Respect • Hope • Social Justice • Safety • Excellence

Mercy Family Services

A Series of Papers Submitted to the Queensland Child Protection Commission of Inquiry

December 2012

A Series of Papers Examining Critical Issues in:

Family Intervention Services

Kinship Care

Foster Care

Sexual Abuse Counselling Programs

Residential Care Services

Therapeutic Secure Care

Understanding the Experiences and Needs of Children and Young People in Care

COVER LETTER

The Honourable Tim Carmody SC
Queensland Child Protection Commission of Inquiry
PO Box 12196
George Street
BRISBANE QLD 4003

10 December

Submission by Mercy Family Services to the Queensland Child Protection Commission of Inquiry

Dear Commissioner Carmody,

Mercy Family Services is pleased to provide the Commission with this series of papers addressing a range of critical issues being experienced by Queensland's child protection and out-of-home care placement and placement support services. We thank the Commission for this opportunity to share our perspectives on some of the issues we face in our work with vulnerable children and families today, and for the opportunity to present a number of recommendations for your consideration.

This submission consists of seven papers, each focusing on a particular aspect of placement and placement support for children and young people in care (and their families), specifically:

1. Family Intervention Services
2. Kinship Care
3. Foster Care
4. Residential Care Services
5. Therapeutic Secure Care Services
6. Sexual Abuse Counselling Programs
7. Understanding the Experiences and Needs of Children and Young People in Care

Written by teams of highly experienced and qualified practitioners and senior managers from across Mercy Family Services, our aim has been to provide the Commission with an introduction to these important areas of service provision. Mercy Family Services places considerable emphasis on ensuring that the programs and services we provide are based on sound practice wisdom and evidenced-based knowledge, and to this end, throughout the various papers we have highlighted a number of critical articles, conference presentations and industry reports to provide the Commission with a useful starting point for examining in further detail the issues raised and/or recommendations made.

We would be happy to discuss these papers in further detail with Commission personnel should the need arise.

Yours Sincerely,

Steven King
Executive Director
Mercy Family Services

TABLE OF CONTENTS

Table of Contents

AUTHORS

Contributing Authors

This series of paper was written by the following team of Mercy Family Services Practitioners and Senior Management:

Perry Bowe *– BSocSci, MSW (current)*
Team Leader
Family Programs

Anthony Brown *– BSocSci (Human Services)*
Team Leader
Foster and Kinship Care, Intensive Intervention Placement Support Program

Martin Greller *– BSocSci (Human Services)*
Manager
Mercy Family Services – Goodna

Dianne Kemp *– BSocSWk*
Caseworker
Intensive Intervention Placement Support Program

Steven King *– BAHons (Psychology)*
Executive Director
Mercy Family Services

Frances Klaassen *– BSocSWk*
Manager
Mercy Family Services – Toowoomba and Southern Downs

Kelly Pickering *– BApp.SocSci (Counselling)*
Foster and Kinship Care, Intensive Intervention Placement Support Program

Stewart Redshaw *– PhD (Social Work), MSocSci (Counselling)*
Research and Practice Development Manager
Mercy Family Services

Shenade Sawyer *– BA (Psychology), BSocSWk*
Manager
Mercy Family Services – Brisbane and Logan

Clare Sillence – *BSocSWk*
Coordinator/Counsellor
Sexual Abuse Counselling Program

Shelley Wall *– MSocWk (PQ)*
Manager
Residential Care and Transition Services

CONTACT DETAILS

Mercy Family Services Head Office (Nudgee)

125 Queens Road Nudgee Qld 4014
PO Box 182 Banyo Qld 4014

Phone: 07 3267 9000

Fax: 07 3267 0569
Email: mfs.admin@mfsq.org.au

Respect • Hope • Social Justice • Safety • Excellence

Mercy Family Services

Submission 1: Family Intervention Services

Submission to the 2012 Queensland Child Protection Commission of Inquiry

Prepared by Frances Klaassen and Perry Bowe

CURRENT PRACTICES

Family Intervention Services

There is currently a gap between Child Safety Services, as the sole statutory child protection authority in Queensland, and the gamut of government, non-government and community services who share the brief of maintaining the safety and wellbeing of children in this state. It is this divide, more than anything else, which needs to be bridged if the resources available to strengthen families are to be mobilised, with a concomitant reduction in the number of children and young people finding themselves in foster and residential care, or alternatively, homeless.

The Forde Inquiry (1999), the CMC Inquiry (2004), and the subsequent implementation of recommendations launched the [then] Department of Child Safety into what has been a continuous change process that has fundamentally re-shaped the landscape of child protection work in Queensland. Over the past eight years Child Safety Services has endured a transformation entailing the adoption of a language and systems of exclusivity that can serve to alienate community partners, resulting in increasing centralisation of power and responsibility to the state. As caseloads and accountability have simultaneously increased, a risk-averse culture has emerged in which parents and other services are viewed with equal suspicion, as crisis-driven authorised officers have engaged in the impossible and ill-conceived task of 'rescuing children' (Gillingham, 2011) from their abusive parents. Ever-increasing administrative demands associated with accountability practices have seen skilled professionals spend the majority of their time completing paperwork and managing data. In such an environment, critical and complex decision-making can be reduced to a 'numbers game' through misuse of the Structured Decision-Making (SDM) tools; a framework that can easily be manipulated to validate poor practice.

Not only have these pressures resulted in a gap between Child Safety Service Centre (CSSC) workers and the broader professional community, but they have created an overwhelming internal tension between well-intentioned policy and procedural changes and practice. The rhetoric of the Child Safety Practice Manual is all too often forgotten under the pressure of daily responsibilities. For example, in a recent study Healy, Darlington and Yellowlees (2012) observed a random sample of eleven Family Group Meetings, noting serious inconsistencies in practice, significant dominance by authority figures and lack of preparation of participants and material. These observations reflect Mercy Family Services' experience of these processes. It has also been our experience that all too often Case Plans are not verified and distributed within set timeframes (meaning families forfeit their right to contest elements and have them re-opened for review), a significant concern when parents (let alone children and young people) rarely understand what they need to do to meet the objectives of the Case Plan, or the rationale behind them. Communication with Child Safety Officers and their Team Leaders can at times be extremely difficult, leaving children, young people, parents and the professionals supporting them in vulnerable and disempowered situations, perpetuating adversarial relations. As tensions build, children and young people's views and needs become secondary to managing their parents' frustrated (and often misinterpreted) behaviours.

The constant pressure experienced by Child Safety Officers of never being able to get on top of the workload, responding to endless crises and having to make life-changing decisions in relation to children they have rarely (if ever) seen - whose lives they understand only by virtue of pieces of information often received second-hand - has been professionally demotivating and traumatic for many practitioners, who have consequently chosen to seek employment in more therapeutic settings. The inefficiencies of high staff turnover (including de-skilling) are well understood, but more serious is the dramatic, destabilising impacts in the lives of children, young people and their families as their 'story' is continually interrupted, distorted or lost in the process.

As is the case with any system under siege, Child Safety Services has attempted to 'control' its environment by extending its resource capacity through funded services. Thus funded services have been burdened with commensurate (and in some cases more extensive) accountability mechanisms that have constrained reflexivity and reduced service efficiency.

With few perceived reliable partners to support its forensic risk assessment work, Child Safety Services has struggled to understand the complex, individual needs of children, young people and families. Whilst partnerships with other government and non-government service providers are commonplace, these can be tokenistic: feedback from services is often used selectively to support pre-determined decisions, resulting in frustration for the external professionals and the breakdown of collaborative dialogue. This has led to poor quality casework and inadequate Court briefs that have placed strain on the judicial system and hindered permanency outcomes for children and young people. In many instances Children's Court processes have been instigated and protracted unnecessarily, with outcomes all too often hinging on expensive social assessments that provide a 'snapshot' of child circumstances and family life, whilst invaluable contextual information contained within extended family, friends, long-term support services and professional organisations is never brought to the Magistrate's attention. The resultant systemic abuse of children, parents and families is unacceptable.

IDENTIFIED NEED

From intake, to investigation and assessment, to intervention and maintenance of children in various out-of-home care options, the funnelling of all critical decision-making through a resource-depleted and traumatised central authority has perpetuated gross inefficiencies in the child protection system with grave consequences.

Mercy Family Services sees the solution to this unacceptable situation as twofold:

1. Reduce the responsibility of Child Safety Services to the vital, centralised functions that it does well through a re-distribution of statutory authority.

2. Provide the necessary environment for secondary and tertiary services, with a child protection focus, to work effectively with traumatised children, young people and families toward their optimal safety and wellbeing.

ADDRESSING THE NEED

1. Reduce the responsibility of Child Safety Services

Intake Phase

It is the opinion of Mercy Family Services that the screening of child protection concerns is generally managed quite effectively within the SDM framework. As described by the Queensland Child Protection Commission of Inquiry (2012), there is no doubt that this function of Child Safety Services has been over-burdened through mandatory reporting requirements. It is with great hope that Mercy Family Services is watching the trial of the Queensland Child Protection Guide (CPG) as a critical tool in community education and increased social responsibility for child safety, with significant workload benefits for Child Safety Officers at the intake stage.

A filtering of received concerns will allow intake officers to focus more effort on appropriate diversionary work. Better processes have been initiated to respond to cumulative Child Concern Reports; unfortunately with high resource demands, officers do not have time to remain current in their community resource knowledge and capacity to support targeted diversionary responses to received 'one-off' concerns that do not meet SDM thresholds. Once again it is with interest that Mercy Family Services is watching the Helping Out Families (HOF) initiative, especially the trial of the Family Support Alliance strategy, as a way of tapping into community resource networks and moving families quickly toward appropriate services before problems grow.

With potentially exponential benefits, it is unfortunate that these trials have been restricted to such limited geographical areas and populations to date.

Investigation & Assessment Phase

Efficiencies at intake will have flow-on effects to subsequent layers of the Child Safety Services system. The investigation and assessment of 'screened-in' child protection notifications is another function that, by virtue of its forensic nature, sits naturally under state regulation: it is difficult to see this statutory function performed consistently without such centralised control. With better diversionary processes at intake, time pressures should be relieved to facilitate thorough information-gathering with backlogs reduced. With better coordination of secondary services, investigating and assessing Child Safety Officers should have more intervention options open to them.

As discussed by Gillingham (2011), the value of the SDM tools in risk assessment is debatable. Mercy Family Services does not hold a clear preference between actuarial (e.g. SDM) and consensus-based approaches to risk assessment, as compared by Price-Robertson & Bromfield (2011). Both systems require a learning and operational environment, conducive to thorough, multi-dimensional information gathering and sound application of theoretical frameworks, not currently existent in Child Safety Services.

Case Management (Intervention) Phase

As discussed above, case management within the current Child Safety Services context is poor as a result of resource constraints borne of broad role definition. Serious inefficiencies exist within this model of centralised decision-making. It is the opinion of Mercy Family Services that the local service providers within the community sector are far better equipped than a centralised government authority to work creatively, reflexively, proactively, collaboratively and efficiently with children, young people and families toward fast, sustainable, positive outcomes.

Within such a landscape Child Safety Services would maintain case management responsibility for only a small percentage of the most serious cases of child abuse, as well as tracking children and families through the system and supporting legal processes, but all other case management functions (including foster and residential care) would be outsourced.

2. Create an climate for secondary and tertiary services conducive of effective work with traumatised children, young people and families

Secondary Services

Bromfield, Lamont, Parker, & Horsfall (2010) highlight the emerging global recognition of the importance of early intervention and the need for multiple-service responses to the diverse and inter-connected needs of children, young people and parents. Collaboration between service providers and the delivery of wraparound services are increasingly seen as being more successful in engaging with vulnerable families. The network of FaHCSIA-funded Family Support Program ventures operating nationally have been established in accordance with this research base.

In Queensland the secondary service system is seriously under-resourced. Those services that do exist are fragmented, operating independently of each other with little coordination, resulting in difficulties with complementary service provision. Community awareness of these services is often low and access for socio-economically disadvantaged families can be problematic. Robinson, Scott, Meredith, Nair, & Higgins (2012) note the operation of the law of “inverse care”, whereby the most vulnerable are the least likely to receive services. Most professional networks operate within, rather than between, fields of practice, so systemic approaches to family work are difficult to achieve. With high output requirements and few financial resources, time and coordination of collaborative practice is problematic and not required through funding agreements, therefore it generally does not happen.

In an ideal child protection world, secondary services would be plentiful, accessible, well-managed and targeted to the local context. They would operate in true collaborative fashion and have the freedom within their funding agreements to develop creative initiatives around emerging or identified community issues. They would be well-educated in relevant theory

pertaining to child harm and family vulnerability and incorporate sound risk assessment practices in their daily business to mobilise Child Safety Services intervention should that become necessary. A shared knowledge and language base is essential to the mutual respect that underpins effective collaborative practice. Together, they would offer a continuum of services to families on either side of tertiary involvement (i.e. pre *and* post intervention).

The Helping out Families (HOF) initiative is a small but quantum step in the direction of such a responsive, contemporary child protection system. There is a need for more of these services. The current government commitment of $4 million over two years through the Fostering Families funding round, whilst welcome, represents only a fraction of the savings that could be achieved, in service efficiencies and reduction of expensive care options, through a well-developed secondary service network.

Tertiary Services

As proposed, in an ideal child protection world, tertiary intervention services would hold case management responsibility for the majority of high risk families where children have remained in parental care (i.e. Intervention with Parental Agreement and Protective Supervision Orders) and where removal of children by Child Safety Services on the grounds of safety has been necessary.

Referral by Child Safety Services would generally be made at the point of completion of the investigation and assessment (except for cases where serious family trauma and significant unresolved risk would dictate interim or ongoing case management by Child Safety Services).

Intervention would commence quickly. In the case of child removals from family, thorough assessment of kinship possibilities would be a formal part of the early assessment work. This does not currently happen.

Tertiary intervention services are already required (through their funding agreements) to incorporate sound theoretical and risk assessment practices alongside their practical support of families and have considerable experience interfacing with Child Safety Services core business. Under the proposed model, tertiary intervention services would hold statutory decision-making authority in relation to the children and young people with whom they are working and could provide direct forensic evidence in Children's Court proceedings. With regard to the legal processes surrounding Children's Court proceedings, much could be learned from the collaborative initiatives encouraged through Family Law processes. The Family Law Pathways Network, that brings legal practitioners and human services professionals together through coordinated forums, training and resources, can be seen as a best practice model in the exercise of justice with a focus on empowerment.

To support this working model, tertiary intervention services, already working collaboratively in many instances, would need to consolidate and formalise these collaborative relationships; the efficiency of their practice could be greatly enhanced via connection with a more coordinated secondary service layer.

Once again, such a fundamental redistribution of responsibility for protection of children in our society would call for significant funding commitment to tertiary services, but as with the preceding argument, the economic efficiencies generated would more than compensate through:

- More functional and self-reliant communities where agencies work collaboratively and individuals and families have easy access to quality services and information.
- Circumvention of inefficient and expensive Child Safety Services and judicial processes.
- Reduction in the need for costly placement services.
- Reduced criminality and social problems.

Mercy Family Services believes that the vision outlined could become a reality. Much of the infrastructure is in place and there is a willing workforce of professionals across the sector, many of whom have spent some time in Child Safety Services gaining an understanding of risk assessment in child and family work.

In considering such a paradigm shift, Mercy Family Services acknowledges the tension that exists between economic rationalist mindset of government and the more humanistic focus of people work. The shift away from 'outcome-based' funding toward 'output-based' funding represents a concerning trend. As identified by Bromfield, Lamont, Parker, & Horsfall (2010) the safety of children within families is often compromised by a complex of mental health, domestic and family violence, and drug and alcohol abuse factors. To work effectively with families experiencing these difficulties requires considerable knowledge and professional expertise. Funding of both secondary and tertiary intervention services must be adequate to employ professionals with the necessary skills if the sustainable *outcomes* dot-pointed above are to be achieved.

As discovered in the preparation of our organisation's submissions for the recent Fostering Families funding grant, current output targets (hours) set for intervention services demand that quite large numbers of workers be employed in each program. Within funding constraints these workers need to be remunerated at a rate well below current equivalent government positions. As such, it will be virtually impossible to attract workers with the necessary skill levels to work with complex issues. Consequently, children may well remain at risk as unskilled and under-qualified workers, operating in good faith, perpetuate (and perhaps exacerbate) the disempowerment of families. It is hoped that as the Commission considers these submissions, due consideration will be given to the complexity of the work undertaken by these services and the far-reaching positive social ramifications if they are adequately and appropriately resourced.

KEY REFERENCES

Bromfield, L., Lamont, A., Parker, R., & Horsfall, B. (2010). *Issues for the Safety and Wellbeing of Children in Families with Multiple and Complex Problems: The Co-occurrence of Domestic Violence, Parental Substance Misuse, and Mental Health Problems*. Australian Institute of Family Studies. Melbourne: Australia. http://www.aifs.gov.au/nch/pubs/issues

Commission of Inquiry into Child Abuse in Queensland Institutions (1999) [Forde Inquiry]. *Report of the Commission of Inquiry into Child Abuse in Queensland Institutions*. Brisbane: Queensland Government.

Crime and Misconduct Commission (CMC) (2004). *Protecting Children: An Inquiry into the Abuse of Children in Foster Care*. Brisbane: Queensland Government.

Gillingham, P. (2011). Decision making tools and the development of expertise in child protection practitioners: are we "just breeding workers who are good at ticking boxes"? *Child and Family Social Work, 16*(4), 412-421.

