey Report examined a wide range of submissions and evidence, including the views of local government, which has responsibility for providing residential OOHC in England, of practitioners of individuals who had themselves experience of living in residential OOHC. Leeds County Council advocated:

Placing children with similar needs and care plans in the same home together, [which] in most part, works as each child can see how other children are progressing towards their goals or plan.²⁶¹

259. Hart D, La Valle I, & Holmes L. (2015). [The place of residential care in the English child welfare system](#). London, England: Department for Education

260. Narey, M (2016) [Residential Care in England](#) Report of Sir Martin Narey’s independent review of children’s residential care, July 2016 p 77

261. op.cit p

11.3 WHEN CHILDREN ARE KEPT SAFE AND FEEL SAFE

The Royal Commission into Institutional Response to the Exploitation of Children underscored the risk of sexual exploitation of children and young people in residential OOH. Moore et al. (2018) presented views about safety obtained from 27 children and young people in residential care. Participants of all ages said that they confronted a number of risks while living in residential care.

All participants felt that violence and bullying by their peers was pervasive while older participants identified sexual harassment, coercion and being ‘forced into doing things that they felt was (sic) unsafe’ as a considerable concern.²⁶²

Being able to establish a relationship with an adult who could be trusted to protect them and actually step in when they were threatened with harm was of great importance. The best staff would “hang in”, taking the time needed to overcome barriers to establishing relationships of trust with children and young people with a history of abuse.²⁶³

The role of secure homes was considered by Commissioner Narey in his report. He felt that for children who posed the highest risks to themselves and others a secure home might offer the best prospect of keeping them safe, reducing chaos in their lives, providing a place where their mental health issues could be diagnosed and addressed, and assisting educational achievement.²⁶⁴

262. Moore, T., McArthur, M., Death, J., Tilbury, C., & Roche, S. (2017). Young people's views on safety and preventing abuse and harm in residential care: "It's got to be better than home". *Children and Youth Services Review*, 81, 212-219.

263. Moore T, McArthur M, Death J, Tilbury C & Roche S Sticking with us through it all: The importance of trustworthy relationships for children and young people in residential care. *Children and Youth Services Review*, 84 (2018) 68-75.

264. Narey, M (2016) [Residential Care in England](#) Report of Sir Martin Narey's independent review of children's residential care, July 2016, p31

12

WHAT WORKS IN RESIDENTIAL OOHC

12.1 QUALITY OF CARE – NAREY REPORT OVERVIEW

This is from the conclusions of the Narey Report. Note that there is no mention of a ‘model of care’ as such.

Clear messages frequently identified in terms of what works included warm and supportive relationships between children and residential care staff, strong leadership, a stable and committed staff team, a positive home ethos and good use of and access to relevant support services. In particular, careful and proactive care planning, adequate assessment, placement stability and high aspirations were strong recommendations from a range of stakeholders. According to evidence submitted by one individual academic, ‘a central issue is the quality of care’ with the determinants of quality placements in children’s homes those which are ‘small, well-staffed, well led and managed, having a low turnover of staff and young people, adopting a consistent regime and positive culture which supports education and wellbeing, and which may also include therapeutic programmes.’²⁶⁵

12.2 BUILDING RESILIENCE

Resilience is seen in successful adaption to past, current and future challenges.²⁶⁶ Assisting children and young people to develop resilience is critical to achieving positive post-care outcomes. Some of the tested techniques for developing resilience are listed below.

Construction of children’s narratives and the role of the in-care experience

How children perceive their own journey through care can affect post-care adjustment and wellbeing. A study of the narratives used by a sample of children who had transitioned from care (including: Love and loss to moving on; Victim to survivor; Victim to struggling; ‘Bad child’ to survivor; ‘Bad child’ to struggling) showed that the form of narrative was strongly associated with resilience.

265. op. cit. p77

266. Masten, A. (2014) *Ordinary Magic: Resilience in Development*. The Guilford Press, New York.

... the different narratives, in particular the specific ways in which young people defined themselves and their situation earlier in childhood, continued to have an impact during adolescence and in adulthood. Very powerful in these accounts was the fact that some young people with adverse backgrounds had experienced significant transformations in the way in which they defined their sense of self – for example, the ability to move on from defining themselves as a victim. Their identity could be refashioned in preparation for a more successful transition to adulthood. But equally, some young people were still struggling with patterns of troubled behaviour as they attempted to engage with the adult world of relationships and work.²⁶⁷

Critical aspects of the narrative – and the in-care experience – were these:

- **Connection:** how young people described the quality of their relationships and sense of family and belonging with parents, relatives, peers, foster carers, children's home and transitions staff.
- **Agency:** the extent to which young people felt they had been and were currently able to exercise agency, make choices about their lives and influence events by their own actions.
- **Constructive activity:** how young people described their engagement with education, activities and the world of work.
- **Coherence of the narrative:** whether stories made sense and indicated that past experiences had been processed cognitively and feelings resolved to some degree.

Finding positive pathways that children can integrate into their own narrative thus becomes an important target of the OOHC system.

Developing functional attachment style

There is a general agreement that disorganised attachment is strongly associated with the experience of child abuse and neglect (i.e., a fear inducing caregiver results in an incoherent internalised model of self and others, together with the inability to clearly signal distress to an unreliable and frightening caregiver).²⁶⁸

Children with both secure and insecure (avoidant and ambivalent) attachment are posited to be capable of developing and using strategies to induce their carer(s) to meet their needs.²⁶⁹ Not so in the case of children with disorganised attachment, which is more prevalent in at-risk populations, and is strongly associated with situations of extreme neglect and the absence of a specific caregiver.²⁷⁰ Assessment of attachment style requires clinical expertise.²⁷¹

267. Schofield, G., Larsson, B., & Ward, E. (2017). 'Risk, resilience and identity construction in the life narratives of young people leaving residential care' *Child & Family Social Work*, 22(2), 782-791. doi:10.1111/cfs.12295

268. McLean S (2016) [Children's attachment needs in the context of out-of-home care](#). CFCA Practice Resource, November 2016.

269. *ibid.*

270. *ibid.*

271. *ibid.*

The child's experience of attachment is considered to influence development in:

- cognitive development (internal representations of self and others);
- emotional regulation (ability to experience, tolerate, express and regulate strong emotions); exploratory play and other behaviour (ability to show initiative to investigate the world through play and socialisation);²⁷² and
- pro-social orientation towards others (motivated to please others and seek social rewards).²⁷³

There are significant gaps in research about attachment and its relevance to OOHC practice, however, there is evidence that children can manifest different styles of attachment in response to different carers, and that:

disorganised attachment, reflecting a lack of a well-integrated working model of self and other, is related to increased risk of poor mental health later in life. This tells us that we should endeavour to ensure children experience predictable caregiving that allows them to develop a set of expectations about themselves and others.²⁷⁴

Facilitation of emotional development

Findings of studies reviewed by Steels & Simpson (2017)²⁷⁵ included:

- Staff support and care, including 'treating children as though they were their own'²⁷⁶ or 'making an effort to create a bond between themselves and the child'²⁷⁷ could have a positive impact on a child's emotional development.
- Staff care and support led to improvement in children's ability to understand the consequences and impact of their actions on others;²⁷⁸
- There could be tensions between children's need to express emotions through challenging behaviour and the potentially negative impact of that behaviour on other children;²⁷⁹ and
- Children could be assisted to deal with difficult emotions through learned strategies such as thinking and talking about their emotions.²⁸⁰

Behavioural development

Steels & Simpson's 2017 review included evidence that:

- 'uncertainty was a major influence on unpredictability and inconsistency' of children's actions and could result in displays of challenging behaviour;²⁸¹
- some staff felt it impossible to reconcile prioritising the needs of the individual with meeting the needs of the majority of children;²⁸² but

272. DeKlyen & Greenberg (2008) cited in McLean (2016) supra.

273. McLean (2013) cited in McLean (2016) supra.

274. McLean (2016), op. cit.

275. Steels S & Simpson H (2017) 'Perceptions of Children in Residential Care Homes: A Critical Review of the Literature', *British Journal of Social Work*, **47**, 1704-1722, p1711

276. Bettman et al. (2015) cited in Steels S & Simpson H (2017) op.cit.

277. Harriss et al. (2008); Moreno Manso et al. (2011); McLean (2013); Crettenden et al. (2014); Bettmann et al. (2015); Humphreys et al., (2015) cited in Steels & Simpson op.cit. p1712.

278. Harriss et al. (2008); McLean (2013) cited in Steels & Simpson (2017) op.cit. p.1712

279. Harriss et al (2008) cited in Steels & Simpson (2017), p1712

280. *ibid.*

281. McLean (2013); Crettenden et al. (2014); Humphreys et al. (2015) cited in Steels & Simpson op.cit. p.1712

282. McLean (2013) cited in Steels & Simpson op.cit. p.1712

- the ‘implementation of rules and boundaries’ could lead to the development of trust and the reduction of ‘difficult behaviours’.²⁸³

Social development and relationships

Although several studies reviewed by Steels and Simpson found that staff had difficulties maintaining relationships, especially with young people, such relationships were reported as important for residents’ social development and relationship building capability. As mentioned under ‘Facilitation of Emotional Development’ above, staff felt tensions between the need for professionalism and the goal of trying to care for children as though they were their own.²⁸⁴

Where staff lacked legal authority (as possessed by the statutory guardian) over children’s behaviour, this could result in a struggle to enforce consequences without reference to outside authority – action that undermined relationships between staff and child, as did negative behaviour targeting staff.²⁸⁵

Children in OOHC often exhibited poor relationships with their peers – but where this could be overcome, it had a positive effect by enhancing self-esteem.²⁸⁶

Effectively addressing mental health issues

The higher incidence of mental health problems amongst children in residential as opposed to other forms of OOHC may be associated with increased prior experience of trauma in the former group.²⁸⁷ A poor working relationship between mental health workers and residential care staff may even contribute to increase in mental health problems in residents,²⁸⁸ but ‘having structure in terms of role models, routines and procedures is significant in being able to control and protect young people from acting-out and from self-destructiveness’.²⁸⁹

Promoting academic progress

Instability in a child’s life is associated with ‘reduced interest in learning and poor educational attainment’²⁹⁰, but in classrooms with fewer students where they received individual attention from staff, children were more engaged and able to take on more challenging work, learn new skills and experience a boost in self-esteem.²⁹¹

Healthy connections between children and young people and residential and transition staff have the potential to be perceived as positive family connections.

283. McLean (2013); Crettenden et al. (2014) cited in Steels & Simpson op.cit. p.1712.

284. McLean (2013) cited in Steels & Simpson op. cit. pp1712.

285. *ibid.*

286. Andersson and Johansson (2008); Harriss et al. (2008) cited in Steels & Simpson, op. cit. p 1713

287. Andersson and Johansson (2008); McLean (2013); Crettenden et al. (2014); Humphreys et al. (2015) cited in Steels & Simpson (2017) op. cit. p1713.

288. Andersson and Johansson (2008); McLean (2013); Crettenden et al. (2014) cited in Steels & Simpson (2017) op. cit. p1713

289. Steels and Simpson op. cit., p 1713 citing Andersson & Johansson (2008) and Crettenden et al. (2014).

290. Harriss et al. (2008); Moreno Manso et al. (2011); McLean (2013) cited in Steels & Simpson op. cit. p1713

291. Harriss et al (2008) cited in Steels & Simpson op. cit. pp 1713-1714

13

RISK IDENTIFICATION AND MANAGEMENT

All OOHC services are inherently risky. Those risks are heightened in the case of residential care.

The children are more highly traumatised. They are more likely to demonstrate behavioural problems – including aggression toward staff and other residents or self-harm. They need to develop relationships of trust with staff, but they are inherently at greater risk of abuse and exploitation as a result of their accumulated experience of maltreatment and (usually) of failed prior placements.

All jurisdictions in Australia have identified the need for policies and programs to limit the experience of maltreatment and limit the trauma of removal, failed placements and exclusion from family and community. Accordingly, they have adopted this hierarchy of priorities:

1. Work with at risk families at risk to prevent maltreatment without removing children;
2. Where 1 fails, intervene early and work with families and removed children to achieve safe reunification within the shortest possible period;
3. Where 2 fails, achieve permanent placement of the child within the shortest possible time.

These priorities are laudable – they accord with the best interests of the child. However, the policies and resources required to treat child protection as a systemic rather than individual issue are not yet in place. As the research on risk factors for children indicates (see Sections 2 and 3 above), addressing the conditions that are likely to lead to failure of the normative, customary child protection system and to engagement of the expensive and sometimes iatrogenic statutory child protection system, requires investment and cooperation across all levels of government and across all sectors – government, business and civil society – but the primary responsibility for prevention must lie with the federal government. It alone has the resources and statutory power to affect the prevalence of risk factors related, *inter alia*, to:

- chronic financial stress – particularly that related to unemployment or precarious, poor quality employment;

- lack of access to secure, appropriate and affordable housing;
- inadequate access to the knowledge and means to determine the number and timing of children in a family;
- poor access to mental health treatment, including substance abuse, especially for parents who have themselves experienced maltreatment, and most the statutory child protection system.

The need to use federal resources by way of preventive (and equitable) investment to assist First National Families living in Reservations in Canada was recognised in a 2016 decision of the Canadian Human Rights Commission.²⁹² The background of underfunding and recommendations to reduce the disproportionate number of First Nations Children removed from their families in Canada were provided in a Truth and Reconciliation Report of 2015.²⁹³

The cost-effectiveness of preventive investment to support families before complex needs develop or issues arise is evident in the NSW Government's recent announcement that it will pay OzChild \$4.75 million over a two-year period to deliver the Therapeutic Foster Families Oregon (TFCO) to 30 children, aged between seven and 17, who will be placed with specialised foster carers for the 6-12-month program. These complex needs children will have a history of failed foster care placements or of assessment as unsuitable for removal from residential to foster care on account of their emotional and behavioural problems.²⁹⁴

Although conditions vary between services, residential care is the most restrictive and isolated of OOHC environments. The children in it are the most excluded from family, friends and outside networks of support. These conditions contribute to elevated risks of abuse.

To meet the therapeutic needs of children and young people in residential care, staff need to be highly skilled, have a thorough understanding of trauma-informed care, and be personally invested in the wellbeing and future of the children in their care. They need to be able to form healthy, warm and supportive relationships with those children. Continuity of care is a critical part of the therapeutic environment.

