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Report by - JANICE CARROLL - 2010 Churchill Fellow

To study models of therapeutic residential care for children recovering from abuse and neglect

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Introduction

Children are born to do well and succeed. As the child's brain develops she is able to sit, crawl, walk, smile, laugh and talk. The child moves from one success to another. Decades of research have taught us about brain development and brain function, and science continues to inform us.

Following birth, in order to progress along the trajectory of successful and healthy development, a child needs love and nurture, a nutritious diet, learning experiences and affirmation.

Sadly, there are many children in Australia whose childhood has been characterised by abuse and neglect, and unfortunately research shows that, overall, children placed in Out of Home Care (OOHC) generally experience poorer outcomes in terms of their education (and employment), health and safety. In particular, multiple and unstable placements can have further detrimental effects on a child's development.

Research also shows that approximately 15-20 per cent of children in Australian OOHC have significant emotional and behavioural problems that make it very difficult for them to achieve placement stability in conventional family foster care. [1]

In 2006 the *National Comparative Study of Children and Young People With High Support Needs In Australian Out-of-Home Care*[2] found that the majority of these children had suffered physical abuse (73.4%), sexual abuse (65.9%) and neglect (58.2%).

Children with hard to manage behaviours are difficult to place. Too often their care experience is disrupted by unplanned placement changes. Their early life experiences teach them that adults are not safe and cannot be trusted. Subsequent apparent abandonment and rejection by the adults entrusted with their care reinforces this perception. With every change comes a sense of not belonging, a loss of self. With strengthened resolve to survive in spite of it all means that challenging Difficult behaviours become functional.

DeBellis (2002)[3] validates the impact of trauma through chronic abusive childhood experiences on the developing brain. Brain size in abused children is smaller and areas of brain development are impaired. He found that abused children with PTSD have differences in their intracranial and cerebral volumes, ventricles, and a smaller corpus callosum.

This report is about responding to the needs of those children whose care is complicated by their pain based behaviour. Responding to these children must happen within the context of understanding what has happened to them, and how they as individual children and a collective group have been impacted upon by

[1] Australian Institute Health and Welfare (2011)

[2] Osbourne, A., & Delfabbro, P. (2006) p6

[3] DeBellis, M. (2002) p 23

events beyond their control. Their behaviour needs to be understood within the framework of the child's experiences, their developmental level and capacity.

The following three areas have therefore been considered are addressed in the main body of the report.

1. Understanding a child's behaviour in the context of childhood trauma

2. Responding to the needs of children and young people adversely affected by childhood trauma; and

3. Models and systems of care

Receiving the Churchill Fellowship afforded me the opportunity to explore a range of service models for a particularly vulnerable group of children. I will be forever grateful for this experience which has furthered my resolve to do my very best to influence the system changes required to better care for children.

I would also like to acknowledge and thank the two people who acted as my referees during the application process; Ms Annette Gallard, who was the Chief Executive of the Department of Community Services, and Ms Kerryn Boland, the NSW Children's Guardian. I am indebted to them for their encouragement. They are two champions of vulnerable children.

I was truly privileged to meet so many people across the United States of America and the United Kingdom who are passionate about their work and generous with their knowledge, expertise and time.

A special thought to the little girl whose circumstances motivated my application. She deserved better. This report is dedicated to her.

Executive Summary

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To study models of therapeutic residential care for children recovering from abuse and neglect

Highlights:

- The Churchill Fellowship provided me with an opportunity I would not have otherwise had. While focussed on therapeutic residential care, I saw in action the different ways that a variety of trauma informed services can be delivered.
- Encountering people whose motivation and passion is really making a difference; seeing the congruence within agencies that do what they say they do; and meeting the children and families who welcomed me into their homes.
- I was given a real opportunity to consider the pathway to services for children and their families other than formal state care arrangements.
- I developed an awareness that the service system's response to managing risk may be limiting opportunities for families to realise their strengths and that children and families would benefit from a specialised trauma treatment service continuum.

Recommendations:

1. The individual child protection jurisdictions within Australia should continue to progress the work already started on developing and refining residential care, therapeutic residential care and secure care options.
2. There is no one right way to deliver these services, however it is very clear that jurisdictions/services need to be clear about their philosophy and know that this is 'lived out' in practice.
3. Agencies delivering therapeutic services must consider program evaluation as an essential part of their responsibility towards the children and families they service.
4. Australian service providers and statutory jurisdictions should continue to research what is happening elsewhere in the world and seek to emulate the best practice possible.

5. Australian policy makers should continue to refine their service systems and promote residential care, and in particular, therapeutic residential care services as legitimate service options appropriate as a first choice care option when appropriate to assessed need.

6. Secure therapeutic care needs to be considered within the context of a care continuum, and there may be reason to extend the type of secure accommodation options to include a service which offers short term care and assessment. The effectiveness of this model should be further explored with reference to existing practice in the United Kingdom.

7. There is a need to review policy and law on the application of restriction on younger children. I noted that across the agencies I visited there was a low level of children absconding from placement and procedures were in place to keep children safe by means of staff intervention.

Program

United States of America 22 June - 30 July 2011

Reclaiming Youth Training and Conference
Rapid City, South Dakota
Dr Larry Brendtro

Sandhill Child Development Centre
Los Lunas, New Mexico
Kurt Wulfekuhler, Elizabeth McGhee and staff

Mount St. Vincent Home
Denver, Colorado
Sister Amy Willcott, Kirk Ward, Alisa Adams, Dennis Kennedy and Kendra Schpok

Alexander Youth Network
Charlotte, North Carolina
Dr Dawn O'Malley, Leondara Shinhoster, Ryan Shuford and King Jones

Wraparound Milwaukee
Milwaukee, Wisconsin
Bruce Kamradt and the Wraparound staff

St Aemelian-Lakeside
Milwaukee, Wisconsin
Sandra Engelhardt, Anne Leinfelder Terri Jamieson, Leanne Delsart, Jane Ottow, Becky Hollister, Karen Johnson, Laura Con Alstine, Sally Kelsy and staff

New York City Administration for Children's Services
New York City, New York
Jan Flory

The Children's Village
Dobbs Ferry, New York, New York
Daniel Melnick, Peter Friedman, Donald Somerville, Paul, Schiller

Andrus Children's Centre
Yonkers, New York, New York
Brice Moss, Siobhan Masterson and staff

The Sanctuary Institute
Yonkers, New York, New York

Program

The United Kingdom 2 August – 8 September 2011

Kibble Education and Care Centre

Paisley, Scotland

Jim Mullan, Jim Goodwin, Mark Macmillan, Neil Mcmillan, Joan Mackenzie, Ruby Whitelaw and staff

Good Shepherd Centre

Bishopton, Scotland

Marie Heart and centre staff

SACCS

Montford Bridge, Shropshire

Rob McKay and program staff

Aycliffe Young People's Centre

Newton, Aycliffe County Durham

Gill Palin and centre staff

London Care Solutions

Enfield, London

Jeff Burt

Lansdowne Secure Unit

Hailsham, East Sussex

Martin Sutcliffe and unit staff

Section 1. Context

In order to fully understand the range of services and models I experienced over this program, it is helpful to first provide some background information.

1. Residential care in Australia

From the 1970s onwards Australian governments progressively closed residential institutions as a result of numerous government enquiries into child abuse[4]. Since the 1990s the majority of children in State care across Australia have been in foster or kinship care. In 2007 95% of children in care were in foster situations[5] and 5% were in some form of residential care. Although foster care is the preferred option it can be less suitable for some children – particularly those with long term trauma and abuse backgrounds, clinical disorders and emerging mental health issues who often experience multiple foster placement breakdowns.

There has been congruence between the social academic world and government on achieving the aims of a system almost completely based on family/home based care.

Despite this, an alternate view has emerged over the past ten years in Australian literature advocating residential care for some children and young people. This trend has focussed on the needs of children and young people who are described as having high or complex needs, a growing population for which home based care has not been successful. Flynn et al (2005)[6] noted a widely acknowledged need for therapeutically oriented programs, but found that these in the main did not exist.

Bath (2008)[7] concluded that government programs needed to move beyond a focus on accommodation and adopt a therapeutic perspective to address the multidimensional needs of troubled children and young people.

Burt and Halfpenny (2008)[8] described a program catering for specialised needs in Victoria. Ainsworth and Hansen (2005)[9] found that *'a mature child care and protection system requires some residential education and residential treatment programs'.*

In 2005 the Association of Children's Welfare Agencies[10] found that 59% of survey respondents saw a need for residential care.

A common thread in the literature is that residential care is mainly used for children and young people who have complex needs[11]. Bath (2008)[12] concluded

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4 Usher (1992)
5 Australian Institute of Health and Welfare (2008)
6 Flynn (2005)p 46
7 Bath (2008) a, p15
8 Burt and Halfpenny (2008) p50
9 Ainsworth and Hansen (2005) p199
10 Flynn, Ludowici, Scott and Spence (2005) p30

that this is not a homogenous group but a multi dimensional one which includes children with behavioural, developmental, psychiatric, education and social deficits. Osborn et al (2008)[13] found that over 75% of young people entering care had a clinical level conduct disorder and many had associated problems with socialisation and depression.

Flynn et al (2005)[14] defined this group as exhibiting or including "sexualised behaviour, sex offenders, intellectual disability, drug/alcohol or mental health issues, risk taking and those that did not fit within a foster care environment".

In the United States Leichtman (2008)[15] noted the long standing history of child treatment centres but described these as heterogeneous, spanning a variety of milieus and mental health disorders.

There is a growing recognition in Australia that some form of group care for children and young people who have complex needs is required, and that this needs to be founded in a model where the major focus is a therapeutic program, not just simply somewhere for the child or young person to live.

Flynn et al (2005)[16] defined therapeutic care as "*a program systematically applying a formal clinical therapy*". Ainsworth and Hansen (2008)[17] were more prescriptive, proposing: "*a 24/7 curriculum ...activities the children will pursue in order to achieve the behaviour change objective*".

Schmied et al (2006)[18] noted a shift from care settings addressing behaviour to those incorporating a more therapeutic model promoting a safe supportive environment.

Internationally, therapeutic group care has a longer history and is more developed that any care situation currently found in Australia. In Scotland Hewitt (2007)[19] defined 5 Principles of Therapeutic Living in children's homes and, in Canada, Anglin (2002)[20] defined the Canadian experience of well run programs as involving "11 interactional dynamics and 3 psycho-social processes". This echoes the larger body of knowledge from the United States where Leichtman (2007)[21] defined the essence of residential treatment as 24/7 assistance to children to negotiate tasks of daily living effectively and where therapy is mainly done by carers as the agents for change.

