The Winston Churchill Memorial Trust of Australia

Report by Lisa Hillan
2005 Churchill Fellow

RECLAIMING RESIDENTIAL CARE
A POSITIVE CHOICE FOR CHILDREN AND YOUNG PEOPLE IN CARE

An exploration of differing models and outcomes of residential care provision for young people, with an examination of the links to evidence and research in the design and evaluation of out of home care.

Signed…….. Dated…….

Acknowledgements

I would like to start by acknowledging the support of the Churchill trust that made this research possible. The helpfulness of the trust staff and their faith in my ability to undertake this work was a cornerstone in this paper being a reality. I was ever grateful for this opportunity and never lost sight of what a privilege it was.

I wish to acknowledge the enormous generosity of all the researchers, residential care providers, residential care staff and government staff that I spoke with on my journey (see appendix A). Their insight and often frank and reflective discussions helped me to shape my thinking in relation to this paper. Without their great dedication to providing excellent services to children and young people in care this paper would not exist. I hope it does justice to their work and amazing efforts, often in the face of great adversity, that they undertake daily to meet their commitments to children and young people.

I would also like to thank my colleagues at Save the Children, especially Lynn Thompson Executive Director Queensland office, who were ever supportive of my research and gave me the time to undertake this work. On top of this they gave unqualified support to me in the importance of this study.

I am grateful for my family and friends who were encouraging, supportive and whose care and belief in me sustained me now and always.

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Most importantly I would like to thank the children and young people whom I have had the privilege to care for and who I met in my travels, who shared their time and their home with me and generously at times insights into their own fears, hopes and dreams. I hope this report contributes something to their experience and to the experiences of children and young people to come.

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Executive Summary

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It would be fair to say that residential care is in a state of transition across the world, and in some jurisdictions it is in crisis. All countries are struggling to make sense of how to care for children and young people in care. The struggle of what types of care are most useful, cost affective and create difference are questions being asked across the world. The place of residential care in this system or continuum is consistently being re-evaluated.

The alternative care environment is one that is complicated across countries. There are many competing demands and social complexities to address. Across all jurisdictions there has been a significant increase in the use of drugs by parental households where abuse is present.

Many children and young people are being left in situations of significant distress for much longer. Many children then present with significant distress, trauma and mental health issues at very early ages. This cohort of children and young people is proving difficult to care for and difficult to provide stability for.

What is clear from this research is that all jurisdictions need a range of options in alternative care to best meet the needs of children and young people in care. Systems that have tried to exist without residential care have failed to provide stability and continuity for children and young people in care. Residential care can be a very positive and successful intervention for children and young people, what is needed to ensure this will be explored further in this paper.

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

I have called this paper reclaiming residential care because for all of its difficulties, negative outcomes and the concerns raised on this trip it is evident that we can not provide an appropriate alternative care system without residential care.

What is apparent is that we need to continue to strive to make residential care of the highest quality so that young people in care claim a life due them, not half a life or a good enough life but a life as active citizens of society with an ability to reach their full potential. The rest of this paper is dedicated to assisting us to understand how best to provide residential care based on practice, research and evaluation.

Highlights:

- **Scottish Institute for Residential Child Care – a dedicated centre of learning, training and research into residential care**
- **Kibble Residential School, Glasgow Scotland and Maples Adolescent Centre Vancouver and getting a number of days exploring models and seeing programs in action**
- **Meeting Dr James Anglin Victoria University, Canada and getting to spend time with him understanding the importance and place of residential care for children and young people**
- **Northwestern University Chicago and the Institute for Juvenile research and their evaluation framework and methodology for residential care**
- **Chapin Hall and talking with staff about research and the place of research in assisting children and young people in care**
- **Andrus Children's Centre in New York and getting to see the Sanctuary model of care in action – getting time to spend with children and young people.**

Implementation and Dissemination

- **The information and insights gained will be used by Save the Children to shape their own residential care services**
- **The paper will be sent to all participants in this study tour internationally**
- **Presentations will be conducted for Government and Non-government service providers in Queensland**
- **Papers will be written for journals relevant to the sector**
- **Conference presentations are to be given and papers submitted across Australia**
- **The paper will be distributed to Peak Bodies of the Non-Government sector for distribution to their members**

Recommendations

1. *Residential care can provide a significant intervention and a quality care environment. As Skinner (1992) concludes residential care should be embraced as a positive option for young people in meeting their needs, not simply as a last resort. Placement in residential care should be a mindful process. States in Australia must examine their practice and policy in this area and look to examine their relationship to needs based planning, this requires attention to the following two points.*

2. *Systems need to define the types of residential care required and work to develop a system of residential care options that matches the needs of*

children and young people within a range of out of home care and support options.