However, staff are poorly paid. They may not have access to ongoing employment. They may be injured by the children in their care, burn out rapidly as a result of the vicarious trauma of exposure to the horrific background stories of their charges and their struggles to assist traumatised children to manage their emotions and challenging behaviour whose triggers may be difficult to identify. These conditions contribute to an already elevated risk that the services provided will not be effective.

Children who cannot be restrained may abscond, gravitate to risky situations outside the residence, invite potentially abusive outsiders to enter the residence, encounter abuse at the hands of fellow residents, or harm themselves. Such risks need to be assessed individually and mitigated but they cannot be entirely eliminated, even in 'secure care'.

292. [First Nations Child and Family Caring Society of Canada and Assembly of First Nations \(Complainants\) and Canadian Human Rights Commission](#).

293. [Justice Murray Sinclair calls for change in child welfare system](#) CBC Canada, June 02, 2015.

294. [NSW foster carers to be paid \\$75,000 'salary' in complex needs trial](#) Helen Davidson, Guardian, 13 September 2018.

13.1 THE IMPACT OF RISKS IS CUMULATIVE

Abiding by the Child Safe Principles (Church and National) will help reduce risks; possible exceptions include those that relate to ineffective practices, selection of insufficiently skilled but well-meaning staff, or inadequate access to high level professional services for assessment, monitoring or assistance when emergencies arise. Moreover, staff vetting, regardless of its thoroughness, may not be sufficient to identify all staff who pose a risk of intentional or unintentional harm.

13.2 THE DESIGN OF THE FACILITY ITSELF MAY HEIGHTEN RISKS OF HARM

Some facilities may pose unacceptably high risks of harm through:

- Lack of therapeutic features – appearance and quality are welcoming and reassuring but convey the impression that residents are of little account;
- location in an environment suffering high degrees of noise, or exposure to environmental toxins;
- physical dangers posed by old, poorly maintained or poorly constructed building;
- design that makes it hard to protect residents against dangers posed by intruders, other residents, or visitors, whether family or friends;
- design that makes it hard to protect residents from self-harm; and
- poor thermal or acoustic insulation.

13.3 MALTREATMENT RISK FACTORS MAY BE UNACCEPTABLY HIGH IN SOME KIN OR FOSTER FAMILIES' CARERS

It is worth noting that kin or relative carers may suffer from the disadvantage that the risks of maltreatment related to their Social and Economic Status (SES) may not be lower than in the child's immediate family.²⁹⁵

13.4 FOCUS ON RISK REDUCTION MAY COME AT THE COST OF THERAPEUTIC EFFICACY

Some submissions to the UK's Narey Inquiry drew attention to the dangers of an OOHC system that is overly focused on risk reduction rather than the provision of quality care:

The Community of Communities response echoed this: 'The inspection regime for children's homes and residential special schools focusses on a model of identifying deficits in provision in relation to quality, rather than promoting best practice. The inspection handbook remains focussed on risk avoidance, limiting litigation and increased bureaucracy rather than happy healthy children.' A more bespoke way of baselining a young person's progress over time was repeatedly mentioned, with an individual summing this up by stating 'Frameworks should be adjusted to reflect a young person's starting point pre-admission (SDQ²⁹⁶ progress may assist)' with the inspector taking this into account.²⁹⁷

295. Font (2015) [Are children safer with kin? A comparison of maltreatment risks in out-of-home care](#). Child Youth Serv Rev. Author manuscript; available in PMC 2016 Jul 1. Published in final edited form as: Child Youth Serv Rev. 2015 Jul 1; 54: 20-29. doi: 10.1016/j.childyouth.2015.04.012

296. Strengths and Difficulties Questionnaire

297. Narey, M (2016) [Residential Care in England](#) Report of Sir Martin Narey's independent review of children's residential care, July 2016 p80

13.5 NOT-FOR-PROFITS URGED TO RETURN TO RESIDENTIAL OOHc PROVISION

The Narey Report noted that past scandals in England, and the perception that residential care was a concept whose time had passed, had seriously depressed the provision of residential OOHc by not-for-profit providers, leaving the field more open to commercial providers, and:

There would certainly be more confidence in the market if providers from the not-for-profit sector were willing to return to this work in larger numbers. At the moment the presence of the voluntary sector is too small to offer a competitive challenge to private sector providers. This may not be straightforward. Public awareness of historical abuse scandals may have reduced somewhat, but the memories still scar the large charities such as Barnardo's, which once dominated this work. The fear of further reputational damage, caused perhaps by the exposure of further abuse, has been enough to deter their return to residential care. Simultaneously, I believe that other charities, those which currently provide or have provided residential care, and those which have not, are discouraged by the perception that residential care is an anachronism, demand for which will continue to decline.²⁹⁸

13.6 CHILD SAFE RECOMMENDATIONS OF THE ROYAL COMMISSION

The Royal Commission into Institutional Responses to Child Sexual Abuse²⁹⁹ identified a range of policies and practices to reduce the risk of sexual abuse of children in care. These included:

- Raising awareness of the community, staff and children about children's rights, and the boundaries of appropriate behaviour;
- Ensuring that child safe standards are integrated into all aspects of organisational leadership, governance and culture;
- Implementing effective and child friendly complaints mechanisms; and
- Ensuring that these initiatives harmonise with national programs to protect children from maltreatment.

298. Op.cit.p18

299. See Appendix D for relevant recommendations

14

FINDINGS OF SELECTED REVIEWS

Recommendations relevant to child protection made by the Royal Commission into Institutional Responses to Child Sexual Abuse are in Appendix D.

There are numerous other inquiries – federal, state and territory – not covered here, although some findings appear in the preceding literature review.

14.1 Comparison of published quality standards for residential OOHC: Table 19³⁰⁰

Source ^a	Scotland, 1992	Boys Town, 1996	Ireland, 2001	CWLA, 2004	AACAP, 2010	Queensland, 2010	Commun. 2012
Service planning							
A1. Assessment driven services (comprehensive assessment)	x		x	x	x	x	x
A2. Respectful admission process	x		x	x			
A3. Individualized treatment plans (flexible)	x	x	x	x	x	x	x
A4. Youth involved in treatment plans	x		x	x	x	x	x
A5. Strength-based, trauma informed	x	x	x	x	x	x	x
A6. Establish measurable goals	x	x		x	x	x	x
A7. Focus on permanency, safety, and well-being	x			x		x	
Safe, abuse free							
B1. No physical, verbal, or emotional abuse (no physical discipline)	x	x	x	x		x	
B2. Maintain children's rights (no humiliation, no meaningless make-work)	x	x	x	x	x	x	x
B3. Basic needs met (food, clothing, shelter)	x		x	x	x	x	x
B4. Clean, hygienic, well-maintained facility	x		x	x	x	x	x
B5. Keep youth safe from other youths problem behavior	x	x		x	x	x	
B6. Effective crisis management (de-escalation training, formal policies)	x	x	x	x	x		x
B7. Limited seclusion and restraint	x	x	x	x	x		x
B8. Prevention of self-harm	x	x		x	x		x
Maintain positive group culture							
C1. Demonstrate that peers exert positive influence (positive group culture)	x	x	x	x			x
C2. Assess child, parent, payer satisfaction (youth and family feedback)	x	x	x	x			
C3. Staff trained to immediately report problems	x	x				x	x
C4. Established grievance process	x	x	x	x	x		x
C5. Independent audit (for compliance with regulations, of egregious incidents)	x		x			x	
C6. Report all allegations to external agencies	x	x		x			
Family and Culture							
D1. Maintain child's emotional link with family and community	x	x	x	x	x	x	x
D2. Involve families in treatment decisions, care, and positive activities (family centered)	x	x	x	x	x	x	x
D3. Provide training supportive of reunification	x	x		x	x	x	x
D4. Encourage home visits	x	x		x		x	x
D5. Community involvement (program elements)	x	x		x	x	x	x
D6. Provide culturally relevant models and activities (culturally competent)	x	x	x	x	x	x	x
D7. Community based (close to home)	x	x		x		x	x
D8. Help youth develop religious, spiritual, and moral values	x	x	x	x	x	x	x
Least restrictive environment							
E1. Provide the least restrictive level of care	x	x		x	x		x
E2. Care in as family-like environment as allowed by child's needs	x	x	x	x			
E3. As normal activities and freedoms as allowed by child's needs (e.g., schooling, hobbies)	x	x	x	x		x	x
E4. Youth can maintain personal identity (incl. secure place for personal items)	x	x	x	x	x	x	
E5. Respect for privacy	x		x	x	x		
E6. Recreation, socialization, sports, and exercise activities	x	x	x	x		x	x
Program elements							
F1. Strong program (research & evidence based, clear model of care, best practice)	x	x	x	x	x	x	x
F2. Full range of need services (therapeutic, psychotropic, substance abuse, LD)	x		x	x	x	x	x
F3. Program licensed and accredited	x		x	x	x	x	
F4. Appropriately qualified staff (e.g., inpatient is MD monitored)	x		x	x	x	x	x
F5. Assure that children have medical, dental, optical, auditory, etc. needs met	x		x	x	x		x
F6. Watchful supervision of youth	x	x	x	x	x	x	x
F7. Staff trained (and retrained)	x	x	x	x	x	x	x
F8. Quality improvement approach	x		x	x	x	x	x
F9. Criminal record screens for staff	x		x	x	x	x	x
F10. Strong supervision support for staff (regular & formal)	x		x	x	x	x	x
F11. Regular staff meetings to coordinate care	x		x	x	x	x	x
F12. Collaborative care (multi-system coordination)	x		x	x	x	x	x
F13. Smaller groups/close supervision/low youth to staff ratio	x		x	x	x	x	
F14. Psychotropics psychiatrically monitored, minimum for clinical need				x	x		x
Education, skills, and outcomes							
G1. Academic testing	x		x	x	x		
G2. Education progress	x	x	x	x	x	x	x
G3. Support for special education needs (IEPs)	x		x	x	x	x	x
G4. Vocational training	x		x	x			
G5. Development of prosocial behavioral skills	x	x		x		x	
G6. Symptom reduction	x	x		x			
G7. Meet treatment goals	x		x	x			x
G8. Skills, competencies, and knowledge needed for adulthood and citizenship	x	x		x			
G9. Measure and regularly report children's emotional, behavioral, and education progress			x	x	x	x	x
G10. Place accountability for child progress on program structure and staff performance		x	x	x		x	
Aftercare							
H1. Transition planning (education, employment, and treatment)	x		x	x	x	x	x
H2. Provide services that support family reunification	x	x	x	x	x	x	x
H3. Connect family to community resources	x			x	x	x	x
H5. Aftercare	x	x	x	x	x	x	x
H6. Measure educational, functional, and delinquency outcomes		x		x			

^a Scotland (Skinner, 1992); Boys Town (Daly & Peter, 1996); Ireland (Department of Health and Children, 2001); CWLA (Child Welfare League of America, 2004); AACAP (Houston et al., 2010); Queensland (Department of Communities, 2010); Commun. Care (Community Care, 2012).

300. Huefner J (2018) Crosswalk of published quality standards for residential care for children and adolescents. *Children & Youth Review* 88, May 2018, pp267-273

Table 19 above shows a selection of published standards of residential OOHC. It covers 65 aspects of care, grouped under eight headings: service planning; provision of a safe, abuse free environment; maintenance of positive group culture; connecting with family and culture; providing least restrictive environment; evidence-based therapeutic program; education; and aftercare. Seventy-three percent of standards were required by all jurisdictions/providers.³⁰¹

As extensive and useful as they are, these standards do not explicitly cover the full range of conditions that have been identified in this paper as having a material effect on the therapeutic potential of the OOHC environment. The list lacks at least two elements of the Child Safe Organisation – a child friendly complaints mechanism, and a protocol for protecting children from sexual exploitation/abuse by other children, staff, strangers or family members. Other areas where standards would be beneficial include preventive health standards, e.g. for food – participating in its selection and preparation, nutritional requirements, whether the variety and accessibility of food is ‘homelike’ or ‘institutional-like’; and for exercise – matching the aspirations and motivation of care staff with those of residents, ensuring the compatibility of residents. However, the ‘best practice’ requirement should cover everything not elsewhere mentioned.

IT IS AN IMPLIED PROMISE OF QUALITY STANDARDS THAT DEDICATED IMPLEMENTATION WILL LEAD TO THE BEST OUTCOMES. BUT IT IS IMPORTANT TO NOTE THAT ‘QUALITY’ RESULTS FROM THE INTERACTION OF A COMPLEX ARRAY OF CONDITIONS RATHER THAN A LIST OF INDEPENDENT ELEMENTS THAT CAN BE TICKED OFF A LIST.

301. *ibid.*

15

WHAT PRODUCES THE BEST OUTCOMES FOR CHILDREN IN RESIDENTIAL CARE

There is very limited evidence available on ‘what works’ in residential care, in particular the more robust type of evidence that links the process and structural features of a residential placement with outcomes for children. Hart et al. (2015)³⁰²

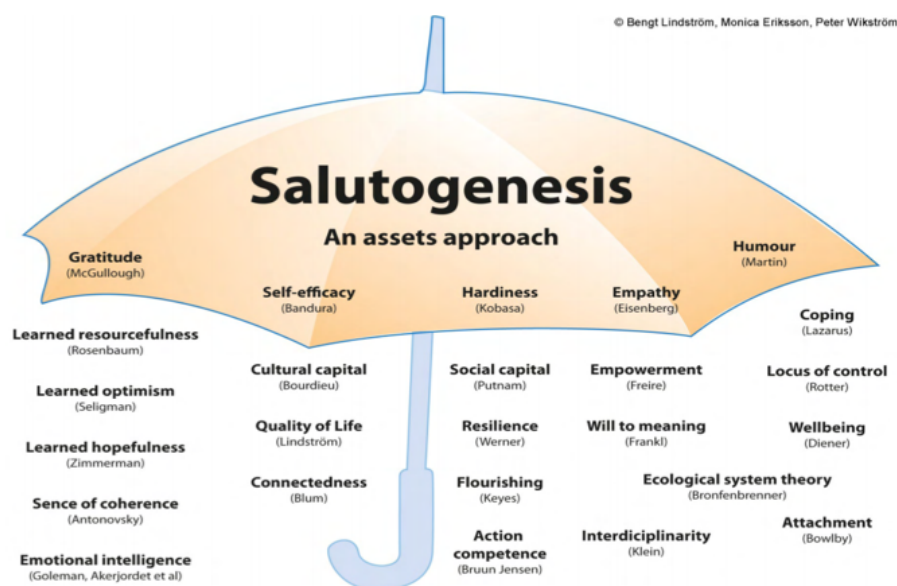
Despite the dearth of ‘robust evidence’ of the sort lamented by Hart et al. (2018) it is possible to list general requirements from an understanding of child developmental health needs, as well as from research exploring the subjective experiences of children and young people in care, and findings from research on the factors associated with better outcomes. These factors are listed below.

