



Institute of Child Protection Studies

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# What works in residential care? – A review of the literature

Report by Institute of Child Protection Studies for Marist Youth Care

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## WHAT WORKS IN RESIDENTIAL CARE.

### EXECUTIVE SUMMARY

#### *Introduction*

This literature review examines literature on what works in residential care. The review has not identified any one right way to do residential care, and certainly has not found evaluated models which have shown exceptionally effective results across a range of measures. It has, however, identified some key principles for providing residential care for young people which takes account of the current literature.

The literature review has been undertaken following a thirty year period during which Australian government policies of deinstitutionalisation have led to a heavy reliance on foster care as the preferred method of looking after children who are unable to live with parents (Ainsworth & Hansen, 2005; Bath, 2002; Scott, 2003).

Today a young person is normally referred to residential care because of complex needs or the need to keep siblings together (Australian Institute of Health and Welfare (AIHW), 2005). Often these young people may display behaviours which are difficult to manage and which have been factors in the reasons that other forms of care have not been successful (Ainsworth & Hansen, 2005).

Whilst residential care may often be seen as a last resort, Anglin argues that for some young people, at a certain stage of their lives it could be regarded as the preferred option (Anglin, 2004). What a well functioning residential environment can offer is a structured supervised, environment which is ‘less emotionally charged’ and ‘more consistently responsive’ for young people who need high levels of support (Anglin, 2004, p.188).

#### *Approach to the literature*

For the purposes of the review, the Australian Institute of Health and Welfare’s current definitions of out-of-home care and residential care are used. Out-of-home care refers to ‘out-of-home overnight care for children aged 0-17 years where the State makes a financial payment’ and residential care is ‘where placement is in a residential building

whose purpose is to provide placements for children and where there are paid staff (AIHW, 2004, pp. 7- 8). Given the dearth of Australian research into residential care, the literature is drawn from both Australian and overseas sources and includes theoretical and empirical studies, government reports and policy statements.

Literature pertaining to residential treatment centres in USA, and forms of residential care found in Canada and Europe may have varying purposes, structures and auspices from those found in Australia. These different conditions mean that there is an issue about how appropriately overseas findings can be transferred to local contexts. Other methodological issues include the difficulty in controlling for all variables in research and the differences in measurements used.

The literature review is divided into two main sections.

- a discussion of the key themes or principles to emerge from the reading of the literature
- a review of the literature identified for each of the Looking After Children (LAC) life areas. These were selected because they emerged from research in the United Kingdom about the essential areas of children's lives which needed to develop in order to achieve well being and independence (Wise, 1999). Finally some of the literature about leaving care is presented.

### ***Key themes***

#### **Focus on the individual needs and situation of the young person**

This theme emphasises individualised holistic assessment and care and therapeutic plans (Barth, 2005; Morton, Clark, & Pead, 1999). Both in Australia and the United Kingdom, young people in residential care tend to have more complex problems than those cared for by relatives and foster care (Bath, 1998b; Department of Health, 1998). One of the challenges for a residential program is to develop the capacity to provide an individualised approach in a programmed and group environment (Barth, 2005).

### **Facilitating normalcy in the lives of young people and meeting their individualised needs**

Research has shown that many young people in out of home care want their lives to be as normal as possible or to feel normal (Anglin, 2002; Gilligan, 2001; P. Martin & Jackson, 2002). At the same time many young people now in residential care have very special and individualised needs which have to be attended to in order for them to be in a position to attain the 'normal' relationship and work skills which will give them opportunities for life (Bath, 2003; J. Ward, 2004). Therefore whilst an 'ordinary everyday life' may be the goal in residential care, it needs to stand alongside 'special every day living'. The ways this balance can be achieved may include individualised support with daily living, and opportunity led work (J. Ward, 2004). It may include individually selected leisure and educational activities (Gilligan, 2001).

### **All aspects of the residential care situation organised in 'congruence with the children's best interests'**

Anglin's (2004) study of group care residences in Canada, reveals the competing claims of different aspects of the organisation of a residential care facility. He describes this struggle taking place through three psychosocial processes : the need to create an 'extrafamilial' home which is not a family home; the challenge of day to day recognising and responding to 'pain and pain-based behaviour' ; and 'developing a sense of normality' (Anglin, 2004, pp.178-179).

The struggle to achieve the residents' best interests needs to occur at the different levels of operation of the residential care facility: extra-agency; management; supervision; casework and teamwork; youth resident and family level (Anglin, 2004). This supports the findings of United Kingdom research that a well functioning residential facility exhibits concordance between the expressed goals of the staff and managers, societal goals for children in care, and staff and child culture (Brown, Bullock, Hobson, & Little, 1998).

### **Connections, collaborations and continuity of care**

Bronfenbrenner's influential bioecological model highlights the range of psychosocial environments which move out from the face to face family or caring environment to encompass the neighbourhood and other communities in children's lives (Bronfenbrenner, 1999). Current aspects of residential work include the importance of promoting continuity of care through the maintenance of significant relationships during times of transition, and the residential care facility being outwardly orientated to and involved with family and community (Barth, 2005; Milligan, 2003). Forming collaborative relationships is important to many areas of young people's lives (Borland, 1998; Francis, 2000; Richardson & Lelliott, 2003; Sinclair).

The Wraparound program illustrates both individually focussed planning and service delivery and cross sectoral collaboration (Burns, Schoenwald, Burchard, Faw, & Santos, 2000). Whilst it has a strong evidence base in a community context, its applicability to residential care appears yet to be fully tested.

### **Participation in decision making**

Article 12 of the United Nations 1989 Convention on the Rights of Child emphasises children's rights to participate in decision making in matters affecting them (Office of the United Nations High Commissioner for Human Rights, 1989). In NSW the participation principle is foundational to the Children and Young Persons (Care and Protection) Act 1998 (Parkinson, 2001). CREATE Foundation is becoming influential in promoting young people's participation in policy and planning of out-of-home care services (Create Foundation, 2000).

There are difficulties in the implementation of such participation. Some children and young people in care feeling alienated by decision making processes such as case conferences (Cashmore, 2002). Cashmore suggests that the following are conditions which will facilitate participation at the individual level:

- The opportunity and choice of ways to participate
- Access to relevant information

- A trusted advocate or mentor
- Policy and legislation that require children and young people to be consulted and informed
- Ways to complain
- Ways for services to evaluate their performance and the way they encourage the involvement of children and young people (Cashmore, 2002, p. 841)

### **Resilience**

Many young people in residential care will have suffered multiple risk factors prior to entering care. One role of residential care can be to build some protective factors (for example education, skills acquisition) with the aim of promoting resilience (Gilligan, 2001). Resilience work with young people builds on a strengths- based tradition.

Newman's review of the literature suggests the following key points which promote resilience across the lifecycle:

- Strong social support networks
  - The presence of at least one unconditionally supportive parent or parent substitute
  - A committed mentor or other person from outside the family
  - Positive school experiences
  - A sense of mastery and a belief that one's own efforts can make a difference
  - Participation in a range of extra curricular activities
  - The capacity to re-frame adversities so that the beneficial as well as the damaging effects are recognised
  - The ability- or opportunity-to 'make a difference' by helping others through part-time work
  - Not to be excessively sheltered from challenging situations to develop coping skills.
- (Newman, 2002, p.69)

### **Programs need to occur on the basis of agreed and shared theoretical frameworks**

The literature highlights the necessity for clear theoretical underpinnings for residential care (Bath, 1998a; Morton et al., 1999). There is a need in residential care to understand behaviour, so that interventions and programs have a rationale and method of accountability (Bath, 1998a; Clough, 2000).

Morton et al (1999) suggest the frameworks of attachment, trauma and social learning. In Clough's (2000) terminology these form 'theories of the resident

world'. Other theories in this category which have already been identified as relevant to residential care are resilience theory and bioecological theory. Additional relevant theories relate to function and task, methods of intervention (discussed throughout the review) and residential homes as systems. Values and beliefs are pivotal to the development of a residential framework (Clough, 2000).

### **Safety is a priority**

The provision of a safe environment for residents and staff is fundamental to good residential care practice (Abramovitz & Bloom, 2003; Morton et al., 1999; Scottish Institute for Residential Child Care, 2004). Clear policies to manage abuse or maltreatment allegations are required (Create Foundation, 2005). Documented strategies for preventing and managing crises in resident behaviour include the Sanctuary Model (Abramovitz & Bloom, 2003) and Therapeutic Crisis Intervention (Residential Child Care Project, 2003). Restorative practices, beginning to develop an evidence base, may contribute to a safe environment (McCold, 2005).

### **Training of and support for staff**

All literature reviewed indicated the importance of trained staff and ongoing consultation and support for staff (Lindsay & Foley, 1999; Milligan, 2003; Morton et al., 1999; Residential Child Care Project, 2003). The training of social pedagogues or social educational professionals has influenced the new Scottish 'particular pathway' for residential care within the professional qualification in social work, the Diploma in Social Work (DipSW) (Milligan, 2003). Subject areas include child development, group care, use of self, and interdisciplinary subjects including the creative arts and health matters (Milligan, 2003).

### ***Physical and mental health***

Young people in residential care are likely to have mental health issues/ problems which need careful assessment and attention (Richardson & Lelliott, 2003). Research from the United Kingdom has highlighted the importance of establishing strong links with child and adolescent mental health services and to health services in general, and that this kind of collaboration may require additional resources (Audit Commission, 1999; Department of Health, 1998; Vostanis, 2003).

### ***Emotional/ behavioural development***

'Opportunity led work' (A. Ward, 2002) and other models of connecting with young people, such as the 'circle of courage' are relevant to promoting social and emotional development in the day to day care of young people (Brendtro, Brokenleg, & Van Bockern, 2002). In social pedagogy, the social care tradition in Europe each daily activity is seen as a social education possibility, and workers respect the individuality of each resident, as well as working with the peer group as an opportunity for social education (Cameron, 2004). Social pedagogues use 'heart, brains and hands' (Cameron, 2004, p. 144).

Moving away from the everyday, promising therapeutic approaches include multisystemic therapy (MST) (Henggeler, 1999), and some cognitive behavioural interventions (Stevens, 2004). The Youth Horizon's Trust program in New Zealand has adapted both MST and Wraparound, which are community based approaches, to the residential care environment, with encouraging results (Saville-Smith, Warren, Ronan, & Salter, 2005).

The peer group presents special challenges in residential care and some writers are concerned about its iatrogenic effects (Barth, 2005; Handwerk, Field, & Friman, 2000). Smaller groups, and the residential care facility having control over selection may be important (Barth, 2005; Morton et al., 1999). The group can also be viewed as a resource and the positive peer culture program (PPC) has some positive results in some conditions, as has the EQUIP program which has added a training element to PPC (Gibbs, Potter, & Goldstein, 1995; Vorrath & Bendtro, 1985).

Handling issues of sexual identity in a residential care environment requires sensitivity to the needs of young people who have suffered abuse and/or perpetrated abuse (Farmer & Pollock, 2003). This may require an extra level of supervision, sex education and staff training and support.

### ***Self care skills***

Self care skills can be seen as part of the day to day social education of the young people, requiring an individualised approach (Clough, 2000). Recreation and leisure also provide opportunities for learning self care skills and for promoting resilience generally, and for developing community connections (Daniel, Wassell, & Gilligan, 1999). Self care skills are also developed in wilderness or adventure activities, and these require special training and risk-management (Romi & Kohan, 2004).

### ***Family and social relationships***

The literature indicates that promoting and developing relationships with significant others is vitally important to the well-being of young people in residential care (Barth, 2005; Morton et al., 1999). Young people may need assistance to maintain relationships with family members who are not associated with conflict or abuse, and specialist assistance to address issues of past or ongoing conflict and abuse (Maunder, Liddell, Liddell, & Green, 1999). Some programs and traditions draw family members into residential care activities where possible or appropriate (Cameron, 2004; Scholte & van der Ploeg, 2000).