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11 Schmied, Brownhill and Walsh (2006) p2
12 Bath (2008) p10
13 Osborn, Delfabbro and Barber (2008) p855
14 Flynn, Ludowici, Scott and Spence (2005)
15 Liechtman (2008) p 176
16 Flynn, Ludowici, Scott and Spence (2005) p 20
17 Ainsworth and Hansen (2008) p44
18 Schmied, Brownhill and Walsh (2006) p6
19 Hewitt (2007)
20 Anglin (2002) p127-128
21 Leichtmann (2007a) p284

Some programs work with specific therapy platforms, such as the Sanctuary® program in the United States[22] which works on a trauma recovery framework and has gained international attention.

Bath (2008)[23] noted that residential treatment in the United States represents an entire service stratum that is missing in Australia. In NSW some modelling for therapeutic services has been described in EOI processes, however no provider has taken up these models. Ainsworth and Hansen (2008)[24] were critical of this process as the described models did not realistically match what is known about complex needs.

This short exploration of the literature therefore suggests that:

1. There is a need for group care settings for children and young people, and

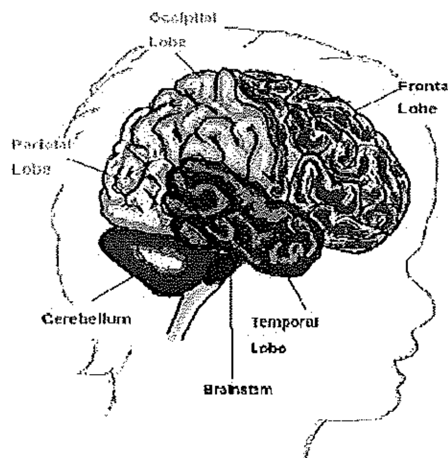
2. The availability of this setting in Australia is limited compared to similarly developed nations.

2. Understanding a child's behaviour in the context of childhood trauma

The brain develops in a sequential fashion, from the bottom to the top, the least complex (brain stem) to the most complex (cortex).

The anatomy and function of the brain structure is highly complex. The interdisciplinary collaboration of neuroscience is dedicated to studying the nervous system. Simplifying this system into a few paragraphs does not do justice to this field of study, but it assists in further establishing the context.

THE HUMAN BRAIN



[22] Rivard, McCorkle et al (2004)
[23] Bath (2008) b p18
[24] Ainsworth and Hansen (2008)

The Brain Stem

The Medulla is the life sustaining control centre. It is responsible controlling the heart, respiratory and vasomotor functions.

The Pons bridges the descending tracts from the midbrain to the lower centres and ascending tracts from Medulla and the spinal cord. It affects respiration, taste, arousal, wakefulness and alertness.

The midbrain affects posture, equilibrium, the Autonomic Nervous System, blood pressure, temperature, emotional influences and consciousness. It regulates appetite and hormones.

The Limbic System

The Hippocampus stores new memories as they occur and organises long term memory.

The amygdala regulates heartbeat, emotional responses and mood. It is where fear is processed, initiating the fight or flight response. Cognitive and sensory integration occurs here. Visual and auditory areas input to the amygdala

The Epithalamus produces melatonin, controls body rhythms and stimulates the immune system.

The Diencephalon affects emotional expression, integrates sensory input with emotional responses and regulates consciousness.

The Cerebellum coordinates movement, balance and posture.

Higher Brain Structures – the Cortex

The Temporal Lobe is the major memory processor and affects hearing, and receptive language.

The Occipital Lobe affects vision and integrates visual stimuli.

The Parietal Lobe affects sensory functioning, motor function, pain, temperature, tactile recognition, perceptual functions, taste, abstract reasoning, body image, spatial awareness, right/left discrimination and the ability to read.

The Frontal Lobe affects emotion, the limbic system, personality, judgement, intellect, morality, planning, abstract thought, voluntary movement, attention, short term memory, and perseverance and impulse control

There is an ever increasing understanding of how the functions as outlined above are impacted upon by the absence of physical care, caregiver warmth, nurture and emotional responsiveness (neglect) and physical, sexual and emotional harm (abuse).

When a child's brain is at its most malleable (as it develops), it is also at its most sensitive as to how experiences impact on how the brain organises itself.

Perry (2006)[25] concluded that chaos, threat, traumatic stress, abuse and neglect are bad for children. These adverse experiences alter a developing child's brain in ways that result in enduring emotional, behavioural, cognitive, social and physical problems. These negative affects are caused by alterations in various neural systems in the brain.

When the source of the trauma is a significant attachment (caregiver) the impact and effects are profound.

Although there are limitations in the diagnosis of Post Traumatic Stress Disorder for children. It has informed the research and thinking about future diagnostic possibilities.

De Bellis (2001)[26] found that children with PTSD symptoms have alterations in the chemical mediators of stress within their neuroendocrine system as well as an abnormal, adverse development in the prefrontal region of the brain which is responsible for cognitive development.

Post traumatic stress is traumatic stress that persists after a traumatic incident has ended and continues to affect a child's capacity to function.

Severe psychological trauma causes impairment of the neuroendocrine systems. Extreme stress triggers the fight or flight survival response Fight or flight responses increase cortisol levels in the central nervous system which, while necessary for survival, can when sustained cause alterations in brain structure and development. Continuing fear and arousal affects a child's ability to develop a capacity to self-regulate.

Enduring symptoms common to the children and young people with a history of abuse and neglect include:

- Intrusive thoughts
- Flashbacks
- Feelings of intense distress
- Feelings of fear
- Intense physical reactions to reminders
- Avoiding activities
- Poor memory
- Lack of interest
- Difficulty falling and staying asleep
- Difficulty concentrating
- Hypervigilance

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[25] Perry, B. in Webb (2006)

[26] De Bellis, M.D. (2001), pp 537 – 561.

- Easily startled
- Problems learning

The behaviours associated with these symptoms include:

- Being non-cooperative
- Running away
- Verbal and physical aggression towards caregivers
- Self harm
- Engaging in inappropriate relationships
- Exposure to risk and harm
- Problem sexual behaviour
- Drug and Alcohol misuse

These behaviours are often extreme and place the child and those caring for them at risk.

Hard to care for during childhood, there is significant evidence of the problems that follow these children into adulthood.

The Adverse Childhood Experiences (ACE) Study[27] is one of the largest ongoing investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study is a collaboration between the Centers for Disease Control and Prevention in Atlanta and Kaiser Permanente's Health Appraisal Clinic in San Diego.

More than 17,000 participants chose to provide detailed information about their childhood experience of abuse, neglect, and family dysfunction.

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life. Many of these problems arise as a consequence of adverse childhood experiences.

Childhood abuse, neglect, and exposure to other traumatic stressors which we term adverse childhood experiences (ACE) are common. Almost two-thirds of study participants reported at least one ACE, and more than one of five reported three or more ACE. The short- and long-term outcomes of these childhood exposures include a multitude of health and social problems.

The ACE Study uses the ACE Score, which is a count of the total number of ACE respondents reported. The ACE Score is used to assess the total amount of stress during childhood and has demonstrated that as the number of ACE increase, the risk for the following health problems increases in a strong and graded fashion:

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[27] Anda, R. F, and Felitti, V.J, (ongoing) http://www.acestudy.org/index.html

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy

3. Responding to the needs of children and young people adversely affected by childhood trauma

Children with complex trauma demonstrate behaviour that further compromises their development, safety and wellbeing. Drawing on the wisdom of experts in the field of trauma assessment and trauma treatment (Bruce Perry, Daniel Siegel, Bessell Van Der Kolk and Joseph Spinazzola), effective trauma treatment includes the following factors for stabilisation and recovery:

a. Safety and stabilisation

- providing a safe and containing environment,
- having a safe and nurturing adult or adults with whom to build an attachment
- caregivers managing the child's emotions when they cannot
- establishing a system external to the child that ensures predictability and consistency
- recognising and working on triggers and teaching self regulation
- teaching the child what safe feels like

b. Understanding and processing what's happened

- With the help of a suitably skilled adult, telling the story of what it was that brought them to this place and making sense of their experiences

- Moderating the child's physiological responses to stress
- Restoring childhood, safely attached to an adult/adults, being able to participate in activities, being loveable, happy and managing everyday challenges

c. Moving on

- Participation in an ordinary life
- Recognising that the impact of trauma may have created gaps in learning, experiences and opportunities, and that their developmental delays will need to be considered with modification as required
- Opportunities to generalise new skills across different environment and experiences
- Ongoing and flexible treatment with opportunity to revisit earlier helpful interventions to manage the ongoing episodes of crisis and regression
- Consolidation of the child's identity and self worth

I visited the Unites States of America and the United Kingdom with the specific intent of looking at Therapeutic Residential care for those children with the very highest needs. I learnt about that and more.

4. Aspects of the care system in the United States of America

The USA has a complex system of federally funded services, administered at a State or local government level. The system of funding in America is strikingly different from that in Australia. Funding and treatment options are linked to a child's diagnosis.

While principal responsibility for addressing child abuse rests with various State and local governments, the Federal Government plays an important supporting role. Efforts are coordinated through the Children's Bureau, a division of the Administration of Children and Families in the Department of Health and Human Services.

While there are differences across the States, the commonality was the commitment to keeping children with their families and, where that was not possible, moving to permanency through adoption.

It should also be noted that there are different pathways into residential treatment. Some children are in formal State care and their foster placements have broken down. Some children enter residential treatment centres without coming into formal State care. They are often placed there voluntarily, funded by their home school. There is legislation regarding the provision of a suitable school placement for a child with a disability. Disability is a far reaching term and includes emotional disturbance. When the placement is provided under these provisions the goal of the placement is to have the child treated and returned home.

During my time in the USA I spent 6 days with the organisation Reclaiming Youth International, attending training and their international conference and I visited 6

residential centres allowing me to become familiar with different models of intervention, all trauma informed. In Milwaukee I spent time with the unique Wraparound Milwaukee Services.

I was inspired by my previous participation in training with Dr Bruce Perry on the Neurosequential Model of Therapeutics (NMT) to investigate this model further. I wanted to see what services look like when NMT is implemented and how NMT influences practice. I visited the Sandhill Children's Centre Los Lunas New Mexico. The Sandhill Children's Centre is the first agency in America to be accredited by the Child Trauma Academy. At the time of my visits the Mount St. Vincent Homes in Denver Colorado, the Alexander Youth Network in Charlotte North Carolina and St Aemilian-Lakeside in Milwaukee Wisconsin were in the accreditation process. These agencies are delivering services that both care for children and treat their trauma.

