The Role of Residential Care in Meeting the Needs of Children and Young People in Care

A Discussion Paper

PeakCare Queensland Inc.

December 2003

Paper # 3
Discussion Paper Series

CONTENT

INTRODUCTION

'As more is learned, so new questions are raised about past practice and our expectations for children in need shift accordingly. In such a climate nothing should be taken for granted'.

In Queensland, as in other Australian States and Territories, the use of residential care for children and young people who cannot live at home has rapidly declined.

Amidst concerns about the capacity of institutional and residential care to ensure the safety and development of children and young people and the high cost of residential care, a trend toward family based care has developed. Over time, the placement of children and young people in family settings with relatives or with foster carers has increasingly become the preferred approach in out of home care.

At the same time, the range of placement and support options for children and young people has decreased, whilst demand for placements has increased and the complexity of children and young people's needs has increased. These trends have placed enormous pressure on family based care across jurisdictions in Australia. Concerns about the appropriateness of family based care for children and young people with complex needs are being identified. Of significant note in Queensland is the Commission of Inquiry into the Abuse of Children in Foster Care (Crime and Misconduct Commission).

Foster care is described as being in crisis, whilst the current availability and capacity of residential care services is limited. In response, children and young people in care are increasingly being placed and supported through 'individual packages of services'. The search is on for alternative out of home care and related services that are able to respond to children and young people with such needs. It is in this context that the role and function of residential care within a continuum of services designed to protect children and young people and strengthen families is again being debated.

PeakCare has produced this discussion paper to stimulate debate about what role, if any, residential care has in meeting the needs of children and young people who cannot live at home. This paper is the third in a series of papers produced by PeakCare that examine key aspects of Queensland's child protection response. As such it builds upon *Strengthening Families to Protect Children* and *Future Directions for Family Based Care*, which were both produced and distributed in 2002. Further, it is informed by other recent publications that have examined the capacity of Queensland's out of home care system including:

- *Mapping of Alternative Care Services in Queensland* (Department of Families and PeakCare Qld Inc. 2002)

- *At What Cost? Resourcing the Safety and Well-Being of Queensland's Children and Young People in Care* (Churches Community Services Forum 2001).

This contribution by PeakCare, as with its previous papers, aims to promote debate about the use of existing resources and the development of future service options in developing a robust child protection system.

The paper identifies and explores key questions that need to be addressed in considering the role of residential care in a continuum of out of home care and related services.

These key questions are:

- What are the current patterns of demand for and use of out of home care services?
- Who is residential care for?
- What is the purpose of residential care?
- What are the elements of effective residential care?

Each of these questions needs to be considered in respect of both the current situation and the desired situation. Such consideration presents significant challenges to policy makers, program managers and service providers to be explicit about the factors that inform their views including:

- beliefs about types of out of home care services based on previous experience and people's likes or dislikes
- pragmatic need to ensure safety and to find placements and support for all children and young people who enter care within available resources
- research about what works in providing out of home care and support to children and young people.

WHAT ARE THE CURRENT PATTERNS OF DEMAND FOR, AND USE OF, OUT OF HOME CARE SERVICES?

This section examines the use and availability of residential care services in the context of other out of home care services.

Traditionally, children and young people who need to be protected and cared for away from their parents have been placed in either foster care or residential care.

Foster care has involved placement with related (also referred to as kinship care) or non-related families and the provision of care within the carers' own homes. Residential care has involved placement with either:

- carers (usually a couple with children) employed to provide care in a house provided for that purpose
- residential care workers (rostered) to provide care in a house provided for that purpose.

As at 30 June 2002 (AIHW 2003), 3,275 Queensland children and young people where living in out of home care. During 2001-02, 1602 children and young people were placed in out of home care, whilst 971 were discharged from out of home care. The Department of Families (2001) has estimated demand for placements at 6000 per annum.

Of the 3,275 children living in out of home care as at 30 June 2002, 99% (3,209) were living in 'home based care' environments, whilst 1% (48) were living in residential care environments.

These figures under represent the use of residential care in Queensland as they only indicate how many children and young people were placed in that type of care at a specific point in time. The number of children and young people placed in residential care over a 12-month period would provide a more accurate picture of the use of residential care over a year. Further, the mapping of alternative care services undertaken in April 2002 (DoF and PeakCare) identified 82 (3%) children and young people placed in residential care services.

Table 1 details the number and proportion of children and young people in different types of placement at 30th June 2002 (AIHW 2003).