Healy, K., Darlington, Y., & Yellowlees, J. (2012). Family participation in child protection practice. *Child and Family Social Work, 17*, 1-12.

Queensland Child Protection Commission of Inquiry (2012). *Queensland Child Protection Commission of Inquiry: emerging issues*. Brisbane: Queensland Government.

Price-Robertson, R., & Bromfield, L. (2011). *Risk assessment in child protection*. Melbourne: Australian Institute of Family Studies..

Robinson, E., Scott, D., Meredith, V., Nair, L., & Higgins, D. (2012). *Good and innovative practice in service delivery to vulnerable and disadvantaged families and children*. Melbourne: Australian Institute of Family Studies.

Respect • Hope • Social Justice • Safety • Excellence

Mercy Family Services

Submission 2: Kinship Care

Submission to the 2012 Queensland Child Protection Commission of Inquiry

Prepared by Frances Klaassen, Anthony Brown, Dianne Kemp, and Kelly Pickering

CURRENT PRACTICE

Kinship Care

Kinship care is one of a suite of out-of-home care options for children and young people who are unable to remain at home due to abuse and/or neglect. Kinship care is viewed as encompassing those relatives, friends, or community members who have a relationship to the child or young person and provide care for them within a statutory framework. The greater reliance on kinship care is accentuated by the difficulties experienced by Government and Non-Government services in the recruitment of appropriate foster carers (Smyth and Eardley, 2008), who have the capacity and skills to meet the growing demands for placements for children and young people coming into the care system.

Kinship care placements are generally sought in situations of crisis, that is, when an alternative longer term out-of-home care placement option cannot be found, and not because the proposed kinship carer initiated the decision to become involved (Boetto 2010). Crisis driven practices, such as not assessing the child's kin network as the first step, is common, despite legislation to the effect stating that "if a child is removed from the child's family, consideration should be given to placing the child, as a first option, in the care of kin" (s5B Child Protection Act 1999- Queensland). Clearly the pressures on the statutory services from high staff caseloads, staff turnover, and the often emergent nature of child protection issues hinder the full exploration of kinship options, leading to less than satisfactory outcomes.

Having to make life-changing decisions in relation to children they have rarely seen and whose lives they understand only by virtue of pieces of information, has often resulted in erroneous recruitment of kin. Frequently, the first kin to be identified and show a willingness to provide care for the child/ren are pursued rather than locating the best person who is able to meet the child's needs.

Examples of poor kinship practice

- Grandparent, who is illiterate caring for 3 young grandchildren and having no understanding of the Statement of Standards, the role of Child Safety, nor being able to comprehend the effects of trauma and abuse on the children.
- Non-relative family recruited as kinship carers for 4 young children despite not having any direct connection with the children. The children have significant behavioural issues with the carers having their working careers put under duress by having to care for them.
- Grandparents caring for grandchild, and continuing to do this despite one grandparent having serious health concerns requiring specialist treatment in Brisbane.
- Grandparent caring for a grandchild with complex care needs and being under emotional duress with balancing family relationships, attending appointments as well as having to care for the child during the week due to managed attendance from school.

(N.B. Details these examples have been altered to maintain anonymity).

For children and young people who cannot remain living at home there is a significant divide within the current practice and the intrinsic need to undertake an exhaustive exploration of the wider kin network to find the most suitable placement option, including assessing kin who live in other state jurisdictions. Such practice has not been widespread due to current workloads of statutory workers as well as resource limitations placed on statutory services to do such comprehensive work.

To achieve such intent, skilled practitioners with the capacity to coordinate and chair complex family group meetings are pivotal to exploring all kin options so as to achieve best practice outcomes. However, as highlighted in a recent study by Healy and colleagues (2012), such meetings are often characterised by inconsistent practice, power imbalances, and a lack of preparation. These observations reflect Mercy Family Services' experience of these processes involving kin carers.

Statutory services have historically struggled to understand the complexity of kinship care and have simply added it to the continuum of Out Of Home Care, resulting in it being influenced by the practice assumptions and framework underpinning foster care (Boetto, 2010). Such views have not enabled wide debate regarding the complex relationship issues that kinship care brings and has resulted in kinship carers feeling devalued, disrespected and in fear of departmental decisions to remove the child/ren without notice.

The Positives and Challenges of Providing Kinship Care

As highlighted in the relevant literature there are both positives and challenges involved in providing kinship care.

The Positives:

- Greater commitment with children feeling loved, valued and cared for
- Children able to maintain a sense of identity and belonging, and feeling settled because they are placed with people they know
- Children having more stable placements than children placed with non-relative carers and being less likely to be subject to placement moves
- The perceived increase in the number of children being abused in general foster care placements
- Children being able to maintain contact with their family and friends.

(Broad et al; Everett 1995; Dubowitz et al. 1994; Department of Health & Human Services 2000; Scatterfield, 2000.)

The Challenges:

- Financial hardship
- Carers having to manage the challenging difficulties of children and young people without the necessary skills
- Lack of support and training
- Overcrowding and housing issues
- Age and health issues of carers

- Limitations to freedom for children and carers
- Less thorough assessments for kinship carers than for general foster carers, and less stringent monitoring of placements
- Lower reunification rates for children and children being less likely to be adopted.

(Broad et al. 2001; the Hadley centre for adoption and foster care studies; Everett 1995; Dubowitz et al. 1994; Department of Health and Human Services 2000.)

IDENTIFIED NEED

Mercy Family Services' practitioners based-in Goodna are currently on a state-wide working party developing new kinship assessment and re-assessment documents. These documents are a radical departure from those currently in use, and will offer a more comprehensive and thorough capturing of the relationship between the applicant and the child/young person.

Notwithstanding, it is also recognised that the assessment report is only one element of the kin assessment process. There is still the intrinsic need to identify the best possible kin match so as to reduce negative long term impacts on the child/young person. Sheahan & Klaassen (2010) reiterate that kinship care is very different to foster care, and requires a dedicated practice model that ensures those who are assessing and working with kinship carers are doing so to support and resource them to meet their articulated needs in relation to the wellbeing of the children/young people in their care.

Mercy Family Services proposes a dedicated practice model that responds to the needs of kinship carers. It identifies three main areas that are crucial to placement stability of child/ren in kinship placements. Sheahan and Klaassen (2010):

(a) A thorough and extensive **assessment** of potential kinship carers and their extended families in the context of their ability, capacity and willingness to meet the needs of the children/young people.

(b) Ongoing provision of **information and training** relevant to the child/young persons' needs and the kinship carer's responsibilities according to legislation.

(c) Ongoing financial, practical, problem solving and emotional **support** to kinship carers and their families to ensure they meet the unique, complex and dynamic needs of kinship carer placements.

ADDRESSING THE NEED

A Dedicated Practice Model that Responds to the Needs of Kinship Carers – Assessment, Information & Training, and Support

Mercy Family Services propose a three tier model of practice that acknowledges the pre-existing relationship history with the biological parents and the history of the child/young person. These relationships invariably introduce a host of complex dynamics that need careful **assessment** if the child/young person is not to sustain further harm or disadvantage.

Through the use of genograms, ecomapping and conferencing establish the widest possible network of kin carers, including relatives, friends and communities from other State jurisdictions so as to provide for an in-depth exploration and thorough assessment of these possibilities to identify the best outcome for the child and young person.

As generic and rigid foster care training packages are not sensitive to the needs of kinship carers who have pre-existing relationships with both the parents and the child/young person, **information and training** for kinship carers needs to be considerate and responsive to the complex family dynamics with a particular focus on boundary setting and communication issues.

Mercy Family Services embraces a strengths-based model which is child-centred, family-focused and within a framework that recognises and understands the complex interrelationship between family members and their environments. Sheahan and Klaassen (2010) describe **monitoring and support** as two separate requirements, but interrelated parts in the process of placement follow up. The monitoring relates to the need for ongoing assessment of the progress of the child/young person within the placement, while the support is about a partnership based relationship; often a difficult balancing act for the practitioner.

The framework for monitoring and evaluating the delivery of kinship care services should not be subject to the same regulatory framework as general foster care due to the differences in motivation and that they are caring for family or a child known to them, placement type, and that they are not seeking to take a number of children over time into their home. They are intent on caring for a specific child or sibling group and need support and information directly related to these particular children and for negotiating the complex care system.

Less mandatory compliance to general foster care regulation would allow a more accessible, softer relational pathway into the system for kinship carers. Rather than a focus on paperwork and compliance, workers aim to form positive coaching and supportive relationships where the primary goal is good assessment of both the children requiring placement and the family's capacity to meet their specific needs, thus ensuring matching of resources and information provision. Effective monitoring to ensure standards of care are maintained would occur within the context of an open and meaningful dialogue driven from shared goal language rather than potential stress that we often observe currently in the compliance driven regulatory framework that is associated with general foster care provision and well above the capacity of many kin carers to manage due to their educational or personal limitations.

	Overall, the outcome of this model is to bring about a structured process that brings together strengths-based practice with thorough, ongoing risk assessment, with a view to providing a strong evidence-base to the statutory authority holding overall responsibility for the child/ren placed with the kinship family. At the same time, safe parenting practices are mobilised in family processes and positive supports promote their wellbeing and safety. In conclusion, Mercy Family Services' proposal for responding to the needs of kinship care, is more fully tabled in the paper titled "Kinship Care: Where does it belong", by Sheahan and Klaassen (2010). This document speaks in greater detail to the perspective that working with kinship care is more in the order of a family intervention and support framework as opposed to general foster care support.
KEY REFERENCES	Boetto, H., (2010). "Kinship Care: A review of issues". *Family Matters 85, Australian Institute of Family Studies Journal* 85, 60-67 Broad, B., Hayes, R. and Rushforth, C. (2001). *Kith and Kinship Care for Vulnerable Young People*, London, National Children's Bureau. Child Protection Act 1999 - Queensland Dubowitz, H., Feigleman, S. and Zuravin, S. (1993). 'A Profile of Kinship Care', *Child Welfare*. Everett, J (1995). Relative foster care: An emerging trend in foster care placement policy and practice. *Smith College Studies in Social Work,* Vol. 65(3), 239-254. Healy, K; Darlington, Y.; & Yellowlees, J. (2012). Family participation in child protection practice. *Child and Family Social Work*, 17, 1-12. Kang, H. (2003). *Well-Being Outcomes of Children in Kinship Care; Literature Review*. MSW, PhD Candidate. Sawyer, R.J; and Dubowitz, H. (1994). School performance of children in kinship care. *Child Abuse and Neglect*, Vol. 18(7), 587-597. Sheahan, T, & Klaassen, F. (2010). Kinship Care: Where does it belong? Is it family support or is it placement support or something in-between? Paper presented at the ACWA National Conference – Building a Child Friendly Australia – Responding to Vulnerable Families, Sydney. (Also presented at the Australian Foster and Kinship Carers Partnership National Conference, Hobart, September, 2010.). Smyth, C., & Eardley. (2008). *"Out of Home Care for Children in Australia: A review of Literature and Policy*; Social Policy Research Centre, University of New South Wales. Yardley, A, Mason, J., and Watson, E. (2009). *"Kinship Care in NSW: Finding a Way Forward"*. Report on a research project: an examination of issues around the support and supervision of Kinship Carers with a particular focus on NSW, University of Western Sydney.

Respect • Hope • Social Justice • Safety • Excellence

Mercy Family Services

Submission 3: Foster Care

Submission to the 2012 Queensland Child Protection Commission of Inquiry

Prepared by Shenade Sawyer, Martin Greller, and Frances Klaassen

CURRENT PRACTICES

Foster Care

Research qualifies that children are best cared for by their own family where it is safe to do so. Where appropriate kinship options are not identified for children and/or young people entering care, one of the placement options available is general or intensive foster care.

Despite the best efforts and intentions of 'volunteer' carer families, due to factors such as high placement demand, placement matching limitations, the demands of the children requiring placement and the overall expectations of carers as part of the "system of care", the current supports fall short of ensuring placement stability and supporting the child or young person through their journey in the care system and transitioning to independence.

The demands of caring for children, young people or sibling groups who have suffered abuse and/or neglect, coupled with associated complexities and placement instability promotes the likelihood of placement breakdown, which often leads to children and young people being placed with multiple carers during their time in care. This has a direct impact on the capacity of statutory and NGO providers to engage thorough and holistic matching principles, not to mention the impact on the child's attachment, identity and general development.

Meanwhile, carers exiting the 'system' as a result of experiencing a placement breakdown (due to factors including stress, limited or transient support, financial hardship and relationship breakdowns) feel dismayed, disenchanted and traumatised. Their journey and experiences are often shared with friends and relatives, and such word-of-mouth publicity promotes a negative image of foster caring.

IDENTIFIED NEED

Mercy Family Services recognises that there are number of key issues and recommendations that have been tendered to this Inquiry to date. Whilst there is substantial need to consider all of these issues and recommendations in full, for the purpose of this submission Mercy Family Services will focus on four key areas of identified need, namely: the demand for new foster carers; permanent care and stability; re-assessment of young people placing without consent; and transition to independence.

Demand for More Carers – Acknowledging and Breaking Down the Barriers

From the outset of their potential involvement with the "foster care system" prospective carers are repeatedly facing obstacles that deter rather than attract them to the role of foster carer. Whilst there was no doubt a need to improve the regulation of foster care in recent years due to the review of foster care as part of the previous CMC Inquiry, the pendulum swung to such an extent that the regulations became oppressive and demotivating. Furthermore, it often fails

to ensure quality experiences for many of the stakeholders in the system, carers, children and young people, the NGO service providers or Child Safety Services workers.

Taking the initial step to making an enquiry to become a volunteer foster carer is not an unconsidered decision. Practice experience indicates that the majority of carers have considered 'caring' over an extended period of time and, on average, on eight separate occasions. It must therefore be recognised that, whilst not all applicants have insight into the effects of trauma in children and young people, every effort must be made to facilitate, support and ensure a quality, transparent and consistent entry into the "foster care system". It is not acceptable to hear feedback from applicant carers who describe having been "scared or warned off caring" during their pre-service training. Whilst establishing clear expectations, explaining the Statement of Standards, and sharing 'real' stories and experiences is essential, it needs to be done tactfully and in the context of sharing information, raising awareness and engaging in a process of reflection. Carers are hard to find, good carers even harder. We must ensure that our focus to support carers appropriately, consistently and thoughtfully extends not only to those carers already 'within the system', but those who are considering becoming a carer.

Pre-service training and assessment needs to have a parallel focus. It needs to be competency based whilst at the same time being relational, experiential and encourages the applicants to engage in a process of self-reflection. It is our experience that the current Quality Care Training often does not prepare carer applicants for the realities of foster care and more of a focus should be on trauma informed care from the outset, with the provision of ongoing training and a more staged assessment process throughout the placement of children and young people.

Support and monitoring of foster care families once approved is complex work and requires staff in both the Department and NGOs who have the training, experience and understanding of the demands and requirements of the role. Further, it requires workers who can plan and deliver effective support that meets the needs of the carer family, including biological children, as well as the children and young people requiring placement. This is further compounded by the difference in support and monitoring that occurs between foster carers affiliated with the NGO sector and those attached to the statutory body. High caseloads and the competing and compounding demands of Child Safety Officers results in these carers affiliated with the department receiving little or irregular support and monitoring, further compromising their ability to maintain the placements of children.

Unfortunately the reality of the current stressed system is that while children and young people are being placed in a "safe" placement, it is not necessarily the "best" placement for either their current or long term needs. This places the children and young people at risk of placement instability, risk of further harm and impacts on their sense of identity, belonging, security and emotional well-being. The carer family is also placed under significant pressure due to the ongoing shortage of foster carers and placement options for children and young people.

It is further noted that placement breakdowns are often the result of a lack of responsiveness and delays in receiving additional support required at the time, when the need is first identified (e.g., lack of funding, significant waiting periods for specialist services, and delays in the financial approval process).

Permanent Care and Stability

The ultimate goal should always be for the child or young person to return home as quickly as possible, where it is safe to do so and considered in the child's best interests. However, there are times when this is not able to happen and children and young people require long term care with either a kinship carer or foster carer. This requires a timely decision that is based on an assessment of the child or young person's needs.

An emerging issue is the "placement drift" of children and young people in the child protection system. High turnover of CSOs, and high workloads with a focus on the more administrative and statutory functions of paperwork and court work means that there are often delays in making long term decisions about a young person's care arrangements. Multiple extensions of child protection orders, insufficient planning for a child's long term future in a timely manner and, inadequate family contact arrangements are all common features of c child/young person's placement. An absence of long term decision making impacts on the child or young person's stability, sense of permanency and leads to uncertainty about their future. This also places significant pressure on the carer family, in terms of managing the child or young person's reactions to the uncertainty about their future or their own frustrations around lack of clarity and plans for the child or young person.

Research and practice experience indicates that children and young people who experience instability in their care arrangements are more likely to experience poorer outcomes than those who receive stable care. Cashmore (2006) states that better outcomes are achieved for children and young people when there is "a timely decision when children need to enter care, including effecting a change in parental responsibility where required, is also likely to result in better outcomes than when children bounce between voluntary and other care placements, being returned home on several occasions, and then finally after several years or more having to go into care, until they age out of the system" (p. 239).

Young People 'Self-Placing' Without Consent

Children and young people vote with their feet! It does not come as a surprise to anyone working within the child protection industry to hear of yet another example of a young person who is 'self-placing' or 'placing without departmental consent', with their biological parents, extended family members or friends. Many of these young people entered care at an early age and have experienced multiple placement breakdowns. They have experienced a myriad of workers and care environments, limited participation in the decision making process, and sporadic, inconsistent contact with family. The concerns and risks that warranted their

removal from biological parent/s have often changed significantly. Take for example neglect. Whilst it cannot and should not be disputed that a child who suffers neglect is at significant risk of harm, the question must be asked whether this risk assessment, based on probability, severity and vulnerability, still stands for the young person at age 14, as it did when the child was aged 3.