In New York the Andrus Centre is the home of the well evidenced Sanctuary® Model[28], and the New York Children's Village strongly embraces the importance of relationships and redresses disadvantage through education and supporting families through Multi Systemic Therapy.

I was also very pleased to meet Jan Flory the Deputy Commissioner for Child Protection of the New York City Administration for Children's Services. In a city of 8 million people the State runs a shelter as an emergency placement option.

5. Aspects of the care system in the United Kingdom

The United Kingdom has a system of secure accommodation for children and young people, and there is growing interest and development of services in Australia in this model of care. This was an area that I was keen to know more about.

The Secure Accommodation Network (SAN) represents and promotes the work of Secure Children's Homes in England and Wales. It was established in the mid-1980. SAN connects Secure Accommodation providers, and through that network develops and shares practice guidelines. The SAN also operates a vacancy information system so that the child welfare sector knows by accessing their website where vacancies are in the system.

In Scotland I visited the Kibble Centre a provider of a full suite of services including secure accommodation and the Good Shepherd Centre.

Scotland's response to children is renowned internationally for its unique approach. Children and young people who commit offences or those with welfare and protection needs appear before a Children's Hearing.

In England I visited the Aycliffe Centre in County Durham and the Lansdowne Secure Centre in East Sussex.

[28] http://www.sanctuaryweb.com/

In additional to the secure children's homes I visited London Care Solutions, which runs a successful semi-independent living program for hard to place youth, and SACCS, an agency delivering high level therapeutic care in group home settings for very high needs younger children.

Poignantly, my visit to England coincided with the London riots. My reflections on children and young people with high needs took on another dimension as image after image of violence and destruction appeared in every media outlet. I was in Croydon, South London on the day of its devastation.

The latest updating report released by the UK Ministry of Justice on 12th October 2011 advised that 1,984 people have appeared before the courts (a sub-group of people involved) and 26 per cent of those were aged 10-17 (juveniles) and that a further 27 per cent were aged 18-20.

Additional demographic information indicates that the juveniles to have appeared in Court were more likely to be a recipient of free school meals or benefits, have special education needs, absenteeism from school and some previous history of criminal activity.

A panel has been established to examine 6 key areas:

- Why people took part in the riots
- Why the riots happened in some areas and not others
- How key public services engaged with communities before, during and after the riots
- What motivated local people to come together to take civic action to resist riots in their area or to clean up after riots had taken place
- How communities can be made more socially and economically resilient in the future, in order to prevent future problems
- What they think could have been done differently to prevent or manage the riots

My visits to these agencies and meeting such inspirational leaders and practitioners provided me with an opportunity to look at different service systems helping children with high needs and their families.

The Churchill Fellowship experience opened door after door and the programs I saw operating alongside the therapeutic residential services are contributing parts of a continuum of service delivery. In recognition of those, the following chapter of this report is broken down through that continuum.

Section 2. Models of care

A. SUPPORTING CHILDREN IN FAMILIES

The Model - Wraparound

The (USA) National Wraparound Initiative is to promote understanding about the components and benefits of wraparound, and to provide the field with resources and guidance that facilitate high quality and consistent wraparound implementation. The definition of Wraparound is "an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams." [29]

The Provider:

Wraparound Milwaukee

Wraparound Milwaukee is a recipient of the Harvard University Kennedy School of Government Award for Innovations in American Government (2009). Spending time with Bruce Kamradt, Director and the staff at Wraparound was one of the highlights of my trip.

The program appeals at all levels. It is child and family focussed, strengths based, efficient and effective.

Wraparound Milwaukee is a unique managed care program operated by the Milwaukee County Behavioural Health Division. The program serves families living in Milwaukee County who have a child who has serious emotional or mental health needs, who is referred through the Child Welfare or Juvenile Justice System and who is at immediate risk of placement in a residential treatment centre, juvenile correctional facility or psychiatric hospital.

The program is delivered within a 'wraparound' philosophy and the approach is strength-based with an emphasis on individualised care. It is this approach combined with a unique organisational structure and service system design, that makes it stand out.

Wraparound Milwaukee began in 1995. It was developed out of a federal grant, the intent of which was to develop more comprehensive, community-based care for children with serious emotional needs and for their families.

[29] National Wraparound Initiative, Portland State University (2011)

Wraparound Milwaukee aimed to reduce the use of residential treatment centres and inpatient psychiatric hospitals to meet the needs of children and to provide more services in the community and in the child's home. There was commitment to greater family inclusion in treatment programs and collaboration among child welfare education, juvenile justice and mental health in the delivery of services

The program has achieved notable results over its 14 year history and reports significant cost-savings.

A combination of several state and county agencies, including the Bureau of Milwaukee Child Welfare, the County's Delinquency and Court Services, Behavioural Health Division, and the State Division of Heath Care Financing who operates Medicaid, provide funding for the system. Funds from the four agencies are pooled to create maximum flexibility and a sufficient funding source to meet the comprehensive needs of the families served. Part of the County's Behavioural Health Division, Wraparound Milwaukee oversees the management and disbursements of those funds acting as a public care management entity.

Wrapround is not an intervention or a treatment model. It is a system of care. Children and families can enter the program 2 ways, either court directed (Wraparound) or voluntarily (REACH).

A number of system features are centrally managed, services and work with families is locally delivered.

Embedded in the philosophy and practice is that families are valued, equal partners who know their children best.

Children and families are referred in centrally. The referral is assessed as eligible and referred on to a care coordinator. Wraparound Milwaukee contracts with nine community agencies to provide a total of approximately 72 care coordinators, nine lead workers and nine supervisors. Care Coordinators, are degree qualified and work with case loads of 1:8 or 1:9 families. Roles and responsibilities of care coordinators are clearly defined in writing to minimise instances where they overlap with some of the duties associated with child welfare and probation workers.

Within 1 week the coordinator works with the family to develop a strengths inventory, a crisis plan is also developed and within 30 days a plan of care is developed. No plan of care meeting is held without the family present. They are part of the team.

The team decides what services are needed and these are selected from a centrally managed provider network. Providers join the network through an application and credentialing process where agreements, costing and billing factored in and electronically linked so that care coordinators in the field focus on working with families and care planning. Families can select the providers that fit best with their family.

The Plan of Care is submitted back to Wraparound for authorisation. Authorisations, billing and payments are centralised. One of the cleverest, most

intuitive, client information systems I have ever seen is used to support the functions of both care coordinators and the Bureau.

Wraparound Milwaukee has developed a network of community agencies and individual providers to deliver services based on a comprehensive fee-for-service approach. No formal contracting with Providers is used. Wraparound Milwaukee develops service descriptions, standards for all services, and the unit rate. Community agencies are invited apply to provide one or more of the 80 core services based on service needs which are re-evaluated throughout the course of the year. Wraparound Milwaukee then credentials providers who seek to become a Network Provider as an agency or individually.

There are in excess of 200 agency and individual providers (i.e., independent psychiatrists, psychologists, therapists) involved in the provider network. Certain high cost and restrictive services such as residential treatment, psychiatric hospitalization and day treatment require prior authorization. For most services, authorization to a provider to provide services is through the care coordinator entering the requested services, units needed, and name of provider into the automated information system called Synthesis. Vendors are immediately notified on-line of units of service approved for the upcoming month. Providers invoice on-line and the automatically generates payment.

Providers work to a standard set of policies and procedures.

The Wraparound Milwaukee Program has partnered with Families United of Milwaukee, Inc. Wraparound Milwaukee contracts with Families United to provide family support and advocacy services, to organize family events and run support groups, to assist conducting family satisfaction surveys, to serve on committees and to assist in training care coordinators, providers, and child welfare staff and to develop and disseminate information and other material about the program to families.

A recent federally funded initiative recognises that not all young people assume all the responsibilities of adulthood at 18. Project O-YEAH is designed to provide services and support young people aged 16 to 25 to successfully transition to adulthood.

To complete the system and ensure continuous improvement there is a robust and sophisticated system of ongoing quality assurance. Like the other parts of the program the QA focuses strongly on families and their satisfaction with services provided. Polices and procedures are regularly reviewed and updated, agencies are audited, care coordinator and provider established performance indicators and requirements of contracts are monitored, yearly performance improvement projects are administered.

The program is subject to ongoing evaluation through data collected about each child. The information collected allows Wraparound to evaluate both individual and overall changes in a child's functioning from a variety of informants and in various settings.

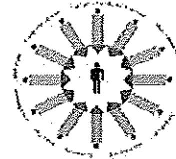
Service utilisation data is also collected for time periods corresponding to the collection of the clinical measures which gives Wraparound Milwaukee information on changes in service utilisation over time, as well as effectiveness of various services.

In recognition of the value and innovative aspects of this program, in 2009, Wraparound Milwaukee was awarded an Innovations Award in Children and Family System Reform by the Ash Center for Democratic Governance and Innovation, John F Kennedy School of Government, Harvard University.

In the words of Stephen Goldsmith, Director of the Innovations in American Government program at Harvard Kennedy School, "*Wraparound Milwaukee's care model breaks through rigid program silos and delivers cost effective and higher quality care that involves families from day one," The program champions a unique approach to care where one size doesn't fit all*".[30]

The Provider:

The Alexander Youth Network



Small by comparison in program size to Wraparound Milwaukee, the commitment of the Alexander Youth Network to work with families to keep children safe at home is comparable. The Intensive In–home Program is a time limited service for 3 to 18 year olds.

The team to family ratio is 1:8 and team members are licensed qualified professional and associate professionals.

The program is prescribed and the aim is to diffuse the presenting crisis, intervene to reduce the likelihood of a recurrence, ensure linkages to community services and resources, monitor and manage presenting psychiatric and/or addiction symptoms and provide skills training to family to prevent an out of home care placement for the child.

The program uses the "wraparound" philosophy.

A team of three, including a licensed clinician and two coordinators works with each child and family using the Transtheoretical Model of Change[31], a sequential behaviour modification therapy. The approach helps youth understand responsibility and consequences for behaviour while parents learn how to best manage the youth at home, at school and in the community.

Typically intervention lasts 3-5 months and initially home visits are 3-5 times weekly.

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[30] Press Release (2009), http://ash.harvard.edu/

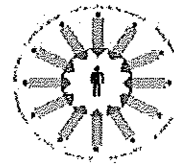
[31] Prochaska, J O; DiClemente, C.C (2005)

B. FOSTER CARE

The Model – Therapeutic Carers

The model incorporates the foster carer as part of the clinical team. This may be either as a paid staff member, or under the foster carer licensing system appropriate to the statutory framework of the location. The carers are supported by clinical and casework staff.