15.1 SALUTOGENIC ENVIRONMENT

Whether living with family or in OOHC, children and young people respond best to a salutogenic environment. The published quality standards above represent an incomplete attempt to specify the conditions for such an environment in OOHC. A salutogenic environment would promote optimal health and wellbeing for parents and children alike – it would minimise the risk of maltreatment and promote healing. Government policy at all levels should be directed toward establishing such an environment. Note that exclusion and chronic material deprivation, and family exclusion from economic activity, are incompatible with a salutogenic environment. Similarly, stigma attached to OOHC and loss of the sense of a ‘normal’ way of living, detract from a potentially therapeutic environment. Figure 3 below lists the advantageous qualities of an environment that promotes optimal health and wellbeing.

302. Hart D, La Valle I, & Holmes L. (2015). [The place of residential care in the English child welfare system](#). London, England: Department for Education

Figure 3. Concepts related to resilience – the salutogenic umbrella³⁰³



A salutogenic environment can be developed in any system of child protection, including OOHC.

15.2 GETTING THE SUPPORT THAT THEY NEED

Ward et al. (2008) sought the ‘views, experiences, and perspectives’ of young people in care to determine what factors were important for satisfactory placements. Their subjects reported ‘placements that provided them with the support that was required to meet their needs’ rather than placement type per se were of prime importance.³⁰⁴

15.3 WHAT ‘MATTERS TO THEM’ INFLUENCES DECISIONS CONCERNING THEM

From their review of the conditions affecting the success of placements, Hart et al. (2015) concluded that:

it is children and young people’s experience of a placement and “what matters to children” that should underpin placement decisions, rather than the placement type or that it works from the perspective of an adult.³⁰⁵

This is a reminder that the voice of the child is critically important in creating an environment of responsive care – a basis for establishing secure attachment and a sense of self-efficacy. Listening is also critical for promoting placement stability.

303. Eriksson, M., & Lindström, B. (2010). ‘Bringing it all together: The salutogenic response to some of the most pertinent public health dilemmas.’ In A. Morgan, E. Ziglio, & M. Davies (Eds.), *Health assets in a global context: Theory, methods, action* (pp. 339-351). New York: Springer.

304. Ward H, Holmes L & Soper J. (2008). *Costs and consequences of placing children in care*. London, England: Jessica Kingsley Publishers, cited in Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth*, 35:3, 209-224.

305. Hart D, La Valle I, & Holmes L. (2015). [The place of residential care in the English child welfare system](#). London, England: Department for Education cited in Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth*, 35:3, 209-224.

If children do not feel listened to, they may communicate through their behaviour. This can include acting in a way that they think will disrupt an unhappy placement:

I learned that no-one listens to you in foster and children's homes. Even if you run away. Running away was a protest but it never even worked (16-year-old girl quoted in Barry, 2001: p. 14).

This was confirmed by children specifically consulted about running away from care, who said it could be a way of getting moved to a new placement: 'it was my way of saying I didn't want to be there, without actually saying' (Ofsted, Office of the Children's Rights Director, 2012: p. 10).³⁰⁶

Preferred placement type, sense of comfort with carers and children already resident, or being considered for possible introduction to a placement (thus affecting the mix of children and young people), are all matters that concern children in OOHC, affect outcomes for them, and their views on such matters should be sought and seriously taken into account.

15.4 RELATIONSHIPS WITH STAFF

Hart et al. identified children's relationships with staff as:

[t]he biggest single variable that determines satisfaction with a placement.³⁰⁷

Although the quality of relationships may be difficult to define, high rates of staff turnover, poor levels of training and staff who are paid to 'care', but don't CARE, are obvious barriers.

Schofield et al. (2015) found that some children and young people preferred residential care:

Children are mainly positive about the people who care for them. When the Children's Rights Director consulted children about the best things about living in a children's home, the most positive aspect was the staff: ...you have loads of staff that you can talk to and they're good listeners; ...the staff actually care and keep you safe (Ofsted, Office of the Children's Rights Director, 2013: p. 4).³⁰⁸

A qualitative study elicited from children and young people in OOHC an indication of the importance of:

sustaining relationships with available, caring and consistent adults to promote positive, trustworthy relationships and to prevent harm.³⁰⁹

306. op. cit. p.88

307. op. cit. p.81

308. Schofield G, Ward E & Larsson B (2015). Moving on – but staying connected: An exploration of young people's transitions from break and the role of the moving on team. Norwich, England: UEA Centre for Research on Children and Families. Report at <https://www.uea.ac.uk/centre-research-child-family/child-placement/evaluation-of-the-moving-on-team-at-break> pp213-214.

309. Moore T et al (2018) cited in Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth*, 35:3, 209-224, p217

This suggests that:

Residential childcare can offer a different experience from that of foster care. It can provide an ethos of professional neutrality, which allows children and young people a safe environment and the conditions in which to explore relationships.³¹⁰

15.5 AGE AT ENTRY AND NUMBER OF PRIOR PLACEMENTS

The effects of age at entry into residential care is difficult to disentangle from cumulative experience of maltreatment and number of prior (failed) placements. Hart et al. (2015) reported research indicating that age of entry into home based as well as residential care was strongly associated with outcomes.

A study of British children who were in care in the 1970s and 1980s (Dregan and Gulliford, 2012) found an association between older age at first admission to the care system and extensive disadvantage in adulthood in most of the outcomes explored including depression, life satisfaction, self-efficacy, addiction and criminal conviction.³¹¹ While this point related to children who had been in foster/kinship care, as well as those with experience of residential care, as discussed earlier, the latter are more likely to first enter the care system at an older age.

However, one study found that younger age at entry into residential care could be problematic. Southwell and Fraser (2010) found that the children who were the least positive about their caregivers in children's residential homes were younger children (particularly under 12 years) and those who had experienced more than four placement breakdowns.³¹²

This concern was echoed by Tregeagle (2018), who argued that, although residential placement may be needed to accommodate larger sibling groups, it was unsuitable for children under 12, in part because of the danger presented by the proximity of older children, and in part because of the difficulty of 'managing multiple relationships with adults.'³¹³

15.6 NOT INDIVIDUAL VS GROUP CARE BUT 'QUALITY OF CARE'

Residential care has declined and fallen out of favour in part because of its identification with the evils of 'institutional care':

children exposed to institutional care often suffer from structural neglect, described as including minimum physical resources, unfavourable and unstable staffing patterns, and socially emotionally inadequate caregiver-child interactions. Using this description, institutional care can be provided in any placement type where the care is formulaic, not personalized and not relational.³¹⁴

310. Clough et al. (2006) cited in Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth*, 35:3, 209-224, p217

311. Cited in Hart D, La Valle I, & Holmes L. (2015). [The place of residential care in the English child welfare system](#). p.77

312. Southwell J & Fraser E (2010). Young people's satisfaction with residential care: Identifying strengths and weaknesses in service delivery. *Child Welfare*, 89(2), 209-228 quotation from Holmes et al. op. cit.

313. Tregeagle S (2018) Letter to the Editor: Response to Ainsworth and Holden's Review of 'Weighing Up the Evidence and Local Experience of Residential Care.' *Children Australia* 43,3,173-174

314. van IJzendoorn M, Palacios J Sonuga-Barke et al. (2011) Children in institutional care: Delayed development and resilience. *Monographs of the Society for Research in Child Development* 76(4), 8-30 cited in Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth*, 35:3, 209-224.

Hart et al. (2015) found that the:

Hallmarks of good quality in residential care often mentioned in the literature include: a home with vision and purpose; strong leadership; highly skilled, motivated and qualified staff. However, we found very few studies that tried to link these features with children's outcomes.³¹⁵

Foster care (versus residential or group care) is neither necessary nor sufficient for 'quality', as:

The nature of the engagement with the young people and the social interaction and activities in a placement make the difference.³¹⁶

15.7 EVIDENCE-BASED PRACTICE

The use of EBP has been reported to place residential care on an equal footing with foster care in terms of outcomes for children and young people.

Strijbosch et al. (2015) found that there were no differences between children receiving foster care compared to children in institutional care when the latter was evidence-based. Furthermore, research on the effectiveness of institutional care settings using evidence-based practice demonstrated improvements in multiple areas of functioning (James, Alemi, & Zepeda, 2013) when compared to institutional care as usual (De Swart et al., 2012).³¹⁷

15.8 INSTILLING A SENSE OF BELONGING

A sense of belonging is central to concepts of human development and wellbeing.

The self-determination theory posits that human beings are motivated by growth; the need to feel autonomous, competent, and related (Ryan & Deci, 2000). Indeed, a sense of belonging has been associated with an increase in happiness, a reduction in health problems (Pearce & Pickard, 2013), and the development of identity (Vandenbroeck, 1999). In contrast, a lack of belonging has been linked with increased aggression, difficulties regulating emotion, and social withdrawal (Baumeister, Brewer, Tice, & Twenge, 2007). As such, generating an authentic sense of relatedness for children in care is key to understanding how to better support young people to fulfil their life chances.³¹⁸

Whether a care placement cultivates a sense of belonging plays an important role in affecting outcomes for children and young people.

Fostering a sense of belongingness involves encompassing ideas such as home, togetherness, and acceptance (Maslow & Lewis, 1987) and is one of the main tasks for any caregiver.³¹⁹

315. Hart et al. op. cit. p.80

316. Schofield G, Larsson B & Ward E (2017). Risk, resilience and identity construction in the life narratives of young people leaving residential care. *Child & Family Social Work*, 22(2), 782-791 cited in Holmes et al. (2018), p8.

317. Holmes et al. (2018) op. cit. p.215

318. Holmes et al.(2018) op. cit. p 218

319. Holmes et al. (2018) op. cit. pp 217-218.

For those children whose experience of maltreatment and disruption of family life has impeded the development of a sense of belonging, residential placement may have advantages.

The notion of intimacy and the idea of a prescribed family life may be extremely difficult (Diamond, 2015). For these children, we must question whether a residential placement in which staff are trained to support children's social, relational, and behavioural development, for example through positive reinforcement, shared tasks and relationship building can cultivate a more appropriate environment in which the child feels safe, stable, can form trusting relationships (Baumeister & Leary, 1995), and ultimately develop a sense of belonging.³²⁰

15.9 THE ROLE AND VARIETIES OF SOCIAL PARENTING

'Alloparental care'³²¹ or 'allocare' is any form of care for non-descendant young. Social structures and cultural traditions that provide support for new parents, particularly new mothers, play an important role in determining the healthy development and wellbeing of human offspring, and hence, of the survival of human populations.³²² The system through which individuals provide support and care for the offspring of others can be called 'social parenting.'³²³ The emergence of this practice has been credited with promoting social and cognitive evolution of the human species.³²⁴

A normative view of the 'nuclear family' as a self-sufficient and fundamental unit of society,³²⁵ neglects the essential role of social parenting provided by extended family, community and social institutions, including those in childcare, health and education. It may also result in an 'unconscious bias' in favour of foster care and adoption instead of residential care,³²⁶ although all are forms of alloparental or social care.

If we were to challenge the dominant discourses of what parenting looks like, or to broaden our focus on the wide spectrum of child-rearing practices around the world, we may observe placement options through a more neutral lens. For example, unlike the nuclear family model, in some hunter gatherer societies children are cared for by multiple caretakers and are encouraged to utilize additional sources of help (Meehan, 2005).

[...] The alloparent can be a relation or a group of unrelated helpers. Alloparents can be individuals, pairs, or groups, as can be seen in both fostering and residential settings. Good rearing experience results in the belief that one is valued and cared for by others, that care and concern is stable across time and will endure even in the face of conflict (Lambert et al. 2013).³²⁷

320. *ibid.*

321. 'Alloparenting' was coined by Edmund Wilson (1975) *Sociobiology: the new synthesis*. Cambridge, Mass.: Belknap Press of Harvard University Press.

322. Kramer K (2010) Cooperative breeding and its significance to the demographic success of humans. *Annu. Rev. Anthropol.* v39, pp417-36.

323. In ethology and anthropology it is called 'cooperative breeding.' Kramer (2010) *op.cit.* p418

324. For example, see Kramer, *op.cit.*, Burkart J et al (2009) [Cooperative breeding and human cognitive evolution](#) *Evolutionary Anthropology*, v 18, pp175-186, and Hrdy S (2009) [Meet the Alloparents: Shared childcare may be the secret of human evolutionary success](#). *Natural History*, adapted from *Mothers and Others: The Evolutionary Origins of Mutual Understanding*, by Sarah Blaffer Hrdy, 2009, Harvard University Press.

325. See for example, Uzoka A (1979) The myth of the nuclear family: Historical background and clinical implications, *American Psychologist*, 34, 11:1095-1106;

326. Holmes et al. (2018) p216

327. *ibid.*

The customary child protection system stands or falls on the quality of the environment it creates for the nurture and care of children. Perry (2006) considers that the environment of our human ancestors was much richer relationally than that of (non-Indigenous) people living in developed countries:

For each child under the age of 6, there were four developmentally more mature persons who could protect, educate, enrich, and nurture the developing child – a ratio of 4:1. In contrast, our modern world is defining a caregiver-to-child ratio of 1:4 as a ‘best practice’ ratio for young children (1/16th the relational ratio the human brain is designed for). [...]