It is often the case that due to the number of departmental case managers allocated to the child/young person throughout their journey in care, the capacity to develop a relationship between a child/young person and workers is often limited. This lack of relationship impacts on the young person's ability to develop trust in their worker and to share their views and wishes openly. Subsequently, as information is not shared or received between the young person and worker, during times of change or escalation the young person is perceived to be making ill-informed decisions about their safety and wellbeing when 'self-placing'. Whilst at times this is an accurate assessment, there are also many examples where the young person has given significant thought and consideration ahead of taking action. It is therefore essential that workers are encouraged and supported to develop appropriate relationships with children/young people, to enable a forum where they child/young person's voice is heard and acknowledged. This enables their views and wishes to be taken into consideration when re-assessing the parent/s ability and willingness to care for their child.

Of equal importance is the relationship between the case manager and the parent/s during the period of the child protection order. This relationship, for the reasons nominated above, enables the worker to clearly define departmental expectations and identify supports available to the parent/s that will assist them to address the areas of concern and risk.

Transition to Independence

What's the 'right' age to be leaving home? The Australian Bureau of Statistics, via data sourced in the 2006 ABS Census of Population and Housing and the ABS 2006-07 Family Characteristics and Transitions Survey, reported in 2006, almost one in four (23%) people aged 20–34 years were living at home with their parents, compared with 19% in 1986. *The Home and Away: the living arrangements of young people* report also identified that for men aged 18–34 years in 2006–07, the median age of first leaving home was 20.9 years (including those who left then returned later). Women in this age group tended to leave home for the first time at a slightly younger age (19.8 years).

Research indicates that the average age of young people leaving home, permanently, is increasing. Whilst many young people outside of the care system move out for brief periods of time ahead of turning 18, the vast majority return home for the support of their parents and family. Currently, this is not an option for young people in statutory care.

The Child Safety Practice Manual prescribes that Transition From Care planning should commence, formally, at age 15 and needs to include the young person in the decision making process. Unfortunately, this practice is sporadic at best. The reality for most young people in care is that their transition from care or in

contemporary terms, transition to independence, commences around their seventeenth birthday, if not later. Adequate planning is either not undertaken or if planning occurs, plans are not actioned due to the turnover of CSOs, limited resources, or workload demands. It is often the case that the foster carer (who is sometimes uncertain about whether they can continue to have the child reside with them) takes on the responsibility of completing the majority of tasks or the agency assists the carer to complete these tasks. However, there are difficulties associated with this due to case management for the young person not resting with the agency.

Mendes, Johnson and Moslehuddin (2011) state that "many young people leaving State out-of home care experience rapid, uneven and compressed transitions to adulthood, whereby they have to obtain independent housing, leave school, move into further education, training or employment; and in some cases become a parent – all at the same time, and at a much younger age than their peers" (p. 61).

There are many case examples of young people reporting that they feel extremely anxious, uncertain and scared about their transition into independence. For young people aged seventeen, who should be focussing on their education and future rather than housing and income; the emotional impact of this uncertainty is overwhelming and detrimental. Their capacity to focus on and make clear decisions about their future is impacted and inhibited by a lack of and inconsistent participation in decision making throughout their teenage years. Put simply, the system has failed to teach them how to plan and make sound decisions about their future. Cashmore (2002) suggests that meaningful participation of young people in decisions that affect them positively impacts on their self-esteem and confidence and that through participation they learn that they can be active agents in their own lives.

When transition from care planning is inadequate, the subsequent uncertainty, instability and emotional turmoil, coupled with feelings about returning to their family of origin and a lack of options and security, increases the likelihood of young people becoming homeless and becoming involved in anti-social and criminal activity. The likelihood of pregnancy, unstable housing and income, and a lack of parenting skills increases the risk of these young people again coming into contact with the child protection system and having their offspring enter the care system.

Cashmore and Paxman (2006) state that "the most likely means of translating stability in care into felt security, and into ongoing social support, is through the continuity of relationships, acceptance and the normality of these young people's daily lives – and continuity that does not end on their 18 birthday (or before)" (p. 239).

ADDRESSING THE NEED

Carer recruitment and retention

- Ensure that staff are fully trained to identify and explore kinship care options at the outset – Mercy Family Services has submitted a separate submission in relation to a model of identification and support of kinship carers.
- Continue to explore innovative methods for carer recruitment, taking into consideration the different demographics in each region; explore the use of social media in the recruitment of carers.
- The enquiry process needs to include the provision of information sharing; enable an initial screening of suitability; and ensure that enquiries are followed up in a timely manner.
- Clear, real, honest conversations to occur with prospective carers at point of enquiry. Where initial issues emerge that are likely to deem a family as unsuitable, these need to be addressed at the outset and not avoided in the hope that they will drop out further along the way. This leads to false hopes on the part of the prospective carers and a waste of the human resources associated with progressing carers through to a point where they may have a non-recommendation of approval and the associated appeals processes.
- Review quality of pre-service training to ensure consistency across agencies/trainers in terms of qualifications and skills.
- Ensure sufficient time occurs to undertake the training, allow for reflection and family discussion and thorough assessment to ensure Quality Assurance process.
- Assessments should only be completed by assessors who are tertiary human services qualified and who have undergone further specialist training in assessment, both in the Department of Communities, Child Safety and Disability Services and the NGO sector. This does not occur consistently across the board, with inexperienced and underqualified persons undertaking the complex work that is assessment. Assessors require the expertise and ability to ask the hard questions; explore themes and issues in-depth; consider matching from the beginning; fully assess the family's existing supports and strengths; identify limitations to placement types from the outset; and formulate support protocols and planning as part of the assessment phase and most importantly this occur in a "relational context".
- Provision of quality pre-service, standard and advanced training. Initial pre-service training should focus more on *'Transforming Care'* or similar training programs to ensure that prospective carers are well informed about the effects of trauma and are able to competently and consistently meet the needs of young people who have experienced trauma.
- Flexible training options such as self-paced, online learning is essential to meet the needs of busy carer households, however, funding for NGOs needs to provide for this to be developed and maintained. Further, review of emerging trends and needs is essential so as to ensure the provision of relevant and timely additional training for carers to meet the needs of children placed with them. Sharing of training innovations across the state by various NGOs in a more structured way could assist in disseminating

new training options e.g. by an online shared forum.

- Adopt a best practice approach to matching - i.e. clear, honest and frank information sharing; facilitation of a "meet and greet" between the child and prospective carer; consideration of overnight stays and weekend respite prior to placement; clear consideration of the Foster Care Agreement, specifically in relation to the carer's skills and capacity to meet the particular needs of the child or young person.
- Focus must be on providing timely, quality, consistent and transparent support to current carers in order to increase retention and promote positive word-of-mouth. Placement Agreements need to be based on a clear and thorough understanding of the child or young person's assessed need and the support required for the carer to meet these needs – not what is often a "token" gesture to meet the procedural requirements in the Department (e.g., completing the initial placement agreement within a short period of time from commencement of placement).

Permanent care and stability

- Ensure timely planning and decision making for a child or young person's long term care to enhance their placement stability and to provide them with certainty about their ongoing future.
- The adequate resourcing and exploration of a continuum of permanency options for children and young people.

Young people 'self-placing' without consent

- With the added pressure of limited carer and placement options, and in instances where the young person is 'placing without consent' a timely, thorough re-assessment of risk of harm should occur. The assessment should certainly focus on the identification of current risk factors, but also needs to take into account the young person's capacity and maturity, networks, and available assistance and in-home support options through statutory and NGO providers.
- The relationship between the young person, parent and CSO is imperative. There needs to be a common understanding of why the young person is self-placing and assessment needs to focus on 'current' observations and evidence of risks posed by parent/s, rather than historical risk/s. The assessment also needs to focus on the young person's strengths, networks and capacity to protect themselves.

Transition to Independence

- There must be specific training for staff and a commitment to begin transition from care planning, that is gradual, flexible and responsive to development and need, for young people when they turn 15 years. This must include active involvement of the carer, family, young person and other key stakeholders in decision making and planning. The focus must not just be on the financial aspects of transition from care, but also with a planned focus on: building the resiliency of the young person and enhancing their skills and resources to make decisions and lead independent lives; enhancing their family, peer and community

	connectedness; reconnecting the young person safely and positively with family; enhancing their vocational and educational pathways; and providing targeted support to meet the additional needs that a particular young person may have, for example, mental health, health or substance misuse; • Consider extending the foster and kinship carer reimbursement or some other form of reimbursement to age 21 to ensure that young people can remain in the placement and receive adequate adult support; • Increase investment into support services/mentoring programs that provide support to young people transitioning to independence until the young person reaches the age of 25.
KEY REFERENCES	Australian Bureau of Statistics (2009). Home and away: the living arrangements of young people. (2009). Australian Social Trends, 4102. June. Cashmore, J. (2002). Promoting the participation of children and young people in care. *Child Abuse and Neglect* (26) 837-847. Cashmore, J. and Paxman, M. (2006). Predicting after-care outcomes: the importance of "felt" security. *Child and Family Social Work*, 11, 232-241. Mendes, P., Johnson, G., and Moslehuddin, B. (2011). Effectively preparing young people to transition from out-of-home care – an examination of three recent Australian studies. *Family Matters*, 89, 61-70.

Respect • Hope • Social Justice • Safety • Excellence

Residential Care Services

Submission to the 2012 Queensland Child Protection Commission of Inquiry

Dr Stewart Redshaw, Shelley Wall and Steven King

INTRODUCTION TO AND SUMMARY OF THIS PAPER

Residential Care Services

The purpose of this paper is to discuss the critical role of residential care services for children and young people in the Queensland child protection and out-of-home care system. It consists of three parts:

1) The current context in which residential care operates in Queensland is discussed and how this contributes in part to a number of the issues being experienced, and how this understanding is critical to addressing them. Specifically discussed is the comprehensive placement continuum that has evolved in Queensland over the last decade, the assessment regime that plays a major role in determining which placements children and young people are placed, and the important issue of placement match (mis-match). Finally, the implications of these three issues for residential care in Queensland are discussed.

2) Drawing on the writings on key Australian experts in Residential Care, this section addresses the diverse ideological differences that have always existed about residential care as a placement option, arguing that increasingly over the last decade the debate has largely moved on from this continued controversy to one where it is being increasingly recognised that residential care has a legitimate (if not critical) place in the placement continuum, and therefore, how then can we do it better. The focus is on identifying key papers the commission should be aware of, as well as summarising some of the key points.

3) A discussion about the provision of residential care services in Queensland, current service needs, and the potential impacts on children and young people, foster carers, and the sector in general if the availability of this placement option is significantly reduced.

1) THE CURRENT CONTEXT:

THE QUEENSLAND CHILD PROTECTION PLACEMENT CONTINUUM, ASSESSMENT FRAMEWORK, AND PLACEMENT MATCH (MIS-MATCH)

Placement continuum and availability, assessment framework and placement match (mis-match) – and the implications for residential care services

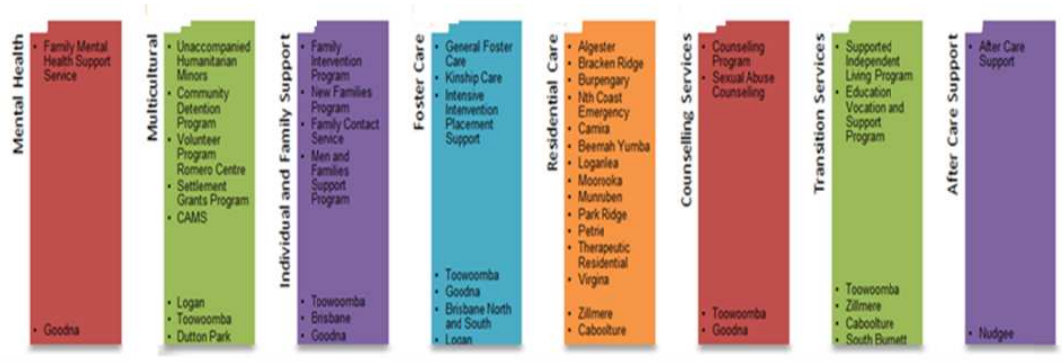
To understand some of the fundamental challenges being experienced by residential care services in Queensland, it is important to be aware of the comprehensive placement continuum that has evolved in Queensland over the last decade, the assessment regime that determines where children and young people are placed, and day-to-day practices around placement match (mis-match). The nexus between these three factors has significant implications for residential care in Queensland.

Placement continuum and availability - the current placement continuum - a comprehensive range of options

One of the most important things about child protection and out-of-home care service provision in Queensland over the last decade or so has been the gradual development of a comprehensive continuum of placement (and placement support) options. From Intensive family support services to minimise the potential for statutory intervention (e.g., Family Intervention Program, Helping out Families, and Rapid Assessment and Intervention), to family-based placements (kinship/foster care, and specialised foster care), to residential care type services (general residential care and therapeutic residential services), to transition from care (including supported independent-living and after-care services).

Further, placement support services such as EVOLVE, and agency based family contact and counselling services provide critical support for children and young people (and their families) in these placements (Department of Child Safety 2005a, 2010).

The diagram below illustrates the practical application of the elements of this placement and placement support continuum as provided by Mercy Family Services:



This diagram illustrates Mercy Family Services' effort over many years to develop this broad continuum of placement and placement support services across our regions throughout south-east and south-west Queensland so that we are in a better position to provide the best placement match and support services possible.

The steady development of this comprehensive range of placement options in Queensland by the Department of Communities, Child Safety and Disability Services is to be applauded as it has been critical in ongoing efforts to improve the quality of care provided to vulnerable children and young people unable to live with their families because of neglect and/or abuse. And while an excellent start, the continued expansion and enhancement of foster and kinship care, enhanced specialised foster care, residential and therapeutic residential care, and supported independent living programs is needed not only across the state in general, but critically, also within each departmental region as well.

It should also be noted, that the Early Intervention and Prevention Sector remains significantly under-developed, leading to increased pressure on and reliance on the out-of-home care sector. In the same way that continued investment in out-of-home care services, significant investment in early intervention and prevention services is also needed to not only protect vulnerable children, young people and families, but this in turn reduces pressure on placement and placement support services. The need for enhanced Family Intervention Services has been addressed in the first paper in this series.

The assessment framework that informs decisions around the most appropriate placement for a child/young person.

With this basic understanding of the current placement continuum in mind, it is then important to understand the assessment framework that plays *some part* in determining which of the placement types a child or young person is placed. And informing this decision is the broad *Strengths and Needs Assessment Framework.* One of the outcomes of this assessment process is an understanding of the particular level of child/young person's needs, which spans a continuum ranging from *Moderate* to *High*, *Complex*, and *Extreme*.

Understanding these four levels of needs is important when discussing the placement continuum and placement match (and the placement capacity to manage the complex and challenging behaviours of some children/young people), because the level of need framework provides a basic guide to determining whether a child/young person is best suited for a family-based placement or a more structured residential or therapeutic residential care service.

Various departmental placement funding information papers released during the decade of growth use of this *Level of Needs Framework* when describing the nature of the program to be provided, and profile the types of needs and behaviours that would be typical of a child/young person placed within a particular placement (Department of Child Safety 2005a). From these documents the intention of matching various placement types to cater for children and young people with particular needs is clear; the designated allocation of various levels of need children and have people have to particular placement types are:

- Foster/Kinship Care – catering for those with *moderate* to *high* needs
- Specialised Foster Care – catering for those with *complex* to *extreme* needs
- Residential Care – catering for those with *moderate* to *extreme* needs
- Individualised Placement and Support Packages – catering for those with *extreme* needs
- Supported Independent Living – catering for those with *moderate* to *high* needs.

And it is the inappropriateness of the allocation of certain levels of needs to particular placement types that is problematic and lies at the heart of many of the problems being experienced today, not only in residential care, but other forms of care as well. Central to the focus of this paper, it is our belief that children and young people with *extreme needs* should not be placed in either family-based settings or in generalised residential care programs. In residential care specifically, placing young people with a broad range of needs extending across the continuum (from moderate to high, to complex and extreme) in the one placement is seriously flawed, and poses a significant risk to those young people with moderate to high needs who are exposed to the often distressing and challenging behaviours of those with highly complex and extreme needs. It is important to note that despite the roll out of significant funds for out of home care services in recent years, none of these services have been targeted at the 'extreme' needs level, other than the four Therapeutic Residential Services across the state. This has placed great pressure on services to place children with needs beyond the capacity of their funded purpose and more concerning, has led to an over reliance on unsustainable temporary individualised models of care, for example, 'transitional placement packages'.

These criteria of needs and the placement types they are associated with need to be revisited and reviewed, and importantly, additional placement types that can best meet the needs of those with more extreme needs, including increasing the number of Therapeutic Residential Care Services throughout the state, and (as discussed in the next paper in this series), consider the use of Therapeutic Secure Services to prepare those with particularly extreme and challenging behaviours to successfully transition into placement in less-intensive services.

It should be noted at this point that the increasingly accepted practice wisdom is that assessment and initial placement match are crucial, rather than viewing the more intensive services such as residential care, therapeutic residential care or even

therapeutic secure care (as discussed in the next paper in this series) as placement options of *a last resort*. This means that if a child or young person's assessment identifies that a more intensive therapeutic-based placement is required from the onset, then it should be provided in the first instance rather than waiting for multiple placement breakdowns before a decision is made to place them in a therapeutic residential care service for example (Osborne & Bromfield, 2007).