Table 1: Types of placement – 30th June 2002

Type of Placement	No.	%
Foster Care	2,385	73
Relatives	824	25
Total Home Based Care	3,209	99
Residential Care	48	1
Total	**3,257**	**100**

In the five years between 1997 and 2002 (AIHW 2003, 2002, 2001, 2000, 1999, 1998)), the number of children placed in out of home care has increased from 2,211 to 3,257 - an increase of 47.3%. Over this time, the number of children and young people placed:

- in foster care has increased 37.9%
- with relatives has increased 65.8%
- in residential care has decreased 71.6%

Placement patterns between 1997 and 2002 indicated an increasing proportion of children and young people being placed in home based care from 92% to 99%, with the proportion placed with relatives increasing from 21% to 25%. During this period the proportion of children placed in residential care fell from 8% to 1%.

Table 2 details the number and proportion of children and young people placed in each type of placement between 30th June 1997 and 30th June 2002.

Table 2: Types of placement over time – 30th June 1997 to 30th June 2002

Type of Placement	1997		1998		1999		2000		2001		2002	
	No	%	No	%	No	%	No	%	No	%	No	%
Foster Care	-	-	1729	74	1922	74	1910	73	2221	73	2385	73
Relative Care	-	-	497	21	579	22	639	24	719	24	824	25
Total Home Based Care	2044	92	2226	95	2501	96	2549	97	2930	97	3209	99
Residential Care	167	8	120	5	112	4	85	3	81	3	48	1
Total	2211	100	2346	100	2613	100	2634	100	3011	100	3257	100

Note 1: The figures for foster care and relatives were not provided in 1997
Note 2: There have been changes over time in how Queensland reports on the number of children and young people placed in out of home care

Placement patterns vary considerably across Australian jurisdictions. As of 30th June 2002 (AIHW 2003), the proportion of children and young people placed in residential care in Queensland (1%) was the lowest of all Australian jurisdictions and significantly lower than Tasmania (13%), Victoria (11%), Western Australia (10%) and the Australian Capital Territory (9%). South Australia (82%) recorded the highest proportion of children and young people placed with non-related foster carers, with Queensland (73%) and the Northern Territory (73%) the second highest. Queensland's use of relative carers (25%) was significantly less than the Australian average (39%).

Table 3 details the proportion of children and young people placed in different types of placements for each Australian jurisdiction.

Table 3: Type of placement across jurisdictions

Type of Placement	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
	Per cent								
Foster Care	35	58	73	52	82	37	62	73	51
Relatives	57	26	25	34	13	41	28	18	39
Other home based	-	4	-	-	1	2	-	-	1
Total Home Based Care	92	88	99	86	96	80	90	91	91
Residential Care	3	11	1	10	4	13	9	4	6
Independent living	1	1	-	3	-	4	-	1	1
Other	4	-	-	-	-	3	-	4	2

In 2002, there were 20 funded residential care services in Queensland (PeakCare and DoF 2002).

The key characteristics of these services are detailed as follows (CCSF 2001).

Staffing Model	
House Parent	12
Rostered Youth Worker	7
Unable to classify	1
Funding	
House parent staffing models	Range from $142,419 to $313,936
Rostered youth worker models	Range from $416,344 to $515,678
Target groups	
Age	12-18 years 10-14 years 7-12 years Not specified – subject to need and matching with other children placed
Gender	Male – 2 Female – 2 Mixed – 16
Indigenous	4 (2 since closed)
Sibling groups	2

Auspice	
Church based	13
Non Church based	6
Location	
Brisbane City	4
Gold Coast	2
Ipswich/Logan	4
Caboolture/Redcliffe	1
Sunshine Coast	1
Toowoomba/SW	1
Wide Bay	3
Central	1
Townsville	2

A report by the Churches Community Services Forum (2001) described the current service system as being characterised by:

- a focus on placement which encourages the further entry of children and young people into the service system to receive a service
- the development of single, stand alone service types (residential care, foster care, relative care), which
    - are program based and have difficulty in responding to the individual needs of children, young people and their families
    - do not have access to the range of other supports required to meet the needs of children and young people
    - lack integration with other services
- the lack of a clear framework for determining the level of funding for out of home care and preventive services at either the individual service or service system levels.

As a consequence, there has been little development of the core out of home care services; that is foster care and residential care.

The capacity of these services to meet the needs of children and young people in Queensland has diminished. This is evidenced by the increasing use of 'individual packages' to provide care and support for children and young people with a disability and/or extremely challenging behaviours. In some instances, these packages have involved building on the existing service system, whilst in others it has involved the use of other means of accommodating children and young people and/or services not normally involved in their care.

Aggregate data on the number of children and young people with individual packages, the care and support provided and the cost of that care and support is not publicly available. However, anecdotal evidence indicates that more than 200 children and young people are placed and supported through individual packages at a cost of over $15m per year.

The Department of Families has funded a number of trials (Future Directions) in relation to responsive placement options for young people, foster carer and relative care support and short-term respite. At this stage, it is unclear how outcomes from these trials may affect service planning and development across Queensland.