Many of our current lifestyle choices. Though well intended, are probably contributing to emotional, social, and cognitive problems in our children. The most alarming of these is the relational poverty that many of our children are experiencing. This is most disturbing because we humans are fundamentally relational creatures.³²⁸

15.10 THE DESIRE TO BE ‘NORMAL’

Children and young people in residential care, and those who have experienced it, want to feel ‘normal’. This can mean:

- Wanting not to be seen as having ‘failed into’ residential care, and being too ‘troubled or troubling’ to live a normal life – which can lead to behavioural problems;³²⁹
- Desiring more privacy, especially when faced with the reality that detailed clinical reports on them are prepared on a regular basis and may be used in making decisions concerning them with no or little comeback;³³⁰
- Wanting to be treated with respect, being seen as more than a barcode or number, having the same rights as children or adolescents with their parents;³³¹
- Wanting the perquisites of a ‘normal life: provision of recreational and academic facilities and support; quantity and variety of food provided; use of spaces; the physical environment; particular ‘family-like’ features (e.g. use of house parents); children’s involvement in the running of the home; working practices.’³³²
- The desire for ‘home-like’ accommodation rather than living in a facility that feels like an office or institution – in terms of décor and rules, for example, concerning access to and choice of food:

Children’s homes are like prisons or waiting rooms. The entrance is nondescript, empty and foreboding. There are locks on doors, fire extinguishers and cheap Monet wannabe copies on the walls. The carpet is the same throughout the building: a cheap office variety, in muted tones. The whole building evinces a cold feeling the walls are peach, white or blue. Any attempt to make the place homely has been tainted by some drab infusion of

328. Perry B (2006) Applying principles of neurodevelopment to clinical work with maltreated and traumatised children. *The Neurosequential Model of Therapeutics* The Guildford Press, NY. p 45

329. Hart D, La Valle I, & Holmes L. (2015). [The place of residential care in the English child welfare system](#). London, England, p8

330. op. cit. p83

331. What children say about child protection and out of home care. A consultation report for the South Australian Child Protection Systems Royal Commission, Office of the Guardian for Children and Young People, October 2015, p 6.

332. Hart et al. op. cit. p95

oppressiveness. Staff carry big wads of keys. The landing doors where I lived were alarmed on all floors to notify staff if children left their rooms at night.³³³

15.11 CONSIDERING DIMENSIONS OF LIFE SPACE

Life-space intervention is a way of conceptualizing work with young people in the spaces where their lives unfold³³⁴.

Life Space aims to improve the quality of interventions through envisaging and taking into account four salient dimensions of a 'single life space' life as experienced by the children and young people in residential care. These four dimensions are:

- the physical dimension, where young people's lives unfold;
- the mental dimension, reflecting how young people make sense of their life-space;
- the relational dimension, assigning 'space' to young people's relationships; and,
- the virtual dimension constituted by technology-based platforms for the construction of identity as well as by the imagination and fantasies held by young people.³³⁵

15.12 SIZE OF RESIDENTIAL FACILITY

Ainsworth & Hansen (2018) question the empirical basis of the common assertion that small group homes have more therapeutic potential than larger facilities, citing, *inter alia*, economies of scale:

Interestingly, there are no empirical studies to indicate that having only 4-6 places in a group home produces better outcomes for children and young people than the larger homes in Europe. On the contrary, it can be argued that the larger homes, by virtue of size, permit the full-time employment of therapeutic specialists such as clinical and counselling psychologists, and qualified direct care persons such as social pedagogues for the benefit of children. Small is not always beautiful, and small group homes are a problem not the solution. They are, given their design and staffing complement, most unlikely to be able to deliver services of sufficient power, intensity and duration (Ainsworth & Hansen, 2008) to meet the therapeutic needs of young people with serious emotional and behavioural issues. It is time to rethink our approach to therapeutic care.³³⁶

333. Prew (2007) cited in Hart D, La Valle I, & Holmes L. (2015). [The place of residential care in the English child welfare system](#). London, England, p83

334. Gharabaghi K & Stuart C (2013) Life-space Intervention: Implications for *Caregiving Scottish Journal Residential Childcare* December 2013 – Vol.12, No.3

335. *ibid.*

336. Ainsworth F & Hansen P (2018) Group Homes for Children and Young People: The Problem Not the Solution, Opinion, *Child Australia*, V43 No. 1 pp. 42-46

15.13 PROXIMITY TO SUPPORT NETWORKS: FAMILY, PEERS AND COMMUNITY

Consideration needs to be given to the geographic location of a potential placement to enable children and young people, wherever possible, to have continued engagement with supportive networks, family, friends, schools etc. Holmes et al. (2018) note that the declining provision of residential care, particularly public sector, meant that:

many children placed in residential children's homes are placed some distance from their local area and their support networks (community, peers, and family).³³⁷

15.14 WORKING WITH FAMILIES

This has to go beyond mere contact if relationships with parents are to be 'rehabilitated.' Relationships with siblings can be preserved by co-placement, in default of which arrangements for significant contact and interaction need to be made. The requisite level of engagement in both cases may be easier to achieve when children are in residential care.

Boddy et al. (2013) argue that there is a need to go 'beyond contact' and look at ways of actively involving parents in their children's lives. We know that many children end up returning to their families when they move on from care and, even if they do not, they will have a psychological need to make sense of the relationship. They suggest that parental involvement is less challenging when children are in residential care rather than a family placement. The fact that more children are in this placement option in Denmark, France and the Netherlands, combined with a better-qualified workforce and much lower rates of legally enforced removal from home, gives residential staff the opportunity to work constructively with parents. Parents were encouraged to parent 'at a distance' or on a part-time basis and were often actively involved in decision making and the child's everyday life.³³⁸

A Finnish family rehabilitation centre for children 12 or over assigns them the following tasks:

- resolving issues of maltreatment;
- forming at least one close relationship;
- improving lost self-esteem and maturing emotionally/socially;
- making peace with the family.³³⁹

In order to break away from the simple view of parents as the problem rather than as potentially part of the solution:

The first step is to adopt a different value system. Instead of seeing parents just as the perpetrators of harm there needs to be recognition of the psychological and environmental stresses that have caused their problems in coping. The role of staff is not to be the parents' therapist but a 'parent educator, trainer, and supporter'.³⁴⁰

337. Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth*, 35:3, 209-224, p 210.

338. Hart D, La Valle I, & Holmes L. (2015). [The place of residential care in the English child welfare system](#). London, England, p 48

339. Klap (2008) cited in Hart et al. (2015) p48.

340. Ainsworth F (2005) cited in Hart et al. (2015) p49.

15.15 WHAT ADOLESCENTS NEED

Most of the children and young people entering residential OOHC will do so as adolescents. Indeed, Tregeagle has warned against the placement of children under 12 in residential OOHC.

...it is very important that children under 12 years of age are not in residential units – a previously well-established principle in Australia that is increasingly being breached. Whilst it may occasionally be necessary that young children stay with siblings, residential care can be a very difficult environment for young children because of the influence of older children and difficulty of managing multiple relationships with adults. We fear that residential beds may be increasingly used for younger children only because there are no alternate placements.³⁴¹

The need to prepare adolescents in TRC for the demands of transition from care, requires the development of a wide range of skills in addition to those derived from education. Holmes et al. (2018) canvassed these needs and described a promising training program for staff dealing with adolescents.

Thus, given the influence relationships and the provision of care can have on the developing adolescent, improving our understanding of how best to support these individuals appears imperative. In addition to assisting young people with engaging in education and acquiring skills for independence, carers must support young people with softer skills – with developing and ending social relationships, negotiating closeness and distance, and sometimes recapturing missed skills from earlier stages, such as development of self-regulation and self-soothing skills. One of the core developmental tasks of adolescence is the advancement of perspective taking skills and the growth of executive function skills, e.g. cognitive flexibility, inhibitory control, initiating and maintaining task focus, and attentional control. The quality of the relationship between the carers and the young people is often the vehicle for allowing this learning to take place.

While this appears to be a challenging task, there has been an increase in the interest of promoting staff training in residential care homes, with a focus on understanding adolescent development and how best to communicate and support the children and young people placed within residential settings. The Narey Review (2016) emphasized the importance and positive impact of investing in such training. A recent evaluation of a new residential training program, RESuLT, which is founded in Social Learning Theory (Bandura & Walters, 1977) found that following training, staff showed improvements in their ratings of the quality of their work, communication with young people, and motivation at work (Berridge et al., 2016³⁴²). Furthermore, the evaluation of the evidence-based, whole-home training program indicated that staff were able to incorporate elements of Social Learning Theory, such as modeling and positive reinforcement, into everyday practice, to support each other and to discuss both challenges and positive outcomes.³⁴³

341. Tregeagle S (2018) Letter to the Editor: Response to Ainsworth and Holden's Review of 'Weighing Up the Evidence and Local Experience of Residential Care.' *Children Australia* 43,3,173-174

342. Berridge D, Holmes L et al (2016), [RESuLT Training Evaluation Report](#) Department for Education, UK

343. Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth*, 35:3, 209-224,

16

MEASURING OUTCOMES

16.1 OUTCOMES SOUGHT BY POLICY-MAKERS AND PRACTITIONERS

Thoburn enumerated the types of outcome sought by policy-makers and practitioners when evaluating placement outcomes:

...though there are differences in emphasis and prioritisation depending on country, context and research design, the wellbeing outcomes that policy-makers seek to achieve, and researchers seek to evaluate are:

- Physical, emotional, 'educational' wellbeing into adulthood;
- Stability- keep any moves to a minimum (Canada uses a principle of 'least disruption');
- A sense of permanence;
- Family membership (foster family and birth family);
- Continuity – links with relatives, friends and community;
- Minimum length of stay in out-of-home care [a key aim in USA and UK policy but less apparent in other countries (Skivenes and Thoburn, 2016)] – however, this has emerged as a key aim in Australia in the last few years;
- Normality – but different family forms including being part of a foster family should not be seen as conveying the stigma associated with the 'abnormal', as recounted by several of the presenters at the Siegan workshop who reported on children's views.³⁴⁴

However, she cautions that many of these are interim measures or proxies for real wellbeing outcomes:

Some of these 'outputs' listed above are not child wellbeing 'outcomes' but can be useful proxy interim outcomes if longer term outcome data is not yet available. [...] Some measures listed above are 'outputs' and some have more relevance to political or economic goals than child welfare outcomes.³⁴⁵

344. Thoburn J (2016) Achieving good outcomes in foster care: a personal perspective on research across contexts and cultures. *Social Work & Society*, Volume 14, Issue 2, 1-15, p2.

345. op. cit. p3.

Further, some measures that are taken as *prima facie* evidence that the formal system of child protection has failed – such as placement instability – do not automatically lead to poor outcomes and may even represent a system responding to negative feedback.

Multiple changes of placement (placement instability) comes through in qualitative studies as a proxy for a poor outcome, at least in terms of what young people have to say about their experience. But young people contributing to research report that one or even two moves as teenagers from placements that were not working for them could be followed by more successful placements (Schofield, 2003).³⁴⁶

Length of placement is another indicator is taken as evidence of formal system failure – on the dual grounds of cost and assumed exposure to harm. However, time in care does not imply bad outcomes.

In the UK and USA, being in care is, in the eyes of many politicians and the public, a ‘last resort’ because it ‘causes’ poor outcomes. The subtext of much discourse on children in care is ‘keep them out of care if you can, and if you can’t, get them out as quickly as possible’ (Cameron, 2015). This prevailing view is not supported by research going back over the years (the latest being Sebba et al. 2015) and earlier summarised by Bullock et al. (2006), Biehal et al. 2010; Thoburn and Courtney (2011) and Boddy (2013). Whilst qualitative studies provide evidence that the care system badly fails a minority of those who enter care, the majority (both in the eyes of the young people themselves (Office of the Children’s Commissioner, 2015) as well as research reports using quantitative and standardised measures, do as well or better than if they had remained at home or returned quickly home. Those who go home too quickly, have inadequate support, and return to care on more than one occasion do least well. This is an example of an ‘output’ not shared across all countries. Most European countries have tended to view placement in care as a positive response in appropriate circumstances, although more governments seeking to cut public expenditure are calling into question why so many children need to be in care. This is one reason why the use of the most expensive placement (residential care) is declining across Europe and foster carers are caring for children and young people with very complex needs who would previously have been placed in a residential setting.³⁴⁷

Finally, a ‘sense of permanence’ does not imply that adoption is required in all cases where reunification is not feasible given

..evidence from data analysis and longitudinal studies (Sinclair et al., 2007; Biehal et al., 2010, Biehal, 2014) that adoption is a ‘permanence’ route for only a small minority of care entrants, and research studies that concluded that, provided that placements are made initially or confirmed as ‘permanent’, long term foster care can have positive long term outcomes (Schofield and Beek, 2009; Biehal et al., 2010).³⁴⁸

346. *ibid.*

347. *ibid.*

348. *op. cit.* p6

There are several conclusions to be drawn from the above. To assess the effectiveness of formal systems of care, there is a need to distinguish between process indicators, such as speed of throughput, from outcome indicators, to use valid measures of developmental wellbeing and health, to make longitudinal measurements to track trajectories well into adulthood, and to compare outcomes for alumni of the formal care system with a comparison group who have had similar ‘obstacles and challenges’ to overcome³⁴⁹.

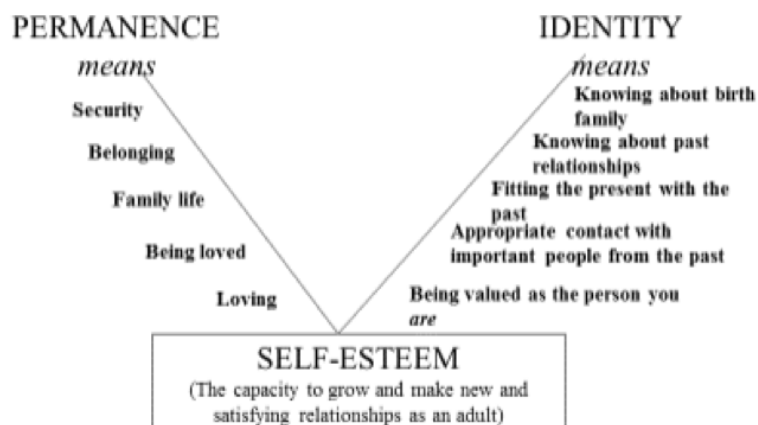
Thoburn (2016) summed it up thus:

In a sentence, child welfare systems serving children and families with different characteristics will have different ‘success’ rates. So, to end on a message for researchers to pass on to policy makers and service planners. There is no ‘right’ or ‘wrong’ rate of children in care. Children should not be in care if their wellbeing can be secured, with appropriate help, by remaining with their families. But those children who need and can benefit from care should come into care. And when making that decision, (an important message from research and from care leavers’ groups), we all share the duty to take seriously what children tell us and not to over-rule their wishes unless absolutely necessary in order to secure their safety – to do so seriously impacts on their self-esteem, self-efficacy and resilience.³⁵⁰

16.2 OUTCOMES THAT REFLECT CHILDREN’S UNDERSTANDING OF WELLBEING

Thoburn (1994) has attempted to represent the psychological needs of children in OOHC – for permanence, identity and self-esteem – in the diagram reproduced at Figure 4 below, which also sets out her understanding of what those needs entail.