3. *Children and young people entering residential care should have their needs identified to match the level of intensity of the service they require to meet those needs and should have available options that do not lead them to be in services that are either over-restrictive or under capacity to meet their needs.*

4. *That Australia contracts and enables the use of universities, research centres and partnerships with providers to establish evaluation models and methods in the residential care sector that allow for rigorous assessment of the functioning of residential care models and the capacity of their interventions to affect change*

5. *That any evaluation methodology designed incorporates the views and experiences of young people who have resided and continue to reside in residential care.*

6. *Outcomes of evaluation should be incorporated into ongoing professional development across the sector, not just individual programs, to provide opportunity for continuous improvement and a focus on what works and what does not thus ensuring high quality care environments for children and young people.*

7. *That children and young people entering residential care should have basic psychological assessments undertaken including an assessment of their learning needs to ensure that an adequate care plan and intervention is designed to meet their needs.*

8. *That processes are undertaken to ongoingly review assessments ensuring that staff are using the information in the ongoing care they are providing.*

9. *That Residential care systems have access to therapy and therapeutic consultancy to assist staff to better plan interventions and assist children and young people develop the skills to allow them a better life within our society.*

10. *That family work/family therapy is incorporated into residential care models to ensure that the whole needs of children and young people are met and that children and young people are enabled to reconnect with family and kinship systems that will be important to them on leaving care.*

11. *There needs to be a renewed focus on the needs of older young people in this age range with further model development undertaken to better ensure positive options for young people leaving care.*

12. *Continued higher levels of care should be available for this group if needed with specialist support offered.*

13. *An independent living skills program needs development in all residential care facilities to ensure that young people leave with appropriate skills that equip them to live independently into the future.*

14. *That models are developed in residential care that make use of the relationships established with children and young people and to use these relationships thoughtfully to assist them transition to new care environments.*

15. *That children and young people are enabled to make use of the residential care relationships they have established for a period of time post the residential care experience to ensure that they have a sense of connectedness and value.*

16. *There is a need to develop a range of strategies in response to the needs of children and young people who are at significant risk of harm to themselves or to others.*

17. *Any model development in relation to young people at significant risk needs to consider the interface between other service systems, including substance abuse and treatment services, mental health, homelessness and youth justice.*

18. *There is a need to consider what role, if any, secure care may have in the range of responses based on thorough review of policy, practice and research in Australia and overseas and debate of the outcomes of this review.*

19. *Minimum standards for training of Residential care staff should be developed within Australia.*

20. *Any training developed should incorporate an emphasis on mental health, attachment, trauma, life span development and loss and grief.*

21. *All training should have a focus on assisting residential carers to develop personal reflective skills.*

22. *All States in Australia should have clear policy development about restraint and its place in caring for children and young people in care – this should include parameters and approved restraint practice within an overall framework of therapeutic care.*

23. *Significant training of residential carers must be undertaken in the use of restraint and restraint should only be practiced within the context of therapeutic care with a well developed therapeutic intervention model that ensures restraint is only ever a last resort.*

24. *All residential care providers need identified policy provision about restraint and a demonstrated capacity to monitor its use and develop alternatives that honour children and young people's experience.*

25. Models of care should be developed in all states in Australia that provide specialised care for children and young people who exhibit highly complex behaviours.

26. Service delivery models within mental health systems in Australia need further development to provide services to residential care providers and recognise the significant place of residential care in providing care for young people with mental health issues. This includes greater respect and acknowledgement of residential services place within the mental health system.