DEFINING CARE ENVIRONMENTS

The terms 'foster care' and 'residential care' are used in this paper as they are commonly used in policy and practice. However, the usefulness of using such terms needs to be considered given the increasing blurring of the boundaries.

Traditionally, foster care has involved care of a child in the carers' own family home and carers being paid an allowance to assist in providing care, whilst residential care has involved the provision of care in a house provided for that purpose by staff paid for providing care. Family Group Homes have always blurred these boundaries in that it has involved the care of children in a house provided for that purpose by a family with the female partner paid to provide care.

These distinctions are continuing to be blurred by the:

- increasing number of unrelated children being placed with some foster carers and the decreasing number being placed in residential care
- growing use of respite in foster care increasing the number of persons involved in the child's care, which is more akin to residential care
- linking of payments for care to the complexity of the task rather than the cost of looking after a child (in some instances this has involved use of loadings, whilst in others it has involved the payment of a taxable income to foster carers)
- offering of housing to foster carers (rent free or as part of a taxable income package) from which the care is provided.

Therefore, 'foster care' and 'residential care' no longer provides a clear basis for classifying placements of children and young people.

The overview of the 'Caring For Children Away From Home' research program in the UK (DoH 1998) suggested that in future it might be more helpful to classify placements according to the following criteria:

- Do children in need live in the placement?
- What groups of children in need are accepted for placement?
- How many other children live in the placement?
- What services are provided within the placement?
- Do the carers live permanently in the placement?

In addition, whilst terms such as foster care and residential care attempt to distinguish between who is providing the care, where they are providing the care and the basis of remuneration, they do not denote the purpose for which such care is provided. In future, it may be more useful to classify care arrangements in terms of their purpose and the components of care required to meet the needs of the child/ren placed.

WHO IS RESIDENTIAL CARE FOR?

This section examines the range of factors commonly associated with considering the suitability of residential care for children and young people. These include:

- age
- sibling groups
- nature of need
- level of need.

Each of these factors is clearly inter-related.

Age

Younger children

It is generally accepted that residential care is not suitable for younger children and that these children are best placed in family based care. Berrick (1997) suggests 'Given that placement into group care costs much more, provides less stability of caregiving, and does not increase the likelihood of adoption, very young children (under the age of six) should not be placed in group care'.

In the United States, some states require a special review before allowing children under 10 years to be placed in residential treatment. In a debate about whether such obstacles should be removed (CLWA 2003) the following factors were identified:

For

Whilst less restrictive options should be exhausted before referring a young child to residential care, a select group of these children may benefit greatly from the services and programming that residential facilities provide.

These children include those who, as a result of their behaviour, have exhausted other less restricted options and are in need of the structure that residential care provides.

There is 'evidence' that young children's behaviour improved significantly and maintained these improvements post discharge.

Against

Young children in residential treatment are at great risk of not having their developmental needs met. The critical developmental stages young children are passing through require state oversight of their placement in residential care.

> Criteria for the placement of children in particular forms of out of home care are equivocal and decisions are described as individualised and defying categorisation. Research indicates that case managers may be driven by expediency and availability of the placement setting rather than the child's treatment needs. Further, evidence has shown that once referred to residential facilities, young children are more likely to be accepted than their older counterparts.
>
> Most residential care settings are not prepared to deal with the developmental needs of young children. School age children are at a vulnerable stage of development as they transition from primary involvement with the microexperiences of home and family to macroexperiences of school and neighborhood exploration. As they are in the midst of learning how to best mitigate such transitions, rapid removal from home and placement in a residential setting, without the support of their primary caregivers, young children are likely to experience distress and developmental setbacks. It is important to focus on the developmental needs of school-age children in residential settings: developing personal competence, forming close peer associations and facilitating encounters with the outside world.
>
> Without a proper research base, providing effective services to young children in residential placement is extremely difficult.

In Australia, the proportion of children aged under 12 placed in family based care is an indicator of quality or standard of care for national reporting purposes (SCRCSSP 2002). The age used for reporting on this indicator varies from 12 and under in the US to under 10 in the UK. (AIHW 2002b).

In the Mapping of Alternative Care Project (2002) previously discussed, 45 (54%) of the 82 children and young people placed in residential care were aged 12 or under. However, these figures include two sibling groups mostly involving children aged 12 or under.

Further, analysis of the individual children aged under 12 placed in residential care would need to be undertaken to identify their needs, why they could not be met in family based care and/or why those needs were considered best met in residential care. Anecdotal evidence indicates that such placements occur due to a range of factors including:

- increasing demand
- a lack of foster placements
- increasing levels of emotional and behavioural disturbance in younger children that cannot be managed in family settings
- a lack of specialist foster care options.