The Provider:
The Alexander Youth Network



The Alexander Youth Network Treatment Parents provide a highly supervised, therapeutic environment in their home for children and teens from throughout the state who are receiving treatment for emotional challenges. Treatment Parents are fully screened, trained, and supervised by Treatment Coaches.

Treatment Coaches offer support and direction during weekly supervision with the Treatment Parents, and are available for crisis assistance and consultation 24 hours a day. The child is seen weekly.

Additionally the child receives outpatient psychiatric treatment, and is either in day treatment, a behavioural school or is being home schooled.

Multi-Dimensional Treatment Foster Care is a research-based out-of-home treatment option for severely emotionally disturbed children who require multiple mental health services in order to maintain life in a family and community setting.

Services may include individual, family and group therapy, community support services and family training, Day Treatment, psychiatric treatment and medication management, and others. Treatment parents are limited to treating one MTFC child at a time in their home.

The Alexander Youth Network's Rapid Response Crisis Foster Homes provide emergency and temporary out-of-home placement for a child with mental health disorders to prevent the breakdown of their existing placement. Therapeutic Foster Carers are trained to stabilise behaviours while the existing carers work with the appropriate professionals and other support systems. Length of stay is limited to two weeks. Rapid Response Crisis carers are paid a daily retainer fee and in addition a fee for transporting the child to their home school.

Young people leaving care in North Carolina are eligible for services until they are 21 years of age, including remaining in Foster Care.

The Provider:
The Kibble Education and Care Centre

Kibble Education and Care Centre Intensive Fostering Services (IFS) provides a community-based alternative to residential school for young people aged 12-18 years who present with challenging behaviour and are at risk, and who have a connection with the Kibble Education and Care Centre. This usually means that they are children who have been in placement at the residential school.

The children placed in the program have very high needs.

The program was established in 2005. The aims and objectives of the service are to recruit, train and support carers to provide quality life experiences to the young people by living within a family setting.

The Foster Carers are professional members of the team. They are paid but work from their home. Foster Carers are required to complete SVQ (Scotland Vocational Qualification) and HNC (Higher National Certificate) or equivalent qualifications – if they do not already have these. They receive regular supervision from allocated Foster Care Social Workers.

The Scottish Commission for the Regulation of Care's inspection report of September 2010 found the quality of care to be very good (a rating of 5 out of 6) and the quality of management and leadership excellent (a rating of 6 out of 6).

C. THERAPEUTIC GROUP HOMES

The Model - Therapeutic Parenting

Therapeutic Parenting[32] is founded upon the principles of 'good parenting', or indeed 'ideal parenting'. There are, of course, other forms of alternative parenting to assist children whose lives suffer disruption, the most obvious being adoption and fostering. Fostering, particularly, can be used when a child's parents are temporarily unable to care for her, perhaps through illness or other personal difficulty. However, alongside 'good parenting' principles, therapeutic parenting is underpinned by psychodynamic theories of child development and an understanding of attachment theory. Such parenting offers the child, directly or indirectly, symbolically or actually, important experiences denied by his or her own natural parenting. It is offered within a substitute environment which must be safe and which the child must be able to trust. The kind of child to whom we are referring will need this specialist treatment before she is able to reach a point in her recovery which will enable her to be parented within a family'.

[32] Pughe, B. and Philpot, T. (2007)

The Provider:
SACCS

SACCS is a uniquely placed provider of therapeutic residential care in group homes. Children are referred to SACCS by Local Authority Children's Service Departments from all over the UK. The agency responds to very young children, on referral they are aged from 4 to 12 years. The cycle of repeated foster care breakdown is broken.

The group homes have capacity for 5 children, and there is a maximum age difference amongst the group of 5 years.

The houses are managed by an experienced Registered Manager with a core team including a Deputy Manager, Senior Care Workers and Residential Care Workers (these titles change to Senior Recovery Practitioner and Recovery Practitioner upon graduation of the Foundation Degree in Therapeutic Child Care).

Each house affords the child their own room, and the house I visited was well appointed, warm and welcoming. It felt like walking into a neighbour's house. The children and staff had baked for my arrival, and I so enjoyed sharing the afternoon with them. SACCS aims to deliver a "high level of nurture and replicate normal family life". This is the first level of recovery, the containment of the child in a comfortable environment; safe from harm with a space that they can call their own.

The Recovery Program describes 4 treatment levels across phases in time, and developmental gains. SACCS summarises these into plain language as:

Level 1 – the child is not able to

Level 2 – the child can sometimes with a prompt

Level 3 – The child can most of the time

Level 4 – the child can transfer to different environments

Each child has an individual recovery program and SACCS has developed and implements a working methodology to support the Individual Recovery Plan (IRP):

Step 1 – pre-admission

Step 2 – the development of a detailed recovery plan

Step 3 – the monthly report

Step 4 – the assessment

Step 5 – the statutory review

The Recovery Matrix identifies 6 areas of development: learning, physical development, emotional development, attachment, identity and social and communication development.

The SACCS recovery program measures 24 outcomes. These are matches to the 5 Every Child Matters outcomes and the 7 Core Aims of Wales.

Children's education needs are met initially through the SACCS School, until such time as the child is able to transition to the mainstream system. Children transitioned with support needs receive that support from SACCS.

The children at SACCS receive therapy as part of their recovery plan. The key worker is the constant support who accompanies the child. There is a team of therapists providing play, movement, art and more cognitive based therapy. The child is assessed within the first 12 weeks and matched to the most appropriate team member.

Life story Work at SACCS is provided by a team of staff. The first stage requires the staff team to compile a factual account of the child's past. All relevant material is gathered from records and interviews of significant people past and present. Fact, opinion and anecdotes are collated. In stage two the life story workers share the information with the child. Different mediums are used; wallpaper rolls have proven an effective way to map their journey. Finally the Life Story Book is completed, and this occurs as they near the end their placement with SACCS.

The SACCS approach to staffing and staff training is impressive. Those with responsibility for staffing residential care settings know that attracting and retaining good staff is a significant challenge. The SACCS investment includes:

- 3 staff are rostered on in houses with 5 children
- There are 2 "sleep in " staff overnight
- Each child has a key worker who plays a vital role in the recovery team, particularly in the area of attachment
- There is a zero agency policy (ie there is no contracting of staff into the homes), rather the houses are staffed over numbers to account for staff absences and training.

The therapeutic parenting teams undergo an intensive programme of training and development to ensure that they have the self-awareness, skills and theoretically underpinned knowledge required to offer safety and containment, behavioural development and internalised change to each child.

Each staff member is provided with training that takes up to two years to complete to support the three levels of recovery. The first is training required to achieve statutory compliance and is expected to be completed within the first 12 weeks of employment. The second is NVQ level 3 and 4 equivalent by the end of year one enabling staff to understand aspects of behaviour, to work with the IRP and monitor, observe and report on behavioural change. Finally, a Level 5 Foundation Degree is achieved at the end of year two. Level 5 graduates are able to understand, practically apply and articulate the intricacies of trauma as the child

recovers from a poor internalised model to one that is much more positive and healthy.

Children moving on from SACCS generally go to foster care.

SACCS has bravely addressed the needs of very young children with extreme trauma related behaviours, who are hard to place and who have had, or who are at risk of having, multiple failed placements.

D. RESIDENTIAL TREATMENT CENTRES AND RESIDENTIAL SCHOOLS

The Model - The Neurosequential Model

Bruce Perry describes the Neurosequential Model of Therapeutics[33] as a developmentally informed biologically respectful approach to working with at risk children. NMT is not a specific therapeutic technique or intervention; it is a way to organize the child's history and current functioning to optimally inform the therapeutic process.

The NMT integrates several core principles of neurodevelopment and traumatology into a comprehensive approach to the child, family and their broader community. The NMT process helps match the nature and timing of specific therapeutic techniques to the developmental stage of the child, and to the brain region and neural networks that are likely mediating the neuropsychiatric problems.

The goal of this approach is to structure assessment of the child, the articulation of the primary problems, identification of key strengths and the application of interventions (educational, enrichment and therapeutic) in a way that will help family, educators, therapists and related professionals best meet the needs of the child.

There are three elements to the model – history, current functioning and specific recommendations.

The NMT history considers the child's development as well as the timing and severity of the development challenges. These are scored, resulting in an estimate of developmental "load". This produces an estimate of which functions might be impacted upon by the developmental challenges and trauma history. The relational history captures information about attachments, resiliency and vulnerability. This NMT relational health history provides important insights into attachment and related resiliency or vulnerability factors.

Through interdisciplinary staff consultation a working brain map is developed. This visual representation gives an impression of the developmental status of the child in various domains of functioning.

The map can provide a helpful visual aid to understand the "8-year-old, the social skills of a 5-year-old, and the self-regulation skills of a 2-year old".

The maps are a powerful tool for tracking progress.

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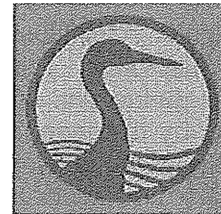
[33] Perry, B. (2009)

While Bruce Perry maintains that NMT is not an intervention, the assessment and mapping is a powerful tool that can guide developmentally appropriate interventions to mirror the sequentially developing brain. Bruce Perry describes initially focussing on the brain stem (self regulation, attention, arousal, impulsivity) with patterned repetitive activity such as music, movement, yoga and therapeutic drumming. As self regulation improves, the therapeutic work can move to the limbic area (relational-related problems) using more traditional approaches. In time the therapeutic techniques can be targeted to the cortex (expressive language and insight) through therapies such as Cognitive Behavioural Therapy.

Dr Perry emphasises that "Patterned, repetitive activities shape the brain in patterned ways, while chaotic experiences create chaotic dysfunctional organization. Therapeutic activities, then, are most effective when implemented with focused repetition targeting the neural systems one wishes to modify".[34]

It was a remarkable experience to be in the milieu of the following agencies, watching how NMT has informed their practice, and how the staff working there are taking this knowledge and are transforming the lives of children.

The Provider:
Sandhill Child Development Centre



The Sandhill Child Development Centre is a residential program for children between the ages of five and fourteen experiencing significant difficulties functioning in their current home environments, schools or communities.

Linda Zimmerman is the Chief Executive Officer and President. She founded the Sandhill Child Development Centre in 2004. When I visited the Centre the majority of children in placement were children from home, placed by their families for treatment. Significantly, and a stark reminder of the impact of early neglect, more that two thirds of the children in residence were adopted.