Placement match (mis-match) to provide the most appropriate level of care

Placement match (and the associated issue of timely assessments), have been identified as critical factors in quality practice with children and young people in care (Farmer & Pollock 1999).

The extensive range of placement options that have evolved in Queensland over the last decade (foster/kinship care, specialised foster care, residential and therapeutic residential care, and supported independent living), in theory at least, provide a greater likelihood that critically important placement match with a child/young person's identified level of need (low, moderate, high or extreme needs) can be achieved.

The reality, however, is that placement match is often simply not possible. The required placement is often not available, either at the time it is needed, or is not available within the local region, resulting in the child/young person being placed in a placement that is less than ideal, and with inadequate support to manage their complex needs and/or challenging behaviours. Or in other instances, a child/young person is placed in a relevant service (matching their level of need), but far removed geographically from their family and community network. Similarly, because of numerous pressures, the match between a child/young person being referred, and those currently in the placement (not to mention the carers' own children), are not matched. The priority to secure the placement becomes the imperative and at times this overrides best practice considerations such as the impact on the existing placements and long term outcomes for both individual children and the group as a whole.

For example, children and young people with highly complex and challenging behaviours who should be placed in more intensive, non-family-based settings are placed in foster care. The consequence is that such placements are very disruptive leading to multiple placement breakdowns, with serious impacts on both the children/young people and the carer/s involved. Further, additional pressure is placed on departmental officers who need to then urgently find another placement, and often the most expedient placement is chosen rather than one that is specifically matched to the child/young person's needs. And unfortunately, this well-known cycle of placement mis-match, and placement disruption and breakdown, continues to the serious detriment of a child/young person's wellbeing (Delfabbro, Barber & Cooper, 2000; Delfabbro & Barber, 2003).

Implications for residential care in Queensland

Turning specifically to residential care services, it is necessary at this point to define what is generally meant by *General Residential Care Services* in Queensland as funded by the Department of Communities (Child Safety). In general, these programs are characterised by:

- homes provided in the local community;
- catering for between 2 to 5 young people;
- with varying levels of need (moderate, high, complex, and extreme);
- staffed by residential care workers on a 24 hour roster (including 'sleepover' arrangements in the main or in some limited services, an awake shift overnight); and
- supported by professionally qualified case workers, and coordinators (Care Team).

Put simply, the nexus between placement availability (the broad placement options available), the particular assessment of a child/young person's level of need (whether moderate, high, complex or extreme), and placement match (mis-match) has contributed to a number of long-standing problems being experienced by residential care service providers in Queensland and most other jurisdictions throughout Australia.

Many children and young people totally unsuitable for these community-based residential care settings have been, and continue to be, placed in these programs. Because of limited funding models such programs only have the capacity to adequately cater for young people with moderate to high needs (or in some instances, those with *some* complex needs), those who are able to reasonably manage their emotions and behaviours and are able to function adequately on a day-to-day basis with the level of support available.

As discussed above, the problem has been that children and young people with often very complex needs and/or extremely challenging behaviours are also being placed in these community-based settings. These generalised residential care services are simply not adequately resourced to care for these young people who really should be placed in more intensive programs such as new *Therapeutic Residential Care Services* which have considerably higher levels of support and therapeutic intervention (Department of Child Safety, 2010), or as suggested in the next paper in this series, *Therapeutic Secure Care* services.

The consequences of placing such children and young people in these generalist residential care programs are the types of issues often reported in the media: serious property damage (at times requiring police intervention), assaults to other young people and / or staff, repeated pattern of absconding from the placement, putting themselves at risk, or exposing other young people in the placement to the sometimes distressing behaviours of these young people.

Further to this, Mercy Family Services' practice experience highlights that the placement of young people in residential settings that are unable to respond to their extreme needs often results in an unacceptable disruption to the community in which the houses are located. In some extreme cases, this has resulted in the relocation of services to alternative properties (at a high financial cost to the agency) in order to continue operations as neighbours reach a saturation point of tolerance for disruption to their enjoyment of their homes. This issue can be somewhat addressed by maintaining vigilance of communication and consultation with neighbours on a regular basis, however, it is often inadequate to address the concerns in the long term if the issues persist. A recent trip to the United Kingdom to present our paper '*Beyond Containment – Driving Change in Residential Care - A Queensland Model of Therapeutic Residential*

Care' at the 12th European Scientific Association on Residential Foster Care for Children and Adolescents Conference (EUSARF) 2012 also provided an opportunity to visit a number of non-government agencies operating a range of service models which cater to young people with broad ranging needs, including those with 'extreme needs'. These included 'campus' style models, purpose built facilities on which a 'hub' of services can be operated, including education. This was further supported when visiting a range of services in the New York, United States where they offered a similar range of services which incorporated 'cottage' style residential homes on large properties including purpose built facilities also incorporating education. These settings appeared to blend the best of small group care with the benefit of having a range of support services available on site, including education provided by the local school board, meaning young people's ability to engage in services which were designed to meet theirs needs was readily available with minimal unintended disruption to the community at large but not at the expense of young people still being able to participate in their local community where appropriate to their needs and levels of coping. This however, does not mean isolating these children and young people in self-contained, institutional-type 'communities' (as was often the case in decades past), as considerable efforts would need to be made to ensure that each child/young person maintains connectedness with their individual community network of family, friends, and social supports.

Whilst a more detailed discussion of the service needs of Queensland residential care service is provided below, understanding the nexus between the depth and breadth of the placement continuum, the particular level of need ascribed to a child/young person, and the reality of placement match (mis-match) on a day-to-day basis is critical to grasping some of the fundamental problems that exist in Queensland today. As discussed, this placement mis-match lies at the heart of many of the problems being experienced in residential care services today. In addition to addressing a number of other core issues that have been discussed elsewhere (adequately funded programs, qualified and experienced direct care staff, and the support provided by multi-disciplinary teams), one of the first things that must be done to enhance the quality of *generalised residential services* is to ensure that they are utilised for those children and young people with needs which the service model and staffing arrangements can adequately respond. This will require a review and revision of the level of need to placement type criteria. To place those with highly complex needs and/or extremely challenging behaviours in such inadequately resourced programs and then to criticise those same programs for failing to provide adequate care and 'control' is not only illogical, but unhelpful.

2) THE DEBATE ABOUT THE LEGITIMACY OF RESIDENTIAL CARE

This section draws on the writings on key Australian experts in Residential Care. The focus is on drawing the Commission's attention to the diverse ideological differences that have always existed about residential care as a placement option, but also to note that increasingly over the last decade the debate has largely moved on from this continued controversy to one where it is being increasingly recognised that residential care has a legitimate (if not critical) place in the placement continuum, and therefore, how then can we do it better. Further, the consequences of a radical departure from providing a range of residential care services are also canvassed. The purpose is to identify key papers that the commission should be aware of, as well as summarising some of the key arguments, findings and conclusions.

The Key References

The following references provide a very useful collection for understanding the nature and service needs of residential care in Australia, and for gaining an understanding of the ongoing controversy that has surrounded the provision of residential care services in this country and internationally, and, the consequences of trying to do without this critical resource as a part of a sector's placement continuum. A detailed analysis is beyond the scope of this paper; the purpose is to bring these key papers to the Commission's attention and to provide a brief summary derived largely from the abstracts.

The recommended papers are:

Ainsworth, F. (2001). After ideology: The effectiveness of residential programs for 'at risk' adolescents. Children Australia, 26(2), 11-18.

Ainsworth, F., & Hansen, P. (2005). A dream come true - no more residential care. A corrective note. International Journal of Social Welfare, 14, 195-199.

Ainsworth, F. (2007). Residential programs for children and young people: What we need and what we don't need. Children Australia, 32(1), 32-36.

Ainsworth, F., & Hansen, P. (2008). Programs for high needs children and young people: Group homes are not enough. Children Australia, 33(2), 41-47.

Bath, H. (2002-2003). Services for children and young people with high support needs - it's time to rethink. Developing Practice: The Child, Youth and Family Work Journal, Summer, 5-10.

Bath, H. (2008a). Residential care in Australia, Part 1: Service trends, the young people in care, and needs-based responses. Children Australia, 33(2), 6-17.

Bath, H. (2008b). Residential care in Australia, Part II: A review of recent literature and emerging themes to inform service development. Children Australia, 33(2), 18-36.

McLean, S., Price-Robertson, R., & Robinson, E. (2011). Therapeutic residential care in Australia: Taking stock and looking forward. National Child Protection Clearinghouse Issues, 35, 1-24.

Osborn, A., & Bromfield, L. (2007). Residential and specialised models of care. National Child Protection Clearinghouse: Research Brief, 9, 1-13.

Summary of Salient Points

The following abstracts are largely self-explanatory, but in some instances additional comments have been made. Whilst the views about what exactly is residential care and who should be placed in such settings differ somewhat, all agree that additional work is needed to improve the quality of such services, and critically, that there is a pressing need to investigate and develop more intensive, therapeutically-focused services for those children and young people with increasingly complex and challenging behaviours.

Ainsworth, F. (2001). After ideology: The effectiveness of residential programs for 'at risk' adolescents. Children Australia, 26(2), 11-18.

- Examining the literature about residential care, education and treatment programs for at-risk young people, Ainsworth notes that "… national and international evidence is that foster care is in crisis and is unable to provide stable and continuous placements for many of our most difficult youth. The

research suggests that these alternatives are not 'all bad' and that they have an important place in the continuum of child and family services" (Abstract, p. 11).

Ainsworth, F., & Hansen, P. (2005). A dream come true - no more residential care. A corrective note. International Journal of Social Welfare, 14, 195-199.

- From the Abstract (p. 195). "This note is about the attempt by the Australian State and Territory child care and protection systems to do without residential programmes. It traces the process of moving to this position and the historical and policy imperatives that supported this service direction. It also outlines the consequences of the absence of 24 hours-a-day 7-days-a-week residential education or treatment programmes for difficult and disturbed young people. It is both a cautionary and corrective note designed to underline the need for some specialised and highly selective residential programmes as part of any mature child care and protection system. This is something that Australia forgot".

Ainsworth, F. (2007). Residential programs for children and young people: What we need and what we don't need. Children Australia, 32(1), 32-36.

- In this important opinion piece, Ainsworth argues that while on the one hand there are calls for a wider use of residential care services (to address the closure of many services in the 90s and early 2000s), on the other hand continuing revelations of abuse and poor quality care in such services in jurisdictions across Australia raises serious questions about the effectiveness and impact of such generally inadequately resourced services. Ainsworth argues that to increase the use of residential care services without first doing critical work around clarifying the functions of these programs as well as being very clear about the knowledge and skills required by residential care staff to ensure quality care would be 'disastrous (p. 32).

- He also notes that "… Given the high cost of residential programs by comparison with other out-of-home care options, it is important that these programs are highly specialised and only available to a rigorously selected group of children and young people" (p. 33).

- To conclude he comments "What we do need are residential treatment and residential education programs that are staffed by adequately trained direct care workers and others. And above all we need residential programs that are non-abusive and effective" (p. 35).

Ainsworth, F., & Hansen, P. (2008). Programs for high needs children and young people: Group homes are not enough. Children Australia, 33(2), 41-47.

- From the Abstract (p. 41). "Recently the Department of Community Services in New South Wales and the Department of Child Safety in Queensland have both released information about funding and the award of contracts for group homes and other residential services. In addition, in the 2008 discussion about out-of-home care at the Wood Commission of Inquiry into the Child Protection Services in New South Wales, group homes were discussed in terms of them being less demanding environments than foster care. The view presented was that group homes are appropriate for some young people who are either unsuitable for foster care or who want a less intimate setting than that provided by foster care.

This article argues that group homes or residential programs, against the New South Wales and Queensland descriptions, fail to respond to the need for quality residential programs for children and youth. This is partly due to the low level of training for staff in group homes and high staff turnover."

- The authors also note that "What we have learnt at the expense of two generations or more of vulnerable children and young people is that foster care cannot serve every child or young person, and that some, highly selective, specialised, residential services with clear therapeutic objectives are needed" (p. 45).

- In summary, Ainsworth and Hansen in their various papers are very clear that the very minimalist types of residential care service as is generally provided in Australia (as defined on page 8 of this submission) is inadequate to provide the level of care required by those children and young people. As noted earlier, quality residential care needs to be adequately resourced, targeted towards children and young people with specific needs (e.g., treatment for sexualised behaviours), are staffed by skilled and knowledgeable direct care staff and caseworkers, with a clear therapeutic objective.

Bath, H. (2002-2003). Services for children and young people with high support needs - it's time to rethink. Developing Practice: The Child, Youth and Family Work Journal, Summer, 5-10.

- Discussing the plethora of inadequate placement options currently being used for children and young people with high support needs (including one-on-one wrap-around care, placement in shelters, motels and the small number of small-scale residential units, Bath argues that "… the service response for high needs children and young people are grossly inadequate and sometimes border on being abusive" (p.6). Further, that "… there is evidence that it is the more troubled young people that are being inappropriately placed and who are suffering the most from the paucity and inadequacy of current service options" (p. 6, quoting Delfabbro and colleagues, 2000).

- Similarly to Ainsworth and Hansen, Bath argues that we need to move from a 'care and accommodation' paradigm, where children and young people are cared for by primarily unskilled or semi-skilled carers in services where clear therapeutic focus is lacking, to programs that are: designed to meet their multiple and complex needs (not just their day-to-day care needs), qualified and trained staff, working collaboratively with multi-disciplinary teams, in services that are goal directed and accountable for positive outcomes.

Bath, H. (2008a). Residential care in Australia, Part 1: Service trends, the young people in care, and needs-based responses. Children Australia, 33(2), 6-17.

Bath, H. (2008b). Residential care in Australia, Part II: A review of recent literature and emerging themes to inform service development. Children Australia, 33(2), 18-36

- These two papers by Howard Bath provide an excellent overview of the issues involved in residential care and of critical service development needs from the national and international literature. The first paper explores service trends over the past few decades, the current place and focus of residential care services,

the nature of the young people being placed into such services, and the imperative for developing a more needs-based approach to service delivery. It concludes with a review of recent calls for the development of therapeutic or treatment orientated models and the initial steps in this direction that have been taken around the country (Abstract, p.6).

- The second paper contains a review of some of the recent literature on residential care from Australia, the UK, Canada and the USA. It concludes with a look at the major themes and issues that emerge from this literature as well as the service trends and developments canvassed in Part I (Abstract, p.18).

Just a few of the pertinent points, relevant to the focus on this submission, made by Howard Bath in the first of these papers include:

- Noting some of the drivers that have influenced the decline in residential care during the 80s and 90s, bath noted "…Various ideological practice drivers such as 'deinstitutionalisation', 'normalisation', and 'localisation' have influenced these trends. These ideals and principles were based on emerging understandings of child development, such as early findings into the importance of attachment. Disenchantment with institutional and residential care was fuelled, in part, by widespread reports of abuse and neglect in institutional settings. Apart from ideology, the much greater costs of group care cannot be discounted as a major driver of the reforms" (2008a, p. 7).

- Describing the resultant use of foster care placements in the absence of residential care Bath notes that "…it is widely recognised that the foster care system across the country is struggling to meet the needs of many children and young people with complex needs and challenging behaviours" (2008a, p.6).

- And further, that "… When we consider that residential care provides a critically-needed option for some of the most disadvantaged, vulnerable and challenging young people in the care system, the neglect of this care modality in the literature is hard to understand (2008a, p. 6).

- Highlighting the changes in how such general residential care services were increasingly being used in the early to late 2000s, Bath notes: "Overall, residential care, considered by some to be the most restrictive and 'abnormal' out-of-home care option in the child welfare system was increasingly used as a last resort for troubled and troubling children rather than for those simply needing care. This trend rapidly became an imperative as the number of available beds diminished and as care costs escalated, with declining staff child ratios and economies of scale" (2008a, p. 8).

- There is an increasing gap between the number of young people who need residential care and the availability of services to meet their needs … This has resulted in many young people being sent to youth services designed for older, more independent (and often streetwise) young people where they may be exposed to negative modelling and/or abuse. Others are temporarily accommodated in motels, crowded into full facilities or simply left to fend for themselves (2008s, p.10).

- In conclusion, Bath notes: “Since the 1960s there has been a significant decline in the use of residential care services across Australia and the shape and size of such services has changed radically. The few existing programs are struggling to accommodate the number of young people in need of placements and to effectively manage their challenging behaviours, An examination of the needs of young people being referred to residential care suggests that existing programs may need to radically re-conceptualise their task. They need to move beyond a simplistic focus on care and accommodation to adopt a broader 'treatment' or therapeutic perspective that considers and endeavours to address the multiple needs of such young people” (2008a, p. 15).

McLean, S., Price-Robertson, R., & Robinson, E. (2011). Therapeutic residential care in Australia: Taking stock and looking forward. National Child Protection Clearinghouse Issues, 35, 1-24.

- This timely paper is one of the first Australian publications to focus specifically on Therapeutic Residential Care.

- From the Abstract (p.1). “Therapeutic residential care (TRC) is becoming an increasingly relevant out-of-home care option for children and young people with multiple and complex needs. It is a new and developing approach in Australia, one aimed not simply at containment of the “hard cases”—as is often the case in traditional residential care—but rather at actively facilitating healing and recovery from the effects of abuse, neglect and separation from family. In this Issues Paper, therapeutic residential care is described and contrasted with other models of out-of-home care. The theory and evidence supporting the use of this form of care are examined and used to develop a set of key elements, which, it is argued, should guide the provision of therapeutic residential care in Australia.”