Figure 4. The special needs of children in OOHC in England, where they are looked after by the local authority³⁵¹



349. op. cit. p3.

350. Thoburn J (2016) Achieving good outcomes in foster care: a personal perspective on research across contexts and cultures. *Social Work & Society*, Volume 14, Issue 2, 1-15, p.10

351. From Thoburn J (1994) Child placement: Principles and Practice. 2nd Edition, Aldershot: Ashgate.

A desire to transcend the thinking behind outcome measurements that are developed from an adult perspective led Fattore and Mason to explore outcomes that reflect children's subjective assessments of wellbeing.

Whilst demonstrating a concern for child outcomes, the adult-centricism in this approach views the child as an adult in deficit. These approaches have therefore raised some discontent in that the use of developmental indicators of wellbeing, whether subjective or objective, generally disregard the importance of how individuals assess aspects of their quality of life as it is lived in the day-to-day, based on what individuals prioritise as important. This discontent has provided some impetus for the development of approaches to measuring children's wellbeing by obtaining their perspectives on their wellbeing.³⁵²

From their qualitative study³⁵³ of children's subjective concepts of wellbeing Fattore & Mason identified three 'domains' of subjective wellbeing – 'agency and autonomy, safety and security, and self and identity' – in addition to three 'dimensions' that reflected 'concrete areas of children's lived experiences: economic wellbeing, health and activities and leisure.'³⁵⁴ The 'indicator concepts' they developed as the basis for developing a set of objective wellbeing outcome indicators that would capture the subjective experiences of their subjects are set out in Table 19 below.

Fattore and Mason found that children's understandings of wellbeing differ from prevailing popular, scientific and policy discourses in important respects. For example, children's sense of agency was required more than participation in infrequent, formal decision-making processes, as in: 'Having the opportunity to engage in decision-making about day-to-day interactions important to the child' and 'Children have opportunities to influence, organize, coordinate and control aspects of their everyday life.'³⁵⁵

352. Fattore, T. and Mason, J. (accepted in press) 'Constructing indicators of child wellbeing from a child standpoint.' *Developing Practice*

353. op.cit. They interviewed children from 8-15 and studied their voluntary projects, from a variety of SES backgrounds, in both rural and urban areas.

354. op.cit.

355. ibid.

Table 20. Indicator concepts – dimensions of children’s wellbeing³⁵⁶

Dimension/theme	Indicator concept
Leisure Leisure as providing opportunities for negative and positive freedom	<ul style="list-style-type: none"> • Degree to which children have opportunities to spend time with other children, free from adult-determined activities, to generate their own leisure activities. • Degree to which children have opportunities for ‘down-time’ to spend with family and friends, characterised by a sense of freedom from expectations of public life, and the performance of identities associated with public life; • Degree to which organised leisure activities provide opportunities for children to experience freedom to choose which activities to undertake and contribute to determining how the activity is conducted – that is, freedom over the what and how of activities. • Leisure activities, whether organised or not provide opportunities for enjoyable sensory experiences.
Leisure facilitates the development of competence as mastery	<ul style="list-style-type: none"> • Children have opportunities for involvement in activities to develop capabilities they wish to gain • Children have opportunities to develop capabilities that provide a sense of mastery and skill development.
Economic Wellbeing Material standard of living: equitable distribution and availability of direct and indirect resources	<ul style="list-style-type: none"> • Households have an adequate level of income to meet the economic needs of its family members. • Degree to which children equitably benefit from the distribution of direct and indirect resources within their households. • Children have opportunities to negotiate with other family members for access to direct and indirect resources within the household.
Children as Economic Agents	<ul style="list-style-type: none"> • Children have opportunities to engage in paid work, so as to provide opportunities to participate in valued cultural practices • Children have opportunities to earn money that facilitates their own autonomous use (to save, to gift and to spend) so as to be able to signify their economic and moral agency. • Children have opportunities to engage in consumption activities that provide opportunities to establish and consolidate social ties with family members and friends.
Health Health as a dimension of wellbeing associated with agency, security and a positive sense of self	<ul style="list-style-type: none"> • Children have opportunities to negotiate everyday health practices with adult carers. • Children have opportunities to access physical environments that allow them to engage in everyday health practices, especially those associated with positive sensory experiences. E.g. environments within which children can freely associate with each other and through which there may be opportunities to do physical activities as part of being sociable. • Children engage in physical activities and health practices that • facilitate a sense of wellbeing, including affective and cognitive states associated with a sense of wellbeing.

356. From Fattore T. and Mason J. (accepted in press) ‘Constructing indicators of child wellbeing from a child standpoint.’ *Developing Practice*

Children's subjective understanding of safety differed significantly from the structure risk-reduction approach of child protection authorities:

In contrast to these dominant frameworks children's discussions of safety revolved around ontological security/insecurity, associated with people 'being there' for them and the presence of having trusted adults in one's life, so that children can engage with risks they might encounter in everyday life with adult support. Children also emphasized how the way most public places are designed, typically with adults in mind, makes them unsafe for children and limits their autonomy, what we describe as a structural inconsiderateness towards children.³⁵⁷

Similarly, children's sense of 'self', was not so much invested in the achievement of developmental milestones, which form the core of public policy assessments, but in relationships and the making of sensitive judgements.

Children's construction of the self is about being moral, purposeful and authentic, and is described as developed through relationships with adults and with other children, and as having both emotional and cognitive elements. We developed indicator concepts that reflect these dimensions of self-concept, with indicator concepts for the moral self, being about children having opportunities to exercise moral agency ('opportunities to develop their capabilities as moral agents') while being supported in the exercise of this moral agency ('children are supported in the moral dilemmas they encounter'); in interpersonal environments where children can learn by doing and learn from their mistakes, the most important being the family ('families are experienced as a site of trust and intimacy in which children feel their self-identity is given recognition'; 'families provide a site in which negotiations around children's changes in self-identity can occur in a fear-free manner').³⁵⁸

Children's sense of economic wellbeing was certainly influenced by their family's capacity to meet material needs of all, but also by the extent to which resources were shared equitably within the household, and by their own opportunities to earn and control money.

Wellbeing was more than the simple experience of happiness, but about the experience of complex emotions in a context of close and supportive relationships.

For children experiences of sadness and adversity, what are typically labelled as 'negative' feelings or experiences can be part of an overall experience of wellbeing, depending on the context of their relationships with others. For example, where children express sadness or joy as associated with wellbeing, it is often as a reaffirmation and expression of the importance of close social ties, such as those with family and friends, and thus is confirming of important social bonds.³⁵⁹

357. *ibid.*

358. *ibid.*

359. *ibid.*

The sense of leading a meaningful life was also important, as was the sense of acting in accordance with a moral code:

treating others with fairness, being open to other's ideas, being helpful and being cooperative, and enacting these in abstract situations (for example, being helpful to other children who are not within a child's friendship group).³⁶⁰

Finally, children experienced the tension between adult efforts to structure their time so as to influence their 'well-becoming' – i.e. preparing for a future as a productive adult – as opposed to their wellbeing in the present, sometimes in contradistinction to the leisure pursuits that expressed their own dreams and aspirations for the future. The authors summed up children's power imbalance with adults in:

The metaphor of childhood as a minority social position [which] foregrounds the vulnerability of children not only to harms by adults, but to system abuse that may result from services not taking into account children's wellbeing in a child-centred way.

360. *ibid.*

17

OOHC CARERS AND THEIR CAREERS – ‘TASK FOCUSED’ VS ‘FAMILY FOR LIFE’

17.1 AMBIGUITY OF PURPOSE

The orientation and attributes of staff selected to undertake OOHC, could be expected to vary according to the major purpose being served by placement. Ambiguity or conflicting aims can compromise staff selection and effective performance of their role.

In some countries, researchers report an uneasy tension between the supposed aim of reunification and the reality that the foster carers have become foster parents, and the child wishes to be assured that he or she will remain part of the foster family. The emphasis on children’s need for a sense of permanence in England has resulted a recognition of the differences between ‘task’ focused’ foster carers and ‘family for life’ foster parents. There is, however, less emphasis on ‘shared parenting’, ‘therapy’ and foster care as family support, than in most European countries.³⁶¹

17.2 MATCHING CLIENT AND CARER

Setting aside the chronic problem of recruiting and retaining suitable OOHC staff, there is potential benefit to be gained by placing greater emphasis on ‘matching’ the needs and aspirations of staff, children and their families.

More attention is paid in the literature to the ‘skills’ of foster carers, and clearly parenting skills are important. But these can be learned, whereas motivations of the potential carers and the special needs of the child are more fixed – though they sometime change over time. Drawing on my own qualitative studies of long term foster care and adoption and those of others, I conclude that matching the needs and wishes of the child with the motivations/aspirations of the proposed carers (and taking into consideration the hopes of birth relatives about the role they can continue to play in their child’s life) is essential to successful long term placements, but often gets left out of a check list of necessary skills and attributes.³⁶²

361. Thoburn J (2016) Achieving good outcomes in foster care: a personal perspective on research across contexts and cultures. *Social Work & Society*, 14 (2) 1-15, pp6-7

362. op. cit. pp8-9

However, the professional skills required in therapeutic residential care, may offer less scope for this matching exercise.

where there is most similarity across boundaries is therapeutic foster care for older children with challenging behaviour. This was first introduced in Sweden as 'professional foster care' in the 1980s and most recently provided as a manualised programme – Multidimensional Treatment Foster Care (MTFC) (see Chamberlain, 2003 and the evaluations in England and Sweden by Biehal et al., 2011 and Hansson and Olsson, 2012).³⁶³

17.3 EMPATHETIC AND CHALLENGE-READY

In any case, OOHC staff need to be able to get on with children and with birth parents, requiring both ready empathy and the ability to deal constructively with challenging behaviour.

the ability to empathise with the child and also with the birth family is as essential for long term foster carers who go on to adopt (even those who have little or no contact with birth parents) as it is for treatment foster carers. Enjoying being with children and also being able to rise to (and even enjoying) a challenge is an attribute that all those caring for children placed from care are likely to need to draw on at some point. Neil et al. (2014) found that even amongst children mostly under 2 when placed for adoption, only around half were 'thriving' between 16 and 18 years after placement and that many were demonstrating seriously challenging behaviour.³⁶⁴

17.4 CARERS' ENGAGEMENT WITH FAMILY

Especially where the greatest priority is placed on reunification, the important influence of carers' engagement with families and other elements of children and young people's networks of support, imply the need for staff to exhibit a wiliness to undertake, and an aptitude for, such engagement.

Farmer et al., (2011), Wade et al., (2011), and Thoburn et al., (2012) have called attention to the poor outcomes for children returning home from care and recommended that task centred foster carers should have a bigger role in working with birth parents when the plan is for children to return home. Although in theory, one might anticipate that countries which emphasise the importance of birth family links might recruit, train and support foster carers who can empathise with and have particular skills in working with birth families, it is not at all clear from the body of research that this happens (an exception is reported in Fernandez, 2012; Fernandez and Lee, 2011).³⁶⁵

363. op. cit. p6

364. Thoburn J (2016) Achieving good outcomes in foster care: a personal perspective on research across contexts and cultures. *Social Work & Society*, Volume 14, Issue 2, 1-15, p.7

365. ibid.

17.5 PROFESSIONAL, FAMILY MEMBER, ADVOCATE

Taking on the role of a family member as well as a member of a therapeutic team, may lead a treatment carer to go well above and beyond the call of duty to take the part of the child in care when it seems necessary to do so.

The ability to be part of the therapeutic team, and to value this part of their role, is essential for treatment foster carers. 'Family for life' foster carers need to be able to work with professionals, but there are examples in the qualitative research literature of foster parents standing up for and advocating for their child, whose disagreements with the professionals led to negative annual appraisals and even removal of the children sometimes against the wishes of the child. Sometimes a change of social worker, at the request of child or foster parents, has led to a positive resolution of the point of disagreement. Schofield and colleagues (2013) explore this question of different role identities in their longitudinal studies of long-term foster carers.

They conclude that successful long-term foster parents can have different role identities, but there must be an element of each. Some identify primarily as foster carers, but also embrace the role of parent; others primarily identity as parents, but also embrace the professional elements of their role of foster carer.³⁶⁶

366. *ibid.*

18

RESEARCH ON VARIABLES THAT AFFECT OUT OF HOME CARE OUTCOMES

Thoburn's 2016 reflections on the OOHC literature and her own decades of practice, produced this summing up of the variables whose effects on OOHC outcomes have been studied:

The breadth and complexity of the foster care knowledge base bears witness to the complexity of the service, provided as it mostly is over long periods with many different 'interventions' and individuals with the potential to impact on outcomes. The variables associated with good or poor outcomes that have been identified and studied by different researchers concern:

- the child, the child's family and biography;
- the professional status, and characteristics of those providing services to the children, their parents and carers;
- the approaches and methods used by social work and other services:
 - decision making
 - placement practice/therapy,
- law, systems and procedures for care planning, review and service delivery.³⁶⁷

18.1 NEED FOR FURTHER RESEARCH

- In the light of the 'longitudinal, and quasi-experimental methods and qualitative studies from several countries presented at the Siegen Conference in 2016, Thoburn (2016) compiled a list of questions for further research:
- Which comparators are to be used:
 - children in care in other placement types?
 - the 'average' child?
 - children with difficulties but not in care?
- Which outputs can be used as proxy measures for long term wellbeing outcomes?
 - stable placement achieved / placement breakdown?
 - child, carers, birth family having a 'sense of permanence'?
 - How to measure?
 - educational success / employment / health / housing?
 - satisfaction (whose?)
 - being a part of the family into adult life (which family/ies)?³⁶⁸

367. Thoburn J (2016) Achieving good outcomes in foster care: a personal perspective on research across contexts and cultures. *Social Work & Society*, 14, 2: 1-15, p8.

368. op. cit.

19

THE IMPORTANCE OF COUNTRY CONTEXT IN TRANSLATING MODELS

In Section 1 above there is a discussion of the importance of the cultural and political context of OOHC. This background forms the informal part of the system of child protection and has a very strong influence on the development of the formal or statutory system in any jurisdiction. The translation from one cultural and political context to another of models of OOHC, including residential care, needs to take into account differences in informal systems that may lead to gaps or incompatibilities in formal systems of child protection.