Sandhill Centre is located in the rural Valencia Valley. The children live in one of two homely and spacious south-western adobe houses. The homes are set on 13 acres. These large properties can accommodate 16 children in each. Bedrooms are shared.

The property has an on site school, a swimming pool, tennis court and a farmyard and a riding arena.

As the first agency acredited with the Child Trauma Academy, Kurt Wulfekuhler, Clinical Director has led the agency in the application of NMT. Children have had brain maps developed and reviewed and I had the opportunity to see first hand the

[34] Perry, B. (2009)

impact of a trauma treatment program and how that has improved the brain function of a child in residence. Kurt and his team, where appropriate, share the brain mapping with the children as part of their therapy. It helps them understand what has happened to them, and engages them in the treatment program.

In recognition of the children and the challenges they may have with attachment, the staff are rostered in teams so that staff groups are consistently working together. Staff rosters are centred on the needs of children. The staff work long hours over few days, thereby reducing the impact of roster changes on the children. A clinician is part of the team and works in the houses on shift with the staff and children.

The milieu approach to treatment ensures that the children's issues are able to be addressed the moment they arise.

Children attend an on site school where the teachers work on behavioural and treatment goals along side educational achievements.

The program recognises that effective resolution of trauma symptoms and attachment problems takes time and the typical length of stay is 12 to 18 months.

The Sandhill Child Development Centre provides extensive training and support to family members. This support is offered throughout the course of treatment, as well as during and after the transition back to the family home. Frequent family contact by telephone and visits is encouraged. Parents spend time side-by-side with the staff to watch and learn as they implement intervention strategies, activities, and facilitate other aspects of the children's' daily routine. Through a "co-parenting" approach, staff teach parents to understand their child and respond in a manner that is productive in order to help build healthy and enduring relationships between children and families. Distance is no barrier and regular meetings and family therapy is ongoing using Skype.

The Centre has developed a technique to assist children with self regulation. It is called "seats" This is not a punitive response to behaviour but rather a strategy taught to children, It provides an opportunity for the child to stop and think, to recognise his behaviour and the feelings that comes with that, and to consider what other things might work.

The Centre is staff secure, and the one non-negotiable rule is that an adult knows there whereabouts of every child, all of the time. There is the provision for holding a child to keep them safe.

The therapeutic relationship with the counsellor is not one to one, rather that person facilitates what it takes to have the child feel safe and be close to caregivers. Individual and family work is available as appropriate.

The Sandhill Child Development Centre provides additional program components to complement the therapeutic milieu. These include:

<u>Neuro-feedback and Biofeedback</u>

Through the use of computer technology, Neuro-feedback and biofeedback techniques measure and feed back subtle changes in brain waves, and body functions such as heart rate and breathing patterns. With this feedback technology, children can gain control over dysregulated body processes and the disorders or problems that are associated with them.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR is a psychotherapy which aims to assist in processing and reducing the long term effects of distressing memories by using cognitive and sensory therapies simultaneously.

Specific Nutritional Supplementation

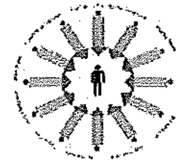
Sandhill Children's Centre staff work with health providers with a specific emphasis on diet and nutrition. The children's diet contains little processed food; meat is organic and nutritional supplements are offered.

Animal Assisted Therapy

Sandhill Children's Centre provides opportunity for children to work with animals. A small animal farmyard is an area that children can learn about caring for others, become skilled in handling animals and participate in local community fairs and shows. There is also program of Equine Assisted Therapy[35].

The Provider:

The Alexander Youth Network



Founded in 1888 as a service provider to women and children, in 1946 the focus shifted to specialise in caring for children with emotional disturbance and mental illness. Today the agency is a provider of an array of clinical and specialist services to children and their families.

In North Carolina, the highest level residential treatment programs are classified as a psychiatric residential treatment facility (PRTF).

The Alexander Youth Network PRTF is located on campus within a service continuum. Community based services are located at different locations throughout Charlotte.

The PRFT can accommodate 36 children aged 6 to 15 years. Length of stay is usually 6 to 7 months.

Dr Dawn O'Malley is the clinical director. There is registered nurse presence on site 24 hours a day. Licensed clinicians provide individual, group and family therapy. Direct care staff are called Behavioural Health Counsellors. There are

[35] Yorke, J, Adams, C, Coady, N. (2008)

recreation specialists on staff and teachers staff the school. There are onsite program supervisors and case managers are the link between home and the PRTF.

The children live across 4 cottages. I was interested to hear that the program does not move children across cottages to accommodate entries and exits. Instead the program manages the client mix. There is not ongoing client movement for matching and compatibility purposes.

Dawn and her staff have taken the trauma treatment elements and designed a child centred program into treatment phases.

A comprehensive program of activity based therapy informed by NMT has been developed. These are grouped:

- Relaxation – calming activities in a healing and nurturing environment
- Drumming – In early stage treatment the African drumming program has been shown to promote regulation. Later in the program enhanced learning includes working as part of a group, skill building and confidence building. Appropriate rhythms are selected and taught to staff
- Yoga and meditation are offered daily, which promotes self regulation
- There is a life skills program
- Creative expression – art, gardening, dance, drama and music
- Outdoor activities include a ropes course to build tolerance, acceptance and trust. This provides problem solving experiences in a fun setting. Risks are recognised and managed.
- Hiking activities build relationships
- Fitness and team games teach play with others. Swimming builds trust in the adults who keep the children safe and structured lap swimming promotes self regulation skills
- Visiting Certified Pets teach control and empathy. The Equine Therapy program is under development

The PRTF model is staff secure. Restrictions are applied to keep a child safe. There are provisions for escorting, restraining and secluding a child for safety reasons.

The Alexander Youth Network has taken NMT and brought it to life in their practice by developing a program of treatment phases.

The way the agency has structured its programs and services, and the way in which staff speak of their children reflects the agency's goal to "provide quality professional treatment to children with emotional and behavioural problems and deliver an effective and efficient array of services, enabling children and their families to exercise self determination, achieve their potential, and find long-lasting positive ways to connect with their community".

The Provider:

St Aemilian-Lakeside

The residential treatment focus at St Aemilian-Lakeside is assessment, stabilisation, and transition planning.

Trauma informed care at St Aemilian-Lakeside is embedded in philosophy and practice. The agency has articulated seven essential ingredients for the implementation of trauma informed care.

1. Prevalence – appreciation of the exposure to adverse events is a key element to understanding the child's needs

2. Impact – understanding adverse childhood experiences affect functioning

3. Perception/Reality – changing the question from "what is wrong with you?" to "what has happened to you and, how can I support you?"

4. The lower brain – targeting sensory interventions

5. Relationships – strong relationships are a key to mitigating trauma

6. Reason for Being – Creating interventions that are driven by the person

7. Caregiver capacity – knowing the limits, taking care and finding the balance

The residential treatment program sits as part of a suite of services. St Aemilian-Lakeside has been a provider for 160 years, and today's mission is to "provide innovative family centred care and educational services that embrace diversity and empower children, families and adults to improve the quality of their lives"

The agency's other services all working with children with complex needs, include the following:

Care Coordination

A partner with Wraparound Milwaukee.

Caregiver support

This provides support to families caring for a child in out of home care. Services include, assessment of need, crisis stabilisation, carer training and support, guidance and advocacy, navigating the system and permanency planning.

Foster Care

Foster care is a long established service at St Aemilian-Lakeside. The concept of foster-biological co-parenting is promoted, where relationships are forged between the foster family and the biological family with the goal of reunification.

Community day treatment

A full academic program is provided to keep students on track toward earning a high school diploma. There is 24-hour crisis support available, community and family-based summer programming and collaboration with the student's home school.

Family Integrated Services

This is a subsidiary to the Bureau of Milwaukee Child Welfare. In Milwaukee ongoing child protection services are provided by non-government agencies. The services include 1) family preservation with intensive in home support 2) caregiver support and kin stabilisation focuses on preventing placement disruption 3) Clinical Services provide assessment, training, individual and family therapy, parent child interaction therapy.

School based Services

The provision of treatment services to a child's home school. These include individual therapy, group therapy and support in the family home.

Transitions Therapeutic School

Children are referred from their school district, and placed in the Transitions Therapeutic School for treatment and ongoing education. Many of the children are enrolled in the therapeutic residential program; some children attend as day students. There is strong family involvement in the development of the individual Education Plan.

In addition to this array of services St Aemilian-Lakeside has a stand out program for young people leaving the care system.

Independent Living Services

The Supportive Permanent Housing Program provides housing in apartments throughout Milwaukee for young people with mental health issues. The young people are supported until they are 24.

The Youth Transitioning to Adulthood Scholars are young care leavers exiting foster care. There is an emphasis of pursuing education.

Youth Moving On provides single person accommodation with 18 months of support. The program is open to 18-24 year olds.

Research findings from many studies both in Australia[36] [37] and internationally consistently report that care leavers are one of the most vulnerable and disadvantaged social groups.

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[36] Cashmore and Paxman (1996) p1

[37] Cashmore and Paxman (2006) pp 232-241

St Aemilian-Lakeside has embraced the needs of this group and developed programs that continue to care for this group. The young people are supported financially, accommodated and supported emotionally. With their basic needs met and a relationally enriched casework system, young people's lives are enhanced as they able to concentrate on further education and vocational training.

It is the staff who are heart of this program. Deeply committed to the young people they are working with, they are their caseworkers, advocates and champions. There are moderate rules for young people to stay in the program. Young people are cared for, looked after and really have a chance to do well as care leavers.

The Provider:

Mount St Vincent Home

Mount St Vincent Home is another agency steeped in the history of caring for children. The Sisters of Charity of Leavenworth started delivering services to the needy in 1883. The organisational journey is mapped on the walls of the hallway in the main building. Initially an orphanage, today Mount St Vincent Homes is a provider of therapeutic programs.

Intervention starts early, and alongside the therapeutic residential services sits a therapeutic preschool. With low teacher to child ratios, specialising in young children with emotional and behavioural problems, the preschool works closely with families.

The residential treatment program is delivered in 3 cottages of 12 children. Children are aged between 5 and 13. The cottages are staffed at 1:4 staff to children, with waking night shifts. Each cottage has an assigned therapist for the program and each child also has an assigned therapist. The therapy team reports to the clinical director. The therapy team is multidisciplinary and structured to deliver therapy to children through the milieu and individually as needed.

The Mount St Vincent Therapy Team is highly creative and has developed a program that specifically compliments NMT. The team is in the process of developing a resource manual of child appropriate activities as interventions.