27. That trauma theory and practice is incorporated in all residential care staff training and that staff are provided practical measures to respond to pain based behaviour in young people.

28. That responding to trauma and pain based behaviour is a central part of all models of residential care.

29. That children and young are provided opportunities and information to understand the impact of trauma on themselves and others so to be provided with an opportunity for change.

30. As Skinner noted the "key to good quality care is the calibre and effectiveness of staff". Residential care staff need to be valued by the system they belong to and remuneration levels need to be assessed against the care they are required to provide.

31. Staffing levels of residential care facilities needs to be adequate to provide safe care for children, young people and staff. Staffing models should be mapped against the types of care environments being provided and the levels needed to provide quality outcomes for children and young people.

32. Further research into residential care should incorporate some study of the impact of the environment and space so that greater emphasis can be placed on this area.

Introduction

It would be fair to say that residential care is in a state of transition across the world, and in some jurisdictions it is in crisis. All countries are struggling to make sense of how to care for children and young people in care. The struggle of what types of care are most useful, cost affective and create difference are questions being asked across the world. The place of residential care in this system or continuum is consistently being re-evaluated.

As Bloom (2005) points out "residential care has long been a subject of concern related to: criteria for admission; inconsistency of community based treatment; the costliness of such services; the risks of treatment, including failure to learn behaviour needed in the community; the possibility of trauma associated with separation from family; difficulty re-entering family or abandonment by family; victimisation by staff; and learning of anti-social or bizarre behaviour from intensive exposure to other children."

Almost all countries visited during this research recognised that often children and young people were coming into care later, after experiencing significant abuse and chronic neglect and that this was creating a range of children and young people who are exhibiting more complex behaviours and trauma as a result. This cohort of children and young people is proving difficult to care for and difficult to provide stability for.

Further to this foster care is also in a state of transition. Carers are increasingly difficult to attract. Carers need to work to live and this means that many carers are now not undertaking foster care unless a living wage can be provided. This has its own budgetary implications and what was once a cheaper option in caring for children is now beginning to have its own drain on budgets for governments across the world. Coupled with this duet to the complexity of the needs of a range of children and young people in care, many are not able to be sustained in foster care.

Questions still need to be asked is being in care the best place for children and young people? Is the State able to provide a good enough parenting experience? It is clear that we should be looking towards supporting more parents to care for their children and intervening earlier in the difficulties. Often in Chicago, people spoke about doing only the bare minimum required to support families at each stage of intervention. It must be queried that if we provided greater services at the first point of contact with families within the child protection system then we may prevent a large range of children and young people ever entering the system. What this system should look like needs further exploration but is not the purpose of this paper.

However, regardless of how good the early intervention system is, there will always be a number of children and young people that will not be safe within their family and will have to be cared for by the state in the long term.

Governments everywhere are often struggling to understand how they wish to provide care for the children and young people in their care. They are often unclear about the types of outcomes that they wish to see for children in their care. Many decisions are being budgetary or politically driven, i.e. to satisfy communities that a significant problem is being addressed. Coupled with this, the fragmentation in the systems between mental health, education and care are creating significant difficulties for children, young people and their families in having their needs met.

Whilst all governments have started to talk about evidence based practice there is still a lot of lack in clarity about what they mean by this. Often this is vaguely mentioned in rhetoric with limited clarification of its purpose, or how evidence will be collected.

It is clear that outcomes for children and young people that live in residential care continue to be poor. The Chapin Hall study of 2004 found in Illinois that over 40%of young people leaving residential care between 1995-2002 had a negative outcome (detention, juvenile corrections or hospitalisation) of those who went to foster care or home 30% returned to higher levels of care.

However, it is difficult to determine what the causes of this are. If a unique group of children and young people are only going into residential care, and as many people spoke of, failing their way into residential care, then is residential care to blame for the poor outcomes. Many young people are going to residential care because something else did not work out for them. As Wulczyn (2006) rightly pointed out are they doing better in residential care than they would have otherwise. What is obvious is that we do not know a lot about what makes the difference.

This paper hopes to identify a number of things:

1. What is residential care and its place in the care system for children and young people
2. What elements are required for it to do well and meet the needs of children and young people
3. What examples of best practice are evident
4. Where is the place of evaluation and research and how does one inform the other
5. What gaps exist and what areas should we concentrate on into the future.