Osborn, A., & Bromfield, L. (2007). Residential and specialised models of care. National Child Protection Clearinghouse: Research Brief, 9, 1-13.

- Similar to McLean and colleagues’ paper above, this paper by two highly regarded Australian authors provides a very valuable examination of residential care in Australia. Of particular interest to this submission is the section where the authors discuss the role of residential care in the care continuum. The various points made (pp. 3-4) include:

  - Conventional home-based (foster and kinship) care is not suitable for some children and young people with complex behavioural problems and high levels of placement instability. Residential care should be considered a viable option for these children and young people.
  - Residential care should be used selectively for children and young people with high support needs, sibling groups, young people moving on to independent living, and children and young people following a foster placement breakdown.
  - While foster care remains the preferred form of out-of-home placement, there is a definite place for residential care in the service system.

- The care continuum itself should be re-evaluated and residential care be considered as an option when children first enter care, where they can be assessed and receive appropriate treatment services.
- There is a need for treatment models of residential care to be developed and evaluated.

The core themes:

The core themes throughout these papers are that despite the largely ideologically driven controversy that has surrounded the use of residential care as a placement option, the growing consensus is that such services play a critical role in the out-of-home care placement continuum. Further, that generalised residential care programs can be appropriate for young people with moderate to high levels of need, not suitable for family-based placements, and in the transition from care to independent living. Finally, that radically reducing the availability of residential care placement options can have (and has had) a detrimental effect on the children and young people themselves, and on other forms of carers (usually foster/kinship) who were required to care for them in the absence of residential care.

But throughout these papers, there is a major caveat:

The type of residential care programs generally provided across a range of Australian jurisdictions (i.e., small residential units based in the community, catering for 2 to 5 young people with varying levels of needs, staffed by largely unqualified direct care staff) are inadequate to meet the highly complex needs and very challenging behaviours of many children and young people who are being placed. To meet these needs, enhanced therapeutic residential care models, adequately funded, with skilled and qualified staff, targeting children and young people with specific treatment needs (e.g., sexualised behaviours), and with a clear therapeutic focus are needed. And clearly this requires a commitment from all involved to both develop such therapeutically-focused residential services and for government to fund them.

This means that a range of residential care programs are needed. Rather than an either/or approach, where those children and young people with moderate to high needs are placed with families and those with highly complex and extreme needs placed in more intense therapeutically-focused residential services, a range of residential care from the generalist (as defined in this paper) to the therapeutic, and even to secure care models (discussed in the next paper) need to be maintained, enhanced and developed across the state, and within each region.

3) RESIDENTIAL CARE IN QUEENSLAND – CRITICAL SERVICE NEEDS AND THE POTENTIAL IMPACT OF REDUCING RESIDENTIAL PLACEMENTS; & OPPORTUNITIES FOR FUTURE PRACTICE

If Residential Care was removed from the placement continuum we risk repeating past system limitations which resulted in an over reliance on the foster care system and an increase in 'unfunded' use of individualised package arrangements that were in existence prior to the last inquiry in to the child protection system.

Despite the reliance on the foster care system in the post Forde Inquiry era, the Crime and Misconduct Commission recognised that "there are significant numbers of children who *do not* benefit from placement in traditional foster care and require placements in residential facilities" (Crime and Misconduct Commission, 2004, p.192). The unintended consequence of the over reliance on the foster care system arising from the last intentional decline in the number of funded residential placements was a trend towards expensive 'containment' based individualised placement packages for those young people who could not be managed in family based care (Department of Child Safety, 2008).

The Crime and Misconduct Commission Inquiry was advised that funding for residential care services had been neglected and no services in Queensland at that time, received sufficient funding to provide the intensive, specialist intervention that many young people require (PeakCare submission cited in Crime and Misconduct Commission, 2004, p.191).

The Crime and Misconduct Commission Inquiry also recognised the need for therapeutic services for children in care due to the complexity of their behaviours and the resulting placement breakdowns. It was recommended that "more therapeutic treatment programs be made available for children with severe psychological and behavioural problems. Successful programs should be identified, implemented and evaluated" (Crime and Misconduct Commission, 2004, p.194).

Despite these findings, it could be argued that even with the significant (and appreciated) investment in the out of home care sector over the last five years, some of these issues remain unresolved, especially in respect to placement options for young people with extreme needs (note earlier point re lack of funding for young people with this level of need over the same period).

Recommendation 1: Delegation of Clinical Oversight/Case Management to the NGO Sector

That consideration is given to the enhancement of current residential models catering to highly complex young people to include 'clinical' oversight of the program intervention and planning. Evidence from the recent evaluation of therapeutic residential care in Victoria would support that this enhancement has resulted in considerable improvements in positive outcomes for young people (Verso Consulting, 2011).

Whilst Mercy Family Services strongly supports the need for residential care as part of the continuum of placement options available to young people, we also recognise that the there is always an opportunity to evolve service models to ensure that both the desired care outcomes are achieved; and the service represents value for money and a solid return on this investment for both the government and the community at large. With this in mind, a possible mechanism for improvement in 'value for money' exists in the consideration of implementation of 'delegated case management'. This would result in the development of protocols / policy / legislation to support the recognition of the

transfer of 'case work' rather than management, to the NGO provider. Most existing residential service providers already have capability and capacity in their models to accommodation such as initiative. Therefore the formal transfer of case work to the NGO provider would not require any large additional funding to operationalise such as option. This strategy would enable a reduction of the amount of case management tasks that need to be performed by the Department CSO resulting in possible cost reductions and / or reductions on workload pressure for statutory staff. It is our understanding that a trial of this approach has been commenced in Western Australia.

That consideration is given to the implementation of 'delegated case work' to NGOs to improve value for money / return on investment in the residential sector; improved outcomes for children and young people in terms of being able to action case work in a more timely manner; and, reduced burden on statutory case workers (CSOs).

Recommendation 2: A 'Shared Needs' Approach

This paper has highlighted significant concerns in respect to 'matching' children and young people's needs to the service response. Mercy Family Services supports the need for reform of the 'categorisation' of needs of young people to assist the ability to appropriate match young people to the service type that best meets their care and support needs.

The traditional approach around consideration of a range of 'compatibility' measures in order to determine if a placement is suitable has many limitations and often results in a 'trial and error' approach to placements seeing many children and young people experiencing unplanned placement endings and transfer to other providers. A more effective approach to matching children and young people to an appropriate placement can be achieved if a *'shared needs*' approach is adopted. This approach places a high focus on developing a model / intervention approach based on a group of young people with similar needs being placed together to enable a 'specialised' approach to this primary need to be effectively implemented by the service. Key feature of the approach include (Fahey, 2012).

- High risk management burden to meet 'Duty of Care'
- Consistent environmental requirements
- Targeted/ specialist staff training and support
- Specific program design
- Therapeutic elements
- Sustainable model of care required to meet the 'shared need'
- 'Safe' support structure to manage impact of others.

This approach also promotes the development of specific models to address particular needs commonly identified in the cohort of children and young people who benefit from placement in residential care including:

- Children and young people 12 – 17 years who have suffered considerable trauma and display complex to extreme behaviours resulting in multiple placement breakdowns in foster / kinship care
- Children under 12 who have suffered considerable trauma and display complex to extreme behaviours resulting in multiple placement breakdowns in foster / kinship care
- Children and young people with significant disabilities when placement in a

family is not viable, resulting in a blending of the best of the knowledge base from the disability sector with the best of the knowledge and practice wisdom from the out of home care sector

- Children and young people with problematic sexualised behaviour where placement in foster / kinship care is not viable due to risk. This option also enables a 'treatment' approach to this type of care

The above is not an exhaustive list but it does provide some examples of the ability to provide specific service model responses to identified needs which enable specialised intervention and enhanced setting conditions to achieve positive outcomes for children and young people placed in residential care.

Recommendation 3:

That consideration is given to reviewing the current practice around categorisation of needs based on the current tool i.e. behavioural indicator resulting in classifications of moderate, high, complex and extreme. That part of this consideration examines the possibility of adopting a 'shared need' framework for matching young people to placements and that existing models of residential care are enhanced to effectively respond to this approach.

REFERENCES

Ainsworth, F. (2001). After ideology: The effectiveness of residential programs for 'at risk' adolescents. Children Australia, 26(2), 11-18.

Ainsworth, F., & Hansen, P. (2005). A dream come true - no more residential care. A corrective note. International Journal of Social Welfare, 14, 195-199.

Ainsworth, F. (2007). Residential programs for children and young people: What we need and what we don't need. Children Australia, 32(1), 32-36.

Ainsworth, F., & Hansen, P. (2008). Programs for high needs children and young people: Group homes are not enough. Children Australia, 33(2), 41-47.

Bath, H. (2002-2003). Services for children and young people with high support needs - it's time to rethink. Developing Practice: The Child, Youth and Family Work Journal, Summer, 5-10.

Bath, H. (2008a). Residential care in Australia, Part 1: Service trends, the young people in care, and needs-based responses. Children Australia, 33(2), 6-17.

Bath, H. (2008b). Residential care in Australia, Part II: A review of recent literature and emerging themes to inform service development. Children Australia, 33(2), 18-36.

Crime and Misconduct Commission. (2004). Protecting children: an inquiry into abuse of children in foster care. Brisbane. Available: http://www.communities.qld.gov.au/childsafety/about-us/publications/protecting-children-an-inquiry-into-abuse-of-children-in-foster-care.

Delfabbro, P., Barber, J., & Cooper, L. (2000). Placement disruption and dislocation in South Australian substitute care. Children Australia, 25(2), 16-20.

Delfabbro, P., & Barber, J. (2003). Before it's too late: Enhancing the early detection and prevention of long-standing placement disruption. Children Australia, 28(2), 14-18.

Department of Child Safety (2005a). Funding information paper 2005-06. Placement services: Foster and relative (kinship) care, specialist foster care, residential care, supported independent living. Queensland Government, Brisbane.

Department of Child Safety (2005b). Attachment 1: Characteristics of children and young people and support levels. Queensland Government, Brisbane.

Department of Child Safety. (2008). Service model for therapeutic residential services.

Retrieved on July 15, 2010, from: http://www.childsafety.qld.gov.au/funding/documents/trcs-model-final.pdf.

Department of Child Safety (2010). Grant funding information paper 2010-11. Therapeutic residential care service – Southern-Queensland (Morayfield). Queensland Government, Brisbane.

Farmer, E., & Pollock, S. (1999). Mix and match: Planning to keep looked after children safe. Child Abuse Review, Vol. 8, 377-391.

Fahey, L. (2012). Client matching, compatibility & service review. Brisbane.

Forde, L. (1999). Commission of inquiry into abuse of children in Queensland institutions. Brisbane, Queensland Parliament. Available: http://www.communities.qld.gov.au/department/forde/publications/index.html.

McLean, S., Price-Robertson, R., & Robinson, E. (2011). Therapeutic residential care in Australia: Taking stock and looking forward. National Child Protection Clearinghouse Issues, 35, 1-24.

Osborn, A., & Bromfield, L. (2007). Residential and specialised models of care. National Child Protection Clearinghouse: Research Brief, 9, 1-13.

Verso Consulting (2011). Evaluation of the Therapeutic Residential Care Pilot Programs: Final summary and technical report. Verso Consulting and the Department of Human Services, Victoria.

Respect • Hope • Social Justice • Safety • Excellence

Mercy Family Services

Submission 5: Therapeutic Secure Care Services

Submission to the 2012 Queensland Child Protection Commission of Inquiry

Prepared by Dr Stewart Redshaw, Shelley Wall, Steven King

INTRODUCTION TO AND SUMMARY OF THIS PAPER

Therapeutic Secure Care

The purpose of this paper is add Mercy Family Services' support for calls to investigate establishing a type of *Therapeutic Secure Care* service for children and young people in the Queensland child protection and out-of-home care system, a view expressed by a number of stakeholders in their submissions to the inquiry. In this brief introductory paper we:

1. Discuss the need for these *Therapeutic Secure Care* services in light of limitations within existing service options to meet the needs of a particular group of children and young people with extraordinarily complex, challenging and extreme behaviours.
2. Profile the characteristics of children and young people generally placed within such services within Australian and international jurisdictions.
3. Outline a number of critical caveats that would need to be considered in the event that such services are developed.
4. Provide a starting list of resources describing secure care services throughout Australia.
5. Provide a list of selected references pertaining to secure care.

This paper should be read in conjunction with the previous one in this series: "Residential Care Services'. This earlier paper provides a more detailed discussion of the existing out-of-home care placement (and placement support) continuum in Queensland, and the problems that have resulted from not having services such as the proposed *Therapeutic Secure Care.*

As for all the papers in this series, it is beyond the scope of this paper to provide a detailed review of the relevant literature, but simply to provide a starting point and resource for the Commission in its considerations about the service needs of children and young people in care in Queensland.

1) THE NEED FOR THERAPEUTIC SECURE CARE SERVICES IN QUEENSLAND – What is it and why do we need it?

Mercy Family Services recommends that *Therapeutic Secure Services* be developed, trialled, and evaluated across a number of Queensland department regions.

The establishment of *Therapeutic Care Services* across Queensland is needed to better cater for those small number of children and young people with extremely complex, challenging and extreme behaviours who are not suitable for placement in general residential care services or even the more intense (and recently established) therapeutic residential care services in Cairns, Townsville, Goodna and Morayfield.

As discussed in the previous paper (Residential Care Services), these young people who continually demonstrate behaviours that make them a danger to themselves, to others in the placement, and the community, need to be placed in a Therapeutic Secure service, one in with they can be contained for their own safety until they can be stabilised to the extent that they are able to be placed in less intensive placements such as a therapeutic residential care service, general residential care or even supported-independent living programs.

In keeping with the well-known Pareto (80/20) principle which states that for many events, roughly 80% of the effects come from 20% of the causes, it is the continued placement of children and young people with such extreme needs in placement settings simply unable to adequately care and support them (such as specialist foster care, general residential care and even therapeutic residential services) that leads to significant problems across the out-of-home care system. And as discussed previously,

this is particularly the case when they are placed in general residential care units in local communities. Multiple placement disruption and breakdown, contagion and vicarious trauma (which is the situation where other children and young people in the placement are impacted by the often distressing behaviours of others, and the inevitable complaints from neighbours and the involvement of police.

In the proposed enhanced out-of-home care placement continuum, such a service would logically be situated after therapeutic residential care and before hospital-based mental health care. For example:

Kinship/Foster Care
-> Residential Care
-> Therapeutic Residential Services
-> Therapeutic Secure Care
-> Hospital-based Mental Health In-patient Care

Far from being a totally new initiative in the Australian child protection and out-of-home care context, Therapeutic Secure Care services have been evolving in a range of jurisdictions for several years, most notably New South Wales, Western Australia, and more recently in the Northern Territory, and the details of a number of documents describing these initiatives are provided in Section Three.

However, it should be note from the outset that such services are considerably controversial in Australia, with very divergent views held about whether they are appropriate for children and young people who have experienced significant abuse and complex trauma. Many view such services as quasi-correctional facilities where children are simply locked-up without adequate treatment or consideration of the underlying causes of their extremely complex and challenging behaviours. However, increasingly (as evidenced by the up-take of secure care in some states), more and more service providers are beginning to reconsider the potential benefits of such services, particularly if they adequately resourced, are targeted for the right types of children and young people, and have adequate judicial and administrative oversight (see caveats below).

Before continuing on to note the caveats and some practice issues, it is necessary to be clear about the general nature of *Therapeutic Secure Care* and of the children and young people who would be referred to such facilities. The following characteristics have been derived from documents that describe both Australian and UK based secure care services (Fahey & Hardman, 2010; Giller 2006). And while there are some minor differences, they are largely compatible.

The client characteristics of young people in *Sherwood House* for example, therapeutic secure care facility in NSW are (Fahey & Hardman 2010):

- In out-of-home care
- Unable to be successfully supported in community settings
- Chronic behavioural challenges that pose significant risk to themselves and others
- Complex trauma symptoms
- Requirements for specialised case management
- Placement approved by the Deputy Chief Executive
- Placement by Supreme Court Order
- Managed under Supreme Court case management.

Fahey and Hardman also note that the specific needs of this group of young people include:

- Access to suitable (safe) accommodation
- Setting with capacity for containment
- Trained staff with a high level of supervision and access to direction
- Staff contingencies that support physical management of high risk behaviours in a safe manner
- Intense targeted therapeutic support that is multi-element and consistently delivered over time and across all settings
- Complex and intensive case management
- Active engagement of specialist services (inter-departmental as required)
- Support that is not time limited but structured around client needs and the outcomes achieved.

Gillar (2006) examines the current thinking on the use of secure care in child welfare in England and Ireland, and looks at the findings of two studies reporting on their secure care services.

Gillar notes that the three service delivery objectives of secure care are: containment, assessment and therapy, and that the characteristics of those placed include:

In England:

- Aged 13-17 on admission (or with the approval of the secretary of state, 10-13), have a history of absconding and are likely to abscond from any other type of accommodation
- If they abscond they are likely to suffer significant harm
- Or if kept in any other type of accommodation they are likely to injure themselves or others.
- An order initially lasts three months, but the local authority can apply for extensions.

In Ireland (in a new initiative at that time 2006):

- To be aged 11-17 on admission
- Demonstrates behaviour that poses a real and substantial risk to their safety, development or welfare or the safety of others
- Has a history of impaired socialisation and impulse control or an established history of absconding
- Is likely to cause self-injury or injury to others if placed in any other form of care
- Would not have their needs met in a less secure environment.