The program has developed strategies specifically to help a child transition form one activity to another, a difficult task for this target group.

There is a consultant Psychiatrist on staff who continues to review children during the course of their stay.

Children in residence attend the Sister Daniel Stefani School, a purpose built facility catering to the needs of the children in care as well as local children with emotional and behavioural health needs. The school is staffed with teachers and mental health workers.

Every child in the residential program attends school full time and children are not excluded on the basis of behaviour. An additional classroom (Room 9) enables a child to come out of class and be managed still in the school environment. They, other students and staff are kept safe.

The program is staff secure and there are provisions for restrictions through restraint and the use of a quiet room.

There agency describes itself as family respectful, and fiercely protective of children. Children are at the centre of staff's work. The agency supports families and children without being a substitute for families, valuing relationships that promote the values of 'dignity, humour, individual responsibility, justice, learning, personal safety, respect, sense of community and spiritual growth'.

The agency values were clear to see in the work of the staff and the sense of community embedded in the service.

The Model - Sanctuary®

The Sanctuary® Model[38], developed over 20 years does not profess to be an intervention model. It was born out of an inpatient unit established by Dr Sandra Bloom. Now it has widespread application across the human services sector internationally.

The model is about organisational culture.

The Sanctuary Institute teaches that "a trauma-informed organization is one that recognizes the inherent vulnerability of all human beings to the effects of trauma and organizes system-wide interventions aimed at mitigating the negative effects of adversity and stress that are manifested in the clients served and the organization itself"

There are 3 main components to the Model.

1. The theory – Sanctuary has drawn on a number of theories including trauma, systems and business. In understanding trauma there is scope to consider the impact of trauma on organisations and how that influences organisational systems, behaviour and culture. To this end there are 7 Sanctuary commitments for organisations a) Nonviolence b) emotional intelligence c) inquiry and social learning d) shared governance e) open communication f) social responsibility and g) growth and change.

2. A shared language is used so that people from different disciplines can be sure they are meaning the same thing. A framework for treatment planning and intervention has been developed and is described under the following areas; Safety, Emotion management, Loss and Future

3. The tools are a practical set of interventions and include community meetings, safety plans, conferencing, team meetings, self care and SELF psych-education

[38] Bloom (2005)

The Provider:
The Andrus Centre

The Andrus Centre provides both campus and community based programs. A provider of a large residential treatment centre, providing care to 70 children, care is provided in large homes on a campus setting. The homes are set on beautiful grounds on a 110 acre campus.

The children are between the ages of 5 and 14 and come with problems associated with trauma and developmental problems including autism.

The children are cared for in the milieu, by a multidisciplinary staff team. The Orchard School provides education in a therapeutic environment and is for children in residence as well as children in the community.

The campus provides a diversity of programs with therapeutic benefit. During my visit at the Andrus Centre I had the opportunity to participate in various activities in the program. I spent time with the children and staff, sat in class, joined in an amazing gardening program and attended a team meeting. I was aware of a child having an incident.

The Sanctuary Model is a way of being.

Banks and Vargas (2009)[39] undertook a study on the effectiveness of the Sanctuary® Model at the Andrus Centre found qualitative improvements in treatment outcomes, staff satisfaction and a significant reduction in client incidents, and the use of restraint.

The Model - Circle of Courage

The Circle of Courage[40] is a model of positive youth development. Enshrined in the philosophy of the Native American of child rearing combined with contemporary resilience research, the model is symbolised by a circle - a medicine wheel, and articulates the universal growth needs of children as belonging, mastery, independence and generosity.

[39] Banks and Vargas (2009)
[40] Brendtro, L. Brokenleg, M., Van Bockern, S. (1990)

The Provider:
Reclaiming Youth International

Reclaiming Youth International (RYI)[41] was founded by Larry Brendtro.

Reclaiming Youth International is dedicated to the dissemination of policy, training, research, programs and strategies to better serve the children and youth who may be in conflict within families, school and community. It is through this training that agencies adopt the model of care. There are now agencies all over the world using this model.

Many different agencies have embraced the philosophy – regular and special purpose schools, welfare agencies working with youth, health facilities, residential programs and juvenile justice programs

There is an international movement of services who have signed up the Circle of Courage Model and implement it in their agencies. Given the model promotes strengths and wellbeing, its applicability in every day settings is its magic. It is not a model just targeted to treating trauma. The model can be used to assist a child's development. Children do not need to fail their way into receiving its benefits.

With this model and in combination with the "tools" Reclaiming Youth agencies working directly with children and young people have targeted their services to better meet the needs of individual children and their families.

<u>Deep Brain Leaning</u>

This training focuses on the recent science of brain development and how this relates specifically to the developing child and adolescent.

The Developmental Audit Training is strengths based approach to assessment and information gathering, recognising the child/young person as the primary source of information.

Through the gathering of data, engagement with the child is achieved, and it is possible to begin to understand how did the child get to where they are.

The Audit can be used as a stand-alone assessment or in conjunction with other diagnostic and assessment tools.

<u>Response Ability Pathways</u>

RAP training provides staff with strength-based strategies to work directly with children and young people. Children and youth need supportive adults who respond to their needs rather than react to their problems.

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[41] http://www.reclaiming.com/content/

Reclaiming Youth Conference

The Reclaiming Youth Conference in South Dakota provided a forum for people to showcase the work they do in responding to children and young people in need. The conference brought together a group of practitioners who shared their collective wisdom with delegates from across the world.

Presenters from a wide range of backgrounds were able to show case how the Circle of Courage model has influenced thinking and practice.

Conference highlights included:

- Dr Larry Brendtro, the founder of the Circle of Courage Institute who delivered a plenary on resilience,
- Dr Martin Brokenleg, VP of Reclaiming Youth International who gave an overview on actioning the Circle of Courage.
- Sarah Drennan and Steve van Bockern on searching for truth using the Developmental Audit,
- Dr Robert Foltz on a study of 50 adolescents and their experiences in residential treatment,
- Judge Ernestine Gray on mending Broken Circles,
- Azim Khamisa, who established the Tariq Khamisa Foundation in response to the murder of his son in the 1990s was very inspirational, and
- Reggie Newkirk on healing the effects of racism and community building.

The conference program provided me with an opportunity to understand how the philosophy of the Circle of Courage can be taken and applied across various and different settings. It is not in conflict with any discipline or sector- legal, health, education or welfare.

The Model - Multi Systemic Therapy

Multi-systemic therapy (MST)[42] is an intensive family and community based treatment program designed to make positive changes in the various social systems (home, school, community, peer relations) where a child's stability may be at risk. The program uses a strength-based model that recognises the positive existing elements of a family's life, and combines these strengths with the areas for change.

MST programs have an extremely strong commitment to removing barriers to service access. MST services are more intensive than traditional family therapies (e.g., several hours of treatment per week vs. 50 minutes).

[42] Henggeler, S, W, Melton, G., B., & Smith, L, A. (1992)

The Provider:
The Children's Village

Since 1851, the mission of The Children's Village has been "to work in partnership with families to help society's most vulnerable children so that they become educationally proficient, economically productive and socially responsible members of their communities"

The Children's Village is currently the largest provider of MST services in the New York area, serving youth and their families in the Bronx, Manhattan, Queens, Brooklyn, and Staten Island as well as in Westchester, Nassau and Suffolk Counties. CV is also the sole provider state-wide of MST Services for New York State's Office of Children and Family Services.

MST-trained clinical therapists visit families in their homes two to three times each week over a 2 to 5month period. There is an intensive level of support initially with a planned reduction over time.

The MST staff carry caseloads of four to six families per therapist/clinician. Work is focussed on developing an enduring system of support.

Flexible schedules are set to accommodate family needs. In addition to regular MST clinical therapist visits, on-call services are available 24/7, addressing crisis needs as well as monitoring daily progress.

Children who can't be at home are cared for in one of the other program areas. The campus is spread over 150 acres.

Children may be in residential treatment, day treatment or Foster Care. Residential programs at The Children's Village are short to long term. The residential programs cater for children and young people 6 -20 years of age.

The program runs as a residential school. Children live on campus and attend the school. The program is strong on teaching pro-social behaviour. There is a strong commitment to education and providing opportunities that will lead to employment. There is always a future in sight. The school, Greenburgh Eleven, covers all ages and grades. Classroom sizes vary from 6-12 students.

A special program specifically for boys with serious emotional problems operates form the same campus. Brooks Cottage cares for up to 14 and serves boys aged between 12 and 15. This program has enhanced clinical services attached. The Office of Mental Health approves placement into this program.

The Louis Jackson Crisis Residence is a therapeutic residential unit that provides short-term care for children and youth as an alternative to admission to a psychiatric unit.

Some programs are staff secure. There is the provision in one unit for time delayed door opening, a strategy that has provided the young person time to consider what is happening and receive support from staff.

The length of stay in the residential programs varies according to the children's needs and the program to which they are referred. Children who are unable to return to family are referred internally for foster care and/or adoption. There is an emphasis on recruitment from the areas of New York that the children came from so they can be returned to community.

The Village is strongly committed to the following four areas: education, work, lifelong relationships and social responsibility. Expectations of students are high, and this is a noticeable program quality. The stories of children's and young people's success resonate throughout the service.

The Model - Secure Care

Different States across Australia have different approaches to the delivery of services to those children in out of home care whose behaviour places them at risk of childhood death.

Most States have developed or are developing secure short stay units. Victoria has operated 2 units for about 10 years, Western Australia has opened a unit as part of a redesigned service system, and the Northern Territory is aiming to establish this service in 2012. New South Wales has a therapeutic secure program with a medium term length of stay (12-18 months). There are differences in legislation and policy.

The United Kingdom has had a lengthy history in providing secure accommodation. I wanted to lean more about that service system to see how their experience could help inform practice here and particularly in New South Wales. I visited Scotland and England. There are differences between their systems too.

A significant difference between the system in Australia and that of the United Kingdom is that a number of secure children's homes in the UK take children on both welfare grounds and criminal grounds. Children in these centres are placed and cared for together.

Scotland

Children who have been found to be a significant danger to themselves or others in the community are placed in Secure Care. The goal of secure accommodation is intervention that reduces the child's risk to themselves and to other people. Young people over the age of 16 years may be placed in a Young Offenders Institution.

Secure Accommodation is provided in Scotland under the provisions of the Secure Accommodation (Scotland) Regulations 1996.

A child may be placed in secure accommodation under a supervision requirement made by a children's hearing, by the court in certain circumstances under the Criminal Procedure (Scotland) Act 1995 or the chief social work officer can authorise a placement in secure accommodation with the agreement of the person in charge of the establishment.