I make one observation about this paper; I am a practitioner at heart and not an academic, so this paper is written from the view of a practitioner. I have had the privilege to work alongside many staff and therapists in the delivery of residential care over the years and it is from the heart of this experience that I write this paper.

To undertake research from this perspective brings its own challenges, requiring you to divorce yourself from your own practice and to acknowledge the deficits in this.

This journey has been a difficult one and at times raised more questions than answers, but being freed from my own context and responsibilities allowed me an opportunity to view more clearly the place of residential care within a system that cares for children and young people. This paper reflects my own journey, questions, answers and opinions.

I have called this paper reclaiming residential care because for all of its difficulties, negative outcomes and the concerns raised on this trip it is evident that we can not provide an appropriate alternative care system without residential care, attempts to do so have failed children and young people. What is apparent is that we need to continue to strive to make residential care of the highest quality so that young people in care claim a life due them, not half a life or a good enough life but a life as active citizens of society with an ability to reach their full potential.

Definitions of Residential Care

Residential Treatment

Residential treatment whilst therapeutic in its milieu also tends to have a strong mental health component. Treatment is defined by a treatment plan and strongly based on a time limited definition that provides intervention strategies aimed at helping young people to achieve resolution of trauma and correct behaviour.

These establishments tend to be larger, (serving a population of up to 60 or more) whilst operating small units of young people grouped together in units of similar diagnosis or undertaking some matching formula for what works in being grouped together. There is often a residential school attached that also has therapists as a component.

It often has a strong diagnostic framework and at times, young people have to meet certain diagnostic criteria to receive a service. In the most part this service would have a strong sense of psychiatric service provision. In essence often these services are providing an ongoing mental health service for young people outside of a hospital system. Often children and young people that are in these services have been hospitalised on numerous occasions due to their mental health.

According to Anglin (2002, pg 17) Treatment consists of:

1. attempting to bring about directed change in a person or persons
2. through individualised attention
3. on the basis of a guiding theoretical framework and
4. a suitably comprehensive and in depth assessment of the situation.

Therapeutic Residential Care

Whilst this type of care could also be defined by its defined therapeutic milieu, it has less focus on psychiatric service provision. There is a well defined therapeutic intervention followed and therapists form part of the service provision that every child or young person receives. Therapists are an integral part of the care team and meet weekly with residential staff and education staff.

Therapy is incorporated in every context with residential carers often being called, residential therapists or professional parents. Therapy is broader with a suite of therapists on the team including psychologists, drama, art, play therapy offered. Whilst therapeutic residential care would be seen to be time limited it is often more open ended and tends to go for longer time frames than residential treatment.

Whilst assessment forms a strong part of the service provision, there may be less emphasis on a psychiatric condition.

Many of these services also have a school attached. Many children and young people leave therapeutic residential care to go into foster care, in some parts of the world they will leave here to go to independent living or return home to birth family or kinship care.

Small Group Homes

Small group homes are seen to operate in the community, have a small amount of children or young people accommodated (4-6) and have rostered staff.

They are seen to take less intense children and young people than the other models, many young people who are seen to “graduate” from the other two models to this model of care.

Whilst they may have a therapeutic design, therapists are not seen to play as an essential role, although involved. Mostly they do not have an attached school, young people attend more services within their community.

Mostly older young people are accommodated in these services and often young people will leave these services to go to independent living.

It is useful to start with definitions of residential care because it has significantly different elements. One of the things that became clear during the course of this research is that the variances of what was called residential care across the jurisdictions visited were significant. During this time I began to look at the differences between models and the place they had in caring and providing intervention for children and young people in care.

It became useful to deconstruct these models and to look at the benefits of each for children and young people. I have provided examples of these models in appendix B in more depth.

What did become clear is that many young people entering residential care did so with much cumulative trauma and as such often displaying significantly distressed behaviours characterised by extremes, poor ability to self-soothe and levels of distress that required intensive support, intervention and assistance. With thoughtful and significant interventions children and young people began to make changes.