These characteristics provided by both Fahey and Hardman (2010), and Giller (2006) provide a useful starting point for coming to terms with nature of the therapeutic secure care services needed in Queensland and the children and young people they would cater for.

In essence, the points of difference between the nature of the proposed *Therapeutic Secure Care* service and general/therapeutic care services are that under the secure care model, young people placed would be able to be contained on the premises to eliminate absconding behaviour, and further, to have the capacity to utilise physical restraint to protect them from harming themselves or others. Necessary containment strategies to

give time for other therapeutic strategies to gain traction.

And whilst it is acknowledged that the use of 'locked doors', and 'physical restraints' are a concern to some, the risk to children and young people and others around them if they are not contained (even for as short as time as necessary) for their own safety and wellbeing is considerable.

2) THERAPEUTIC SECURE – Some Critical Caveats

Given the general disquiet throughout much of the child protection and community services sector about secure care services, and the scarce nature of the practice and research literature related to such service responses, a number of caveats about are needed:

Caveat 1: Caution needed because of the dearth of a practice and outcomes evidence-base

Because of the relatively new status of *Therapeutic Secure Care* services in child welfare and child protection contexts, there is dearth of literature both about practice and outcomes. Because of this, any trials will need to strict monitoring and oversight and research and evaluation strategies embedded from the beginning to ensure both the quality of the service provided, and for providing useful data for informing future service development.

Caveat 2: Therapeutic Intervention and not punishment

Great care is needed when examining the secure care literature because much of the literature that does exist is situated within juvenile justice and offending context (where the focus is on containment and correcting serious and continuing offending behaviour), rather than within a child safety, welfare and protection context (where the focus is on containment, safety, assessment and treatment). And while the reality of separating offending behaviour from trauma-related child protection interventions is not always possible because the two often go hand-n-hand, the difference between a 'treatment mindset' and a 'punishment mindset' cannot be over stated.

The aim of any such service cannot be simply (as discussed in the media), to lock these unruly children up for their (and the community's) protection; but rather to provide a therapeutically-based service to provide intensive support and intervention to enable them to begin to manage their emotions and behaviour. The Forde Inquiry compiled compelling evidence of this nexus between out-of-home care and juvenile justice, and how many children and young people with protective needs were instead locked away in detention centres (for their own 'safety') and then were exposed to high levels of institutional and peer violence and abuse. The lessons learned from these previous inquiries must be heeded.

Caveat 3: Oversight provided by the Department of Communities and/or Health Department

One of the implications of the previous caveat is that legislative and administrative oversight of the *Therapeutic Secure Care* program should be provided by the Department of Communities and/or the Health Department and not Juvenile Justice. Situating such a service with the corrective services system would potentially reinforce the punitive nature of the service provided, and potentially sigmatise the children/young people placed.

Caveat 4: The importance of Judicial and Quality Oversight

One of the features of existing secure care services in Australia and internationally is judicial oversight regarding the placement and management of children and young people in secure care. In the NSW service for example (Sherwood House, see Fahey 2010), placement can only be by Supreme Court Order and subsequently approved by the Deputy Chief Executive (Department of Human Services). This oversight is critical for minimizing inappropriate placement and for the potential of those children/young people placed languishing in the facility. Similarly, to provide additional safety and oversight, such services need to be intensely monitored by the relevant state Child Guardian authority (in Queensland, the *Queensland Commission for Children and Young people, and Child Guardian*), through reporting and complaints mechanisms, community visitor programs and process evaluation strategies (e.g., child/youth satisfaction surveys).

Caveat 7: Avoiding the 'Folly' of the Placement of Last Resort Option

As discussed in the previous paper 'Residential Care Services', the increasingly accepted practice wisdom is that assessment and initial placement match are crucial, rather than viewing the more intensive services such as therapeutic residential care or therapeutic secure care as placement options of *a last resort*. This means that if a child or young person's assessment identifies that a more intensive therapeutically-based placement is required from the onset, then it should be provided in the first instance rather than waiting for multiple placement breakdowns before a decision is made to place them in the proposed secure care environment. Further, decisions about child/young person's length of placement need to be informed by assessment, rather than a blanket regulation that such placements should be strictly limited to a certain period of time. Giller (2006) makes the valid point that such arbitrary time limits have the potential to "… jeopardise the triple delivery objectives of the service – containment, assessment and therapy" (p. 37).

Caveat 6: Adequacy of Funding

One of the most consistent themes from the residential care literature focused on the Australian experience (discussed in the previous paper in this series) is the inadequate funding models applied across the board for residential care services in this country. Clearly, to seek to establish quality therapeutic secure care services without an adequate funding-base can only be setting them up to fail.

3) DOCUMENTS DESCRIBING SECURE CARE SERVICES IN AUSTRALIA

Secure Care Services in Australia

As noted above, caution is needed when examining the literature about secure care services because of the dominance of corrective services models (and related outcome research). The literature focusing specifically on *therapeutic secure care services* for those with protective concerns is quite scarce. The following list focuses on those services that have been or are in the process of being implemented across various Australia jurisdictions, and the various papers have been provided in the attached reading pack.

As for other papers in this series, a detailed analysis is beyond the scope of this paper; the purpose is to bring these key papers to the Commission's attention with a view to recommending that they inform the commission's considerations around this important resource.

The Recommended Resources

New South Wales:

Fahey, L., & Hardman, B. (2010). Therapeutic secure welfare NSW (Workshop C5: National Therapeutic Residential Care Workshop. Melbourne, September 2010.

NSW Department of Human Services. (2010). *Out of home care service model: Therapeutic secure care programs*. Sydney: Out of Home Care Policy Planning Division: Community Services.

NSW Office of the Children's Guardian. (2002). *Is there a place for secure care in the provision of services for children and young people?* Sydney.

Northern Territory:

Department of Children and Families (2011/2012) Secure care services for young people – Fact Sheet. Northern Territory Government. http://www.childrenandfamilies.nt.gov.au/Secure_Care_Facilities_and_Services/index.aspx

Department of Children and Families (2011/2012) Secure care therapeutic framework (Appendix B). Northern Territory Government. http://www.childrenandfamilies.nt.gov.au/Secure_Care_Facilities_and_Services/Therapeutic_Services_for_Young_People/index.aspx

Department of Children and Families (2011/2012) Questions and answers for therapeutic orders (Appendix D). Northern Territory Government. http://www.childrenandfamilies.nt.gov.au/Secure_Care_Facilities_and_Services/Therapeutic_Services_for_Young_People/index.aspx

Western Australia:

Department for Child Protection. (2011). *Kath French Secure Care Centre: Practice Guidelines*. Perth: Government of Western Australia.

REFERENCES

Browne, K., & Falshaw, L. (1996). Factors related to bullying in secure accommodation. *Child Abuse Review, 5*, 123-127.

Browne, K., & Falshaw, L. (1998). Treatment work with young people in secure care. *The Irish Journal of Psychology, 19*(1), 208-225.

Davies, J., & Oldfield, K. (2009). Treatment need and provision in medium secure care. *The British Journal of Forensic Practice, 11*(2), 24-31.

Department for Child Protection. (2011). *Kath French Secure Care Centre: Practice Guidelines*. Perth: Government of Western Australia.

Fahey, L., & Hardman, B. (2010). *Workshop C5: Therapeutic secure welfare NSW*. Paper presented at the National Therapeutic Residential Care Workshop, The Sebel Albert Park, Melbourne.

Flower, C. (1993). Control and creativity: Music therapy with adolescents in secure care. In M. H. Heal & T. Wigram (Eds.), *Music therapy in health and education* (pp. 40-45). London: Jessica Kingsley Publishers.

Giller, H. (2006). Is secure care fair? *Community Care, Sep*(1640), 36-37.

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2011). Transition secured? A follow-up study of adolescents who have left secure residential care. *Children and Youth Services Review, 33*(12), 2482-2488.

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2012). A secure base? The adolescent–staff relationship in secure residential youth care. *Child and Family Social Work*.

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2012). Securing the downside up: Client

and care factors associated with outcomes of secure residential youth care. *Child and Youth Care Forum, 41*, 259-276.

Harrington, R. C., Kroll, R. J., McCarthy, K., Bradley, D., & Bailey, S. (2005). Psychosocial needs of boys in secure care for serious or persistent offending. *Journal of Child Psychology and Psychiatry, 46*(8), 859-866.

Kroll, L., Rothwell, J., Shah, P., Bailey, S., & Harrington, R. C. (2002). Mental health needs of boys in secure care for serious or persistent offending: A prospective, longitudinal study. *The Lancet, Jun*(8), 1975-1979.

Kurtz, Z., Thornes, R., & Bailey, S. (1998). Children in the criminal justice and secure care systems: How their mental health needs are met. *Journal of Adolescence, 21*(5), 543-553.

Lemieux, C. M., Barthelemy, J. J., Schroeder, J. A., & Thomas, J. M. (2012). Therapeutic communities for youths in secure care: Participant characteristics and predictors of treatment and postrelease supervision. *Journal of Social Service Research, 38*(4), 451-467.

Mosseri, R. (1998). Changing the culture of violence: A seven day admission to a secure unit provides a powerful norm in residential care. *Residential Treatment for Children & Youth, 16*(1), 1-9.

Northern Territory Government. (2010). *Secure care: Enhancing care and support services for young people and adults with high risk behaviours - Consultation paper*. Darwin.

Northern Territory Government. (2011). *Appendix B: Secure care therapeutic framework*. Darwin: Department of Children and Families.

Northern Territory Government. (2011). *Appendix D: Questions and answers for therapeutic orders*. Darwin: Department of Children and Families.

Northern Territory Government. (2011). *Secure care services for young people: Fact sheet*. Darwin: Department of Children and Families.

NSW Department of Human Services. (2010). *Out of home care service model: Therapeutic secure care programs*. Sydney: Out of Home Care Policy Planning Division: Community Services.

NSW Office of the Children's Guardian. (2002). *Is there a place for secure care in the provision of services for children and young people?* Sydney.

Office for Standards in Education Children's Services and Skills (Ofsted). (2010). Admission and discharge from secure accommodation. Manchester: Ofsted.

Office of the Guardian for Children and Young People. (2008). *Safe keeping orders in South Australia: Discussion paper*. Adelaide: Government of South Australia.

Rozalski, M., Drasgow, E., Drasgow, F., & Yell, M. (2009). Assessing the relationships among delinquent male students' disruptive and violent behavior and staff's proactive and reactive behavior in a secure residential treatment center. *Journal of Emotional and Behavioral Disorders, 17*(2), 80-92.

Smith, M. (Ed.). (2005). *Secure in the knowledge: Perspectives on practice in secure accommodation*. Glasgow: Scottish Institute for Residential Child Care, and the Universities of Strathclyde and Glasgow.

Underwood, L. A., Robinson, S. B., Mosholder, E., & Warren, K. M. (2008). Sex offender care for adolescents in secure care: Critical factors and counseling strategies. *Clinical Psychology Review, 28*(6), 917-932.

Vaughan, P. J. (2004). Secure care and treatment needs of mentally disordered adolescents. *The British Journal of Forensic Practice, 6*(2), No Pagination specified.

Wheatley, M., Waine, J., Spence, K., & Hollin, C. R. (2004). Characteristics of 80 adolescents referred for secure inpatient care. *Clinical Psychology and Psychotherapy, 11*, 83-89.

Respect • Hope • Social Justice • Safety • Excellence

Mercy Family Services

Submission 6: Sexual Abuse Counselling Programs

Reducing the need for High Complex Placements of children and young people who engage in problem sexual behaviour

Submission to the 2012 Queensland Child Protection Commission of Inquiry

Prepared by Clare Sillence

SUMMARY

Reducing the need for high complex placements of children and young people who engage in problem sexual behaviours through specialised early therapeutic intervention

There are few statistics on children who engage in problem sexual behaviours (PSBs) either in Australia or overseas, partly because parents, teachers and others are reluctant to report the behaviours to agencies (O'Brien, 2010). Nevertheless it is estimated that 12% of adolescents who commit sexual assault are 11 and 12 years of age and at least half of these children displayed PSBs before 10 years of age (Lane, 1991).

Specialised early intervention support for children and young people with problem sexual behaviours, and their carers, can provide both a low-cost alternative to High Complex Placements and significant long-term benefits for children, young people and carer relationships. This submission proposes an expansion of *Sexual Abuse Counselling Services*, throughout Queensland, in order to provide effective and specialised early intervention while reducing the high level of unmet demand for specialist support in regions.

IDENTIFIED NEED

Background

Young people over the age of 12 who exhibit PSBs are often labelled as 'offenders' or 'perpetrators' and there is a serious gap in the services available to them. It is extremely common for these young people to experience multiple placement breakdowns and for some children a High Complex Placement becomes the only available option. High Complex Placements are high cost due to the need to provide dedicated accommodation, multiple carers and other worker involvement.

For many children and young people the key to avoiding High Complex Placement is early intervention.

The case for early intervention with children who display PSB is based on a considerable body of high quality research (Staiger, 2005). Studies in the United States of America have demonstrated that the benefit : cost ratio of early intervention programs can be as high as 19:1 (Valentine and Katz, 2007). Thus, there is potential for significant impact when it is considered that the cost of conduct disorders in Queensland, 2007 for young people up to the age of 28 years (sexual offending behaviours included) was estimated to be up to $1.4 billion per year (Valentine and Katz, 2007).

Furthermore, there are multiple benefits beyond cost savings which make early intervention a sound strategy, chief among these being a better long-term outcome for the child and/or young person.

The Mercy Family Services Sexual Abuse Counselling Program (SACP) South-West Region is funded by the Department of Communities. The service was established to provide sexual abuse counselling to children and young people under 18 years of age subject to child protection statutory intervention, and children under 12 years who display PSBs or early offending behaviours.

	The current SACP funding provided to Mercy Family Services in the South-West region provides for two Full Time Equivalent (FTE) Sexual Abuse Counsellor positions, which operate from our Goodna and Toowoomba sites. The program supports children, young people and non-offending family members/carers requiring therapeutic intervention and implementation of appropriate behavioural management strategies. The case load remains consistently filled and a waiting list for children and young people continues to demonstrate the limitations of the program and a significant level of unmet need and demand. During the course of coordinating the SACP in Goodna and liaising with other children's counselling services in the area, a number of observations have led to the conclusion that there is an urgent need to expand this service: • The prevalence of young people engaged in the Youth Justice System as a result of sexual offending behaviours (both in departmental care and parental care) • The prevalence of children and young people in individual care placements as a result of problem sexual behaviour • The number of placement breakdowns resulting from problem sexual behaviours • The often limited understanding of sexual behaviours by carers, parents and Child Safety Officers and their difficulty in assessing sexual behaviours • The level of understanding of appropriate supervision of children and young people with PSBs resulting in further sexual abuse • The inability of carers to provide necessary supervision due to the large number of children in some placements • The inability of counsellors to address problem sexual behaviours due to their inexperience in this field • The lack of clarity in relation to history of sexual behaviours when placing a child; • Enquiries for SACP intervention not engaged due to over capacity.
ADDRESSING THE NEED	***The Provider*** Mercy Family Services is currently the only provider of a Specialist sexual abuse counselling services for children and young people in the South-West region. Furthermore, Mercy Family Services operates from a strong therapeutic evidence-base, which at its centre is a trauma-sensitive framework. ***The Program*** To enable current service providers, such as Mercy Family Services, to offer early intervention while moving towards meeting the unmet demand, the appointment of additional workers (tertiary qualified social workers, psychologists or counsellors) and additional funds to manage and provide the services is required. Counsellors will work with carers to help them recognise, understand and evaluate PSBs, especially differentiating PSB from normal sexual behaviour. Children and young people will be counselled using a trauma sensitive, attachment theory and holistic framework incorporating a number of therapeutic models such as Sand Play Therapy, Cognitive Behavioural Therapy, Acceptance and Commitment Therapy, Mindfulness and specific behavioural strategies to address any PSB.

Model of Practice

The Australian Childhood Foundation Study (Staiger, Kambouropoulos, et al. 2005) highlights that multi-level streamed treatment interventions need to take account of each family's particular needs. For children and young people with problem sexual behaviours just addressing the problem sexual behaviours is not enough. Cavanagh-Johnson (2002) argues that a stable and healthy caregiver environment is essential to the resolution of problem sexual behaviour in children and young people. In addition she notes that a behavioural plan alone for the child is not sufficient for long term change.

Key Factors

There are a number of factors that need to be addressed for intervention to be effective and prevent the risk of recidivism and for change to be feasible (Farmer and Pollock, 2003,).

- Acknowledge and support high anxiety levels for carers of children with problem sexual behaviours - must be careful not to paralyse, minimise or deny the management of children and therefore, strengthen carers to be able to support children (O'Brien, 2010).
- 'Safe' place for children – stable care, quality of carer relationship, predictability, stability, consistency, structure, routines, pattern repetitive experiences.
- Coordinated response by all stakeholders- who needs to know? (parents, teachers, carers, childcare workers, Out of School Care workers, others working with children).
- Adequate sex education (priority in case planning as to who is responsible) – defining and dissecting problem sexual behaviours from sexual play;
- Supervision;
- Modification of inappropriate sexual behaviours;
- Therapeutic attention to the needs that underlie the behaviour;
- Understanding of all factors such as individual factors of neurology and trauma, gender differences and disabilities (ACF training);
- Carers *must agree* to be part of the intervention – this is crucial in setting up safety plans, ongoing supervision, containment of behaviours and help to develop a shared understanding of the importance of counselling and commitment to the therapeutic process;
- Referrals to specialist programs with experienced and trained counsellors;
- Training provided to child protection workers, foster carers, and education staff;
- An 'Aware Culture' (Tidmarsh, 1997) which is informed, flexible, has protocols, spots problems early and has a clear understanding of boundaries and therefore makes hiding problem sexual behaviours as hard as possible;
- Clear assessment of behaviours in children and young people and thorough understanding of history – e.g. correlation between severe neglect, trauma (not always sexual violence) and problem sexual behaviours;
- Evaluation utilising Problem Sexual Behaviour Checklist Assessment Tools such as the Cavanagh-Johnson (2002) model.