Young People

Notwithstanding the continued use of residential care for some children aged under 12, residential has increasingly been used to care for and accommodate young people.

Residential care is most often seen as an option for young people due to:

- age and development
- wishes of young people themselves
- difficulties in locating foster carers willing to provide care
- levels of emotional and behavioural disturbance
- services being better staffed and resourced
- demand
- no other option being available.

It is sometimes argued that young people may be better placed in an environment where there is not the intensity of family relationships and there are opportunities to develop relationships with their peers as they move toward 'independence'.

Whilst young people's age and stage of development, along with their wishes, are often cited as factors contributing to their suitability for residential care, it is very difficult to separate these factors from those associated with their behavioural and emotional presentation, and the service system's capacity to provide appropriate care and support. These issues are further explored in the next part of this section relating to nature and level of need.

Sibling groups

Sibling groups requiring out of home care and support are difficult to place in the one care environment.

There are no Queensland statistics publicly available on the number of siblings in care, the types of placements used for their care and the proportion that are placed together or separated. However, anecdotal evidence indicates that it is particularly difficult placing sibling groups of three or more in the one family based placement.

As indicated in the Mapping of Alternative Care Project (2002), two residential care services were being used to care and support sibling groups of 6 and 7 children respectively. In addition, anecdotal evidence indicates examples of specific care and support arrangements being developed for sibling groups, which are outside of the funded residential care service system but involve the recruitment of carers and location of appropriate housing (public or private).

A review of the literature relating to sibling relationships in out of home care (Kang 2002) found that in most cases siblings were separated by accident resulting from:

- removal of children at different points in time
- assignment of different caseworkers for siblings
- lack of available placements.

In some instances, siblings were placed apart for reasons of safety or other therapeutic concerns including:

- abuse by a sibling
- need for individual attention and care
- placement with siblings was disrupted
- sibling acting as 'parent' needs chance to be a child
- siblings had large age gaps
- child chose to be placed separately.

A further examination of the separation or placement of siblings together (O'Neill 2002) found that sibling relationships are very likely to be of lifelong importance, in terms of both identity and support, and that these relationships should be nurtured whether or not siblings live together. Further, given that contact between separated siblings tends to lessen over time and that separation is not necessarily appropriate even when children appear very disturbed, separation should only occur as a last resort.

Residential care is often seen as an option for placing and maintaining sibling groups together. This option needs to be considered in the context of other measures that may assist in placing and maintaining siblings together including:

- assessment of relatives' capacity to provide care and provision of financial support
- enhanced payments for foster carers
- financial support for modifications to homes and other resources required to support care of large groups of children
- specific recruitment of carers and establishment of homes from which appropriate care can be provided
- provision of additional resources (regardless of the placement arrangements) required to meet the care and development needs of each of the children.

Nature and level of need

The provision of appropriate care and support of children and young people and interventions to address their needs and promote their development is presenting significant challenges within child protection. Many of these young people are known, and present similar challenges, to other service systems including youth justice, mental health, homelessness and education.

In a longitudinal study of children in foster care, Barber et al (2001) found that adolescents (aged 10 or above) with mental health and behavioural problems are by far the least likely either to achieve placement stability or to display improved psychological adjustment in care. The study concluded that conventional foster care is unsuitable for most adolescents and that other care options including intensive foster care and residential care need to be developed. Further discussion with the principal researcher indicates that of the 50 children and young people who were identified as not achieving placement stability or displaying improved psychological adjustment in care,

- 7 were aged 7-9 (15% of age group)
- 17 were aged 10-12 (28% of age group)
- 26 were aged 13 or above (29% of age group).

So, 24 of the fifty children and young people for whom conventional foster care was considered unsuitable and for whom other placement and support options need to be developed were aged 12 or less.

The proposed use of residential care for young people with high support needs has increasingly been challenged.

In 1994, New South Wales funded fifteen intensive out of home care and support services for this group of young people. A review of these services (Clark 1997) found that 7 of the 15 services had moved away from group care as the sole model, preferring a set of individualised arrangements. The report suggests that these arrangements reduced the likelihood of the young people detrimentally influencing each other, and enabled each young person to receive the level of intensive support required. Of the eight services that persisted with group care, none were able to maintain six residents in care. On average the group size was 4 young people.

Recent developments across Australian jurisdictions (Victoria, Queensland, South Australia and the Australian Capital Territory) indicate a growing interest in intensive forms of family based care for this group of children and young people.

In Victoria, the Department of Human Services (Success Works 2001) chose home based care as an alternative to residential care to provide an individualised response to high-risk adolescents. The High Risk Adolescent Service Quality Improvement Initiative established in 1998 has three core components:

- intensive case management
- one-to-one home-based care
- brokerage funds.