A range of options within residential care is necessary that incorporates different models to assist children and young peoples to meet their goal to live well in the world. Each model provides input that should be matched to the needs of children and young people. Some models overseas have managed to build this range into their service delivery models due to their size and experience for many these includes treatment or therapeutic foster care also.

It is not necessary to start in the highest grade of care for all young people, but what is clear is a one size fits all models will not meet the needs of children and young people. A lot more work needs to be undertaken in Australia to look at the needs of children and young people in residential care and the type of continuum needed in each jurisdiction to better serve the needs of the population identified to be in need of residential service provision.

In attachment B you will find showcased a range of models in more depth that describe the type of care environment being provided for young people.

Countries Visited and Background of Residential Care Provision

Scotland

Scotland in the 1970's went through a significant change in their attitude to residential care. The professionalisation of social work meant that a number of workers began to question the care offered by an institution for children.

Many social workers believed that care should be offered by a family and children should not remain in institutions – this was driven by a report in 1973 called children who wait and was concerned with the drift of children in care, this report was very critical of residential care and the institutionalisation of children. It is interesting to not that this report was written by the Association of British adoption agencies and at this time there was a significant decline in the numbers of children available for adoption. The report however, was mostly concerned with children under 12 who were in residential care. This has become one of the most quoted papers in Scotland.

The report did ask some important questions such as – Why had children come into care? Why was no family work being undertaken? However the resulting decommissioning of residentials across the country could be seen as reactive in the efforts to answer these questions and not helpful in looking at how residential care could have been improved or become part of the answer to these questions. Most of this was driven by the social work principles that said children are best supported within families and we don't support residential care for children as it is not normal. Permanency of placement became the key and adhering to the principles meant that residential care could not be considered a permanent placement.

Within Foster Care there are National Standards developed. There are 4 grades of foster care – ranging from the first that is inexperienced up to professional and paid accordingly.

Currently in Scotland there are 32 different local authorities that cover 5 million people in population. Standards are set by the Scottish Central Government. There is tension between the Local Authorities and the Central Government as the LA's believe that they do not have the money to monitor or deliver on the national standards. In many LA's there appears to many in Scotland little commitment to residential care and limited commitment to the quality of the service delivery nor knowledge on how to ensure this. Residential care is run by both the NGO sector and the Local Authorities themselves in Scotland. There is very limited for profit service delivery at present.

Two significant reports were undertaken into residential care in the UK in the 90's these were the Skinner report in 1992 (Another kind of home) and the Utting report in 1991. Utting and Skinner were Chief Inspectors of Social Work. When given the chance both could have closed residential care however, both reaffirmed its place for young people Skinner especially saying that Residential care should be a positive option for children and not the last resort.

It was at this time that the Scottish Institute of Residential Child Care (SIRCC) first became funded – small to start only 4 staff – initially called the Centre for Residential Care. Between 1994-2004 National conferences were arranged, training materials developed and the organisation became the focal point for the residential care sector.

In 1997, the Utting 2 report by Rodger Kent, looked at keeping children safe in care. Kent focused on the quality of staff working in residential staff and found that many staff were unqualified and had very low academic qualifications. Their status was poor and the quality of care provided the low, and the leaving care status of young people was very poor. Kent came up with the idea of a national college for residential care workers – similar to a police training college.

SIRCC at this time went from 4 staff to 40 staff across the country. They now offer a Masters of Residential Care, Qualifying Social work courses with a specialisation in residential care and a National Certificate that has been tailored to residential care. On top of this SIRCC offer short one day courses for the sector across the country, on such issues as managing self harming behaviours, working with loss and grief and working with children who have been sexually abused. All of these courses are tailored to the distinctive environment of group care. Training can be offered by distant education and in smaller areas across the country.

Despite all of this there remain a number of difficulties.

- There is no career structure for residential carers – small units make this difficult
- No strategies for recruitment and retention
- No language of consultancy – use of external therapists to assist in planning residential care
- Problems in back filling staff for them to attend training.