Relationships with community can be enhanced through leisure, volunteering and carefully designed mentoring programs (Gilligan, 2001).

### ***Identity***

Young people are wrestling with questions of who they are, where they belong, what they can do and what they believe in (Charles & Nelson, 2000). For young people in out-of-home care, developing answers to these questions may be complicated by disrupted relationships and lack of information. Life story work and self narrative techniques are

some ways in which young people may be assisted to develop a sense of identity (Community Services Commission, 1999; Gilligan, 2001; F. Martin, 1998). Developing multiple roles through participation in a variety of spheres can mean that being in care does not dominate as an identity.

### ***Education***

Research attests to the important role of educational achievement and positive educational experiences as a protective resilience enhancing factor (Gilligan, 2001; P. Martin & Jackson, 2002). Yet many young people in residential care may have a history of exclusion and expulsion (Hunt, 2000), and may have experienced mainstream schools as alienating. One of the issues in making a difference for young people at risk of premature school leaving is achieving a balance between seeking connection with mainstream schooling (perhaps through innovative or individually planned educational programs) and offering alternative educational approaches (Dusseldorp Skills Forum, 2005; Long, 1998).

Partnership or collaboration between sectors and agencies is central to achieving better outcomes for children in out of home care, with young people important partners in these arrangements (Borland, 1998; Fletcher-Campbell, 1998) The literature indicates a critical role for residential care and residential care to actively support young people's education, building a culture of positive regard for education within the residential care environment, and supporting schools (Gallagher, Brannan, Jones, & Westwood, 2004; Lindsay & Foley, 1999).

### ***Social presentation***

**There is limited research available in this area.**

### ***Leaving care***

A consultation with young people through the CREATE Foundation confirmed the importance of a planned, flexible and graduated process for leaving care identified in the above literature (Create Foundation, 2000). The consultation identified an overriding theme of not wanting to be 'dumped', and wanting to 'be supported until I become an

adult both emotionally and physically and am ready to live independently'(Create Foundation, 2000, p. 24).

Young people living at home usually have the benefit of a graduated process towards independence and the literature supports a graduated approach being available to young people in out of home care, including flexible and individually tailored approaches to the timing of leaving care. One issue is whose responsibility this becomes and who provides the continuity of relationships supported in the literature For some young people work may have been able to be undertaken so that the family or extended family is supportive (Clare & Murphy, 2000). Leaving care schemes and leaving care workers positions can play an important part, particularly when linked with the agency and residential care workers which provided the residential care (Maunder et al., 1999).



## INTRODUCTION

This literature review examines literature on what works in residential care. The literature review has been undertaken following a thirty year period during which Australian government policies of deinstitutionalisation have led to a heavy reliance on foster care as the preferred method of looking after children who are unable to live with parents (Ainsworth & Hansen, 2005; Bath, 2002; Scott, 2003). Australia has demonstrated a greater tendency in that direction than other many other countries (Bath, 2002). In Australia, in 2000, 93% of children in out of home care were in foster care and 7% were in group care. This compares with UK figures in 1999 of 85% in foster care and 15% in group care (Bath, 2002).

The latest figures from the Australian Institute of Health and Welfare indicate that on 30<sup>th</sup> June 2004, 4% of children in out of home care were living in residential care in Australia. This amounts to 970 children out of a total of 21, 795 children and young people in out of home care (Australian Institute of Health and Welfare (AIHW), 2005). However, the foster care system is under strain due to a number of factors, including availability of foster carers and increased numbers of children coming into care (AIHW, 2005; Scott, 2003).

Today a young person is normally referred to residential care because of complex needs or the need to keep siblings together (Australian Institute of Health and Welfare (AIHW), 2005). Often these young people may display behaviours which are difficult to manage and which have been factors in the reasons that other forms of care (family support, perhaps other family intervention, then foster care placements) have not been successful (Ainsworth & Hansen, 2005). In Australia adolescents are more frequently placed in residential care than are other age groups (Morton et al., 1999, p. 4). Bath has traced the policy changes in Australia whereby residential care was a normal option for children needing care and is now a 'last resort' (Bath, 1998b, p. 7). The Victorian and NSW jurisdictions have recently committed resources to new programs for residential care for this group of young people (Out of home care policy directorate, 2004).

Whilst residential care may often be seen as a last resort option, Anglin argues that for some young people, at a certain stage of their lives it could be regarded as the preferred option (Anglin, 2004). What a well functioning residential environment can offer is a structured supervised, environment which is ‘less emotionally charged’ and ‘more consistently responsive’ for young people who need high levels of support (Anglin, 2004, p.188). For some young people, at some stages, the intensity of a family situation may be uncomfortable and unsuitable. Research by Delfabbro and Barber (2003) indicates that it may be possible to identify early those young people for whom foster care would not be suitable, and is likely to breakdown. For such young people residential care could be valued as an the option of choice (Anglin, 2004). Barth (2005) warns that whilst residential care and treatment is seen as last resort, it is not surprising that it is difficult for residential treatment research to show that it is doing ‘substantial good’ (p.161).

Several writers have emphasised the undertheorised nature of the residential care sector (Bath, 1998a; Clough, 2000, pp.67-70; Milligan, 2003, p. 290; Stevens, 2004).

In Australia Bath has argued that ‘there is no significant body of knowledge about contemporary residential care, no available research examining different service models and no generally accepted handbook of practice’ (Bath, 1998a).

Bath further argues that policy development is dominated by ‘traditional social and welfare work models and values which focus on care, rights, social inequality and political action’, to the neglect of treatment (Bath, 2004, p. 10). He (2003) argues that there should be a shift to incorporate a treatment focus into the care and accommodation models. The conclusions of a consultancy in Victoria were that for a group of high- need children and adolescents in care, aged 11-16, ‘care was not enough’. They need ‘consistent and high quality care, which offers continuity of positive relationships. They also need ‘systematic therapeutic interventions’ (Morton et al., 1999, p. viii).

The United Kingdom, through a series of Government funded projects in the 1990s, has invested considerable resources in researching best practices in residential care (Department of Health, 1998). Residential facilities in the United Kingdom have been commonly called ‘children’s homes’ or ‘residential schools’. In the United States of

America, residential care facilities are often called 'residential treatment centres' (RTCs) and out of this treatment model some treatment approaches have emerged with some research base (Gibbs et al., 1995; Vorrath & Bendtro, 1985).

Nevertheless, a report by the United States Surgeon General appears unconvinced by the current state of evidence about the effectiveness of current practices:

Given the limitations of current research, it is premature to endorse the effectiveness of residential treatment for adolescents. Moreover, research is needed to identify those groups of children and adolescents for whom the benefits of residential care outweigh the potential risks (US Department of Health and Human Services, 1999).

Research on what works in Australia is limited. The Audit of Australian Out-of-Home Care Research found that most of the research projects focussed on foster care, with only three on residential programs. Research on residential care was identified as a gap in this audit (Cashmore & Ainsworth, 2004, p. 28). A need has been identified for coordinated multi-site projects and comparisons.

[If] and when Australia develops a new generation of residential programs with a focus on residential education, re-socialisation and treatment as an alternative to foster care for some of these young people, this will need to be accompanied by systematic and thorough evaluation (Cashmore & Ainsworth, 2004, p. 24).

The Audit report identified the importance of using consistent definitions and measures in research undertaken, such as those developed by the Australian Institute of Health and Welfare (AIHW) and the Looking after Children materials originally developed in the United Kingdom (LAC) (Cashmore & Ainsworth, 2004; Wise, 2003b). In this way the state of knowledge about residential care in Australia may be developed in a systematic way, with comparisons between studies made possible by consistent use of definitions, terms and measures.

## THE LITERATURE REVIEW

### *Definitions*

For the purposes of the review, the Australian Institute of Health and Welfare's current definitions of out-of-home care and residential care are used. Out-of-home care refers to 'out-of-home overnight care for children aged 0-17 years where the State makes a financial payment' and residential care is 'where placement is in a residential building whose purpose is to provide placements for children and where there are paid staff' (AIHW, 2004, pp. 7- 8).

However the literature in this review also covers the literature arising from residential treatment centres in the USA and forms of residential care found in Canada and Europe, which may have varying structures, auspices and purposes from those found in Australia. Where possible these different contexts and conditions are identified.

### *Approach to the review*

The literature covers theoretical and empirical studies, government reports and policy statements from Australia and overseas. There are both empirical studies and principles developed from practice. The disciplines from which the literature is drawn include psychology, education and social work. Increasingly some specialist journals in residential care are emerging, for example *Child and Youth Care Forums*, from Canada, and *Residential Treatment for Children and Youth*, from United States of America. Where possible, the review identifies evaluative studies. The literature is drawn largely from the United Kingdom, United States of America, Canada, Europe and Australia. Whilst the search largely focused on keywords 'residential care', 'residential treatment', 'residential care and education', some literature has been drawn from other literatures areas of relevance to young people's wellbeing, including alternative educational approaches for young people at risk.

This literature review canvasses the topic of what works in residential care by considering, firstly, the key themes which have emerged from the literature.

Secondly, the literature focuses on the areas of care identified in the LAC framework (Wise, 1999). This framework arose from research in the United Kingdom as a way ensuring care is tailored to individual children in all the significant areas of their lives, so that they are prepared for leaving care and for independence: health; emotional and behavioural development; self-care skills; family and social relationships; identity; social presentation; self care skills (Wise, 1999). Finally, the literature available on leaving care is canvassed.

The Child and Family Welfare Association of Australia (CAFWAA) has recommended that state and territory governments provide leadership and funding to implement the Looking after Children case management system in out of home care (Child and Family Welfare Association of Australia, ?). Currently research is being conducted on the comparative implementation of LAC in Australia, Canada and Sweden (The LAC Project Australia, 2005, p. 3).

### ***Limitations of the literature***

Before moving into a discussion of the key principles to emerge from the literature, it is important to canvas some of the methodological issues.

One of the major issues in this review, which draws so heavily on research from overseas is how appropriately overseas findings can be transferred to local community and policy contexts. For example, one of the studies reviewed from Holland refers to good practices in residential care treatment, but there is no indication that this has occurred in a mandated context (Scholte & van der Ploeg, 2000). A useful approach to this issue is to look at the evidence available without ‘implying that a straightforward transplant of one system onto another country is possible or desirable’ (Cameron, 2004). The literature review did not reveal a best practice model of the totality of life which is residential care which could be transplanted to a new environment with confidence. Evaluation studies were often conducted of parts of programs (for example, education), and could not with necessarily attribute outcomes to any single factor. The literature review did reveal key themes and trends, and did identify practices which seem to have a good or promising evidence base under certain conditions.

A further problem in social science and applied social research is that it is impossible to control for all variables. In the same study, Scholte and van der Ploeg acknowledge that whilst they have attributed success to certain factors in the residential care environment (firm but not harsh control, consistent but not obtrusive emotional support, cognitive behavioural training intensive monitoring of treatment, and including the family), other variables, for example school and peer relationships were not considered (Scholte & van der Ploeg, 2000).

Thirdly, what can be regarded as a positive outcome can vary from study to study, and can be affected by what is measured and when it is measured. Due to funding and other practical limitations, it is very difficult to consider the stability of outcomes over time. When looking at studies it is important to be aware of the arbitrary points at which assessment occurs due to funding (Parker, 1998). There are also difficulties in attribution, prediction and explanation. The danger can be that we learn more about one alternative course of action than another, and therefore regard that course of action/treatment/ method too optimistically or pessimistically. 'Although we may untangle the problem of attributing outcomes to key influences, we do not necessarily explain what we discover' (Parker, 1998, p. 200).