The sharing of information about systems and across a range of countries at the Siegen Conference in 2016 led Thoburn to this conclusion:

We all have much to learn from researchers in other countries that could be usefully adapted to our own foster care services. But before reaching conclusions that what seems to work in one country will work in your own, it is essential to seek information on historical, policy and cultural contexts. What, for example is the societal opinion of foster care? Are children growing up in foster care stigmatised? (Whether 'being in care' is seen as stigmatising depends on foster care systems and practice as well as societal attitudes and the circumstances of the young people themselves.) Does 'public opinion' see foster families as 'normal' families putting in something extra to meet the needs of special children, or just 'doing it for the money'? Contexts and policies also have an impact on costs and outcomes. If the care system is mainly providing for teenagers with challenging behaviour, the cost per child is likely to be higher and the proportion of 'good' outcomes is likely to be lower than in some countries (mainly in Eastern or Southern Europe), in which fairly young children come into care largely because of absolute poverty, family tragedy, are placed in a stable kin or non-kin foster family (or even small family group home) and remain there until they are ready to make the transition to adulthood. In England and the USA, where almost all the youngest entrants leave care quickly through return to a birth family member or adoption, those who 'age out' of care at 16 or 18 are likely to be the 'unadoptable' ones with more complex histories who are more likely to have less good outcomes.³⁶⁹

369. Thoburn J (2016) Achieving good outcomes in foster care: a personal perspective on research across contexts and cultures. *Social Work & Society*, 14, 2: 1-15, 10

20

THE ‘HOME’, ‘BELONGING’ AND ‘PERMANENCE’ CONUNDRUMS

20.1 MANY PATHWAYS TO ‘PERMANENCE’

A major objection to the use of residential care has been the conundrum it poses for the goal of achieving ‘permanency’ of children and young people in OOHC – it may constitute the best, or, indeed, the only OOHC option for a child, but not offer the assurance of on-going relationships and a network of support.

...continuity of relationships is especially valuable in the transition from care to adult life (Stein 2012). Here, there are tensions between the stated goal of the care system, to achieve ‘permanence’ and a sense of belonging (Department for Education 2015b), and the expectations around leaving care when young people are expected to move from children’s homes into ‘independence’. ‘Staying Put’ arrangements (Department for Education 2013) offer young people in foster care the opportunity to stay till age 21, but this option is not available for the group who are probably the most vulnerable in the care system – young people in residential care (National Children’s Bureau 2014).³⁷⁰

No Australian jurisdiction currently offers a statutory leaving-care age beyond 18, although most jurisdictions offer some period of after-care support.³⁷¹

Boddy’s research review for the Care Inquiry in the UK concluded that legal permanence was not attainable in every case, necessitating the development of ‘individual solutions for individual children’:

The research reviewed here suggests the need for a broader and better differentiated understanding of permanence, spanning the diversity of children’s needs and circumstances. There are constraints on the supply of placements that can offer legal permanence, and legally permanent solutions are not appropriate for all children. Some will remain formally ‘looked after’ throughout the remainder of their childhood, others will return to their birth parents, either in childhood,

370. Risk, resilience and identity construction in the life narratives of young people leaving residential care. *Child and Family Social Work* 2017, 22, pp 782-791

371. ‘For example, in Victoria and Queensland legislation provides for after-care support for young people up to 21 years of age. Comparatively, New South Wales, South Australia, the Northern Territory and Western Australia provide support for young people up to 25 years of age. Although the Australian Capital Territory and Tasmania have provisions for after-care support, no age limit is stated.’ From [Australian child protection legislation](#), CFCA Resource Sheet— March 2018, Australian Institute of Family Studies.

or in early adulthood when leaving care. Whichever route to permanence is appropriate for a child, it is essential that planning takes account of children's wishes, to ensure a sense of belonging and the best possible care.

What matters is quality and relationships. To provide individual solutions for individual children, we not only need to support routes to legal permanence, but to place equal value on other ways of achieving permanence, including support for children and families at the 'edges of care', as well as through permanent return to birth parents and permanence in shared or full-time care. All options for the child need to be conceptualised with a common understanding and an objective of permanence:

- aiming to provide high-quality and stable care;
- supporting children's sense of identity and belonging; and
- connecting past, present and future through childhood and transitions out of care, and on into adult life.³⁷²

20.2 THERE'S NO PLACE LIKE 'HOME'

The importance of 'home' and a sense of belonging are also at the heart of the search for permanence. However, a sense of 'home' need not be incompatible with an OOHC residence and a sense of belonging can be achieved through the quality of relationships and placement stability.

Another discourse which heavily influences the narrative about children in care is the idea of what home itself looks like and what it feels like. For children who have been removed from their family home, adjusting to a new home can be complicated. Children can experience feelings of loyalty to their family, survivor's guilt about being safe, and worry about their family. The notion of home for human beings is very powerful in literature, both within families and across cultures. Home is variously described as a house, family, or haven (Mallett, 2004). However, whether an 'outside of family' placement is viewed as a "home" is a very personal experience. The concept of whether residential children's homes can be categorized as homes rather than institutions has been debated. Berridge et al. (2012) emphasized the importance of the feel of a home and how institutional features such as an office can impact negatively on the view of the placement as a home.

Conversely, it is possible for alloparents to promote and engender a feeling of home. For example, the location of "home" may not be the critical factor; instead a positive experience and a sense of belonging may be key to cultivating the inner experience of home (Rowles, 2006). It should also be noted that embodying meanings of home involving feelings, emotions, and actions is likely to build up over time (Tuan, 1977), which again highlights the importance of providing stable and appropriate placements and reducing the likelihood of

372. Boddy J (2013) Understanding Permanence for Looked After Children: a review of research for the Care Inquiry http://sro.sussex.ac.uk/44711/1/Boddy_2013_Understanding_Permanence.pdf

placement breakdown. Addressing this complex human experience must be considered and prioritized wherever a child's placement is.³⁷³

20.3 WAYS OF BELONGING

If living within a family is essential to a sense of 'belonging', and that sense is fundamental to achieving good outcomes for the child or young person in care, the residential care is inherently problematic. However, the potential of stability and relationship quality to engender a sense of belonging should not be underestimated.

Being cared for and building trusting relationships encompasses shared cultural ideas of family. For example, Thoburn (2016b) described an environment in which the philosophy and characteristics of the care home aimed to build a sense of stability and belonging through the care system into adulthood, whereby young people were able to visit their children's home and seek support after they had left the placement. Such attachments can consequently help to foster resilience and enable a more positive transition into adulthood by allowing the young person to feel a continued sense of support and belonging (Schofield et al., 2017). It must however be noted that a sense of belonging builds up over time, therefore ensuring a child is able to stay in a placement long enough to develop feelings/ attachments to a place seems essential; as Berridge et al. (2016) states "stability is very important for children, and successful services need to experience this too" (p. 37).

Moreover, it might be that it matters more that the child is able to feel a sense of belonging – both to a place and to the people in that place, rather than the specific environment (family versus group) the child is raised in. Placement moves, relationship with staff/foster carers, staffing structure (residential care), and the stigma behind residential/foster care (particularly if the child views themselves as different to their peers because of this) may be some of the barriers associated with a child developing a sense of belonging within a care setting (Leathers, 2006; Rogers, 2016; Schofield et al., 2017).³⁷⁴

373. Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth*, 35(3): 209-224, p 217

374. Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth*, 35(3): 209-224, pp 218-219

21

CHOOSING A MODEL OF THERAPEUTIC RESIDENTIAL CARE

21.1 SOME IMPORTANT CONSIDERATIONS

A model of TRC must be fit for purpose. It must be feasible, in terms of available resources and capability, effective in addressing the issues that led to children and young people being placed in OOHC, and lead to the best possible outcomes for children and young people and their families.

It must not be 'care as usual' which seems mainly defined by what it is not, that is: it does not have a clear purpose; the service delivery is not guided by a theoretical underpinning; it is not evidence-based and outcome focused; it is not staffed by well-qualified professionals who receive adequate training and support. Children in this type of care are not placed there based on a robust assessment of their needs and the kind of placement that can effectively meet these needs; they are typically placed in 'residential care as usual' because everything else has failed.³⁷⁵

The following aspects have been identified as important.

Demonstrated effectiveness

This could be assessed through CEBC rating, through peer reviewed reporting, or even promising reports from 'practice-based evidence'. For example, Treatment Foster Care Oregon (TFCO) is rated as well-supported (CEBC 1)³⁷⁶ for situations including residential care – the only one in the group of residential care models to be so. Its first use in Australia was jointly sponsored by the Victorian Government, OzChild and Anglicare Victoria in late 2016. The major aim of the 6-9-month program is to help children manage their feelings, thoughts and behaviours and to provide support for foster carers and birth parents with a view to enabling family reunification or placement in a less intensive and expensive form of OOHC.

375. Hart D, La Valle I, & Holmes L. (2015). [The place of residential care in the English child welfare system](#). London, England: Department for Education

376. The highest rating of the California Evidence-Based Clearinghouse for Child Welfare (CEBC)

Jurisdictional considerations

Finance for OOHC is a state/territory responsibility and each jurisdiction may favour a particular model. In mid-2017 the NSW Government announced that it would allocate \$90.5 million over four years for intensive family preservation programs MST-CAN and FFT.³⁷⁷ If these programs succeed, a high proportion of the children who would otherwise have been placed in OOHC will not need it. More recently it has announced a grant to OzChild to deliver TFCO for children with complex needs and their families.³⁷⁸ As part of its Permanency Support program, NSW has announced the replacement of residential care with Intensive Therapeutic Care (ITC) over a two-year period. The Central Access Unit will refer children over 12 with complex needs to 9 selected providers of an intensive 13-week program of ITC that aims to promote placement stability or prepare children for foster care placement.³⁷⁹ Research, consultancy and dissemination of best practice knowledge will be provided by the Centre for Excellence in Therapeutic Care, led by the Australian Childhood Foundation and Southern Cross University.³⁸⁰ The Permanency Program works to achieve a form of permanency for a child in OOHC within two years, explicitly considering this list of alternatives in this order of preferred outcomes:

- keeping them in or returning them to their family (preservation and restoration);
- guardianship;
- open adoption;
- parental responsibility to the Minister.³⁸¹

The Western Australian Government has also embarked on a program of earlier intervention with families whose children are at risk, awarding contracts for provision of 12 months of family support services to a variety of services in metropolitan and remote areas.³⁸² Stronger safety and quality of Care standards have been in place since 2017.³⁸³

In the last few years all jurisdictions have placed increased emphasis on coordinated services for prevention, early intervention to support families at risk, support services that work with families to promote reunification where possible, and permanency planning to ensure long term stability and a pathway out of care.

Financial resources

Funding levels should be consistent with the level and intensity of services needed to stabilise children, promote healing and enable them to catch up to age appropriate norms in emotional regulation, cognitive development, executive function and peer relationships. High levels of investment at the outset will be more cost-effective than a series of failed placements with consequent re-traumatising of children.

377. [Their Futures Matter, Job Opportunities and Family Restoration](#), June 2017. Under this program an additional 900 children would be assisted – with half of all places reserved for Aboriginal children.

378. Davidson H (2018) [NSW foster carers to be paid \\$75,000 'salary' in complex needs trial](#) *Guardian Australia* Thu 13 Sep 2018 17.30 AEST

379. [Intensive Therapeutic Care](#), NSW Family & Community Services, last updated November 2018.

380. op.cit.

381. [Paths to Permanency Overview NSW Government](#) Last updated 19 March 2018.

382. [Contracts for the Family Care Support Service have been awarded](#), WA Department of Communities, Child Protection & Family Support. Accessed 7/2/2019.

383. [Better Care, Better Services. Safety and quality standards for children and young people in protection and care](#) Government of western Australia, Department of Communities.

Some off-the-shelf models such as TFCO, CARE, MST and FFT, are expensive to purchase and to maintain. They require considerable investment in staff training and the updating of skills. State/territory funding may not be sufficient to cover these costs. However, a model requiring a smaller up-front investment may necessitate buying in a larger range of professional services from outside.

Child safe

Above all any model of care must incorporate child safe principles – building on the recommendations of the Royal Commission to ensure that children are not abused or exploited in care, but also offering them a therapeutic environment that meets developmental needs and encourages them to thrive.

Voice of the child

The model of care should ensure that the child or young person in OOHC has a voice in and contributes to all decisions concerning them at a level consistent with their age and maturity. Like other states and territories, the Victorian Government has developed a Charter of Rights for young people in care: it lists and explains their rights, including cultural rights, and provides details of what to do and where to go if they have a complaint.³⁸⁴

Engagement of parents in a way that promotes the best interests of the child.

Parents form a major part of the customary, informal child protection system and relationships with family is important for the child's sense of identity. Even children who have been disconnected from parents during time in OOHC will, in most cases, reconnect with them on exiting care. Early and effective engagement with parents, except where this would be harmful, is an important part of therapeutic response.

Indigenous placement principle

Aboriginal and Torres Strait Islander children should be placed in accordance with the Aboriginal and Torres Strait Islander Placement Principle³⁸⁵:

- Each Aboriginal and Torres Strait Islander child has the right to be brought up within their own family and community.
- The participation of Aboriginal and Torres Strait Islander community representatives, external to the statutory agency, is required in all child protection decision making, including intake, assessment, intervention, placement and care, including judicial decision-making processes.
- Placement of all Aboriginal and Torres Strait Islander children into out-of-home care must be considered in the following order:
 - a) With the child's extended family or kinship group.
 - b) Within the child's Aboriginal and Torres Strait Islander community or group.
 - c) With another Aboriginal and Torres Strait Islander family, where culturally appropriate.
 - d) Where no other option is available, with a non-Aboriginal or Torres Strait Islander family.

384. [Aboriginal and Torres Strait Islander Placement Principle](#) Secretariat of National Aboriginal and Islander Child Care(SNAICC).

385. [Charter for children in out of home care](#). Department of Human Services, State Government of Victoria Accessed 7 February 2019. For charters in other jurisdictions except the ACT see CREATE Foundation website on [State Resources](#), and for [ACT](#) see [ACT Charter of Rights for Children and Young People in Out of Home Care](#)

- If the preferred options are not available, as a last resort the child may be placed with a non-Indigenous carer assessed as ready, willing and able to support the maintenance of community and cultural connections for the child or in a similarly assessed residential setting.
- If the child is not placed with their extended Aboriginal or Torres Strait Islander family, the placement must be within close geographic proximity to the child's community. An Aboriginal or Torres Strait Islander Community Controlled Organisation should also be involved in supervising the placement to ensure that the child is able to maintain links with their people and culture.
- Aboriginal and Torres Strait Islander children in out-of-home care are supported to maintain connection to their family, community and culture, especially children placed with non-Indigenous carers. Aboriginal and Torres Strait Islander children, parents and family members are entitled to participate in all child protection decisions affecting them regarding intervention, placement and care, including judicial decisions.