The initiative provided an intensive highly resourced response to young people aged 12-18 who present with serious personal or community risk issues and pose difficult management problems. The Department had identified 228 young people as high-risk adolescents in the care system. This group was approximately 18% of the total adolescent child protection population.

In considering the options for this group of young people, residential care was considered to have limitations in terms of a lack of clarity in implementing effective practice models, and inadequate resourcing to provide appropriate structures and staffing models necessary to achieve positive outcomes. The potential for associations between young people to exacerbate negative and undesirable behaviour was also identified.

An external evaluation of the initiative was conducted between 1998 and 2000 (Success Works 2001). The evaluation indicated significant progress in decreasing high risk behaviours and increases in finding stable and secure accommodation. However, the initial concept of providing a home base in the community for young people to normalise their lives proved extremely difficult to achieve in most geographic areas. The major factor contributing to this difficulty identified was the inability to recruit carers who could manage the nature and complexity of the work. Successful one on one placements were predominantly in:

- agencies where ex-residential care workers were used (paid a salary – over and above higher carer reimbursement)

- cases where the young person created their own placement, through their own networks.

In place of one on one placement, agencies used other options for placing young people including contingency models with two young people and residential staff, or other individually customised models. Even where there had been success in recruiting and maintaining home based carers, placements broke down when the level of risk changed and the payments are decreased.

In Queensland, Boystown Beaudesert, the last large-scale campus based residential care service, was closed in 2000. The Department of Families allocated the available funds to an intensive family based model of care and support.

The experience of a number of agencies previously involved in accommodating young people with the most intensive support needs led to the view that residential care is not appropriate for this group (Uniting*Care* Burnside 2001).

Following a review of its Minnamurra residential care service, Uniting*Care* Burnside (2001) decided to retain and reform the services with a primary focus on education. Young people aged 14-16 are accommodated who can benefit socially and emotionally from living with five other young people. These are described as young people who have a network of social supports already in the community and are developmentally moving on from the need or desire for a strong parent figure. Throughout the same period, Uniting*Care* Burnside has also moved to developing specialist and professional models of foster care (Drielsma 2003) for children and young people with high support needs.

Barnardos (Monograph 23) also describes moving from residential care to foster care arguing that residential care can more than adequately be replaced by well resourced professional foster care programs based on the philosophy of paying carers. It further describes using government or agency owned homes to place two or three unrelated 'very difficult children' with a couple. Any property damage is therefore not against the carers' own home.

Bath (2003) highlights the changing needs of young people requiring care and protection and suggests that there is no future for residential care services as they are currently configured and with their current referral patterns. The urgent need for a 'paradigm shift' that weds a 'treatment' focus to care and accommodation models is detailed by Bath (2003), 'We need:

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

'At risk' young people comprise a significant group of vulnerable young people in our community. Ainsworth (2003) describes this group '..those between 12-17 years of age, of either gender, whose anti-social activities range from disruptive and delinquent acts through to serious aggressive and violent behaviours. These activities are often linked to mental health (including self harm) and substance abuse problems arising in many instances from abuse and neglect'.

Ainsworth (2003) argues that this is the group towards which new residential and treatment programs need to be directed. He suggests that 'Without effective interventions designed to alter their problematic and destructive behaviour patterns, these at risk young people face a grim future that is likely to include one or all of the following: low-level educational achievements, substantial periods of unemployment, an inability to maintain relationships, and the potential for homelessness, adult criminality, poor mental health and long-term poverty'.

One of the major issues raised about the placement of young people experiencing severe disturbance with other similar young people is that, 'The peer group environment itself becomes a fertile setting for modeling maladaptive behaviours and potently reinforcing the social learning that had its origins in the abusive family situation' (Morton, Pead and Clark 1999). Where residential care is used for this group, Morton, Pead and Clark (1999) state that '…systematic and assertive measures must be taken by a service to set the group culture of therapeutic care and to counter the group's potential to have a profoundly negative influence upon the young people in it'. Further, they conclude that '…while a small capacity of residential treatment is an important component of a service system for young people with extreme levels of disturbance, this should be medium term, with the main focus on treatment and care, and primary attachments, remaining in the community'.

Determining level of need and matching services

In considering the needs of children and young people and the services required to meet those needs, a framework that supported determination of level of need with services required would be useful for service planning and development. A review of the literature indicates that whilst levels of care have been defined in respect of needs and degree of difficulty (DoF 2001, DoF and PeakCare 2002, WISPP 2001) and attempts have been made to link the level of care with the type of placement required (WISPP 2001a, WISSP 2001b), these attempts have had mixed success.