## KEY THEMES TO EMERGE FROM THE LITERATURE

### ***A focus on the individual needs and situation of the young person.***

This theme emphasises individualised holistic assessment and care and therapeutic plans (Morton et al., 1999). Both in Australia and the United Kingdom, young people in residential care tend to have more complex problems than those cared for by relatives and foster care (Bath, 1998b; Department of Health, 1998). Many young people in residential care have experienced neglect, varying types of abuse, instability of caring relationships and to have experienced difficulties in relating to their community (J. Ward, 2004). Young people leaving out of home care in the United Kingdom have been shown to experience disadvantage across a range of measures, include health, mental health, homelessness and education (Richardson & Lelliott, 2003). In the United Kingdom research has indicated that there are high levels of psychiatric disorder amongst

young people in residential care (J. Ward, 2004). In NSW, Robin Clark found that the young people in residential intensive support were largely over 13 years old, had schooling issues, over 30% had a diagnosed disability or conduct disorder, a third had some relationship with the juvenile justice system, and most were boys (Clark, 1997, cited in Bath, 1998b, p. 3). A significant proportion of children and young people in the care of the state in Australia have a disability (Kids in Care Education Committee Working Group, 2003).

Individualised assessment of needs, planning and provision of individualised services is required (Barth, 2005). In the United Kingdom this has been enshrined in the National Service Framework for all children, including looked after children. The Every Child Matters strategy is designed to ensure that a common assessment framework is utilised across agencies to ensure that children's needs are identified and met (UK Chief Secretary to the Treasury, 2003). Such individualised assessment is embodied for children in out of home care in the seven areas of the LAC framework. Each young person will differ in their developmental stages and needs in each of these areas, and will need individualised care arrangements to promote their development and well being in those areas (Department of Health, 1998; Wise, 1999).

One of the challenges for a residential program is to develop the capacity to provide an individualised approach in a programmed and group environment (Barth, 2005).

### ***Facilitating normalcy in the lives of young people and meeting their individualised needs***

Research has shown that many young people in out of home care want their lives to be as normal as possible or to feel normal (Anglin, 2002; Gilligan, 2001; P. Martin & Jackson, 2002). At the same time many young people now in residential care have very special and individualised needs (some of which are outlined above) which have to be attended to in order for them to be in a position to attain the 'normal' relationship and work skills which will give them opportunities for life (Bath, 2003; J. Ward, 2004).

This relationship between the ‘ordinary and the special in daily living in residential care’ (J. Ward, 2004) can be seen as similar to the importance of including both care and treatment in residential care, as highlighted by Bath (2003). Ward points out that children who have only experienced conflict and uncertainty, may not experience ‘normal’ living as normal, and that it is important to understand that the whole idea of what is ‘ordinary’ is contested. Therefore whilst an ‘ordinary everyday life’ may be the goal in residential care, it needs to stand alongside ‘special every day living’. The ways this balance can be achieved depend upon the individual young person and the agency, but include individualised support with daily living, and opportunity led work, such as the life space interview (J. Ward, 2004). It may include individually selected leisure and educational activities (Gilligan, 2001).

### ***All aspects of the residential care situation organised in ‘congruence with the children’s best interests’***

Anglin’s (2004) study of group care residences in Canada, reveals the competing claims of different aspects of the organisation of a residential care facility . He describes this struggle taking place through three psychosocial processes : the need to create an ‘extrafamilial’ living environment, a home which is not a family home; the challenge of day to day recognising and responding to ‘pain and pain-based behaviour’ ; and ‘developing a sense of normality’ (Anglin, 2004, pp.178-179). He argues that creating an environment which promotes the residents’ best interests consists of the following interactional dynamics:

- a. Listening and responding with respect
- b. Communicating a framework for understanding
- c. Building rapport and relationship
- d. Establishing structure, routine and expectations
- e. Inspiring commitment
- f. Offering emotional and developmental support
- g. Challenging thinking and action
- h. Sharing power and decision-making
- i. Respecting personal space and time
- j. Discovering and uncovering potential; and
- k. Providing resources. (Anglin, 2004, p. 180)

The struggle to achieve the residents’ best interests needs to occur at the different levels of operation of the residential care facility: extra-agency; management; supervision; casework and teamwork; youth resident and family level (Anglin, 2004). This supports the findings of United Kingdom research that a well functioning residential facility

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exhibits concordance between the expressed goals of the staff and managers, societal goals for children in care, and staff and child culture (Brown et al., 1998). There is a need for clearly stated objectives of what the residential care unit wishes to achieve (Department of Health, 1998).

Hatter and Van Bockern (2005) describe a process whereby a child welfare organisation (which included residential care services) wanted to set up a new strengths based approach to its service delivery. Senior management set up and supported a guiding coalition, which included a cross section of employees, to enable a new philosophy to permeate the organisation (Hatter & Van Bockern, 2005).



### *Connection, collaboration and continuity of care*

Bronfenbrenner's influential bioecological model highlights the range of psychosocial environments which move out from the face to face family or caring environment to encompass the neighbourhood and other communities in children's lives (Bronfenbrenner, 1999). In this model the person-in-context relationships, given their plasticity, should be the focus both for scholarship and for efforts to improve life for both individuals and their 'social worlds' (Lerner, 2005, p.xix)

Current aspects of residential work include the importance of maintaining significant relationships, thus promoting continuity of care at times of transition in and out of care or between care situations (Community Services Commission, 1999). The residential care facility needs to be outwardly orientated to and involved with family and community (Barth, 2005; Milligan, 2003). Family relationships are explored later in this literature review.

The research indicates the importance of promoting a collaborative approach to influencing children's multiple environments (residential, school, community and society) as well as the interactions among these environments (Fletcher-Campbell, 1998).

This is not to say that such collaboration is easy (Flood, 2005). However literature in a number of areas, including mental health and educational outcomes, stresses its importance (Borland, 1998; Francis, 2000; Richardson & Lelliott, 2003; Sinclair).

The Wraparound program illustrates individually focussed planning and service delivery, cross sectoral collaboration and continuity of care. Wraparound originated in the USA and refers to a specific set of programs, policies and procedures which are used to develop individualised services for children and families experiencing problems through a community collaborative structure (Bath, 1998a, p. 21; Burns et al., 2000). It needs to be implemented on a cross agency basis and be supported by the community. Funding needs to be flexible and not tied to specific categories. Young people and children accepted into a wraparound project are accepted on an unconditional basis, until they decide to end the relationship, thus providing continuity of care. The family is an active

partner at all levels in the wraparound process (Burns et al., 2000).

There is an enormous amount of material available on the wraparound model, which includes positive evaluations of services in the child and adolescent mental health area (Bath, 1998a; Burns et al., 2000). It has a strong evidence base as a community based intervention (Burns et al., 2000). Its applicability to residential care appears yet to be fully tested, but is being used by Youth Horizons Trust in New Zealand, as outlined later in this review.

The Turnaround program in ACT is modelled on a wraparound or individual service model (Turnaround Evaluation Sub Committee & Milne, 2004). Similarly multi-sector community strategies include the Youth Treatment Program in New Brunswick, Canada. (Morton et al., 1999, p. 82).

### ***Participation in decision making***

There is a worldwide trend to promote a young person's participation in decision making about care plans and daily living (Cashmore, 2002). Gradually the participation policy is being extended to policy and planning of services. In Australia the CREATE foundation has been influential in promoting the views and participation of young people in care and in legislative change (CREATE Foundation, 2002; NSW Community Services Commission, 2000; Parkinson, 2001).

Article 12 of the United Nations 1989 Convention on the Rights of Child, which emphasises children's rights to participate in decision making in matters affecting them, was influential in the 1989 Children's Act in the United Kingdom (Cashmore, 2002). Research in the United Kingdom both leading up to the Act and afterwards stressed the importance of this (Department of Health, 1998). In NSW the participation principle is foundational to the Children and Young Persons (Care and Protection) Act 1998 (Parkinson, 2001).

Nevertheless there are difficulties in the implementation of such participation, with some children and young people in care feeling alienated by decision making processes such as case conferences (Cashmore, 2002). Cashmore suggests that the following are conditions which will facilitate participation:

- The opportunity and choice of ways to participate
- Access to relevant information
- A trusted advocate or mentor
- Policy and legislation that require children and young people to be consulted and informed
- Ways to complain
- Ways for services to evaluate their performance and the way they encourage the involvement of children and young people (Cashmore, 2002, p. 841)

An emphasis on young people's participation in decision making is a basic principle of social pedagogical practice in residential care found in Germany and in Denmark (Cameron, 2004). In these countries residential care is seen as working towards responsible citizenship through participatory and decision –making opportunities (Cameron, 2004).

### ***Resilience***

Resilience is a 'quality that helps individuals or communities resist and recover from adversities' (Newman, 2002, p.5). 'Resilience appears to be determined by the presence of risk factors in combination or interaction with the positive forces (protective factors) that contribute to adaptive outcomes' (Tomison & Wise, 1999, p.2). As already noted, many young people in residential care will have suffered multiple risk factors prior to entering care. One role of residential care can be to build some protective factors (for example education, skills acquisition) with the aim of promoting resilience (Gilligan, 2001).

For young people who have an accumulation of problem areas in their lives, a reduction by one problem area may reduce the risks of problems later (Stattin & Magnusson, 1996, cited in Gilligan, 2001). The research certainly suggests that it is easier to achieve useful changes where there are moderate, rather than high risk levels, but this is no reason to work on reducing the number of problems areas (Fergusson, Lynskey, & Horwood, 1996; Gilligan, 2000).

Resilience based work with young people is based on a strengths based- tradition, which works from identifying positives in a person's situation (Anglin, 1999; Gilligan, 2001). Gilligan (2000) identifies three sources of resilience: a secure base; self-esteem; and self efficacy. All three can be affected by positive daily experiences. In out of home care, there can be efforts made to build a 'base camp' of a network of supports for the young person which can endure (Gilligan, 2000). Self esteem is a complex concept enhanced by positive relationships (Gilligan, 2000). The presence of at least one caring relationship with an adult is documented as an important protective factor for at-risk youth (Laursen & Birmingham, 2003). A sense of self efficacy can be promoted by involving young people in the planning processes involved in care and by developing positive leisure and educational experiences (Gilligan, 2000).

These three sources of resilience are similar to the values suggested by Bendtro, Brokenleg and Van Bockern (2002) as providing a basis for developing positive cultures for youth work and education programs. These positive values, derived from western theories of self esteem and Native American cultures are: belonging; mastery; independence; and generosity (Brendtro et al., 2002).