Case Example

A twelve year old boy has been in alternative care from the age of one year. He was referred to the SACP after receiving counselling from eleven previous counsellors. He has been in multiple foster care placements; all breaking down. He has also been sexually harmed whilst in care and is now in a high complex placement as a result of engaging in significant problem sexual behaviours. With appropriate specialist wrap-around intervention and support, the extent of the young man's behaviours could have been limited and/or reduced.

CONCLUSION

A preliminary evaluation of a specialist programs for children and young people (Australian Childhood Foundation, 2005) clearly highlights not only Victorian State recommendations, but includes all State Governments in supporting the early intervention needs of the systems surrounding children and young people. Some of the recommendations include:

- Specialist programs for children and young people engaging in PSBs need to be adequately funded and supported by State Child Protection Services;
- Parents and/or carers should be included in the referral process and engage in a specialist program to limit the view that the child or young person is in isolation;
- Comprehensive training is provided to specialist services that encapsulates current research trends and meets the needs of the local community.

A coordinated response by all stakeholders provides children and young people with the message that as adults, we are taking responsibility and helping and supporting them to sort through the issues that underlie their behaviours. Specialist sexual abuse counselling services provide early intervention and prevention to children, young people and their families. These services have a significant impact on recidivism and reduce the likelihood of youth and adult offending behaviours. Further outcomes include the promotion of safety and wellbeing for the child, young person, family and the broader community. Such outcomes highlight the provision of specialist services reducing the likelihood of placement breakdowns and thus, limit the likelihood of alternative care environments such High Complex Placements being accessed as the only remaining placement option.

KEY REFERENCES

Boyd, C. (2006). Young people who sexually abuse: Key issues. Retrieved from http://www.aifs.gov.au/nch/pubs/brief/pbl/pbl.html September 2010.

Cavanagh-Johnson, T. (2002). *Treatment Exercises for Child Abuse Victims and Children with Sexual Behaviour Problems.* Pasadena, CA: Johnson

Cavanagh-Johnson, T. (2002). *Child Sexual Behaviour Checklist (CSBCL).* Pasadena, CA: Johnson

Farmer, E. and Pollock, S. (2002). Managing sexually abused and/or abusing children in substitute care. *Journal of Child and Family Social Work, 8, pp 101-112.*

Lane, S. (1991). The sexual abuse cycle. In G.D. Ryan and S.L. Lane (Eds) *Juvenile sexual offending: Causes, consequences and correction,* pp. 103-141. Lexington, MA: Lexington Books

O'Brien, M. (2010). *Australia's Response to Sexualised or Sexually Abusive Behaviours in Children and Young People.* Australian Crime Commission

Staiger, P. (2005). *Children who engage in problem sexual behaviours: Context characteristics and treatment – A review of the literature.* Australian Childhood Foundation.

Staiger, P., Kambouropolous, N., Evertsz, J., Mitchell, M., Tucci, J. (2005). *A preliminary evaluation of the transformers program for children who engage in problem sexual behaviour.* Retrieved from 20th September 2009 from www.childhood.org.au

Tidmarsh, P. (1997). Young men, sexuality and sexual offending (risk management and public education). Conference presentation: Australian Institute of Criminology. Retrieved 20th September 2009 from http://www.aic.gov.au/en/events/aic%20upcoming%events/1997/~media/conferences/paedophilia//tidmarsh.pdf

Valentine, K. and Katz, I. (2007). *Cost Effectiveness of Early Intervention Programs for Queensland: Report prepared for the Queensland Council of Social Services Inc. (QCOSS)* QCOSS.

Respect • Hope • Social Justice • Safety • Excellence

Mercy Family Services

Submission 7: Understanding the Experiences and Needs of Children and Young People in Care

Submission to the 2012 Queensland Child Protection Commission of Inquiry

Prepared by Dr Stewart Redshaw

INTRODUCTION

Understanding the Experiences and Needs of Children and Young People in Care

The purpose of this brief paper is to introduce a PhD research project I undertook with the University of Queensland during the 2000s.

In this paper I will describe how the documentary data used in this study included a significant number of documents drawn from a range of judicial, parliamentary and departmental inquiries held across the country during the late 90s to the late 2000s.

This is followed by an introduction to the two main categories of findings, (1) understanding the experiences of children and young people in care in Australia, and (2) understanding the depth and breadth of their many needs. To provide a readily accessible overview of these findings I have included a number of informative tables and tag clouds that were included both in my thesis and in subsequent publications.

I conclude with a discussion about the relevance and importance of these findings for child protection and out of home care policy and practice in Queensland today.

Note: Significant proportions of the material in this submission have been drawn directly from my thesis, and two subsequent publications describing this research:

Redshaw, S. (2009). Needs-based and needs-focused care: Understanding the needs of children and young people in care through the documentary analysis of multiple stakeholder perspectives. PhD Thesis - School of Social Work and Human Services, University of Queensland. September, 2009.

Redshaw, S. (2011*). Understanding the needs of children and young people in care: Towards a taxonomy of needs. Communities, Children, and Families Australia, 6(1), 13-29. (*Publication delayed due to change in journal ownership.)

Redshaw, S. (2012). Tag Clouds: Visual representations of the experiences and needs of children and young people in care. Children Australia, 37(2), 56-68.

1) THE DOCUMENTS USED IN THE RESEARCH PROJECT INCLUDED SUBMISSIONS, HEARING TRANSCRIPTS AND INQUIRY FINDINGS FROM MAJOR AUSTRALIAN INQUIRIES OVER THE LAST

The Documents Used and the Study Methodology

In my work with Mercy Family Services, I had collected a large number of inquiry submissions and transcripts of public hearings (from Royal Commissions and Parliamentary Inquiries that had been posted on the internet), interviews, personal stories and relevant empirical and practice papers. This collection amounted to literally hundreds of primary documents and similarly hundreds of research papers and reports developed by agencies, industry representatives, academics, and state and national peak bodies, all describing (to some extent) the experiences and needs of children and young people in care. These documents became the 'library' I used to examine the needs of children and young people in care, and from the many hundreds of documents a final sample of 580 was chosen. To facilitate the analysis, I arranged the document sample (n=580) into five categories:
(1) primary documents (letters and submissions to inquiries, transcripts of interviews and public hearings, and personal accounts)
(2) secondary documents (reports resulting from commissions of inquiries and departmental reviews, audits and investigations)

(3) empirical documents (published findings from empirical research)
(4) legislative and policy documents (legislation, regulation and quality frameworks), and
(5) industry and practitioner documents (reports by academics, peak bodies and advocacy groups, and writings by out-of-home care practitioners).

The document sample reflected the views of five stakeholder groups:
(1) children and young people in care
(2) parents
(3) carers, agency staff and practitioners
(4) statutory workers
(5) and advocates, academics, and peak bodies.

The perspectives of Indigenous stakeholders were reflected throughout the document sample. Specifically, 69 of the 580 documents were purposely written by, or directly involved Indigenous stakeholders in the research process.

This blend of multiple stakeholder perspectives and multiple document sources (in particular, the use of largely untapped primary documents); coupled with over 20 years' experience in the out-of-home care sector in a range of capacities (direct care, casework and coordination, senior management, research and practice development, and as a sector-wide consultant) provided a rich knowledge base from which to explore the experiences and needs of children and young people in care.

This document sample was subjected to a prolonged analysis using the constant comparative method in which explicit and implicit references to need in out-of-home care were identified, coded and melded into the final domains, dimensions and attributes that form the taxonomy. The analysis began with the least structured documents (e.g., submissions, letters, edited interview transcripts), and progressed towards the more structured documents (departmental representatives, academics, advocates and representatives from peak bodies). This allowed the voices of less powerful stakeholders to have maximum influence on the initial labels assigned to the codes during the unitisation and categorisation process, codes which in time became the building blocks of the *Taxonomy of Needs* and the *Tag Clouds* highlighting their experiences.

Of perhaps particular interest and relevance to the current commission of inquiry is that the study sample included hundreds of submissions, transcripts of hearings, interview transcripts and inquiry reports (reports of findings produced by the various investigators) from many of the major inquiries held across Australian over the last decade or so. Examples of the major inquiries include the:

- Human Rights and Equal Opportunity Commission (1997). Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families.
- Forde, L. (1999). Commission of inquiry into abuse of children in Queensland institutions. Brisbane, Queensland Parliament..
- Crime and Misconduct Commission Queensland. (2004). "Protecting children: An inquiry into abuse of children in foster care."
- Senate Community Affairs References Committee. (2004). "Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children."

3) UNDERSTANDING THE EXPERIENCES OF CHILDREN AND YOUNG PEOPLE IN CARE

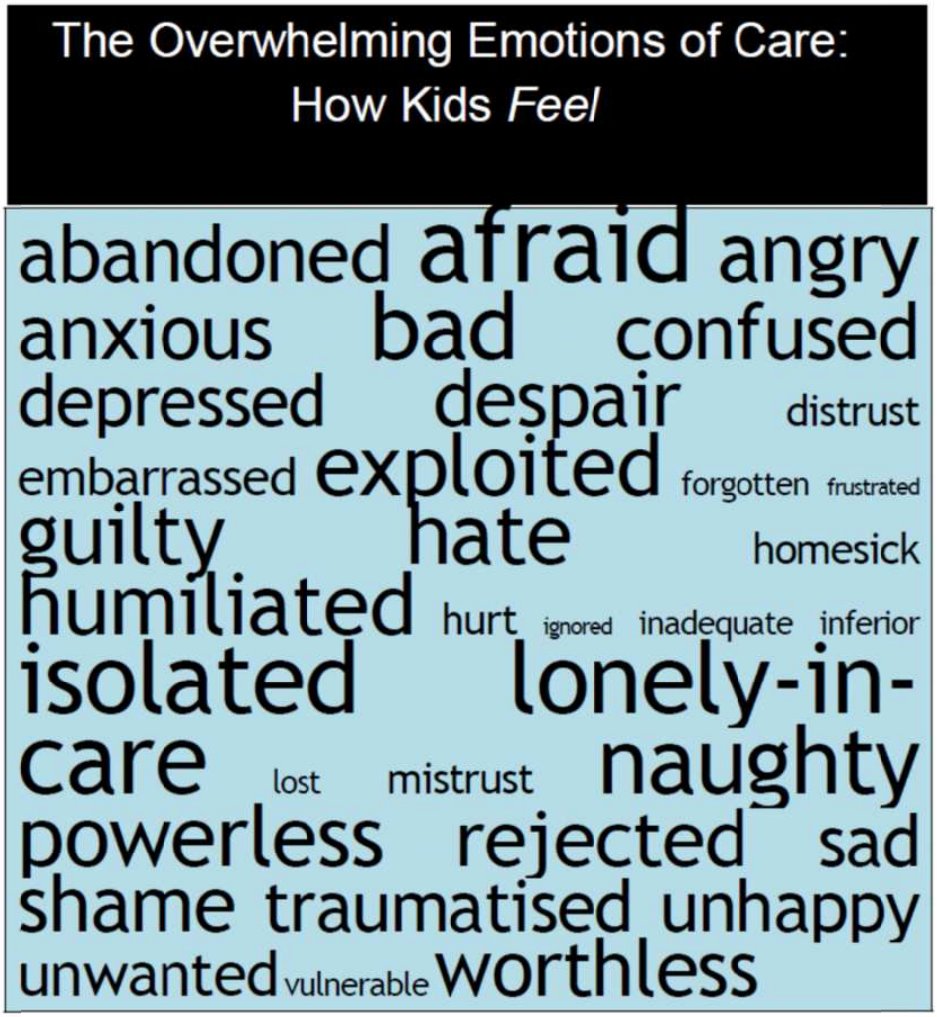
The in-depth analysis of the document sample revealed a plethora of experiences for children and young people in care. In the submissions, letters, interviews, and book chapters in which they (and many other stakeholders) told their stories, a picture of considerable pain and distress emerged. And whilst there were certainly many examples of positive experiences where these children and young people received the love, care and nurture they so desperately needed, for many, their care experienced was characterised by individual and systemic neglect. The following tag cloud highlights the many themes of this care experience:

Diagram 1: Tag Cloud – The themes of the care experience

Taken directly from the codes (and code families) devised during the analysis, this figure highlights the many themes that emerged from their stories. The larger the text, the more prominent that theme was in the document sample. However, as noted below, it should be pointed out that far from being 'insignificant', many of the *smaller* tags belie the intense emotional responses expressed by a smaller number of children and young people about their experiences (e.g., the very last tag, vicarious trauma).

Another tag cloud illustrates the range of overwhelming emotions that many children and young people expressed feeling while in care. And far from simply resulting from when they first entered care (where such feelings are much more understandable), these were experienced throughout their time in care, and across the placement continuum of foster care, residential care, and institutional care.

Diagram 2: Tag Cloud – The Overwhelming Emotions of Care



Other insights into their experience (as reported in my thesis but not portrayed as tag clouds), included: The prevalence of the emotional putdown of children and young people by carers and others involved in their lives; Vicarious trauma – the witnessing of violence and abuse in out-of-home care; and Symptom intolerance – where carers, and even the professional network demonstrated extraordinary intolerance of the trauma-related behaviours of the children and young people in their care.

4) UNDERSTANDING THE NEEDS OF CHILDREN AND YOUNG PEOPLE IN CARE

Moving beyond simply telling the story of their experiences, one of the primary aims of the study was to examine their needs, and further, to develop a formal 'Taxonomy of Needs' to help understand the depth and breadth and complexity of their needs.

As part of this process I undertook a review of what the general philosophical literature had to say about the nature of need, the types of needs that people in general have, and whether or not there was a broad 'theoretical' hierarchy of needs (reflecting the argument around basic fundamental needs versus those things not necessary for life, or the perennial argument about needs versus wants). The findings of this review are discussed in considerable detail in both my thesis (2009), and a paper (2011), but the tables below provide a good introductory summary to these important concepts. And while there might be a temptation to dismiss this material as overly theoretical, its relevance to, and importance for understanding both the needs of children and young people in care, and the harm that can result when they are not met cannot be over-stated. In this first table, I summarised the range of need theories advanced by a range of theorists.

Table 1: Summary of Need Frameworks

Author	Need Conceptualisations	
Thomson (1987, pp. 19, 70)	**Fundamental needs** Inescapable and natural necessities needed if a person is to avoid harm	**Instrumental needs** Things which help one to fulfil their goals, projects and plans
Thomson (1987, p. 96)	**Need** **Benefit** Needs and benefits involve the notion of wellbeing as defined with reference to a person's interest	**Luxury** Things that are good, but do not pertain to our wellbeing. Something enjoyable, which is neither beneficial or useful
Thomson (2005, p. 175)	**Interest** Individual experiences, activities and personal interests. 'Core motivations' for desires	**Desire** Desires can be instrumental (things wanted as a means to something else) or non-instrumental (things desired for their own sake)
Braybrooke (1987, p. 31)	**Course of life needs** Essential to living or to functioning normally, live independently, avoid hardship and suffering and fulfil basic social roles	**Preferences** Or adventitious needs
Doyal & Gough (1991, p.155)	**Basic human needs** Physical, health and autonomy	**Intermediate satisfiers** Objects, activities and relationships which satisfy basic needs
Wiggins (2005, p. 31)	**Vital needs** That without which it is impossible to live.	**Desires or fulfilment** Needs that do not correspond to vital needs
Reader (2005, p. 118)	**Aristotle's first 'necessity'** That which must be if something is to exist or live	**Aristotle's second necessity** That which must be if some good is to be achieved or evil avoided

A common theme throughout this broad philosophical literature is the idea that needs exist on a continuum ranging from the 'must-have' (as being vital and fundamental for life) to those things considered preferences, desires, or wants (things that are enjoyable and interesting, but not directly impacting on wellbeing) with considerable variation in between. While the terms the authors use vary, and their definitions differ in the particular areas of

need focused upon, they share the view that some needs are essential for life, others are important for achieving some purpose, others still for self-development and experiencing personal interest and desires, whilst some are simply wants and luxuries.

In this second table, I sought to loosely order them into some form of hierarchy so as to develop a broad framework to begin to understand the extent that the needs of children and young people in care were (or were not) being met.

Level 4 'Luxuries'	Luxuries – things that are nice, enjoyable, useful or desired, but not essential to wellbeing
Level 3 Needs	Preferences Desires Wants Self-development (course of life need) Personal-interests needs
Level 2 Needs	Instrumental needs Intermediate satisfiers Social being (course of life need) Aristotle's second necessity
Level 1 Needs	Basic human needs Fundamental needs Physical functioning (course of life need) Vital needs Aristotle's first necessity

The descriptors in this table were presented only as indicative of the types of needs that might exist on that level. It is not meant to be an exhaustive list, but simply a way of capturing the essence of the authors' conceptualisations of need. Many of the writers engaged in the ongoing debate appeared to equate meeting level one and level two needs with being important for safeguarding one's wellbeing and avoiding serious harm. Some, such as Braybrooke and Thomson, concede that level three type needs (particularly self-development and personal interest needs) are also important, whereas it appears that most hold the view that it is at level four (luxuries) where the line between need (what is needed) and want (what is not necessary) is drawn.