Secure accommodation is residential care from which they can not leave. In Scotland secure care is considered an essential part of the service system. It is also recognised that it should only be used when all other options have been explored.

A child may be placed into a secure accommodation facility for a maximum period of seventy-two hours (excluding Sundays and public holidays) under the Act or the Criminal Procedure (Scotland) Act 1995 without the authority of a children's hearing or a sheriff.

The grounds (legal reasons) for bringing a child or young person before a hearing are set down in section 52(2) of the Children (Scotland) Act 1995 and include that the child:

- is beyond the control of parents or carers
- is at risk of moral danger
- is or has been the victim of an offence, including physical injury or sexual abuse
- is likely to suffer serious harm to health or development through lack of care
- is misusing drugs, alcohol or solvents
- has committed an offence
- is not attending school regularly without a reasonable excuse
- is subject to an antisocial behaviour order and the Sheriff requires the case to be referred to a children's hearing.

Children under 16 are only considered for prosecution in court for serious offences such as murder, assault which puts a life in danger or certain road traffic offences.

Where the child or young person is prosecuted in court, the court may, and in some cases must, refer the case to a hearing for advice on the best way of dealing with the child. The court, when it considers that advice, may also refer the case back to a hearing for a decision.

The Children's Hearing System is administered through the Scottish Children's Reported Administration. Children and young people who commit offences or those with welfare and protection needs appear before a Children's Hearing.

Scotland's children's Hearing system relies on the involvement of around 2,500 people from all walks of life, who give their time and commitment voluntarily to train and serve as children's panel members. Panel members are selected and trained to sit on children's hearings in their own local authority area. At each hearing, panel members work with the child, parents or carers and professionals to make decisions which are in the best interests of the child.

In Scotland the providers are non-government agencies.

England

In England there are 3 systems of custody for children and young people who commit offences. These are Young Offender Institutions; Secure Training Centres and secure accommodation in Secure Children's Homes. Where children are placed in custody will depend on their age, gender, and individual needs.

Young offender institutions are run by the Prison Service and by private companies. They hold 15 to 21-year-olds, but those under 18 are held in different buildings from those over 18. Some share a site with an adult prison, and some are stand-alone.

They vary in size, some holding around 60 people while others house more than 400. However, most of them are big places, split into 'wings' that hold between 30 and 60 young people. Children receive up to 25 hours of education, skills and other activities every week, which include programs looking at improving behaviour. The staff to child ratio is about 1:10.

Secure Training Centers hold young people up to the age of 17, and are run by private companies. They hold between 50 and 80 young people, and are split into units. Each unit has between five and eight people in it.

Children in secure training centers receive up to 30 hours of education and training every week. Staff to children ratios is around 3:8. An individual will get more individual support in a secure training centre than a young offender institution, as generally there will be three members of staff for every eight young people.

Secure children's homes are for the youngest offenders (aged between ten and 14), those who may have been in care or have mental health problems and those deemed vulnerable. They are run by local councils.

There are schools attached. They vary in size between eight and 40 people. Staff to children ratio is around 1: 2.

Secure accommodation in Children's Homes means accommodation which is provided for the purpose of restricting the liberty of children.

As well, children in England are placed in secure children's homes under Section 25, Children Act 1989 and the provisions of the Children (Secure Accommodation) Regulations 1991.

The Local Authority must be able to demonstrate that:

- S/he has a history of absconding and is likely to abscond from any other description of accommodation AND
- If s/he absconds s/he is likely to suffer significant harm OR
- If s/he is kept in any other description of accommodation s/he is likely to injure her/himself or other persons.

A child under the age of 13 years shall not be placed in secure accommodation in a children's home without the prior approval of the Secretary of State.

The maximum period beyond which a child to whom section 25 of the Act applies may not be kept in secure accommodation without the authority of a court is 72 in any period of 28 consecutive days.

The maximum period for which a court may authorise a child to whom section 25 of the Act applies to be kept in secure accommodation is three months.

The court can authorise an extension for a further period not exceeding six months at any one time.

The Local Authority must also conduct a Secure Accommodation Review within 28 days of the young person being placed and thereafter at 3 monthly intervals. A minimum of three people are appointed to the review panel, at least one of which should be independent of the Local Authority and none should be from the Local Authority managing the Secure Unit.

The role of the panel is to consider if the reasons for placing the young person in secure accommodation still apply, and that the placement is still necessary. If the young person has been placed in secure accommodation on criminal grounds, the panel will also consider pending bail applications and any other relevant issues related to the young person's placement, care, legal status, and individual needs including the arrangements for family and legal visits[43].

The issue of placing children on criminal grounds and children on welfare grounds was discussed often during my visits. There are 2 distinct views. One is that they shouldn't be placed together; the other is that the two groups are very similar in terms of what has happened to bring them to where they are and therefore placing them together is not a problem.

The challenge of having the children placed together is that the facilities have to meet the security standards of a detention/custodial centre to ensure the compliance of those children who are placed because of criminal charges. The new build facilities offer a very high quality environment but they are clearly highly secure. There are central monitoring hubs, restricted access zones, high tech CCTV camera systems, duress alarms and video recording, while attractively appointed bedrooms have been carefully designed with no hanging points, modulated furniture and sensor controlled en-suite facilities. Children are locked in their rooms overnight. There are state-of the art educational and recreational facilities. The new build agencies with improved facilities advised that children's behaviour had responded positively to a better physical environment.

Agencies that provide services to both groups of children are generally funded recurrently for the custodial beds. When children are placed on welfare grounds their placement is purchased by the local authority. The agencies access clinical and health services through different means, according to their local authority.

I visited 4 agencies. The services they provide are similar, the variations being driven by their size and therefore their funding levels, as well as the quality of their facilities. Larger agencies have more scope because of the economies of scale. Newer builds have better facilities. These two things however do not drive culture

[43] Bedford County Council (2006)

and commitment and the 4 agencies I visited all stood out as being highly committed to the most vulnerable children in the care system. The leaders in these agencies are passionate about their work.

The provision of education services to children in these settings far exceeds what they have access to when in community behaving unsafely.

There were similarities amongst the agencies of issues raised. These included:

- Placement distance from family
- Length of stay for children placed on welfare grounds can be vulnerable to funding availability
- Extending a child's stay who has settled in response to the safety and containment of the placement but whose needs are long term
- Exit options that are suitable for very high needs children and young people, unless the agencies themselves have placement options, and
- That family work remains with the local authority, and this is not integrated into the program

Recent policy changes in Scotland have required single gender units to become mixed.

In England Secure Children's Homes are operated by the local councils.

The Provider:
The Kibble Education and Care Centre

The Safe Centre at Kibble Education and Care Centre has capacity for 18 children and young people.

The Safe Centre is part of a suite of services provided by the Kibble Education and Care Centre. This and the other services that the agency provides places its secure accommodation within the context of a continuum of service options to be able to meet the child's needs at the right time. If supported by the child's local authority they can offer an alternative placement to the child on exiting secure care. The range of options is significant. The agency embraces the Scottish Policy "Getting it Right for Every Child" by its capacity to respond to changing needs.

The residential program which shares the same campus has a village feel. The houses are set around a green. The unit use is flexible according to the needs of the children in program. The level of support varies from intensive to low.

Children in residence attend the on site school.

Kibble's Day Services provide the support needed to maintain educational placements for young people who live at home or in local authority care.

The Foster Care program has been mentioned already in this report.

In addition to home and school, Kibble Works is based in local business parks close to the main Kibble campus. Kibble Works operates 16 social enterprises which offer skill building opportunities, professional training and employment for young people in residence and care leavers.

Kibble Works Uses a traditional pre-apprenticeship model to support young people who have a range of social, emotional, behavioural and educational difficulties. The staff are qualified in their own areas of expertise and many also have child and youth care qualifications. There are placement and training opportunities in furniture removal, office works, metal work, horticulture, car mechanics, tiling, fork lift driving, design and production, framing, lawn mowing and catering. Trainees are paid for their hours worked.

Jim Mullen who heads this program area and the staff that work alongside him are giving young people the opportunity to succeed into adulthood. Young people with very high needs are engaged in this program.

They are very future focused. The program has recently expanded to provide training and employment opportunities to the 18-24 year olds.

The Provider:

The Good Shepherd Centre

The Good Shepherd Centre can cater for 18 children and young people in secure care and 6 children in a close support unit. The home has traditionally provided for girls and is now accepting referrals for boys.

In keeping with Scotland's welfare approach to children and young people who have committed offences, the Good Shepherd Centre is firmly connected to the local community.

The unit was purpose designed and built. The facilities are of very high quality.

Young people are involved in the pupil council and have supported the centre to achieve an Eco-Schools Scotland award. There is high value placed on creativity and the young people are provided with a wide range of introductory courses and work experience placements, including excellent in-house hair and beauty courses and film making in creative digital media, in partnership with BBC Scotland. Young people value highly the extensive range of therapeutic programmes within the curriculum and view them as life changing.

HM Inspectorate of Education (HMIE) and the Care Commission inspect schools and in March 2011 found the Good Shepherd to school to be good, very good and excellent in the inspected areas. This means the school is regarded as having major strengths and to be sector-leading.

The Good Shepherd Centre is a non-government provider. There is a long history of care provision and the services have now specialised to the target group of very high needs young people.

There is strength in across-discipline team work.

In response to the difficulties of transitioning children from secure care, the Good Shepherd Centre has opened a step-down group home. The group home is on the same campus. Staff report that children exiting this way are supported through relationships they have made at the Centre.

The Provider:

Aycliffe Secure Centre

The Aycliffe Secure Centre can cater for 42 children and young people. I am grateful to the staff for accommodating my visit given they had just moved into their new promises that week. The Centre is operated by Durham County Council.

The Centre was opening section by section. At full capacity it will have four homes accommodating eight young people, a specialist needs unit with integrated medical/detoxification facilities and two leaving care homes each accommodating two young people. The homes are all under the one roof.

Aycliffe is the newest built centre in the United Kingdom and has benefitted from the secure accommodation building program of the last 5 years. Everything is purpose designed. The facilities are exceptional.

High quality vocational resources include courses in motor vehicle maintenance, construction skills, horticulture, health and beauty, IT skills, food technology, music technology, the performing arts, the plastic arts, and retail skills through a cyber-cafe and retail outlet.

The yung people's involvement in decisions that affect them is evident through multiple processes including student councils, a magazine produced by them and various panels.