Newman's review of the literature confirms the above ideas and suggests the following key points which promote resilience across the lifecycle:

- Strong social support networks
  - The presence of at least one unconditionally supportive parent or parent substitute
  - A committed mentor or other person from outside the family
  - Positive school experiences
  - A sense of mastery and a belief that one's own efforts can make a difference
  - Participation in a range of extra curricular activities
  - The capacity to re-frame adversities so that the beneficial as well as the damaging effects are recognised
  - The ability- or opportunity-to 'make a difference' by helping others through part-time work
  - Not to be excessively sheltered from challenging situations to develop coping skills.
- (Newman, 2002, p.69)

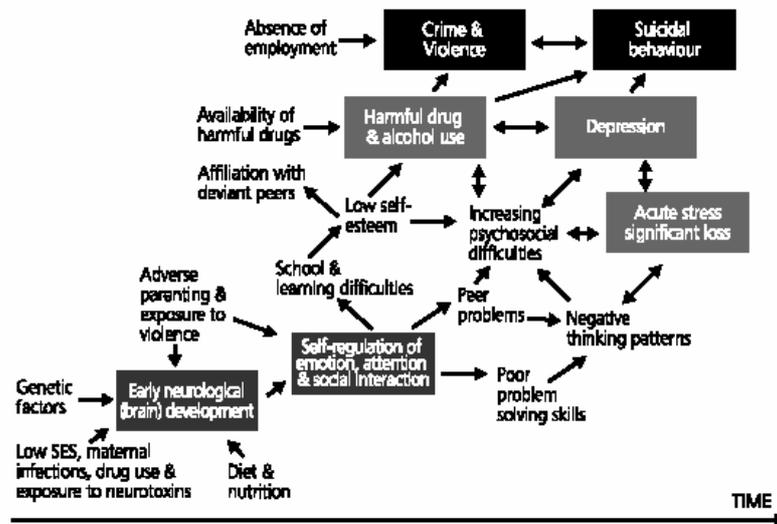
## What works in residential care? A review of the literature

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Comprehensive accounts of protective and risk factors have been formulated in relation to crime (National Crime Prevention, 1999) and suicide. The following diagrams relate to protective and risk factors associated with suicide. They, together with Newman's list above, provide an indication of the range of possibilities for building protective factors in residential care. Examples are 'engaging community activities', 'positive interaction with adults' (NSW CCYP & CCYP QLD, 2004).

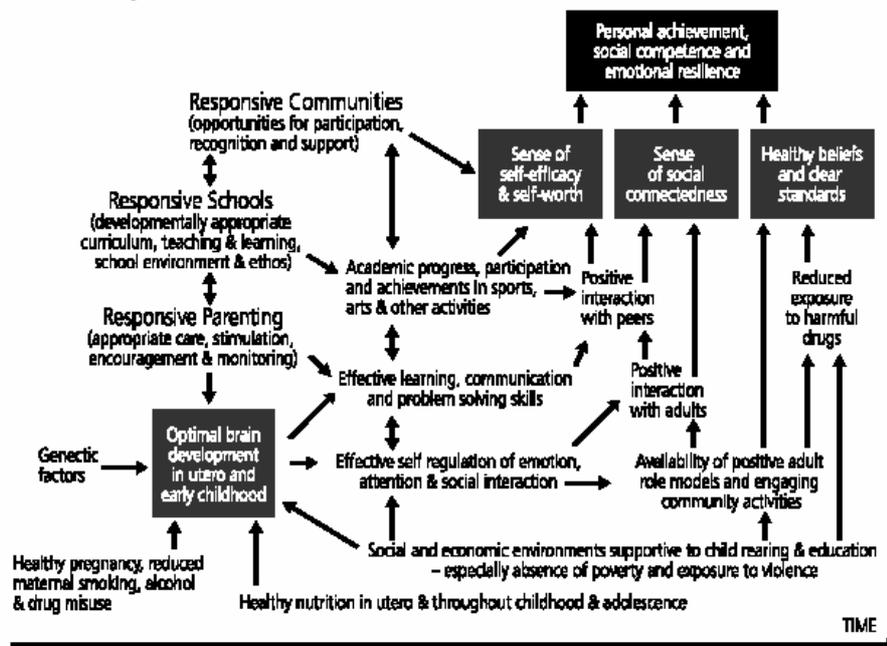


Figure 3: Pathways to poor outcomes



Note: From *New directions in Australian suicide prevention*, by S. R. Silburn, 2003, Keynote address to the 1st Asia-Pacific Injury Prevention Conference and 6th National Conference on Injury Prevention and Control, Perth, Western Australia, 16-18 March.

Figure 4: Pathways to resilience



Note: From *New directions in Australian suicide prevention*, by S. R. Silburn, 2003, Keynote address to the 1st Asia-Pacific Injury Prevention Conference and 6th National Conference on Injury Prevention and Control, Perth, Western Australia, 16-18 March.

### Programs need to occur on the basis of agreed and shared theoretical frameworks

The literature highlights the necessity for clear theoretical underpinnings for residential care (Bath, 1998a; Morton et al., 1999). It is generally accepted that effective therapeutic

interventions can only take place within clearly articulated conceptual and theoretical frameworks which provide a rationale for specific programming approaches and some degree of accountability' (Bath, 1998a, p. 17).

Clough is also a strong advocate for a theoretical basis of care:

At the heart of good residential practice is an attempt to understand the behaviour of residents: the reasons why people do what they do. The immense significance of theory is apparent here. Without a determined search to understand behaviour residents will be treated in immediate response to their activities, which is both inappropriate and dangerous. We have to examine the interplay between structures, cultures, environments and individual lifestyle. (Clough, 2000, p.70) .

Clough's typology of the theories for residential care work comprises:

- theories of the resident world offer explanations for what has been influential in resident's lives (perspectives from psychology and sociology)
- theories of function and task in residential care
- theories of intervention
- theories of residential homes as systems (Clough, 2000, p.74)

In addition, values and beliefs are pivotal to the development of a theoretical framework (Clough, 2000)

Morton et al (1999) suggest the frameworks of attachment, trauma and social learning. In Clough's terminology these form 'theories of the resident world'. Other theories in this category which have already been identified as relevant to residential care are resilience theory and bioecological theory.

### **Attachment**

Many young people in out of home care have suffered disruptions to attachments and loss. The challenge to residential care is avoid making attachment difficulties worse, and to provide sufficient continuity of care for this to occur. Morton et al argue that the following principles should underpin both treatment and care for young people who were abused as children:

- Attachment is central to treatment and care. It is important to provide and support positive relationships, maximising continuity of key attachments
- Services must be planned to take account of the difficulty these young people have in forming attachments and the difficulty others have in maintaining a relationship with them without becoming 'burnt out'.

- Rectification of attachment disturbance and the development of a secure sense of self is a slow process and requires long term interventions (Morton et al., 1999, p. 48 ).

### **Trauma**

The theories of trauma provide another useful theoretical framework to underpin the care of young people with high support needs who may have suffered repeated traumas (Abramovitz & Bloom, 2003; Morton et al., 1999, p. 51). Whilst specialist therapeutic intervention is required, knowledge of trauma and its multiple effects is important in the residential care setting.

Successful treatment, according to Morton et al., involves:

- Creation of context which is safe, non intrusive and empowering with responsibility remaining in the hands of the young person as much as possible
- Respect for the young person as a survivor, belief that they are doing the best they can
- Use of techniques facilitating the integration of awareness, including the development of a sense of continuity between past and present, tolerance for conflicting emotions, and the full recollection of previously dissociated aspects of the trauma
- Transformation of the traumatic aspects of the experience .... (Morton et al., 1999, p.53)

### **Social learning approach**

Due to persistent relationship problems and patterns, care staff offering a good relationship may not be enough. There may be a need to actively identify abusive relating and encourage and model alternatives. Important principles are: modelling; rewards rather than punishments; and natural consequences and consistently applied limits (Morton et al., 1999, p. 57). Social learning theory together with trauma and non-violence theory can form the basis of models which see the whole environment as a therapeutic agent (Abramovitz & Bloom, 2003).

Other theories which would be termed theories or models of intervention are found later in this review.

### ***Safety is a priority***

The provision of a safe environment for residents and staff is fundamental to good residential care practice (Abramovitz & Bloom, 2003; Morton et al., 1999; Scottish Institute for Residential Child Care, 2004). This is particularly emphasised following findings of systemic violence and sexual abuse in residential care, both in Australia and

abroad over many years (Department of Health, 1998; Senate Community Affairs References Committee, 2005). Systemic abuse needs to be dealt with by jurisdictional legislation, government policy and process. Residential care facilities themselves need clear policies and procedures for managing abuse or maltreatment allegations (Create Foundation, 2005).

Young people with high support needs may display challenging and uncontrolled behaviours (Bell, 1997; Senate Community Affairs References Committee, 2005). The residential care environment shares characteristic with other environments which are conducive to client-initiated violence including face to face contact between workers and clients, service provision to clients who may be distressed or angry, or male with histories of violence, and isolated work environments (Atkins & Pike, 2003). Prevention and management of such behaviours whilst promoting safety for all is a challenge. Shared understandings of behaviour and theoretical perspectives, together with systems for staff support and consultation appear critical to promoting a safe environment (Abramovitz & Bloom, 2003; Atkins & Pike, 2003; Residential Child Care Project, 2003).

The CREATE Foundations recommendations following a consultation with 16 young people indicate how providing a safe environment in residential care is seen as part of providing a whole caring environment (Create Foundation, 2002). These include: adequate funding for appropriate staffing; relationship building; carers need to show respect to residents; individualised support and positive encouragement; family group homes rather than residential care; support for young people to reach potential, particularly around education; mentoring; appropriate placement; respect of privacy; encouraging appropriate emotional outlets; contact with biological family and friends; participation of young people in decision making; house rules should be consistent, with residents involved in negotiation of rules and consequences.

These finding fed into a project by Berry St Victoria to address client initiated violence in residential care (Atkins & Pike, 2003). A planned consultation process with staff, CREATE, and the use of a 'Resi Best Practice Forum' led to recommendations regarding staff training and orientation, client orientation and participation of young people. Task Groups were set up under four areas of activity : human resources; training;

practice; and information technology. A progress evaluation indicated that there had been positive gains in staff support and access to supervision, communication processes and improved workcover claims management (Atkins & Pike, 2003).

**The Sanctuary Model** from the United States of America is focussed on providing a safe environment. It combines four conceptual frameworks: trauma theory, social learning theory, non-violence and complexity theory (Abramovitz & Bloom, 2003). It has application in the development of a therapeutic community environment. The process of introducing this model is participatory with staff involved in developing how the model will work in the particular environment. In one particular residential care home, psychoeducation groups were used to teach how trauma affects young people and adults. An acronym was developed to provide a shared language for the community as whole: SELF (safety, emotions, loss and future). Community meetings are held with the express purpose of keeping the community safe (Bloom et al., 2003). Evaluation is in progress (Rivard et al., 2003).

**Therapeutic Crisis Intervention (TCI)** is a 'crisis prevention and intervention system for residential child care facilities' (Residential Child Care Project, 2003, p. 3). It assists organisations to prevent crises, deescalate crises, reduce injury to young people and staff, and to promote learning in the organisation. The foundations lie in the best interests and the rights of the child, as stated in the UN Convention on the Rights of the Child. Training in TCI has been provided in North America, Russia, United Kingdom, Ireland and Australia (Nunno, Holden, & Leidy, 2003). There is a dual focus in the training: assisting the young person through the crisis; and teaching more constructive ways to handle the feelings or stresses involved in the crisis (Family Life Development Centre, 2001).

Cornell University tested its implementation and outcomes in a residential care setting and found higher staff confidence, consistency in dealing with children in crisis, reduction in the number of critical incidents, staff knowledge on management of critical incidents increased and was sustained at 10 months after the training (Residential Child Care Project, 2003). Bell's (1997) study of TCI implementation in Scotland found that a

small sample of residential care workers confirmed the importance of identifying trigger factors ( time of day, limit-setting, unpleasant news, provocation) and the need for continuing attention to crisis management.

**Restorative practices**, which are interested in understanding and repairing the harm caused by a wrongdoing, are beginning to develop an evidence base of effectiveness in juvenile justice (McCold, 2005) and school settings (Drewery, 2004), though outcome measures vary between studies. In residential care, restorative practices may contribute to the development of a safe environment, where the aim is to ‘help, not hurt, others’ (Steiner & Johnson, 2003, p.53).

Wachtel (2003) describes how the restorative practices in his agency, which involves counselling services, education and residential programs for high risk young people, make every day use of restorative practices, rather than being restricted to the ritual of restorative justice conferences. Evaluation is in progress (Wachtel, 2003). In Duluth, Minnesota, restorative practice circles are used in a correctional residential setting for girls, as part of a therapeutic environment, and as a practice to promote restoration of relationships with family (Steiner & Johnson, 2003). An evaluation indicated promising results, with questions about how long the changes will be sustained (Goodenough Gordon, 2004).