There appear limited linkages between Managers and SIRCC. Graham Bryce of CAMHS (Child Adolescent Mental Health Services) indicated that the place of therapy in residential care is not well developed. He believed that is often now difficult to have good relationships between sectors and social services due to the increased work load and the pressures placed via managing risk. Previous discussions in an effort to assist families and identify difficult families have all but stopped.

There is an increase in children and young people coming into care and the impact of heroin in the Glasgow community is significant. A recent study by the Glasgow University on drug and alcohol in the community found substantial amounts of children living in drug affected households. Glasgow has seen a substantial increase in the numbers of children living in desperate circumstances but not a correlating increase in the services both in social services and the community to deal with these.

Within Scotland Residential care managers must gain a certificate alongside their qualification to be able to manage a residential home. Overall there is an emphasis in Scotland on the fact that residential care requires specific skills that are not encompassed in general degrees or qualifications.

England

In England the National Children's Bureau has just been provided money to develop a National Centre for Residential Care (NCERCC). The aim of this is to work with providers to establish what good practice is in residential care.

Currently

- 62% of residential care is provided in the independent profit sector – provision in the area of learning difficulties, challenging behaviours, austism/aspergers and one to one placements (large growth)
- 30% of care is provided by the local authority provision in mixed needs, mixed economy of care
- 10% in the voluntary sector provision in disability and therapeutic care

Residential child care seen is as an expensive option and having the sector provide the care is seen to export the risk of care.

Recently the commissioner for Social Care Inspection released their report and they have seen standards increase, better morale and retention in residential care. However NCERCC have found that people come into residential work untrained – they are often presenting with difficulties in numeracy and literacy.

The Social Care inspectorate has said that all staff need to have a NVC 3 as there lowest qualification but only 50% of staff need training in this area and many academics and providers are raising concerns that this is too low. However, as wages are so poor in residential care being able to provide greater qualifications is questionable. Managers should have NVQ 4 and a registered manager's award. However, there is not capacity in every region of England for this to be provided through educational institutions.

NCERCC will look to set up regional centres for leadership in every region with a focus on:

- Training
- Qualification for managers
- Training and support and consultancy for leaders

Stanley (2006) believes that residential care needs to understand better what they do and the environment they do it in.

Given the problems of group care (seen that young people are bullied in group care, learn from each other, increase in offending) one on one care is seen to be easier and dissipates community anxiety and problems. Stanley believes there is a danger that we are losing the notion of group care. There is a disparity according to Stanley about how breakdowns in placements are theorised by professionals with Residential care. If a placement breaks down within a foster care situation it is seen to be the child's fault or not a good fit. If the placement breaks down in residential care then the residential is seen to be bad and not to be providing an adequate program. Neither response is useful.

Stanley would say that the level of assessment of children and young people's needs is variable across the UK. Sometimes assessment is brief, there is a failure to collect information and there is an inability to match needs to placement. Overall in residential care there is not a reliable sense of an attachment framework and not a focus on the whole child – only key aspects of the child.

Vancouver Canada

Canada like Australia has child protection services run on a state basis, as such each state will look different in their service system provision. This report will just focus on British Columbia for this reason.

British Columbia is in a significant transition in relation to care of young people looked after. The budget for the Ministry of Families has been cut by 23% and many residential programs have been disbanded including therapeutic foster care.

This has been driven by a number of factors including budgets as residential care was seen by the Government to be a costly provision and the cost of this was not allowing the Ministry to provide other types of service provision, including family preservation. Mostly young people aged 6-12 were in residential care and were staying for up to 3-4 years. There was limited work within the communities that children and young people came from and many children whilst they did well in residential care returned to their community upon leaving, where little had been done to affect change.

Whilst a number of early intervention programs were promised with the savings in closing residential care, many in the community do not believe this did eventuate and feel the Ministry lost staff and practice knowledge.

The inability to resource children and families and under increased public scrutiny a strong divide began to emerge between the government and providers of services.

Further to this a vicarious liability suit upon one non-government organisation that was upheld by the Supreme Court had a huge impact through the system and the system began to respond within a risk management framework.

Many people reported that their system had become very reactive to political pressure and was budgetary driven not driven by research or the needs of children and young people. There was a lack of the sense of outcomes and the goals needed to achieve outcomes for young people.