In 2001, the Child Protection Service Improvement Project undertook a comprehensive assessment of the needs of children and young people in care. All children placed in out of home care were identified as having foundational needs. Children were then grouped into one of four levels according to the level of intensity of supports required to meet their needs. As at 30th June 2001, it was estimated that of children and young people on protective orders placed in out of home care

- 56% (1712) had moderate support needs
- 26% (795) had high support needs
- 13% (397) had complex support needs
- 4% (122) had extremely complex support needs.

Placements in Washington DC (Berliner and Fine 2001) were divided into three levels:

- Level 1: Family Foster Care – Families receive a basic foster care rate. Children may or may not receive additional services (67% of children placed)
- Level 2: Enhanced Foster Care – Families receive higher payments for extra services, help in their home, and/or respite care (23% of children placed)
- Level 3: Therapeutic Care (9% of children placed)

  A: Treatment Foster Care – Specialised foster family homes providing enhanced services and supervision

B: Group home residential care with paid staff.

An analysis of the match between needs and care level indicated that children were largely placed in the 'right' settings. Children in enhanced foster care were identified as the most mismatched. Although 44% were rated as having severe "impairments" that likely needed intensive treatment, many had not received counselling or support services. This was attributed to inadequate supply of therapeutic care. The report noted that children tended to progress through the levels following failure at a lower level. Further, this approach assumes that the role of residential care is for children and young people with high levels of emotional and behavioural disturbance.

A review of approaches to choosing and applying criteria to placement decisions (Doran and Berliner 2001) found that it is not yet possible to use criteria that connect children's characteristics and circumstances with decisions about placement settings.

WHAT IS THE PURPOSE OF RESIDENTIAL CARE?

As with any form of out of home care, it is critical that residential care is purposeful and planned in response to the needs of children and young people.

Residential care in Queensland has predominantly focused on the direct care of children and young people.

The overall report on the independent evaluation of Queensland residential care services for the purposes of licensing (Community Link Australia 2001) indicated that services were in transition from a care focus to one that involved a more active approach to working with children and young people in terms of identifying and responding to their care and developmental needs.

As previously indicated in the overview of residential care services available in Queensland, there is no discernable program approach to the targeting, staffing, funding or location of these services. The role of residential care has largely been determined by local demands rather than through a planned purposeful response.

This is not to say that individual non-government agencies have not been purposeful in planning and providing care and support to children and young people placed in their care. Within existing resources, agencies have developed initiatives including preparation for independent living and outreach services. However, such attempts have occurred outside of an agreed understanding of the role of residential care. In the past, this has resulted in the integrity of service designs coming under threat for various reasons.

It is important that residential care as a primary care option is seen within the broader care system. PeakCare (2003) has defined the essential elements of an effective, contemporary care system as:

- a range of primary care options that must be made available to children and young people

- a casework and counselling service that is additional and complementary to the statutory casework function provided by the Department of Families, which should be provided irrespective of the primary care option selected and, wherever possible, should be consistently continued if and when the primary care arrangements of a child or young person change

- a range of community support options that must be accessible to children, young people and their families based on assessed individual needs

- a system for case managing and coordinating children and young people's care that drives the appropriate selection, monitoring, review and changes to the assembly of primary care and community support options.

A review of the literature indicates a number of areas of need to which residential care does or could respond. These include:

- Emergency shelter and assessment
- Stabilisation, assessment and transition
- Life skills development (transition to family setting)
- Emancipation (transition from care to independent living)
- 'Treatment' for purposes of:
    - behaviour management
    - specific purpose treatment (for example, eating disorders; sexual offending)
    - mental health treatment
    - residential education
    - 'secure care'

Increasingly, specialist or therapeutic foster care services have been developed to fulfill each of these purposes except for residential education.

In considering the role of residential care within child protection it is important to recognise that residential care is also used to accommodate young people and intervene in their lives by a range of other service systems in response to:

- homelessness
- mental health issues
- substance use
- youth justice issues.

Of course, some young people in care also come into contact with one or more of these systems and may have experienced residential care within that system. These young people present a major challenge to government and non-government service providers who attempt to meet their needs.

WHAT ARE THE ELEMENTS OF EFFECTIVE RESIDENTIAL CARE?

So far this paper has discussed the requirements of defining the target group for residential care and their needs, and the purpose of residential care in addressing those needs. These are two critical elements of effective residential care. This section examines other elements of effective residential care.

A number of studies in the US and UK indicate some consistency in identifying the elements of effective residential care.

A re-examination of the role of group care in a family based system of care in California (Department of Social Services 2001) found that 'Group care works best when it is a strategically developed system that reflects a planned decision to place a child in group care, a planned process for implementing that decision, and a planned transition out of group care'. The factors identified as critical to developing this type of system included:

- residential programs must deliver specific sets of services
- clients' needs must be matched with appropriate services
- services must be coordinated and connected to all areas of the child's life and family's needs
- funding must support expectations that are matched to resources
- all systems must uphold the goals of group care
- children and families must be partners in planning and implementing services
- coordinated interdepartmental statewide policies should ensure consistent delivery of services
- state policy should encourage replication effective group care models and practices.