### ***Training of and support for staff***

All literature reviewed indicated the importance of trained staff and ongoing consultation and support for staff (Lindsay & Foley, 1999; Milligan, 2003; Morton et al., 1999; Residential Child Care Project, 2003). The qualifications for residential care staff have been of ongoing concern here and in the United Kingdom (Scottish Institute for Residential Child Care, 2004; Senate Community Affairs References Committee, 2005). Qualifications contrast markedly with those in parts of Europe, where social pedagogues are trained through three- to three and a half years of full-time tertiary education and placement. This social pedagogy or social education profession has over many years provided the staffing of residential care centres in many parts of Europe, although the profession has developed differently according to its context (Kennedy & Gallagher, 1997).

The need for a theoretical basis for residential care has been noted earlier in this literature review (Bath, 1998a). This is most important in training for residential care workers (Milligan, 2003). The importance of understanding the behaviour of residents was highlighted in the study of social education professionals in Denmark and Germany (Cameron, 2004). These workers utilised their professional training in psychology and sociology to understand the children's behaviour and to make judgements about the appropriate way to respond in each individual situation.

James Anglin has written about the distinctive nature of what he calls the 'child and youth care profession' which he says has five characteristics

- a main focus on the growth and development of children and youth
- concern with totality of a young person's functioning, rather than one part of functioning
- 'a social competence perspective', which builds on strengths, rather than a problem- based approach
- direct day- to day work with children and young people in their environment, rather than being restricted to interviews or sessions
- the development of therapeutic relationship with children, their families and other helpers (Anglin, 1999, pp.144-145).

The Scottish government has funded the development of a residential child care 'particular pathway' within the professional qualification in social work, the Diploma in Social Work (DipSW) (Milligan, 2003). In developing this, there has been recognition of the 'social care' or social education profession in Europe and some of characteristics of this training have been incorporated into this DipSW. James Anglin's view of the key characteristics of the 'child and youth care professional' has also been influential. Part of the theoretical basis in this Scottish model of training has included the 'life-space' approach developed by Ward for use in the UK as 'opportunity led work' (Milligan, 2003; A. Ward, 2002). The emphasis is this approach, or theory of intervention, is related to maximising the opportunities for therapeutic communication in everyday situations,

on responding, rather than reacting, on working in both the individual and the group situation (A. Ward, 2002).

The Scottish DipSW curriculum covers the theory and practice of residential child care , including child development, group care and use of self, promoting the development of the reflective practitioner. It has interdisciplinary subjects including the creative arts and health matters. There are also placements (Milligan, 2003).

Following the identification of the above themes, literature has been identified in the LAC areas, which need to be attended to prepare young people for independence: physical and mental health; It can be seen from the literature examined, that there is considerable overlap between areas, which is to be expected when considering a holistic approach to young people's well-being.

## PHYSICAL AND MENTAL HEALTH

Young people in residential care are likely to have mental health issues/ problems which need careful assessment and attention (Richardson & Lelliott, 2003). The Victorian study which looked at young people on the Victorian High Risk Adolescents Schedule (HRAS), young people who were thought to pose a risk to themselves or others, found that in 1999, of the metropolitan young people on the HRAS, 56% had substance abuse problems and a quarter were thought to be suicidal or have a mental illness (Morton et al., 1999).

Research from the United Kingdom has shown that parents were more effective in accessing resources needed by their children than were the child protection authorities for children in their care (Richardson & Lelliott, 2003). Reasons include quality of medical reports which may lack access to the medical history of the children, young people may not attend their annual check, instability of health care which means that young people lose contact with their usual providers. Other UK research pointed to weak links between service providers as another reason and to the necessity of establishing strong links with child and adolescent mental health services and to health services in general (Audit Commission, 1999; Department of Health, 1998).

Unless resources for such collaborative measures are available, partnerships can be difficult to achieve. Some systemic arrangements to promote this include designated mental health teams offering services for looked after children and staff, or designated mental health workers for children in residential care (Vostanis, 2003).

## EMOTIONAL/ BEHAVIOURAL DEVELOPMENT

### *Day to day care*

In day to day care the balance between the normal and the special is negotiated (J. Ward, 2004). Ward's (A. Ward, 2002) 'opportunity led work' already briefly discussed is highly relevant here, as are other models of connecting with young people, such as the 'circle of courage' (Brendtro et al., 2002). It has been difficult, however, to find empirical and solid evidence of effectiveness.

### **Possible contributions from social pedagogy for day to day care**

Social pedagogy is the main discipline which informs both training and practice for residential care for children and young people in many parts of Europe. It is a profession which combines academic and professional training in psychology, sociology cultural studies and practical subjects like art, drama and music, usually over three years of study (Cameron, 2004). In social pedagogy each daily activity is seen as a social education possibility, and workers respect the individuality of each resident, as well as working with the peer group as an opportunity for social education (Cameron, 2004).

Particular themes emerging from a UK study of social pedagogic practice in Denmark and Germany included the child or young person is seen as an active citizen, rather than simply in need of care and protection. A second theme was that of physical care and contact. Pedagogic care involves meeting everyday day needs for 'health, education, relationships, intimacy and understanding' (Cameron, 2004, p.144). Within this context careful use of physical contact may occur. The third theme is that 'heart, brains and hands' are utilised (Cameron, 2004, p. 144). The heart refers to compassion and understanding for the young person's situation, to offer warmth without expecting that

the young person can accept it. 'Brains' refers to using intellectual, critical, professional knowledge and skills to assess each individual situation and respond accordingly. This may be called a reflexive pedagogy (Cameron, 2004). The 'hands' provide a way of developing the relationship between workers and young people, through arts and crafts, sports and leisure activities an outdoors activities, including holidays, and sometimes involving the parents(Cameron, 2004). The conscious use of group activities can provide a means for dealing with group issues (for example, respect for diversity).

No evaluations of adopting a social pedagogical approach in the UK or Australia have been located. It appears that in Denmark and Germany, residential placements for children and young people may continue for a number of years and with 'high expectations of successful outcomes' (Cameron, 2004, p. 136)

### *Promising therapeutic approaches*

#### **Multi systemic therapy**

Multi systemic therapy (MST) is the community based tertiary prevention services option with strong research backing (Morton et al., 1999, p. 65). It is based on systems theory and social ecology (Burns et al., 2000). It is raised here, because like wraparound, there is a good evidence base, and it may have potential for use in residential care situations, which the Youth Horizons Trust in New Zealand has initiated.

A very intensive approach, it involves about 5 hours per week contact with a family over about 4 months. Intervention may also take place in other settings, for example, schools. Trained clinical psychologists provide the intervention and doctoral trained psychologists provide supervision and consultation. There is good evidence, including randomised trials for the effectiveness of multisystemic therapy in a home-based situation (Burns et al., 2000; Henggeler, 1999).

#### **Cognitive Behavioural Interventions**

Stevens' review of the literature on cognitive behavioural interventions in residential care indicated that there are many forms of cognitive behavioural interventions, and it is difficult to draw conclusions about cognitive behavioural interventions in general (Stevens, 2004).

For cognitive behavioural interventions to be effective, other elements may need to be included, including support of parents, school and peers. There seem to be some evidence that some cognitive interventions are effective. These include social skills training, assertiveness training, self control and self instruction. Staff training in child development, and the basis of cognitive-behavioural interventions is needed. Assessment is very important, particularly in terms of intellectual development. This was particularly indicated by a study which considered the developmental level: cognitive behavioural approaches ( not necessarily in residential care) were more effective when children were functioning at Piaget's formal operational level (Stevens, 2004). Some young people in residential care may not be functioning at that cognitive level.

### **Program example**

The Youth Horizon's trust program in New Zealand incorporates elements of MST, and wraparound in its residential care program (Harris & Simmonds, 2002). Its residential model is based on cognitive behavioural therapy principles, including social skills training and aggression replacement training. It includes parent management training for caregivers. This residential program is aimed at young people with diagnosed Severe Conduct Disorder, which is characterised by aggression, destruction of property, deceitfulness or theft, and 'serious violation of rules' (Saville-Smith et al., 2005, p.2). They excluded those whose primary problem is sexual offences or drug dependency. HT's primary goal in delivering the Bridging Programme is to normalise the lives of participating young people, leading to improved self-management and behaviour control to the point that they can live safely in the community.(Saville-Smith et al., 2005, p.16).

The Bridging Programme was designed around a combination of a wraparound programme, behaviour modification and residential care. More recently, it has been evolving around an ecological approach and the principles of Multi-Systemic Therapy (MST), which involves intensive work with families.

The programme involves five core activities:

- intensive assessment, goal planning and monitoring of individuals
- provision of a supervised residential environment
- implementation of a coherent behavioural modification programme
- parenting support, training and assistance for the ongoing reintegration and management of young people within their families
- provision of a coordinated set of training, skill-building, education and health services (Saville-Smith et al., 2005, p. 18).

Wraparound services include education and health. Education services include a learning centre within the program, and phased reintegration into school. This aspect of the program has involved Department of Education funding, and is a very difficult area of care. A liaison position has been created to undertake the liaison between the program and the schools. Health and mental health services are provided, but there is ongoing negotiation with the Ministry of Health and the Child Youth and Family Service regarding funding arrangements and responsibilities, particularly for young people leaving the care system.

The evaluation of the program concluded that different approaches are required for young women than young men with SCD and that these are still developing (Saville-Smith et al., 2005p. 38). The evaluation also found:

- reduction in the severity of reported incidents serious enough to be recorded on the YHT in-house database
- individual improvements for the 26 young people participating in the programme at the end of the last calendar year
- educational outcomes that indicated the effectiveness of the Learning Centre

The evaluation concluded that the program can generate improved outcomes in the 'medium term' (Saville-Smith et al., 2005, p.109).

### **Program example**

A program example for which no systematic evaluation has been located is the Parkerville Children's Home (PCH), which offers a therapeutic residential program, based on trauma theory. 'Training direct carers to understand the causes and effects of trauma and the nature and scope of trauma-related behaviours and supporting them in learning how to respond to such behaviour appropriately, is central to a successful residential therapeutic programme' (Jenkins, 2004, p. 23). Carers in the program are trained to manage trauma related behaviours so that they do not escalate and to support constructive behaviours. Power struggles are avoided. Carers are trained in: 'the causes and effects of trauma, nature of traumatic memory, nature of human brain development; traumatic experiences and their effect on brain development; the biology of trauma, recognising the on-going physiological presentation of trauma; recognising the cognitive and verbal presentations of trauma-related behaviour; identifying negative self-defeating behaviours; challenging/reframing negative life scripts or self-defeating behaviours; managing trauma-related behaviours in ways that offer support and encourage the development of constructive alternative behaviours; appropriately managing disclosures; understanding the need (and how) to create emotional and psychological safety as well as physical safety- a holistic dependable. Predictable living environment- which can be used to challenge all the negative (direct and secondary) aspects of their abuse experiences; providing the safety for children to have outbursts and rage at past injustices before catching up on their lost development; and understanding and managing counter-transference and counter-aggressive impulses' (Jenkins, 2004, p.25)

### ***The peer group in residential care***

Bath noted that when smaller non-institutional residential units were set up around 1994, they experienced some problems related to the 'behavioural synergy created by the placement together of high needs young people in the one unit' (Bath, 1998a, p.14). He cites research evidence that placement of a small number of troubled young people

together may increase problems (Bath, 1998a, p. 16). Indeed some have argued that putting young people who display antisocial behaviour together for intervention could actually be unethical (Arnold and Hughes 1999 cited in Handwerk et al., 2000p. 224). Residential care is one group environment where these iatrogenic effects are noted in the literature (Barth, 2005; Handwerk et al., 2000). Barth notes that smaller groups, with one or two children in each home, may avoid what he calls 'deviance contagion' (Barth, 2005, p. 159)

### **Composition**

If young people are placed together then issues of matching and selection are raised. Control by staff and residents of the selection of suitable residents may be important, as distinct from control by outside organisations (Morton et al., 1999, p. 70). However, in contrast, often young people can be placed hurriedly, with limited planning and this can be unsettling both for the young people being placed and those already in residence (Clough, 2000)

Vorrath and Bendtro, discussing group composition for the program Positive Peer Culture (to be outlined later in the paper) indicates that generally homogeneity in 'age, sex, maturity and sophistication' and heterogeneity in 'personality and problem type' is desirable (Vorrath & Bendtro, 1985, p.54). This is consistent with Morton et al's recommendation that for the high needs group they studied in Victoria, there should be an early adolescents unit and mid to late adolescents unit (14 years and over) (Morton et al., 1999, p. 127), with separation of males and females in the residence.