There is a strong relationship with local mental health services and an array of programs including:

- Violence is not the Only Choice (VINTOC)
- Offending is not the Only Choice (OINTOC)
- the ROSS Program (pro-social skills)
- anger management
- substance use
- sexual health
- Motivation for Change
- knife crime
- victim empathy program: and

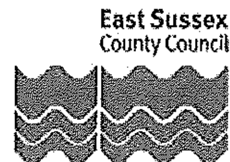
- self-esteem and diversity programs.

The Centre uses the Individual Behaviour for Life (B4L) program.

The facilities at the Aycliffe Secure Centre and the commitment of the leadership combine to create an exciting development in the delivery of these specialist services.

The Provider:

Lansdowne Secure Children's Home



This service is different in many ways. It is small with just 5 beds, it caters for children placed on welfare grounds only and the program operates from a home that was not built for the purpose.

It is uniquely placed in the system, providing a small homelike program with the safety of a secure accommodation. It is an important component in the range of accommodation services of East Sussex Children's Services Department providing services to young people and families across the county.

The unit staff, under the leadership of Martin Sutcliffe, value clear planning, appropriate interventions, evaluation and the resulting positive outcomes for children in their care.

There is a minimum of 4 staff available at any time in the program.

The health of a young person is considered of paramount importance and to support this, the services of a Consultant Child and Adolescent Psychiatrist, Clinical Nurse Specialist (LAC) and local health centre are available to the unit.

There is access to dietetics and drug and alcohol services. A psychologist attends the program weekly.

Young people placed at Lansdowne are engaged in full time education. Children have an Individual Education Plan. There are 2 teachers working 3 days each and a teaching assistant.

The agency recognises that some children's needs are so high that they will need long term therapeutic care. The court has approved some children staying for up to 9 months. Anecdotally, staff report that it is the younger children who reap the greatest benefit of a longer stay.

The program works on a safety based system geared towards "mobility" (leaving the unit and spending time in community). When children are of a suitable age and capacity to have free time in the community, there have been few incidents of absconding. This indicates that the children are positively engaged with the program. Children who have left the program continue to be in touch.

E. INDEPENDENT LIVING

The Provider:
London Care Solutions

It was by chance that I came across London Care Solutions, and my visit was brief.

Remarkably, at the time of visit the agency was supporting 94 young people aged 16 years and over in semi-independent living arrangements.

The reason the young people were mostly living alone was because their behaviour made sharing with others difficult. The young people were mostly exiting from juvenile detention settings and considered hard to place.

Many agencies struggle to provide semi-independent or supported independent living to this group of young people, however this agency, (and St Aemilian-Lakeside, referred to earlier in this report) are doing it.

There are 22 staff providing support in the program, with overnight support available through and on call system. In addition to the youth work staff there are 2 social workers.

Young people entering the program enter into an individual contract with the agency. The contracts are individualized so that they can be tailored to the young person's ability. Expectations and agreements are written with the intention of being successful.

The program has experience in supporting young people who have left street gangs. There are 2 people working in the program who have spent time in prison and they work to divert young people from offending and detention.

There is a strong affiliation with a pupil referral unit so that young people in the program can remain in school when they would be otherwise excluded.

The program rents the properties where young people live and has a maintenance team for repairs.

Discussion

This report is a summary of the commitment of good people working with a group of children and young people who need good people more than anything else.

The report makes reference to the literature and describes a complex and diverse array of services which work to meet the needs of children and young people with complex needs and their families.

1. Service review

Across both the United States and United Kingdom there are strong systems for program evaluation and continuous improvement. This extends from the broad program level down to monitoring and quality assurance at individual residential units and service outlets. There would be value in further exploration of these systems.

2. Funding

Funding systems and purchasing processes in the United States and United Kingdom operate differently but there is a high emphasis on value for money which focuses service providers on delivering competitive, goal and outcome oriented services.

3. Therapeutic Residential Care

Trauma informed therapeutic care will heal children whose development has been impacted by abuse and neglect. As the field of epigenetics advances, we will likely understand better how to respond to families in distress.

Therapeutic Residential Care is new in the Australian care system, however there has been a growing acceptance of residential care as a legitimate service option within the continuum of Out of Home care services.[44]

In 2009 a working group with across jurisdiction representation was established to define therapeutic residential care.

In 2010 Victoria hosted the inaugural Workshop on Therapeutic Residential Care. There was overwhelming interest from across Australia. In 2011 a National definition of therapeutic residential care was developed by the National Therapeutic Care Workshop.[45]

Each Australian State is working towards the provision of therapeutic residential care. Some States are further advanced than others.

There is now opportunity to further develop the service system to enhance the effectiveness of residential care and ensure the definition is taken into practice.

[44] Bath, (2008b), McClean, Price-Robertson and Robinson (2011)
[45] McClean, Price-Robertson and Robinson (2011)

The services which I visited are providing therapeutic care across different settings, including residential homes. Some may be more advanced in their development than others, but the stated aims of each agency were clearly evident in practice. What senior staff described was what I observed as happening within the program.

Although there were differences in size, the array of service delivery and where those services were delivered, there were common program elements across the placed visited. These include:

- **An identified and lived organisational culture**

Staff spoke of and named the beliefs and values of the agency. These were evidenced throughout program operations including, but not limited to, client and staff relationships, staff communication and interaction, the management of the environment and reflective practice. Many of these agencies had long histories in service delivery spanning decades or more.

- **Organisational leadership**

There is no doubt in my mind that the agencies which I visited operate at a high calibre because of the people leading them. The senior staff, the leaders of these agencies demonstrated to me a deep commitment to making things better for children, an understanding of their own agency's strengths, a striving for excellence and an ability to work with others proactively and productively.

- **Safety**

Generally across the United States and United Kingdom there is an acceptance that children may need to have some restrictions placed on them in order to keep them safe.

- **Trauma informed**

The programs visited were all anchored in, and directed by, a thorough understanding of the neurological, biological, psychological and social effects of trauma.

- **Staff strong and relationally rich**

Staff are suitably qualified for the work undertaken, well trained and supported. There was strong evidence that staff are valued and contribute to the success of their programs.

- **Child and family centred**

Programs and facilities were age and developmentally appropriate in a number of agencies. There was also a strong focus for services working with families together to identify goals, and work together towards achieving better outcomes. Services support families to make decisions and help them develop their confidence and competence. Services were observed to share their knowledge with, and respect families.

- **The Milieu**

The congruence of the elements shape the milieu; programs can be developed to meet the needs of individuals, while still working within a group of children who have shared needs.

4. Secure Care

There are now secure care options in place or in development across the different Australian jurisdictions. In most part, these are or will be, short stay residential units addressing immediate safety and providing opportunities for assessment and planning.

In NSW there is a small program of secure therapeutic care with length of stay being 12 to 18 months. The level of containment is flexible to the needs of each individual young person in placement and reduces as the child learns to self regulate their behaviour.

Therapeutic residential settings with the capacity for containment can be the very best thing for some children; however the physical environment and the safety elements are only part of the equation. The quality and commitment of staff who lead and work there is the key to the program's success.

In NSW the authority to place a child or young person in therapeutic secure care rests with the Supreme Court under the Parens Patriae jurisdiction.

There is much thought given to requesting an Order in the Supreme Court to bring a child or young person into a care setting from which they are not free to leave. There is concern about depriving a young person of their liberties; however there is greater concern that they may not survive their childhood without this intervention.

My intent in visiting the secure care system in the United Kingdom was twofold: firstly to explore the services (in their philosophy, environment, programming and staffing) and secondly, to understand the legal framework under which secure care operates and consider its applicability to NSW.

I am not equipped to research and review areas of law, however I did have a preconceived idea that a review of the legislation and administrative decision making would be a possible option for those more expert than I to consider.

On later reflection upon my experiences in the UK, and my knowledge of other Australian jurisdictions, I have changed my mind. While the NSW approach of seeking an Order is very resource and time intensive, it has many features that appeal to me because the focus is clearly on the child in question.

In my opinion, the Supreme Court offers greater scope to ensure an independent and individual approach to each child's needs. This system is attractive in that it is not statutorily time limited, but is responsive to the progress and wellbeing of the individual child.

There is room to further explore the way that the legal system and the child welfare system work together to protect the most vulnerable children and young people in the care system.

Conclusions

Children who don't know how to attach, who harm themselves and hurt others are at very real risk of no one championing their care. The NSW system encourages high level commitment across various disciplines, making sure we get it as right as we possibly can.

Staff working with the highest end children and young people are extraordinary, and they, and those leading them, must believe in what they are doing and that they can make a difference.

Critical thinking and reflective practice are essential to the sustainability and development of such programs.

Our agency has the capacity and expertise to meet the needs of children with very complex needs. In NSW we have the benefit of strong relationships with other Government partners who share our passion and commitment to this group of children and young people.

Often in a system where there is a continuum of care models, the commitment to placing the child in the least restrictive arrangement means that they may not always enter a placement most suitable to their needs.

If we accept the evidence offered from research that residential care is a valid service option, then it should be the first and best placement choice for those children and young people when it will meet their assessed needs.

Children and young people are at the centre of my concern in this report. People working in this sector do so because they want to do their best for vulnerable children. We need to invest the resources available in services that will heal the challenges which these children and young people face, to build on their strengths and develop their resilience so that they can enter their adult years in the best way possible.

Recommendations

There is no one right way to deliver services to children and young people who have complex needs. I was privileged to see a wide range of services operating different therapeutic models and in different environments. These children and young people, like the systems which serve them, are not a homogenous group. Accordingly the recommendations I put forward are broad, and are as follows:

1. The individual child protection jurisdictions within Australia should continue to progress the work already started on developing and refining residential care, therapeutic residential care and secure care options.

2. There is no one right way to deliver these services, however it is very clear that jurisdictions/services need to be clear about their philosophy and know that this is 'lived out' in practice.

3. Agencies delivering therapeutic services must consider program evaluation as an essential part of their responsibility towards the children and families they service.

4. Australian service providers and statutory jurisdictions should continue to research what is happening elsewhere in the world and seek to emulate the best practice possible.

5. Australian policy makers should continue to refine their service systems and promote residential care, and in particular, therapeutic residential care services as legitimate service options appropriate as a first choice care option when appropriate to assessed need.

6. Secure therapeutic care needs to be considered within the context of a care continuum, and there may be reason to extend the type of secure accommodation options to include a service which offers short term care and assessment. The effectiveness of this model should be further explored with reference to existing practice in the United Kingdom.

7. There is a need to review policy and law on the application of restriction on younger children. I noted that across the agencies I visited there was a low level of children absconding from placement and procedures were in place to keep children safe by means of staff intervention.

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