In a study of 48 'children's homes', Sinclair and Gibbs (1998) reported that effective homes were:

- small
- showed staff agreement on how the home should be run
- had heads who felt that they had adequate autonomy, clear and mutually compatible roles and whose work had not been disturbed by excessive reorganisation.

Changes in adjustment of young people were found to be small and could be eroded on discharge to a new environment. Change was more likely to be positive where:

- the head of a home had a coherent philosophy of how change could be enabled in particular areas
- the turnover of staff is low.

The encouragement of contact with family, whilst remaining sensitive to the wish of many young people to stay in contact but not to live with their families was also highlighted as important.

The structure and culture of children's homes were found to be significant determinants of effectiveness by Brown et al (1998). Effective homes showed consistency with expectations of society, the legislation and guidance, the declared function and purpose of the 'home' and staff views on what could be achieved, and a strong child culture that complemented the aims of the home.

A comparison of specialist foster and residential care practices (Collton 1988a, 1988b) found that foster homes were significantly more child oriented than children's homes in terms of four dimensions of care:

- management of recurrent – mainly daily – social events
- children's community contacts
- controls and sanctions employed by caretakers
- caretaker roles and behaviour.

Collton (1988a, 1988b) found that the comparatively institutionally-oriented nature of children's homes owed much to the bureaucratisation of care practice.

The results were used to identify ways in which identified shortcomings might be mitigated including:

- reduce the number of children accommodated to three or four (except large sibling groups)
- use 'ordinary houses' in the community
- employ 'salaried' adults to provide care (if a couple, both partners would be salaried)
- no domestic staff employed, with domestic tasks undertaken by caretakers and children
- a ratio of caretakers to children of 1:2
- the house running on democratic lines – there would be no differentiation in the roles of adults, and children would participate in decisions affecting the running of the homes and their lives more generally

- a level of defined autonomy and administration that supported children living a 'normal life'.

As noted by Collton (1988b), this model of service was not an argument in favour of return to Family Group Homes. Further, if the staff involved were 'husband and wife teams' the sort of provision advocated would be very similar to special foster placements headed by salaried, professional, foster parents.

These elements are presented for discussion and debate rather than prescriptions for how residential care should be planned and constructed.

Debate continues even around elements that people may feel are reasonably clear such as size and location. Ainsworth (2003) argues that 'at risk' youth have been abandoned and challenges the view that residential services should be small and provided locally. He points to other service systems (health, justice and education) and other countries (US and UK) that provide larger scale and more centralised residentially based tertiary services for this and other target groups. Ainsworth (1999, p. 15 in 2003) argues that 'at risk' youth require tertiary level services, '… that have sufficient interventive *power*, are at a higher level of *intensity* and of longer *duration* (PID) than can be provided by … most community based programs, PID services …. involve a degree of compulsion and may include the use of restrictive residential setting'.

WHERE TO FROM HERE?

'We know that our old care models are not up to the job, but we are not sure what to put in their place' (Bath 2003).

The challenge now is to identify what role, if any, residential care has in meeting the needs of children and young people in care.

In responding to this challenge and considering the issues raised in this paper we need to move beyond thinking about residential care (and other types or models of care) as a 'placement'.

If there is a role for residential care, we must identify:

Which children and young people can benefit?

What are the benefits it can provide?

What are the elements of the care environment and services required to deliver those benefits?

If there is not a role for residential care, the same questions need to be considered in relation to other care environments that we have and/or need to develop to meet the needs of children and young people in care.

Necessarily, the role of residential care needs to be considered in the broader context of the range of needs of children and young people in care and the full range of primary care options, casework and counseling services, and other community support options required to meet those needs.

Further, whilst the role of residential care should be considered within the current range and mix of out of home care and related services, we also must think to the immediate and longer-term future. This will ensure that we continue to move forward in developing our knowledge and building more effective models of out of home care and support for children, young people and their families.

Finally, the questions and issues raised in this paper are of interest to all stakeholders involved in the protection and care of children and young people. Encouraging participation in small groups and/or utilising existing local or regional networks will enhance discussion and debate.