### **Bullying**

Bullying in residential care has been identified as a reason some children run away from residential care, and there is limited information about its nature or prevalence (Kendrick, 1998). Kendrick's review suggests that residential establishments should have clear whole of facility policies and procedures about bullying and that, where establishments create an atmosphere in which young people feel valued and safe, there is less likelihood of bullying will occur (Kendrick, 1998).

### **The group as resource**

There is also evidence that structured programs aimed at promoting positive cultures, in residential care can be effective in reducing anti social behaviour (Handwerk et al., 2000), though it is not clear how long or in what contexts these effects are maintained (Kapp, 2000).

The importance of the peer group in adolescent life is well recognised (Fergusson et al., 1996). Emond found, in her ethnographic research, that young people in residential care placed great importance on their co residents and the group. She found that power and roles changed over time. The group played a role in maintaining safety, provided support, and information. She concluded that the resident group could be seen as a resource, and staff need to assess both the individual and the group (Emond, 2002).

The following are some specific group programs which have yielded some positive outcomes in some studies.

### **Positive peer culture (PPC) programs**

Positive peer culture is described as posing positive possibilities in residential care literature (Bath, 2003). PPC programs are based on application of peer concern (Vorrath & Bendtro, 1985). They assume that the person will initially distrust the group. It focuses on change in the immediate problems, not the past. It concentrates on the value of caring rather than rules, and on making caring the norm. It highlights the responsibility the young people need to take for themselves and for the group.

Age groups appropriate for PPC are generally over 10 years old and of one sex to avoid the complexities of sexualised behaviour. (This limitation to one sex assumes a heterosexual norm which is now outdated). The ideal size is 9 members (Vorrath & Bendtro, 1985). Placement of brothers and siblings is not recommended. There are rules for layout and meeting procedures. Several evaluations have indicated positive behavioural, academic and affective outcomes of residential programs using PPC (Vorrath & Bendtro, 1985) Handwerk et al review a number of studies of programs which utilise some variation of PPC, where the emphasis is on the creation of a positive

peer culture that influences values attitudes and behaviour (Handwerk et al., 2000). These studies indicated positive treatment results. From this review, Handwerk et al postulate the following as factors affecting the treatment outcomes: structured behavioural treatment seems more effective than other methods for young people with emotional and behavioural problems; these groups programs seem more effective when applied in community like environments rather than institutional like environments; the establishment of relationships with the adults involved is important, where these adults use positive attention, praise and supervision. Also, the attitudes of the young people towards the setting or treatment influence outcomes (Handwerk et al., 2000)

### **EQUIP Program**

This program combines the Positive Peer Culture approach with an ‘equipping’ training component. This component is based on curriculum elements which include moral education, anger management and correction of thinking errors and social skills. It was evaluated using control groups in 1993 in a medium level security juvenile justice institution and found to be effective (Gibbs et al., 1995). Equivocal results have also been reported (Steele, 2002).

### ***Sexual development***

Adolescence is a time of accelerated sexual development, with issues of sexual identity and exploration of enormous importance. This presents particular challenges to residential care. A study of children’s homes in the United Kingdom revealed that in these homes, rarely was sexual activity a ‘consensual, reciprocal or non-exploitative activity’ (Green & Masson, 2002).

Morton et al.’s study of the high support needs young people in Victoria found that sexual abuse has been experienced by a significant proportion of the young people. Staff in the study in Victoria reported that paedophile rings systematically targeted young people in residential care, presenting themselves as mentors (Morton et al., 1999, p.11). This was found also in Green’s ethnographic study in two children’s homes in UK between 1994 and 1996 (Green & Masson, 2002), and noted by Farmer (Farmer, 2004)

Ensuring no child is at risk when removing sexually offending young person from home limits options for placement. They often require long term care, so carers may require respite (March, 2004). Farmer and Pollock in a survey of looked after children found that abuser children (75% of which were adolescent males) were at a high risk of sexually abusing other children in their placements (Farmer and Pollock cited in Green & Masson, 2002). Attempting interventions with young people in unsafe situations is counter productive.

Farmer and Pollock assert that there has been little research on the placement of sexually abused children in substitute care, and even less on the placement of children who have abused (Farmer & Pollock, 2003, p. 101). However research undertaken in 1992 through the Scottish home office involved qualitative analysis of interviews with caregivers, social workers residential care workers and young people regarding 40 young people placed out of home who had been sexually abused or abusive or both..

This research revealed the following four areas of activity to be important to effective management

- Supervision. Supervision requires adequate information about the histories of these young people). It requires the setting up of ground rules about who the young person can be with, and information for the other children so that they can be safe.
- Enabling the young people to learn how to keep themselves safe when out alone
- Management of contact with family members which may place them at risk
- Sex education. Sexually abused children may be ignorant of sexual health, and contraception. More attention needs to be given to sex education in case planning
- Modification of inappropriate behaviours, and the therapeutic attention to the young person's unmet needs (Farmer & Pollock, 2003).

In addition the evidence available indicates a need for staff training in sexual development of young people, awareness of societal homophobic and gendered stereotypes, and therapeutic management of young people's sexual behaviour (Green &

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Masson, 2002). Farmer and Pollock's research identified the need for the development of practice ideas

and to establishment of improved training, consultancy and support for the caregivers (Farmer & Pollock, 1998).

### **Young people who abuse**

March's (2004) review of research suggests that treatment for adolescent sexual offender has potential to be far more successful than treating adult offenders, particularly using a group model. It is more cost effective than treating subsequent victims.

Treatment for young people who abuse needs to encompass all family members rather than the 'abuser in isolation' (March, 2004, p. 32).

The community based, Male Adolescent Program for Positive Sexuality (MAPPS) program in Victoria has a major focus on the building of a positive pro-social peer culture and is regarded as cost-effective. It includes psycho-educational and support groups for parents and carers of young people attending the program. It has been evaluated with positive results, and is open to young people in residential care (Morton et al., 1999, p. 72).

### **Gay and lesbian young people**

There are challenges in providing a safe environment to gay and lesbian young people who may have been rejected by their families due to their sexuality. A study in USA indicated that young people may not perceive it as safe to identify as gay or lesbian in a group care setting (Mallon, Aldedort, & Ferrera, 2002, p.419). Education and health were shown in this study to be a particular challenge due to (Mallon et al., 2002). This study concludes that it is necessary to see children in the context of their families and deal with them as part of neighbourhoods and communities, building the opportunity for lifetime relationships (Mallon et al., 2002).

## SELF CARE SKILLS

Self care skills concern ‘ the acquisition by a child of practical, emotional and communication competencies required for increasing independence’ (Gray, 2001, p. 6). Some of these skills are developed through the incidental and planned learning of day to day living. Clough argues that there is not one way of approaching these day to day issues, they depend on context and individual need, but it is important to recognise that a matter of daily living which might be insignificant for a worker, may be highly significant in terms of learning or personal meaning, for the resident (Clough, 2000). Some of self care skills can be developed through recreation and leisure activities.

### *Recreation and leisure*

MST and other successful interventions place considerable emphasis on the development of pro-social recreational activities (Morton et al., 1999). Recreation and leisure activities can be seen as apart of the resilience building tools. ‘The emergence of resilience bridges the gap between and adolescent’s past and his or her future’ (Safvenbom & Samdahl, 2000, p. 120).

Leisure is part of a young person’s immediate environment in which resilience can be encouraged, and therefore the leisure context can be considered as a ‘pertinent pedagogical tool’ (Safvenbom & Samdahl, 2000, p. 120). Certainly the use of activities, the arts and crafts are an essential part of the social pedagogue’s skill repertoire in Europe (Cameron, 2004).

Participation in leisure activities is also seen as a strategy for promoting connection with the community and building self-esteem (Daniel et al., 1999). Young people’s interests, rather than necessarily what they perceive themselves as talented in, can be identified and facilitated. Such interests also provide the opportunity for connection with family or befrienders (Daniel et al., 1999). Gilligan (2001) suggests the some possible useful activities for young people in care,: caring for animals; sport and other leisure pursuits; expressive and interpretative arts; and paid or volunteer work.

Leisure activities can be part of a normalising experience for young people who may feel marginalised (Gilligan, 2001). Leisure activities may protect against behaviour problems, more so where the activities are structured, led by a 'competent' adult, with skill building involved, and following a regular schedule (Mahoney & Stattin, 2000, p. 125).

A particular form of leisure activity which has been explored with youth at risk is adventure or wilderness experiences. Some forms of this activity are called wilderness or adventure therapy and there are distinctions between these programs which are intentional, consistent with theory and practised by therapists and those which are largely recreational (Berman & Davis-Berman, 2001). One study was located which looked at young people in out of home care. A pilot outward bound program in the USA for young people in foster care resulted in some positive indications of benefit for the young people involved, but the outcome results remained inconclusive, with some foster parents reporting a worsening of behaviour following the program. The researchers suggested that the program needed to be carefully tailored to the young people participating, and particularly needed to attend to the support required by the young people during the program, and preparation beforehand (Fischer & Attah, 2001). Clearly training of the workers and risk- management is required in implementing such activities (Romi & Kohan, 2004).

## **FAMILY AND SOCIAL RELATIONSHIPS**

### ***Contact with family***

It is known that most young people in out of home care will have contact with their families when they leave care (Community Services Commission, 1999). Therefore improved relationships with the family of origin or extended family could provide enhanced support. 'The relationship of these young people with their families remains a powerful part of their identity and most will continue contact with their families while they are in care and beyond' (Morton et al., 1999, p.96).

Maunder et al note that it is important to make a distinction between family members associated with abuse and conflict and those who are not (Maunder et al., 1999). They

argue that young people need to maintain contact with family members not associated with abuse (for example, siblings, grandparents) and they need ongoing counselling about their relationships with those who have abused or neglected them (Maunder et al., 1999). This is echoed by Morton et al, who note that ‘there is also a need for ongoing highly specialist work with families to address past abuse and current relationships-especially if these are exploitative or sexualised. Young people need help in negotiating the complexities of relating to parents who may continue to be abusive’ (Morton et al., 1999, p.96).

The Community Services Commission in NSW found that contact ‘has a positive impact on the well being of children, whether or not restoration is a goal (Community Services Commission 1999 quoted in Thomson & Thorpe, 2003). Problems identified by the Community Services Commission report (Community Services Commission, 1999) included lack of flexibility in contact arrangements, and poor case planning. Thomson and Thorpe suggested that further research is required to look at the factors influencing problems with contact and keeping children and families connected. Benefits identified by Thomson and Thorpe include identity and continuity in family relations and its potential to facilitate shared care (Thomson & Thorpe, 2003). They argue that it is important to identify organisational and policy barriers to family involvement which may ‘actively or passively’ contribute to parents being unable to form partnerships with child welfare systems (Thomson & Thorpe, 2003).