Where placement with kin, community or another Aboriginal or Torres Strait Islander family is not possible, then co-care involving a collaboration across Indigenous and non-Indigenous providers should be considered. Non-Indigenous providers should be funded to train Indigenous staff with a view to their being able to operate autonomously within a reasonable time frame.

Capability

Therapeutic residential care requires continuous access to highly qualified clinicians as well as to skilled and dedicated carers.

Timing of intervention

MST and FFT, for example are both best suited to early intervention with families when a protection problem has just emerged. Intensive therapeutic interventions will be required when behavioural and emotional problems in children and young people or their parents are well established or entrenched.

Responsive to nature of client needs

In addition to the timing of an intervention, the nature, range and complexity of needs in children and young people and their families determines the selection of a model of care.

Serious child behavioural problems, including aggression, may respond best to behaviour modification paradigms of the sort used in MST-CAN (but there are other examples). Severely traumatised and fragile children and their families may benefit from the strong trauma-informed and holistic approach of CARE or Wraparound.

Wraparound also requires collaboration amongst professionals as well as with families to resolve the problems of clients who may have complex needs. They also insist that each treatment program is individualised.

Single door entry to cross-sector collaborations

‘One door’ should provide access to all necessary services and supports for a child or young person entering OOHC. Models of care should enable cooperation amongst groups of experts who should all be qualified to implement a trauma-informed approach to assessing and designing interventions to meet the needs of children and young people in OOHC. The multi-disciplinary team should include at least: health (including nutrition, fitness, sleep), mental health and behaviour (particularly attachment, peer relationships, identity including cultural knowledge, self-regulation and understanding of personal responses to accumulated trauma, development of happiness practices), criminal justice (if necessary), education (including enrichment and engagement with the arts and interaction with the natural world, including farm animals/pets). It’s an open question how the multi-disciplinary team should be managed. Cultural and community connections

The model of care should encourage assessment of the capacity of the informal protection system that the children and young people has access to and engage with it in developing a program of treatment and care. For example, Wraparound places strong emphasis on cultural competence and connections and is committed to working closely with families and communities. Spiral to Recovery was developed primarily for use with Aboriginal and Torres Strait Islander children and young people and their families, and the CARE program operated by Uniting in Qld has also been adapted for this purpose.

Social ecology

CARE, Sanctuary and Wraparound have a common philosophy. In accordance with the principles of social ecology, all treat the whole environment – staff, organizational culture, the facility, neighbourhood etc. – which residential OOHC services are delivered as vitally important to the achievement of therapeutic outcomes.

Whole-hearted commitment to the child in care

Where residential care is offered as a stable, on-going placement it should be possible to offer a commitment to see it through with the children and young people – regardless of difficulties – as well as offering a substitute family that continues to care and ‘have their back’ after exit to independent living.

For example, Wraparound’s philosophy includes a commitment to continue a treatment program until all partners in the collaboration, including child and family, decide that the agreed goals have been met. This echoes a Uniting Church desire to offer life-long care.

Implementation and monitoring regime

Where a model of care has been purchased or developed, funding will need to cover the on-going costs of staff training and external monitoring of fidelity of implementation.

Customised models also need to obtain funding to cover commissioning of independent experts to ensure staff selection, training and faithful implementation of the model’s core principles in the

necessary process of adaptation to local context. External expert monitoring is essential for ensuring that regardless of who leads and staffs the service provider organisation, fidelity of implementation can be ensured.

Flexibility and adaptability

As a caring regime is implemented, individualised treatment programs need to be monitored and adapted where necessary to take into account feedback from practice, new research, changes in the social and ecological setting (including family, schools, friendship networks etc.) and changes in jurisdictional policy.

Suitability for Australian conditions

The fact that no scientifically rated model has been developed in or for Australia may mean that there is a niche for a locally developed model of residential care with a trauma-informed philosophy that includes professional assessment of child needs, trains skilled and dedicated care staff, orders in individual therapies as indicated, and works in collaboration with child and family, the formal and informal systems of child protection, and the broader social ecology. Any such model would need an external implementation, monitoring and accountability service.

Figure 5 Strategic investment in child protection

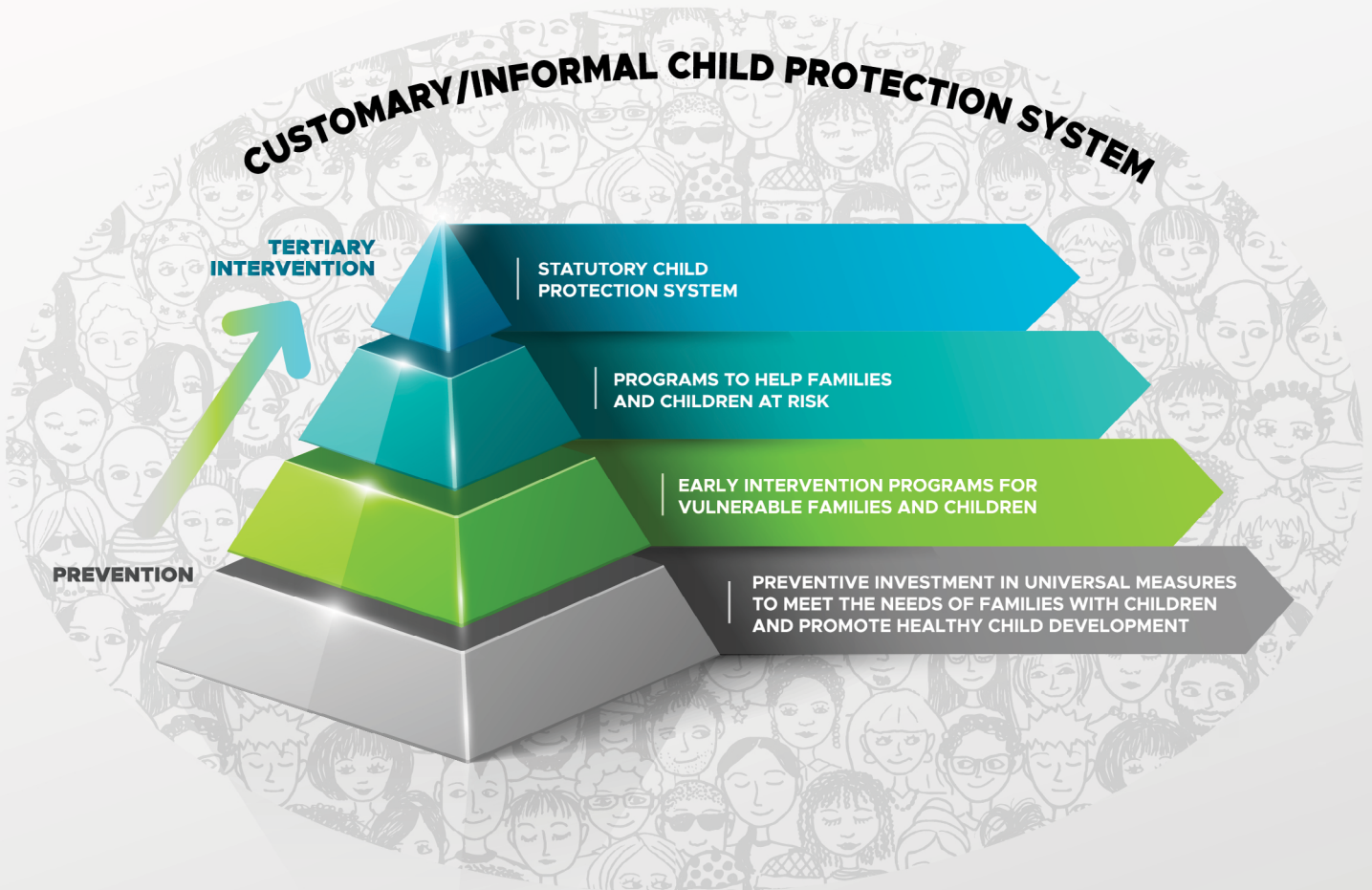


Fig. 5 shows how government can make strategic investment in child protection, starting with preventive investment in universal measures to strengthen the customary/informal child protection system and promote healthy child development, with the statutory child protection system only being brought in prevention, primary and secondary interventions have failed.

22 CONCLUSIONS

Although they will remain a minority, there are children and young people whose needs for a sense of permanence, and their own wishes, can best be met by a longer stay in a children's home in which they can put down roots and which will provide continuity of relationships and a sense of community as they move into adult life (Thoburn, 2016).³⁸⁶

In their paper questioning the prevailing view in England – a view shared by other English speaking countries – that residential care should only be used as a last resort, Homes et al. (2018)³⁸⁷ propose that decisions about placement focus on the developmental needs as well as the preferences (including those concerning the mix of residents) of children and young people. Their conclusion sums up the common history of disillusion with residential care – its cost, both human and financial, the difficulties of recruiting and retaining dedicated, skilled staff who can negotiate the blurred lines between the roles of professional carers and extended family, as well as working with birth family and residents' peers, the challenges of creating a truly salutogenic environment whilst living within financial constraints, continuously making and recording continuous clinical observations, and constructing a facility that is safer than home, but feels like home, and enables residents whose experiences, behaviour and emotions are at the extreme ends of the spectrum, to feel normal.

The history of residential childcare in England has undoubtedly been marred by tragedies. A new era of reforms has begun to test how decisions are made about the purpose of each child's placement, rather than a one-size-fits-all approach. There is some movement toward adopting a child development perspective, by considering placement purpose rather than type to better support a broader range of child needs, and in recognition of the heterogeneity of children and young people placed in out-of-home care. For example, there is a growing interest in the safe recruitment and training of staff in residential care homes and there are recent examples that highlight flexibility in professional thinking about a continuum of care for children in out-of-home care, including residential children's homes. However, at present, the view that family-based care is the preferred placement choice undoubtedly remains.

386. Thoburn J (2016) Residential care as a permanence option for young people needing longer-term care *Children and Youth Services Review* **69** 19-28.

387. Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth* 35 (3): 209-224

While foster care is beneficial to many children, we must consider whether the intimacy and family ideals of this setting are appropriate for all children entering the care system. Furthermore, as argued in this paper, we need to consider the views of children and young people in out-of-home care, in terms of the placements they deem to be most appropriate to meet their needs. We also need to broaden our focus to better understand the impact different placements can have on a child's ability to develop attachments and relationships, a sense of belonging, and an understanding of home. We may also appraise the role of carers, as parents or as trained staff members. [However] much of the research in this area is in its infancy, particularly in terms of high-quality outcomes studies which facilitate attribution of outcomes to specific placements or child welfare interventions. Developing the evidence base and our understanding of these areas will allow us to better understand how placements, regardless of type, can best support the opportunities and life chances of children placed in out-of-home care.³⁸⁸

Despite its limitations there is research showing that residential care can work. When it is built on a platform of therapeutic principles – see for example the Principles of the International Work Group on TRC, of CREATE or of Sanctuary, when it makes use of assessment of children and young people needs, and brings in evidence-based therapeutic interventions as required, residential care can provide a stable setting for children and young people, facilitate healing and produce good developmental outcomes that persist into adulthood.

Thoburn (2016) reports on the success of long-term placements in small group of homes containing 4-5 residents in England.³⁸⁹ The Jo's Place model in Uniting Communities, South Australia, operates on similar lines; it is now being evaluated. Ainsworth has noted that smaller groups may sacrifice economies of scale that would enable the full-time employment of clinicians.³⁹⁰

The systems of child protection – both formal (statutory) and informal (customary) – are complex and dynamic. This means that practitioners need to be alert and adaptable when faced with unintended consequences of their interventions. Quality standards try to sum up the most significant amongst a vast array of conditions that interact to produce the environment for children and young people in OOHC residential care, but therapeutic outcomes are most strongly affected by the quality of the relationships – between staff and residents, between residents and other residents, between residents and their families, and between residents and their peers. Addressing the multiple risks arising in the residential OOHC environment will keep risk managers on their toes – child safe principles will help to reduce these risks but cannot eliminate them entirely.

388. Holmes L, Connolly C, Mortimer E & Hevesi R (2018) Residential Group Care as a Last Resort: Challenging the Rhetoric, *Residential Treatment for Children & Youth*, 35:3, 209-224, p221

389. Thoburn J (2016) Residential care as a permanence option for young people needing longer-term care *Children and Youth Services Review* **69** (2016) 19-28.

390. Ainsworth F & Hansen P (2018) Group Homes for Children and Young People: The Problem Not the Solution, Opinion, *Child Australia*, V43 No. 1 pp. 42-46

Whilst it is misguided to regard residential care as the option to call on when all else has failed, all forms of OOHC should be regarded as options that arise when every possible effort to support the informal system protecting a particular child or young person has failed. If such efforts do not result in the provision of adequate material resources, successful violence prevention initiative, training in authoritative parenting, and access to the full range of health services (including family planning), they are not likely to succeed, even when accompanied by intensive interventions such as TFCO or MST.

Any approach to OOHC provision has to be tailored to meet the needs of the children and young people whom it will accommodate and to take into account the ecological context of those individuals, including cultural identity.

Any approach needs to be thoroughgoing, with all staff, from managers down, steeped in its philosophy, and dedicated to the honest reflection that is required for continuous improvement. It needs an externally driven implementation, monitoring and evaluation mechanism – one of the advantages of off-the-shelf models over custom built alternatives, although it can be contracted out to academic or other specialists.

Finally, any approach needs to leverage the expertise across this and other networks of service provision throughout the community to provide the strongest possible support to children whose informal child protection system has failed, healing the damage and setting them on the best possible developmental trajectory. And it must act in concert with all sectors to address the weaknesses in that informal system of child protection to prevent further harm.

TABLE 21: Comparison of OOH Models

KEY:

Models rated for suitable for group, residential, and community treatment facilities (higher levels of care)

****CEB4CW Ratings 1: Well supported by research evidence; 2: Supported by research evidence; 3 Promising**

Model of care: Model of care/ role of residential care

Main Focus: Main Focus/Individualised Program

Staff: Staff – qualifications etc Collab. Team Incl. profs, family, school/ etc

Cultural Comp: Cultural competence. Voice of child Life time care Trauma-informed Individualised? Relationships/Attachment Systems approach

Governance: Risk management Fidelity Assurance Systems?