As discussed in my thesis and a subsequent paper (2009, 2011), my basic conclusion was that while the department and community agencies generally consider level 1 & level 2 needs (though in early institutional care settings, even such fundamental needs as adequate food, clothing, and shelter were at times seriously inadequate), often those critically important level 3 needs (preferences, desires, and personal interest needs) are seriously neglected. And the impact such neglect can have on children and young people in their placement and for life after care can be longstanding. In my 2011 paper I wrote:

> *Whilst the importance of meeting fundamental and instrumental needs would appear obvious, the data also highlighted how critical it was to also meet their preference, desires and interest needs as well. As discussed earlier, Thomson (2005) defines 'interest' as experiences, activities, and personal interest that are deeply important to an individual, and in the experience of children and young people in care these special interests (for example camping and outdoor activities, sports, participating in social clubs and personal hobbies), were vitally important to their sense of satisfaction and personal*

wellbeing. As Thomson (2005) argues, a person is harmed when he or she is deprived of the opportunity to engage in non-instrumentally valuable experiences and activities (p. 185), and this important (but often neglected) element of need in out of care contexts emerged as being critically important for children and young people in care. In their stories many expressed a deep sense of deprivation and loss when such personal interests were denied, curtailed or left to lapse by their carers and/or departmental workers, perhaps because of a mistaken belief that such things were simply 'wants', and not 'needs' and therefore not a priority.

Beyond reviewing the literature to understand these broad theoretical frameworks of needs, the primary empirical component of the study involved developing a formal 'Taxonomy of Needs' for helping to organise, and hence, understand the breadth and depth of the needs of children and young people in care.

Table 3: Taxonomy of Needs

Taxonomy of Needs			
Personal Domain	**Placement Domain**		**'Community of Care' Domain**
Attachment Trust Attachment **Physical Development & Health** Physical developmental milestones Physical health **Personal Growth** Self-care skills Independent living skills Social skills Self-concept, self-esteem & self-confidence Self-regulation of emotion & behaviour Individual strengths, interests & potential enhanced **Education and Vocational Attainment** Educational attainment Vocational training Employment readiness and or achievement **Development of Identity & Character** Personal identity Familial identity Cultural identity Sense of belonging Resilient character traits, including 12 sub-categories: - Assertiveness - Determination & tenacity - Desire to better oneself - Independence - Courage - Optimism & hopefulness - Sense of purpose - Insight - Personal pride - Humour - Empathy - Self-transcendent beliefs **Hope in Life & for the Future** Hope in life and for future Personal goals and dreams Career aspirations	**Basic Needs** Basic physical & material needs Safety Placement security, stability & match Continuity in care Individual attention Normalcy Positive placement ambience Personal & sentimental belongings & memorabilia Personal space, time & privacy Celebrations – birthdays, achievements & rites of passages **Basic Entitlements** A forum to be heard Advocacy Choices & decision making Complaints processes Confidentiality & anonymity Age and or developmentally appropriate responsibilities Culturally appropriate care Departmental monitoring Equality in placement, resources & opportunities Access to information, records & documentation Participation Carers are trained, skilled and or qualified **Caring Relationships** Cared for & cared about Continuity of relationships Carers who display caring attributes, including 9 sub-categories: - Advocates for children - Loving, affectionate & warm - Spend time with child - Unconditional & tenacious in caring - Approachable , open & honest - Stay in touch - Listen - View children positively - Insight into the needs of children and young people	**Positive Parenting Practices** Structure & routine Reasonable rules, expectations & age appropriate limits Guidance, support & encouragement Positive reinforcement Physical affection - touch Discipline fair, consistent & reasonable Tolerance of normal childhood behaviours Tolerance of symptomatic behaviour **Activity Programming** Stimulation Fun & play Planned activities **Focused-Support** Assessment Casework planning, implementation & review Individual problems and or disabilities addressed **Peer Relations and Positive Group Management** Quality peer relationships Positive group management Adequate supervision of placement **Preparation for and Transition from Care** Transition planning & support Gradual transition Financial support Graduating accommodation	**Clinical Intervention** Therapeutic support Coordination & integration of services **Family Connectedness & Involvement in Placement** Loved by their family Family contact Active involvement in placement Family intervention & support Family reunification **Friends & Social Outlets** Friendships supported Social outlets Networking with other children in care **Significant Others** Significant others Mentors **Cultural, Religious and or Spiritual Connectedness** Cultural connectedness Religious/spiritual connectedness **Departmental Workers Capacity & Support** Departmental worker relationship Departmental worker contact Departmental worker stability Departmental worker support **After Care Support** Contact with previous carers After- care support services Reunions A collective identity

As can be seen in the taxonomy (which was constructed over 2 years from the analysis of 580 documents relating to out-of-home care), the analysis revealed that children and young people in care have an enormously complex array of needs. The taxonomy structures these needs in three domains; their personal developmental needs, their immediate placement needs, and their community-of-care needs.

Personal Domain

Firstly, through the stories told by current and former wards, findings from the numerous inquiries and research studies, and from the theoretical and practice musings of stakeholders from across the out-of-home care sector, the evidence indicated that children and young people in care had personal needs that revolved around attachment, physical development and health, personal growth, education and vocational attainment, development of identity and character, and hope in life and for the future. These personal needs were inherent or innate to the child/young person, and encompassed a complex array of knowledge, skills, attitudes, behaviours, and physical needs that each and every child/young person needed to ensure their personal wellbeing.

Placement Domain

Secondly, it was also evident that they had needs specific to the varied placement settings, needs that had to be met by their carers and agency staff. These placement specific needs included basic day-to-day needs and entitlements, caring relationships, positive parenting practices, activity programming, focused support, peer-relations and positive group management (for those in group care settings), and preparation for and transition from care. In essence, this placement milieu involved providing for basic physical and material needs, developing caring relationships, and facilitating their personal healing and growth through a range of structured programs, services and activities, all within a context of child-focused organisational policies and processes.

'Community-of-Care Domain

Thirdly, stakeholders across the out-of-home care sector stressed just how important it was for children and young people in care to be provided with an individual 'community-of-care'. This community-of-care, consisting of a network of informal and formal supports including clinical intervention, family involvement in placement, friends, significant others, cultural-religious-spiritual connectedness, social and community connectedness, caring and supportive departmental workers, and after care support, was important for ensuring that they had someone who was there to care for them and who was available to support them in their placement, during their transition from care, and later throughout their adult lives.

(Note: For further information, in my thesis approximately 50 pages are dedicated to providing additional definitional material about each of the dimensions included in the taxonomy.)

The needs portrayed in the domains, dimensions, and attributes reflect the philosophical elements of needs described earlier. For example, fundamental needs for life (such as physical development and health, basic physical and material needs, and safety), instrumental needs essential for achieving some clear purpose or goal (such as education, vocational training, and financial support), and preferences, desires and personal interests (such as having the opportunity to engage in activities and hobbies that are personally important to an individual), were all evident in the data.

The needs portrayed in the taxonomy highlight the importance of each need and, by extension, the consequences for children and young people when it was not provided for. For example, the lack of attachment negatively impacted the sense of safety and security felt by many children, and consequently, hindered their personal development and ability to engage with their carers and community-of-care. A lack of support for personal growth (e.g., self-care and independent living skills, social skills, and self-esteem, self-concept, and self-confidence) severely impacted their ability to operate effectively in the wider world. Similarly, a lack of practical and emotional support for life after care seriously impeded their quality of life and sense of personal wellbeing, with many former wards in particular experiencing intense loneliness and anxiety in their adult years.

And so on down through the taxonomy: each domain, dimension, and attribute carries within it an implicit indication of the harm children and young people experienced when that need was not actively pursued. In the words of Thomson (1987), such harm has the capacity to infect all of their life, and further, will continue for as long as the need is not met. This continuing harm is, according to Thomson, an inescapable conclusion. Thomson's full comment on this, a comment central to the findings in my research is:

> *Needs are important because the harm suffered by a person when he lacks what he needs is especially serious. In the extreme, a person literally cannot do without what he needs; without it he is deprived of being an agent and a subject of experience at all. In the less extreme case, whilst the subject is not deprived of all primary goods, the deprivation is not confined to a localised or narrow aspect of his life, but rather infects all of it. Such harm must continue so long as the subject lacks what he needs; it is otherwise inescapable (Thomson, 1987, p. 127).*

IN CONCLUSION

In closing, I concluded my first major paper on this study with the following:

> *The imperative to meet the need and avoid the harm has been addressed by a number of writers (Braybrooke 1987; Doyal and Gough 1991; Miller 2005; Reader 2005b; Thomson, 1987), who, as noted earlier, have argued that meeting needs is important if harm is to be avoided. The relationship between 'need' and 'harm' is an important one, one that has significant implications for enhancing the moral force of need as a concept, and serving to move it from the realm of emotion and rhetoric to being a useful term for describing the human condition and staking a claim for resource provision. This is because when need is understood in this way, the debate moves on from one that centres on whether such 'needs' are justified, to one that acknowledges the consequences of such needs not being provided. As Braybrooke (1987) writes: "Questions about whether needs are genuine or well-founded come to the end of the line when the needs have been connected with life or health" (p. 31). For Thomson's inescapable conclusion remains: when needs are not provided for, people suffer harm.*
>
> *Quality care is care that is not restricted to the barest minimum; it is not selective, inconsistent or subject to review because of budgetary constraints or changing priorities. If out-of-home care providers are to live up to the rhetoric that the needs and wellbeing of children and young people in care are paramount, then those responsible for their care must do their utmost to meet the greatest range*

of needs possible in order to avoid the harm. Unfortunately, in times of economic stress and subsequent funding pressures, their more 'aspirational' needs are often forgotten or deemed 'not a priority' (Cashmore, Dolby, & Brennan, 1994).

Is it 'good enough care' to provide primarily for the fundamental and instrumental needs of children and young people in care, and then try to meet their preference, desire, and interest needs if possible? Or do we adopt, as Cameron and Maginn (2009) strongly suggest, the notion that the higher responsibility and duty of care that comes with providing professional care "… demands that 'good enough parenting' be exceeded", and that "… for such children, 'good enough care' is just not good enough"? (p. 112). Fernandez (1999) raised similar questions in an earlier study examining outcomes for children in care, noting that in many cases the system had failed to provide quality care for the children entrusted to it, leading to questions about whether the state was providing "… 'good enough' parenting or implementing practices in the best interest of the child" (p. 211).

If we accept that children and young people in care have the complex range of needs discussed; and accept that they have little or no capacity to meet their own needs and experience harm if their needs are not met, then the obligation on government and community agencies to respond appropriately to their needs is beyond question. To know that a need exists, and to fail to provide what is needed (especially when it is in one's power to do so), can only exacerbate and perpetuate the harm they have experienced, resulting inevitably, in a failure to provide quality care (Redshaw, 2011).

It is hoped that these publications and the summary provided in this submission will enhance the Commission's understanding of, and sensitivity to the experiences of children and young people in care in Australia, in range of placement settings (institutional, foster care and residential care), and further, grasp the sheer depth and breadth of their needs. Further, that the commission will take into consideration the inescapable harm that is, can, and will be experienced by vulnerable children and young people in state whose fundamental, instrumental, and personal developmental and interest needs are not provided for. As highlighted in my research, in general, because of their age, the trauma they have experienced, and the very nature of the care system, many of these children and young people are simply not able to meet their own needs. And if those who have guardianship and day-to-day responsibilities (the Department of Communities and the Community Sector) for these children do not make a commitment to provide for their needs, then who will?

REFERENCES for this paper

Braybrooke, D. (1987). Meeting needs. Princeton, New Jersey, Princeton University Press.

Braybrooke, D. (2005). Where does the moral force of the concept of needs reside and when? The Philosphy of Need. S. Reader. Cambridge, Cambridge University Press: 209-228.

Cameron, R. J. S. and C. Maginn (2009). Achieving Positive Outcomes for Children in Care. London, Lucky Duck Books, Sage Publications.

Cashmore, J., R. Dolby and D. Brennan (1994). Systems abuse: Problems and solutions. Sydney, NSW Child Protection Council.

Crime and Misconduct Commission Queensland. (2004). "Protecting children: An inquiry

into abuse of children in foster care." Retrieved January 6, 2004, from http://www.cmc.qld.gov.au/FCINQUIRY.html.
Department of Health and Human Services. (2006). "Report on child protection services in Tasmania." Retrieved Jan 29, 2007, from http://www.childcomm.tas.gov.au/docs/childprotectionreport.pdf.
Doyal, L. and I. Gough (1991). A theory of human need. New York, Guildford Press.
Fernandez, E. (1999). "Pathways in substitute care: Representation of placement careers of children using event history analysis." Children & Youth Services Review 21(3): 177-216.
Forde, L. (1999). Commission of inquiry into abuse of children in Queensland institutions. Brisbane, Queensland Parliament. Available: http://www.communities.qld.gov.au/department/forde/publications/index.html.
Human Rights and Equal Opportunity Commission (1997). Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families. Sydney, Commonwealth of Australia. Available: http://www.austlii.edu.au/au/special/rsjproject/rsjlibrary/hreoc/stolen/.
Miller, S. C. (2005). Need, care and obligation. The Philosphy of Need. S. Reader. Cambridge, Cambridge University Press: 137-160.
NSW Community Services Commission (2001). A question of safeguards: Inquiry into the care and circumstances of Aboriginal or Torres Strait Islander children and young people in care. Strawberry Hills, NSW Community Services Commission.
Reader, S. (2005). Aristotle on necessities and needs. The Philosphy of Need. S. Reader. Cambridge, Cambridge University Press: 113-136.
Reader, S., Ed. (2005a). The philosophy of need. Royal Institute of Philosophy Supplement: 57. Cambridge, Cambridge University Press
Senate Community Affairs References Committee. (2004). "Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children." Retrieved March 18, 2005, from http://www.aph.gov.au/senate/committee/clac_ctte/inst_care/report/index.htm.
Redshaw, S. (2009). Needs-based and needs-focused care: Understanding the needs of children and young people in care through the documentary analysis of multiple stakeholder perspectives. PhD Thesis - School of Social Work and Human Services, University of Queensland. September, 2009.
Redshaw, S. (2011*). Understanding the needs of children and young people in care: Towards a taxonomy of needs. Communities, Children, and Families Australia, 6(1), 13-29. (*Publication delayed due to change in journal ownership. Expected to be released late 2012)
Redshaw, S. (2012). Tag Clouds: Visual representations of the experiences and needs of children and young people in care. Children Australia, 37(2), 56-68.
Thomson, G. (1987). Needs. London, Routledge & Kegan Paul.
Thomson, G. (2005). Fundamental needs. The Philosphy of Need. S. Reader. Cambridge, Cambridge University Press: 175-186
Wiggins, D. (2005). An idea we cannot do without. The Philosphy of Need. S. Reader. Cambridge, Cambridge University Press: 25-50.
Wood, J. (2008). "Report of the special commission of inquiry into child protection services in NSW: Executive summary and recommendations." Retrieved April 30, 2008, from http://www.dpc.nsw.gov.au/publications/news/stories/special_commission_of_inquiry_into_child_protection_services_in_new_south_wales.

RESEARCH AUTHOR BIOGRAPHY & PUBLICATIONS

Dr Stewart Redshaw is the Research and Practice Development Manager with Mercy Family Services (MFS). He has worked with MFS since 1991 in a number of capacities and has been involved in senior organisational management since 1996. He has over 25 years' experience in child and family welfare, primarily in youth work, non-statutory child protection and out-of-home care. During this time he has worked as a youth worker, coordinator and manager/director of residential care and early intervention programs; as a consultant with agencies (throughout Australia) working with children and young people with complex and challenging behaviours; and, at times, as a counsellor in private practice. He holds a PhD (in the field of Social Work from the University of Queensland), a Master of Social Science (Counselling), a Bachelor of Arts, and a Bachelor of Ministry. Dr Redshaw has presented papers at state, national and international conferences, and conducted workshops across Australia. He has also published in a range of journals, and written numerous program manuals and organisational monographs. His research and practice interests include: quality practice in out-of-home care settings; the needs of children and young people in care; best practice for caring for children with challenging behaviours; and supervision and team development in not-for-profit community agencies.

Redshaw, S. (2007). 'Cleaning your glasses': A prerequisite for 'catching your child being good'. Australian and New Zealand Journal of Family Therapy, 28(1), 28-34.

Redshaw, S. (2009). 'Working On': Successful collaboration in action. Developing Practice – The Child, Youth and Family Work Journal, 23(Autumn/Winter), 64-73.

Redshaw, S. (2009). Needs-based and needs-focused care: Understanding the needs of children and young people in care through the documentary analysis of multiple stakeholder perspectives. PhD Thesis - School of Social Work and Human Services, University of Queensland. September, 2009.

Redshaw, S. (2011*). Understanding the needs of children and young people in care: Towards a taxonomy of needs. Communities, Children, and Families Australia, 6(1), 13-29. (*Publication delayed due to change in journal ownership. Expected to be released late 2012)

Redshaw, S. (2012). Tag Clouds: Visual representations of the experiences and needs of children and young people in care. Children Australia, 37(2), 56-68.

Redshaw, S. (Submitted). Defensive behaviours of children and youth in out-of-home care: A tentative typology. *Children and Youth Services Review.*