Wraparound and MST treatments are in their purist forms community based, and undertaken whilst the young person is at home. They recognise the multiplicity of systems in which the young person is involved and work with those systems, including family, to promote improved relationships.

Involving family members in residential care activities wherever possible or appropriate has been found to be useful. Scholte and van der Ploeg’s study of 200 young people with ‘serious behavioural difficulties’ in residential treatment in Holland showed that outcomes were enhanced by involving the family members in the residential treatment process wherever possible (Scholte & van der Ploeg, 2000). The social pedagogical

approach to residential care in Germany and Denmark may include activities and holidays with both residential carers and family members (Cameron, 2004).

Barth notes that family involvement is critical in residential care and that this ‘is the most important adaptation that residential care must make to bridge the evidentiary and philosophical concerns that cloud its future’ (Barth, 2005, p. 159). He refers to promising, but not rigorously evaluated programs where families enter residential care (Barth, 2005).

### ***Community relationships***

Working from a resilience and strengths perspective means that building relationships across many areas both within and outside the residential care facility is vitally important. These areas include education, significant others, friendships, talents and interests, building positive values and building social competencies. Young people in care may need assistance of carers and caseworkers to develop relationships in these areas (Daniel et al., 1999)

Mentoring relationships are cited as providing a useful means for building relationships within the wider community and in promoting resilience (Daniel et al., 1999; Gilligan, 1999, 2001; Newman, 2002).

Mentoring uses a relationship for the purposeful encouragement of a (young) person’s all round development or that of some facet of their competence. It is likely to work best as a relationship when based on shared enthusiasm for some common activity. Mentoring thus involves an element of reciprocity in that the encouragement and guidance of the adult is rewarded by the absorption of the youngster into a higher state of competence and commitment. (Gilligan, 2001)

Gilligan argues that there is a ‘reasonably strong’ case for including mentors or ‘befrienders’ in the possible tools of intervention for children in out of home care (Gilligan, 2001, p.58). It is preferable if these people are already known to the young person, but that may not be possible. It is also vitally important that they are assessed for suitability, particularly given the trend cited earlier, of people with paedophilia or other dangerous behaviour targeting children in care (Morton et al., 1999). Gilligan suggests the following criteria for assessing the suitability of a mentor:

- Has technique/ skill and enthusiasm to share with youngster
- Is known to the child already
- Is known to adults committed to the child
- Has experience of relating to children
- Has been vetted for child protection if not already well known
- Knows where to bring issues of child protection or issues of similar complexity
- Has received notes of guidance and had opportunity to discuss same
- Understands meaning of relationship to child and consequence need for reliability
- Appears not to “ need” the relationship with the child
- Is willing to liaise as necessary with the child’s carer or social worker or with appropriate key adult in the child’s social network (Gilligan, 2001, p. 59)

However, a literature review by Lucas and Liabo issues a word of caution about formal mentoring programs (Lucas & Liabo, 2003). In a review covering evaluations of formally organised non-directive programmes only, the authors concluded that they ‘cannot be recommended as an intervention of proven effectiveness for young people already involved in criminal activities’ (Lucas & Liabo, 2003, p. 1)

### **Program example**

In Victoria, Reach and Whitelion, two non-profit organisations have launched a residential care mentoring initiative. Funded by the Victorian Government, it aims to address the needs of young people in residential care who are on child protection orders. It aims to provide consistency and support to young people in residential care (Foundation & Whitelion, 2005).

## **IDENTITY**

In Erik Erikson’s famous developmental framework, the task of adolescence is a formation of identity. For young people in care this can be especially problematic, given the likely history of disruption of relationships and conflict (Gilligan, 2001). Fahlberg argues that the task is individuation and is complicated for those who were removed from families before they were psychologically ready. Charles and Nelson assert that an adolescent is trying to answer four questions: ‘Who am I? where do I belong? What can I do and be? And What do I believe in?’ (Charles & Nelson, 2000, p. 12).

In a consultation with young people in out of home care in 2001, the NSW Community Services Commission found in 2001 there needed to be more attention to the collection of life story materials and life story work with the young person (NSW Community Services Commission, 2000). Assisting young people to develop their family history, and why they are in care may be painful, but necessary so that young people can understand their own identity (Community Services Commission, 1999; Gilligan, 2001).

Martin describes a self-narrative technique used in her research on the experiences of care-leavers in Canada. Using this technique young people were able to reflect upon and narrate their stories, at the same time producing a quality text, through the use of word processing. The process enabled them to clarifying their story, identify important turning points and developing their sense of who they are in the world (F. Martin, 1998). Gilligan suggests that such a technique could be utilised by care workers in partnership with young people (Gilligan, 2001).

Gilligan remarks that it is helpful for young people in care to develop multiple role identities, for example part time worker, softball player, production team member (Gilligan, 2001). This concept has a direct relationship to the bioecological perspective on human development mentioned early in this literature review (Bronfenbrenner, 1999). Such multiple roles can mean that the identity of being in care does not dominate, and that other roles provide meaning and social relationships (Gilligan, 2001).

Empirical research on the effectiveness of techniques for assisting young people in out of home care in their identity development appears very limited, even in when the care provided is kinship care (Hunt, 2001).

## EDUCATION

There are numerous pieces of research, particularly from the United Kingdom attesting to the poor educational outcomes for children in out of home care, compared with other young people (Department of Health, 1998; Fletcher-Campbell, 1998; Francis, 2000). This has also been observed and documented in Australia (Mauders et al., 1999). At the

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same time there is strong evidence attesting to the importance of education and educational experience as a protective, resilience enhancing factor (Gilligan, 2001).

There are a constellation of factors involved in the comparatively poor educational outcomes (Goddard, 2000). The biological, psychological and social backgrounds of the young people contribute, many of which are in place prior to entering care (Sinclair, 1998). Untreated mental health problems also play a part, manifesting in difficult behaviour (P. Martin & Jackson, 2002).

In addition to the overall backgrounds of these children, education has been impeded by circumstances sometimes associated with the out of home care experience. These include lack of encouragement to attend school, low expectations by carers and teachers about what they could achieve, learning disruption due to placement disruption, exclusion from school, inadequate resources, including space, to complete homework, being bullied at school and lack of collaboration between the school and the welfare sector (Borland, 1998; Goddard, 2000). Other factors include inadequate training of residential staff, and a tendency to consider that the education of children in out of home care is somebody else's responsibility other than the out of home care authority (P. Martin & Jackson, 2002).

Research attests to the role of educational achievement and positive educational experiences in protecting against delinquency and serving to mitigate the effects of childhood abuse and neglect (Garry, 1996, cited in Morton et al., 1999, p. 17). In Martin and Jackson's research, educational achievement was a way of normalising life for the young people who did achieve, and a way of overcoming disadvantage (P. Martin & Jackson, 2002)

Fletcher-Campbell argues that the research evidence shows that for young people in care in the United Kingdom, 'once adequate attention is given to education in the life of a young person, once there is planning and appropriate support, and once professionals and other adults working with the young person have a clear understanding of their roles and responsibilities, and have themselves been empowered to fulfil these, then there can be achievement at the normal range' (Fletcher-Campbell, 1998, p. 4). This opinion has

support from other researchers (Gallagher et al., 2004).

Nevertheless, whilst there are examples of improvements in educational experience of young people in out of home care and young people in need, there are as yet few studies which can identify changes in educational progress or outcomes over time (Hunt, 2000).

Young people in care may have a history of exclusion and expulsion (Hunt, 2000), and may have experienced mainstream schools as alienating. An Australian study investigated programs aimed at keeping at-risk young people (not necessarily those in out of home care) connected with school (Brooks, Milne, Paterson, Johansson, & Hart, 1997). The study found that front line practitioners involved in those programs identified some common factors in the school which contributed to pre- compulsory school age school leaving: experiences of academic failure; ‘inflexible school curriculum and teaching strategies; ‘alienating school environments’ ; and ‘poor student-staff relationship’ (Brooks et al., 1997, p. v). This was in addition to personal and social background factors of family conflict and background, and disruptive behaviour. An Australian-wide study of young people considered to be ‘at risk’ of leaving school before completion of Year 12 found major disincentives to school engagement included the type of relationships which they experienced with teachers, including teachers ‘not listening’ and being ‘too busy’, as well as the teaching methods utilised (Australian Centre for Equity through Education & Australian Youth Research Centre, 2001, p. 7). Most of the 1,399 young people had aspirations for education and training, but did not necessarily see attending school as part of fulfilling these (Australian Centre for Equity through Education & Australian Youth Research Centre, 2001).

One of the issues in making a difference for young people at risk of premature school leaving, is achieving a balance between seeking connection with mainstream schooling (perhaps through innovative or individually planned educational programs) and offering alternative educational approaches (Dusseldorp Skills Forum, 2005; Long, 1998). The principle of individualised plans like LAC, for young people in out of home care, clearly has implications for their education: different young people will need different approaches.

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The literature on alternative educational models for young people who are out of mainstream schooling is immense and developing (see Long, 1998). Long argues that young people ‘trapped in cycles of failure’ need new environments where they can ‘believe they can change their future’ (Long, 1998, p. 31). A culture of acceptance within the alternative environment provides a basis for such a new learning environment, and incidental learning forms an important element in alternative pedagogical approaches (Long, 1998). Such an approach may have the aim of eventually reintegrating students into mainstream schooling or it may not.

Varying models of providing alternatives to young people who are out of school or at risk of this have been explored. Brooks et al. classified the programs they examined into six groups:

- Community based partial withdrawal, where students leave mainstream schooling on a part-time or temporary basis to attend a community based alternative, with the intention of a return to school
- School-based partial withdrawal
- Community school, which involve education and support services and where young people are not expected to return to the mainstream schooling system
- Outreach services, where specialist services are provided to a group of schools
- Integrated whole school approach, where innovations and enhancements are integrated into the whole school
- Event based, where there is a focus on one activity (for example wilderness experiences) as an intensive potentially life changing experience (Brooks et al., 1997, p. vii).

What is not clearly covered in the typology above, is the concept of a learning centre or school within a residential care program, which has emerged as a possibility within the literature.

The remainder of this literature review about education will concentrate on findings in the literature specifically related to residential care and education.

### ***Partnerships in education are vital***

Partnership or collaboration between sectors and agencies is central to achieving better outcomes for children in out of home care (Borland, 1998; Fletcher-Campbell, 1998; Francis, 2000; Jackson & Sachdev, 2001). Policy responses need to be flexible enough to take account of young people's views, as this may indicate how much interagency work is required (Goddard, 2000).

Fletcher-Campbell's UK study suggested a 'tedious truism: that effective practice-practice which results in a successful and positive educational career for young people who are looked after- can only be secured by partnership' (Fletcher-Campbell, 1998, p. 7). She argued that only rarely in her research was the non cooperating partner the young person. Usually when this did occur it was because of mistimed intervention, or the young person was not given the opportunity for partnership and participation.

Managers at all levels need to ensure that systems facilitate cooperation and partnerships, including adequate training. Fletcher-Campbell's (1998) research indicated the importance of services within the education system to coordinate the education of young people in care, to facilitate partnerships and collect information. Within the education sector, there needs to be a designated staff member who is responsible for overseeing that the needs of these young people are met, and for liaising with carers and social workers (Borland, 1998; Francis, 2000).

Features which facilitated progress in local areas included an awareness of the problems, a refusal to accept that they could not be overcome, a strengths based perspective on the young people, the importance of treating all the partners with respect and providing support (Fletcher-Campbell, 1998). There also needs to be a system for transfer of information and support if young people change school. Issues such as confidentiality of information need to be negotiated with each child (Borland, 1998) .