Effectiveness: Cost per child and cost effectiveness? Suited for Australia? Suited for ATSI and CALD children?

Model	**	Model of care	Main Focus	Staff	Cultural Comp	Governance	Effectiveness
Treatment Foster Care Oregon -Adolescents	1	Temporary pending resolution of behavioural problems	Focus on behaviour management, not on attachment, relationships or overall development.	Team of 6-8 for one child (may add siblings with same symptoms)	No explicit focus on cultural identity, voice of child.	Strong outside training, implementation and monitoring.	Very High – at outset and on-going
Previously Multi-Dimensional Treatment Foster Care		Consistent reinforcement of positive behaviour, supervision of peer associations, academic support	Emphasis on return to family setting, so no long-term contact with residential staff	Team supervisor – Master's Family & child therapists – Masters Skill teachers – Bachelor's Foster parent Recruiter/Trainer/ PDR Caller	No clear focus on trauma-informed carers/therapists?	Risk management through high staff-child ratio, high professional qualifications	Adequacy of funding?
Recently implemented by Vic Gov with OzChild & Anglicare					No clear focus on attachment, establishment of networks of relationships	Developed in US – translation to Australia especially for ATSI or CALD children uncertain	Cost effectiveness?
					No focus on cultural competency		Suitability for local environment ATSI & CALD children?
					No systems focus		

Model	**	Model of care	Main Focus	Staff	Cultural Comp	Governance	Effectiveness
Positive Peer Culture Not implemented in Australia?	2	For high-risk children in residential & other institutions This is a program to use in an institution, not a model of care 5 x weekly 45-90-min structured group meetings for 6-9 months	Promote empathy, care and concern for others not automatic obedience. Adoption of concern for others replaces bad behaviour. Engage in community service projects	Relevant Bachelor's for direct service workers Relevant Master's for group leaders Five or more years' experience in positive youth development programming for supervisors Staff teams formed around group of 10-12 children Manual	No explicit focus on these components	Program comes into institution, lower risk than for full time residential, but child safe principles need to be implemented on staff and mix of children in program	?
Children And Residential Experiences (CARE)	3	Seeks to instil throughout the whole organisation core research informed principles related to child development, attachment, trauma, family involvement, and human ecology, to promote conscious, purposeful action in the best interests of the child. Relationship-based Trauma-informed Developmentally focused Competence-centred Family-involved Ecologically oriented Compatible with LT/permanent placement	Routines, structures and processes are congruent with the principles to maximise positive learning and minimise conflict. Improve children's relationships and self-efficacy Involve families Recognize and respond appropriately to trauma-based behaviour Enrich physical & social environment to create therapeutic milieu	All agency staff trained No minimum quals. to become trainer of trainers. Manualised 3 years to implement	Focus on best interests of child – with individualised decisions. This should facilitate recognition of cultural needs, voice of child. Strong focus on relationships with staff, peers & family – attachment promoted. Trauma-informed. Recognises systems (ecological) influences	Lengthy implementation period (3 years) with outside training, and on-going monitoring. Provided program is adopted alongside child safety principles then the whole environment should defuse behavioural problems and facilitate healing.	Substantial initial investment and continuing costs. Should be adaptable Should be suitable to cultural context of children

Model	**	Model of care	Main Focus	Staff	Cultural Comp	Governance	Effectiveness
Phoenix House Academy	3	Residential treatment program for adolescents aged 13-18 with substance use and co-occurring mental health disorders, and their families	<p>Modified therapeutic community. Residents attend school full-time and have a variety of activities geared to improving their wellbeing in mental and medical health, family, social, educational/ vocational, legal, and recreational domains.</p> <p>Individual and group counselling</p>	<p>Master's for Supervisor Batchelor's for counsellors or equivalent experience with Certificate Training or experience mental health and/or substance abuse field for field counsellors.</p> <p>1 month to 1 year of residence/treatment</p> <p>3-5 days to train staff Manual</p>	Not known	<p>Special precautions required for managing children with addictions and the people who may seek to supply them.</p> <p>Staff checks and mix of children in group sessions</p>	

Model	**	Model of care	Main Focus	Staff	Cultural Comp	Governance	Effectiveness
Sanctuary Used by authorised provider Mackillop in Victoria, NSW & WA	3	<p>A program to transform a care-providing institution (residential OOH, DV or homeless shelters, mental institutions) into a safe environment which will promote healing in those who are recovering from trauma.</p> <p>7 commitments:</p> <ul style="list-style-type: none"> Nonviolence Emotional intelligence Social learning Democracy Open communication Social responsibility Growth & change <p>Sanctuary Psychoeducation curricula for youth, parents & carers</p>	<p>Promotes safety and recovery from adversity through the active creation of a trauma-informed community.</p> <p>The Sanctuary environment is designed to create a trauma-informed and trauma-sensitive environment in which specific trauma-focused interventions can be effectively implemented.</p> <p>Problem solving framework: Safety, Emotions, Loss, and Future, representing major trauma disrupted areas needed for recovery.</p> <p>Sanctuary Tool Kit: individual and community practices to strengthen emotion regulation skills of individuals and build protective factors into the community.</p> <p>Specific PTSD services for children and safe home services for parents/carers.</p> <p>Improve staff morale Reduce use of constraints</p>	<p>Collaborative environment for staff High functioning multi-disciplinary teams</p> <p>Only qualification willingness to undergo training and introduce the model.</p>	<p>No explicit focus. Needs of children and young people will still need to be assessed by clinically qualified staff and relevant therapies brought in as required.</p>	<p>Safe Child principles will need to be implemented alongside this approach.</p> <p>Approach should reduce risk of harm by staff and residents – if thoroughly implemented.</p>	<p>Funding required for 3 years of initial training & implementation</p> <p>May be less expensive than other package models but offers limited therapeutic interventions as part of package.</p> <p>Elements of the approach are intended to have the force of therapeutic interventions.</p>

Model	**	Model of care	Main Focus	Staff	Cultural Comp	Governance	Effectiveness
Stop Gap Not used in Australia	3	<p>Intensive clinical intervention to reverse escalating bad behaviour for children 6-17 and their parents.</p> <p>Designed as a model for residential treatment centre with 25-35 residents</p> <p>Aims to: Reduce length of stay in residential treatment Reduce disruptive and aggressive behaviours</p> <p>Improve outcomes in post-discharge environment</p>	<p>Environment-Based intervention in residential care:</p> <p>*Token economy to modify problem behaviour</p> <p>*Direct Instruction in reading & maths to improve academic outcomes</p> <p>*Problem solving and & anger management skill training</p> <p>*Social skills training/ reinforcement (incidental teaching training for all staff)</p> <p>Intensive Intervention</p> <p>To achieve rapid step down to EBI through Function-based assessment (FBA and functional analysis) & Function-based behavior support planning</p> <p>Discharge related intervention</p> <p>Also provides children and young people services</p> <p>For Disruptive behavior disorders including non-compliance, conduct problems, and aggression.</p> <p>Services to parents for: Lack of effective parenting practices such as limiting setting, communication, reinforcement procedures, tracking and monitoring behavior, etc.</p>	<p>Direct care staff - all Bachelor's (ratio: 1 staff/8 youths)</p> <p>Direct care supervisor</p> <p>Clinical consultant</p> <p>Master's with training in principles of applied behaviour analysis</p> <p>Does not seem to provide a collaborative team approach</p>	<p>No focus on trauma-informed approach – just with behaviour management.</p> <p>Does not seem to focus on whole-person, voice of child, systemic influences on child's development and wellbeing, attachment and relationship in generals.</p> <p>No allowance for cultural competency</p>	<p>Lack of a trauma-informed approach may promote risk of conflict and violence</p> <p>Need safe child principles.</p>	<p>May be less expensive than a package model that is more holistic and may be effective at curbing overt manifestations of trauma, but ability to promote good overall functioning seems limited.</p>

Model	**	Model of care	Main Focus	Staff	Cultural Comp	Governance	Effectiveness
Teaching Family Model (TFM) Used by Berry Street in Vic	3	<p>Youth who are at-risk, juvenile delinquents, in foster care, mentally retarded/developmentally disabled, or severely emotionally disturbed; families at risk of having children removed. Can be delivered in homes, or OOHC, or other institutions</p> <p>24/7 in residential care – up to 9 months</p> <p>Home based 10-15 sessions per week for 6-10 weeks.</p> <p>For children 0-17 and their parents</p> <p>Can support children and young people 6-17 in family style setting</p> <p>*Teaching systems *Self-determination *Client advocacy *Relationships *Family-sensitive approach *Diversity *Professionalism</p>	<p>The ‘teaching family’ – a couple – live with the children, offering a family-like environment in the residence. The teaching parents help with learning living skills and positive interpersonal interaction skills.</p> <p>*develop proactive social behaviours *increase their social skills *achieve developmental milestones</p> <p>They are also involved with children’s parents, teachers, and other support network to help maintain progress.</p> <p>Also provides services for problem behaviours in children or family problems</p>	<p>Minimum Bachelor’s in Social Work or Psychology for Practitioners</p> <p>But minimum qualifications may vary according to jurisdiction</p> <p>Certification by TFM required</p> <p>Manual and training available</p>	No explicit focus on these elements, so adequacy not clear.	<p>Clinical assessment required to assess extent of child’s needs – undiagnosed mental health or behavioural issues could create risk.</p> <p>Safe Child Principles required</p>	May be less costly than alternatives?

Alternatives to long term residential care							
Multi-dimensional Family Therapy (MDFT) Not in use in Australia?	1	<p>Integrated Family Therapy for children and young people 11-18 (and their parents): substance abuse or at risk, delinquent/ conduct disorder, school and other behavioural problems, and both internalizing and externalizing symptoms.</p> <p>1-3 (45-90 min) sessions per week for 3-6 months</p>	<p>Therapy sessions with child, parents and both together to:</p> <ul style="list-style-type: none"> * improve emotional regulation, coping, and problem-solving skills, *improve expressive and communication skills, *promote youth success in school/work; *reduce youth drug use and problem behaviours; <p>Improve and stabilize mental health problems;</p> <ul style="list-style-type: none"> *improve parenting skills and practices; <p>Enhance parents' individual functioning; Improve family communication and problem-solving skills; Strengthen emotional attachments and feelings of love and connection among family members; Build family member capacity to actively reach out to access resources necessary for stress reduction or daily life needs.</p> <p>Provide services to children and young people for addictions, school or family problems, internalising /externalising behaviours, high-risk sexual behaviours.</p> <p>Provide services to parents of children and young people with problems who may have their own issues with addiction or mental health.</p>	<p>Therapist must have Master's in relevant discipline. Assistant therapists relevant Bachelor's.</p> <p>Manual on implementation Training available</p> <p>Therapist training for full certification takes approximately 5 months to complete, and it includes 3 on-site trainings, weekly consultations, access to the online program, review of video recordings of therapist's work, competence ratings, and written examinations. Supervisor training takes an additional 4 months. MDFT also provides train-the-trainer training where trained MDFT supervisors can be trained as agency-based or regional trainers and have the capacity to train new therapists with only minimal support from MDFT International.</p> <p>No collaborative team approach</p>	<p>Works on building relationships so assume voice of child is heard at least.</p> <p>No explicit focus on these dimensions – especially cultural competence, systemic influences, trauma-informed.</p> <p>This is a limited intervention, so long term care not relevant.</p>	<p>Biannual reporting on fidelity & outcomes via MDFT portal.</p> <p>Safe child principles need to apply.</p> <p>If the program is delivered in residential care, then it should be delivered within the framework of a comprehensive model of care – see models above.</p> <p>Manual</p>	<p>Cost per child?</p> <p>Less than residential program, especially if it can be delivered at child's home.</p>

Multi-Systemic Therapy	1	<p>Family/community-based treatment for serious juvenile offenders with possible substance abuse issues and their families.</p> <p>*Decrease youth criminal behaviour and out-of-home placements.</p> <p>Empower & skill parents and children and young people to deal with problems</p> <p>Delivered in home or other convenient place</p> <p>Intensity – from 1 x week to daily</p> <p>24/7 on-call clinical services</p>	<p>* address a comprehensive range of risk factors across family, peer, school, and community contexts;</p> <p>* promotion of behaviour change in the youth's natural environment, with the overriding goal of empowering caregivers; and</p> <p>*rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behaviour change.</p> <p>Excludes children with identifiable psychiatric problems, autism, sexual offence history</p>		Exclusion of children with psychiatric disorder, autism, sexual offence history, reduces risk for agency delivering program.		
------------------------	---	---	---	--	--	--	--

<p>Functional Family Therapy (FFT)</p> <p>FFT – Child Welfare is one of two programs supported by NSW Government</p> <p>Delivered by MacKillop at 3 sites in NSW</p> <p>For children 0-17</p> <p>-one in partnership with an ACCO</p>	2	<p>Family preservation or reunification program</p> <p>Family intervention for children 11-17 with severe externalising behaviour problems.</p> <p>12 to 14 one-hour sessions (8 sessions for mild cases and up to 30 for more difficult situations), mostly over a three-month period.</p> <p>Can be delivered in birth, adoptive or foster home, in community agency, or school</p>	<p>Aims:</p> <p>Eliminate youth referral problems (i.e., delinquency, oppositional behaviours, violence, substance use)</p> <p>Improve prosocial behaviours (i.e., school attendance)</p> <p>Improve family and individual skills.</p> <p>Five distinct intervention phases:</p> <p>Engagement: Introduction/ Impression (Pre-Intervention)</p> <p>Motivation: Induction/Therapy (Early sessions)</p> <p>Relational Assessment (by conclusion of early sessions)</p> <p>Behavior Change (Middle sessions)</p> <p>Generalization (Later sessions)</p>	<p>Varied qualifications for therapists</p> <p>Onsite Program Supervisor - minimum of Master's level education is required.</p> <p>Training and manual available.</p>			
---	---	---	--	---	--	--	--

Notes

- Any approach will need to conform to Child Safe Principles
- Models rated for suitable for group, residential, and community treatment facilities
- TFCO-A (Treatment Foster Care Oregon-Adolescents)
- MST-CAN (Multi-systemic Therapy for Child Abuse & Neglect)
- SR: Scientific Rating by California Evidence-based Clearing House for Child Welfare