REFERENCES

Ainsworth, F. (2003) 'Unfounded assumptions and the abandonment of 'at risk' youth', *Children Australia*, 28, No.1, 24-28

Australian Institute of Health and Welfare (AIHW) 1998. *Child Protection Australia 1996-97*. AIHW cat. no. CWS 5. Canberra: AIHW (Child Welfare Series no.21)

Australian Institute of Health and Welfare (AIHW) 1999. *Child Protection Australia 1997-98*. AIHW cat. no. CWS 8. Canberra: AIHW (Child Welfare Series)

Australian Institute of Health and Welfare (AIHW) 2000. *Child Protection Australia 1998-99*. AIHW cat. no. CWS 11. Canberra: AIHW (CWS no.25)

Australian Institute of Health and Welfare (AIHW) 2001. *Child Protection Australia 1999-00*. AIHW cat. no. CWS 13. Canberra: AIHW (CWS no.27)

Australian Institute of Health and Welfare (AIHW) 2002. *Child Protection Australia 2000-01*. AIHW cat. no. CWS 16. Canberra: AIHW (CWS no.29)

Australian Institute of Health and Welfare (AIHW) 2002b. Guidelines for Interpretation of Child Protection and Out of Home Care Performance Indicators. AIHW cat. no. CWS 17. Canberra: AIHW

Australian Institute of Health and Welfare (AIHW) 2003. *Child Protection Australia 2001-02*. AIHW cat. no. CWS 20. Canberra: AIHW (CWS no.32)

Barber, J., Delfabbro, P., and Cooper, L. (2001) 'The Predictors of Unsuccessful Transition to Foster Care', *Journal of Child Psychology and Psychiatry*, Vol 42, No.6, 785-790

Barnardos (Undated) *'Moving from Residential Care to Foster Care'* Monograph 23, New South Wales.

Bath, H. (2003) 'Services for children and young people with high support needs', *developing practice*, Summer, 5-10

Berliner, L. and Fine, D. (2001) Long-Term Foster Care in Washington: Children's Status and Placement Decision Making, Washington State Institute for Public Policy, Washington.

Berrick, J., Barth, R., Needell, B. and Jonson-Reid, M. (1997) 'Group care and young children', *Social Service Review*, v71, n2, 257-267

Brown, E., Bullock, R., Hobson,C. and Little, M. (1998) *Making Residential Care Work – Structure and Culture in Children's Homes* , Aldershot, Ashgate

Child Welfare League of America (2003) 'Should obstacles to placing young children in residential care be removed?', *Residential Group Care Quarterly*, Vol 4, No 2, 8-11

Churches Community Services Forum (2001) *At What Cost? Resourcing the Safety and Well-Being of Queensland's Children and Young People in Care*, Brisbane

Clark, R. (1997) *A review of intensive out-of-home-care support services*, New South Wales Department of Community Services, Sydney.

Collton, M. (1988a) 'Foster and Residential Care Practices Compared', *British Journal of Social Work*, 18, No.1, 25-42

Collton, M. (1988b) 'Determinants of Substitute Child Care Practice', *British Journal of Social Work*, 18, No.2, 113-13

Community Link Australia (2001) Meeting the Standards of Care – Overall Report, Commissioned by the Department of Families, Brisbane.

Department of Families (2001) Consultation Paper on the Future Provision of Child Placement Services Within the Queensland Child Protection System, Queensland.

Department of Families and PeakCare Qld Inc.(2002) '*Mapping of Alternative Care Services in Queensland* '

Department of Health (1998) '*Caring For Children Away From Home – Messages from Research'* , Chichester, Wiley

Department of Social Services (2001) Reexamination of the Role of Group Care in a Family Based System of Care, Report to the Legislature, California.

Doran, L. and Berliner, L. (2001) Placement Decisions for Children in Long-Term Foster Care: Innovative Practices and Literature Review, Washington State Institute for Public Policy, Washington.

Drielsma, P. (2003) 'Children and young people first: Relationship, Permanency and Participation', *developing practice,* Summer, 16-18

Kang, H. (2002) '*Sibling Relationship in Out-of-Home Care Literature Review'*, Children and Family Research Centre, School of Social Work, University of Illinois

Morton, J., Clark, R. and Pead, J. (1999) *When care is not enough*, Consultant's report on behalf of Department of Human Services, Victoria.

O'Neill, C. (2002) 'Together or Separate? Sibling placements – A review of the literature', *Children Australia*, Vol 27, No.2, 9-16

PeakCare (2002a) Strengthening Families to Protect Children*, Brisbane*

PeakCare (2002b) *Future Directions for Family Based Care*, Brisbane

PeakCare (2003) Report prepared for the Foster Care Inquiry – Crime and Misconduct Commission, Brisbane.

Steering Committee for the Review of Commonwealth/State Service Provision (SCRCSSP) (2003) *Report on Government Services 2003*, vol 2, Ausinfo, Canberra

Success Works (2001) *Evaluation of the High Risk Adolescent Service Quality Improvement Project Report*, Department of Human Services, Victoria.

Uniting Care Burnside (2001) *'Minnamurra – a new approach to residential care'*, Professional Interchange, Vol 5, No6, New South Wales.