### ***What the residential care facility can do***

The literature indicates a critical role for residential care and residential care workers in promoting and supporting participation in education. The willingness of the residential

care workers to actively support young people's education appears crucial.

A study of 15 children in a UK children's home involved a three year follow up and provided some indications of positive actions in residential care which can affect outcomes (Gallagher et al., 2004). On arriving at the home, all 15 (aged 10-15) children were not in education, some because the placement had occurred out of area. At the end of the evaluation period (13 months) all children were receiving an education program: eight were in mainstream schooling, three in special schools, two in a Tuition Support Unit (TSU) and two receiving home tuition. None had gone 'backwards' during this time.

The evaluators considered that there were both practices in the residential care situation and practices outside which were significant in achieving the degree of stability in education which occurred. The practices within the residential care situation were:

- Acculturate children with a sense of value for education
- Establish expectations of children in regards to education
- Maintain an incremental education re-integration program. The home had a special program for reintegrating children into education, beginning with home
- Tuition, then TSU and then part time, then full-time school. The TSU was community based with a small number of teachers, each working with a small number of children
- Prepare children for educational placements
- Support children in educational placements ( including provision of support worker within the school if necessary, attending parent/carer evenings)
- Support educational placements ( including residential care support workers removing children from school when necessary)
- Develop a learning culture or learning environment.(Gallagher et al., 2004).

Very similar features were observed in the Sycamore Project in Scotland, a residential care setting for 16 young people placed in three different residential units. These are children from very disturbed backgrounds with school non-attendance. Over 15 years 107 children have lived at Sycamore and of these 97 were returned to and supported

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successfully in mainstream schools (Lindsay & Foley, 1999). This success is attributed by staff to

- relationships between teaching and care staff. If a placement at school becomes unmanageable, it Sycamore's problem, not the school's, and the school knows that help a phone call away.
- philosophy of the project. A humanist approach is taken whereby all parties, the care staff, the young people and the school staff are valued.
- careful choice of school and attention to detail regarding this. This is informed by both knowledge of the child and the school.
- creation of a culture in the unit in which education is valued and attendance is a clear expectation.
- joint planning, it may include the referring agency, the school and the residential staff.
- handling of set backs ( for example exclusions) without becoming deflected from the goal, so it can be that the process of exclusion/removal, work at home and return to school may be repeated with some regularity (Lindsay & Foley, 1999).

In addition to the above, a broad review of the literature identified the following initiatives as positive

- Events and award ceremonies to recognise achievement
- Training for care workers, and teachers to raise awareness of importance of education
- Providing transport so young people can stay at their own school
- Developing personal education plans and setting up educational support for these
- Ensuring young people have a place to study
- Ensuring leisure time activities
- Consulting young people, perhaps by using the LAC materials (Jackson & Sachdev, 2001)

### *Advice from high achievers*

Advice from high achievers who came from the care system in the UK also supports the above claims of the importance of the support and encouragement from carers (P. Martin & Jackson, 2002). They need encouragement from significant others regarding their education, well qualified carers and a good relationship with relevant social worker [case worker]. They need to attend school regularly, and to avoid the experience of stereotyping and discrimination. They also need the provision of practical resources, teachers and school support, the same time maintaining normalisation. Encouragement and material support for higher education is required, a matter which often relates to policy approaches to after care. Another factor in achieving educational success may be a mentor or adult who understands and will motivate (P. Martin & Jackson, 2002).

### *Alternative educational programs*

There are a number of alternative educational support services, both government and nongovernmental (Uniting Care Burnside, 2005). The research by Gallagher noted above indicated an important role for the residential program's Tuition Support Unit, usually acting as a transitional program (Gallagher et al., 2004). In Brooks' typology, this represents is a temporary withdrawal program, with the intention to return to school (Brooks et al., 1997). The Rosemount Day Program described below is also a temporary withdrawal program ( although the young people may not be in school in the first place). The Galilee Program operates as a community school, with some young people returning to mainstream schooling.

#### **Program example**

**Rosemount Day Program** in Sydney runs for 10 weeks four times a year with 12 adolescents each time. It is not a school curriculum program. The aim is for adolescents to develop skills, motivation and confidence to achieve their potential. Modules are presented which include anger management, self esteem, interpersonal social skills, work and school directions. Youth workers deliver the content in workshop format in small and large groups. Literacy and numeracy are delivered by a qualified teacher. Family work and follow up occurs. The study conducted by Rosemount revealed that 75% of 240 adolescents went on to some form of education or work (Cunningham, 2004).



### **Program example**

**Galilee Day Program**, part of a non-government service organisation, was set up in 1997 for students in substitute care in ACT aged between 13 and 16 years. Referrals were from the statutory agency, then called Family Services, and substitute care services. It was based upon a morning meeting at which goals were set for the day around a flexible timetable. Opportunities for relationship building and dialogue were optimised during one to one travel to and from the Program (youth workers collecting and returning young people). Collocation with other projects like glass blowing, saddle and leather work business, horticultural project) were critically important in enabling a wide range of educational and training activities. The curriculum was integrated with these collocated services and businesses. Learning outcomes were in social, scholastic, vocational and recreational and life skills areas. In 1998 an anecdotal evaluation indicated its success in assisting young people to progress educationally and vocationally (Long, 1998) .

Subsequently, the Galilee School has been registered as a school and is able to award ACT Year 10 Certificates. Personal communication with Peter Hobbs, the current principal, indicates that youth workers and teachers provide educational experiences to small groups (two or three young people in each group) using a structured, but flexible timetable. Literacy and numeracy and personal development are addressed in the morning and a wide range of electives offered in the afternoon. Several ways of attending the school are available, depending upon individual need and the educational plan:

- Full time and working towards Year 10 within the school
- Part of the week attending Galilee and the other part attending mainstream school
- Flexible learning, whereby Year 10 is completed whilst working

In the past eighteen months, 3 young people have returned to mainstream schooling, 4 have been awarded Year 10 certificates, and 4 have exited to full-time employment (Peter Hobbs, 2005, personal communication).



## **SOCIAL PRESENTATION**

Social presentation concerns the young person's 'growing understanding of the way in which appearance, behaviour and any impairment are perceived by the outside world and the impression being created (Gray, 2001).

Research studies in this area appear limited. However Clough notes the constant dilemma in residential between what is regarded as 'normal' and how people are perceived by others, and the need for self determination (Clough, 2000).

## **LEAVING CARE**

The research undertaken in the United Kingdom on leaving care schemes highlighted the importance of preparation and education prior to leaving care and of providing consistent after care support for young people (Department of Health, 1998). Much research documented the deleterious life events experienced by many young people who have left care, including homelessness and unemployment (Cashmore & Paxon, 1996; Clare & Murphy, 2000; Maunders et al., 1999). Young people leaving care are generally already vulnerable due to life experiences and instability both before entering care, and sometimes, during the out of home care period itself (Maunders et al., 1999). Many young people leave care prior to 18, even though they may not be ready for this and this can be related to both their wishes and unsuitable or conflicted placement situations (Maunders et al., 1999). In the United Kingdom, one aim of the new Children (Leaving Care) Act 2000 is to delay transitions from care (Wade, 2003)

In NSW, Cashmore and Paxon's 1996 longitudinal study of wards leaving care indicated the importance of continuity of care prior to their leaving care to young people's well being after leaving care. The research recommended promoting flexibility in terms of age of leaving care, viewing leaving care as a gradual process, and considering after care policies and services for after care as an essential part of substitute care, with provision of the same kind of extended support which young people living at home usually enjoy (Cashmore & Paxon, 1996). Unless this kind of flexibility and gradual process occurs, 'careism', may be occurring, which is a term coined by Lindsay to denote a type of

discrimination which applies where a decision or action would be unjustifiable if it occurred in relation to any other young person ( that is, a young person not in out of home care) (Lindsay, 1996 cited in Maunders et al., 1999, p. 11).

The Looking After Children documentation system was designed to ensure that the care of young people prepared them for longer- term well being (Clare & Murphy, 2000). This system also provides the opportunity for young people to engage in the planning process at an early stage (Maunders et al., 1999). Out of home care can be seen as preparation for interdependent living along a 'flexible support continuum' (Maunders et al., 1999, p. ix). This means that all the aspects of care already discussed, and particularly education, are vitally important in preparation for leaving care (Wade, 2003).

Revised legislation has begun to recognise the responsibilities of the government as parent when the young people leave care<sup>1</sup>, but there is still a danger that leaving care may be seen as an 'event rather than a process' (Clare & Murphy, 2000, p.2).

Research evidence from the United Kingdom suggests that the following may be of assistance in planning leaving care:

- Planning occurs well before any intended move
- All those with an interests in the support of the young person are involved ( for example, past carers, family members)
- There is consideration of all areas of a young person's life
- Young people know of sources of support.
- Allowance is made for movement back and forth along the pathway to autonomy , depending upon individual and changing needs
- Partnerships may need to be set up with housing, education, health and employment agencies to promote a holistic and supportive approach to leaving care (Wade, 2003)

This suggestion that movement and flexibility is required, is particularly challenging residential care service provision. Whilst some young people may retain contact with

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<sup>1</sup> For example, Children and Young Persons (Care and Protection) Act 1998 (NSW).



foster carers (Wade, 2003), the ability of residential care services to maintain continuity of care following a young person leaving care can be related to funding. In Australia, the required collaborative and joined up working may be impeded by state and Commonwealth funding issues and regulations (Wise, 2003a). One of the issues for young people leaving care has been the danger of falling between the cracks of state governments (with responsibility for child protection) and Commonwealth (responsibility for income support) policies and regulations (Maunder et al., 1999).

Whose responsibility does it become? Who provides the sense of continuity and relationship? For some young people work may have been able to be undertaken so that the family or extended family is supportive (Clare & Murphy, 2000). Leaving care schemes and leaving care workers positions can play an important part, particularly when linked with the agency and residential care workers which provided the residential care (Maunder et al., 1999). In the United Kingdom personal adviser positions have been developed to plan for care leaving and to provide 'continuity of support for the young person through transition' and identify 'the resources and services required to meet their needs.

Clare and Murphy (2000) have evaluated a pilot peer mentor model in Western Australia. The main role was regarded as support during the transition to independent living, rather than that of an advocate. Both mentors (care graduates) and young people preparing to leave care received training. As a small pilot project with limited resources, the short term outcomes are not easily generalisable. However, the qualitative evidence was that both mentors and mentees found the process worthwhile (Clare & Murphy, 2000).

A consultation with young people through the CREATE Foundation confirmed the planned, flexible and graduated process for leaving care identified in the above literature (Create Foundation, 2000). The consultation identified an overriding theme of not wanting to be 'dumped', and wanting to 'be supported until I become an adult both emotionally and physically and am ready to live independently' (Create Foundation, 2000, p. 24)

## CONCLUSIONS

Whilst this literature review has not identified any one right way to do residential care, and certainly has not found evaluated models which have been exceptionally effective results, it has identified some key principles for operating a model of residential care for young people which takes account of the current literature.

Individualised assessment and planning, collaborative practices and promoting connections are important and difficult beginning points. Developing a coherent theoretical framework which can guide the operations of the program begins with identification of values, and goals, then theories of behaviour, of intervention and of organisation. The involvement of young people in planning their lives in the context of their significant relationships and developing those significant relationships appears important. Developing resilience through a number of practices, but particularly through innovative education and learning and leisure programs can also promote independence. The maximising of the day to day and opportunity led communication and connection to promote healing relationships seems to lie at the heart of effective residential care.

Current residential practice offers opportunity for development of knowledge through collaborative and action-oriented research.

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