Canada now only has short term residential care options that are predominately assessment based but many spoke of this not being long enough to stabilise a number of children with limited options for future placements.

A number of people spoke of the hidden cost of foster care, what looked reasonably priced was often misguided, given the number of moves young people were undertaking and therefore requiring significant treatment later on. Foster Carers in the views of many in the community were often being treated like second rate citizens, and as foster carers are getting paid to undertake care they were often not seen to deserve respite. Some providers felt that the government had a vision of non-government agencies providing foster care that they coddled them providing too much support.

Canada has a 3 class system of carers:

- Level 3 – well trained professional
- Level 2 – semi trained, not as competent
- Level 1 – Low level skills, not trained

Depending on what level you are you receive a different payment and supposedly differing children in care. However, often due to stress in the system social workers may place a more complex child with a level 1 carer but not expecting much more than containment.

Many people, whilst agreeing that a reduction in residential care was necessary, felt that they had gone too far in reducing numbers and were now struggling to make sense of what residential care should look like. Residential care was back on the agenda as the foster care system was under too great a strain and it was widely acknowledged that not all children and young people were going to get adopted.

It would be acknowledged by most that the residential system was weakened for the wrong reasons, for both philosophically and monetary reasons, that was not based on evidence.

Chicago

Illinois as a state has also had a significant reduction in residential care but would still have provision for between 10-15% of young people and believe that it could be a little higher.

The significant difference with Chicago as a state is the significant development of its relationship with research institutes in informing public policy. Chicago state government has invested and formed partnerships with Chapin Hall Children's Research Centre, the Institute for Juvenile Mental Health and Northwestern University. These 3 research institutes provide significant input in shaping the system for children and young people in care.

Typically governments do not have time to analyse their own data. Chicago has thus employed both Chapin Hall and Northwestern University to undertake this analysis for them and provide input. Chapin Hall has access to government data on children in care and actually provides a data archive for a number of states in the United States. This allows them to synthesise data in a way that governments often do not, making correlations and providing input about trends.

Chicago has a policy directive to respond to children in the least restrictive settings. Many people spoke of residential care being a place of last resort for children and young people.

Residential care was provided when other placements could not sustain a child or young person. The other factor that guided this was what was available in a child or young person's community. Chicago unlike other jurisdictions had done a reasonable amount of work on trying to keep children and young people in their community and thus many children are residing in areas close to their home and having significant contact with family.

Along with this, Chicago had a significant system that only allows for the minimal intervention for children and their families when they come in contact with the system.

Most residential settings in Chicago had a history of being an old orphanage where children went when very young and aged out of care from these systems. There is no doubt that this needed adjusting. Many of the service closed, however many others have moved to residential treatment services.

Interestingly the state only provides partial grants to care for young people i.e. not all of the funds needed to care for young people adequately. The rest is the responsibility of the organisation. This is a curious position for the state to take given that legally they are the parent and impacts substantially on the care that young people receive, given that many charities struggle to adequately fund raise and care is then reliant on the size of the endowment of your benefactor, or the quality of the fundraising efforts of the people on your board.

New York

New York residentials are somewhat different to those in other jurisdictions due to the numerous ways that children and young people make their way into residential care. Children and young people can go to a residential system through the education system, juvenile justice system or child protection system. This leaves an interesting mix of children and young people in alternative care, with many having stronger family connections as a result.

The Vera institute in New York through their research has found that in group homes in New York that there was a 50% turnover of residential staff. They attribute this to the fact that pay is low and the job difficult. The range of the quality of residentials is of a great variety in New York and for some the standards are not always good. In the most part there was a sense that residentials were housing the children that people don't want anymore. A study of young people that ran away from residential care found that 50% of them were running to someone, but 30% were running from boredom as the facility that they were in had very little programming and a lack of things to do.

There is a sense that within New York State that the social welfare system is about social control. This was evidenced by the fact that 2/3 of children in care are African American with 1/3 being Hispanic. There is research in New York State that talks about the adversarial nature of the child welfare system with families. It would appear that often people are waiting for families to make mistakes.

Residential care continues to be an expensive care option with it costing approximately $25-$30 US a day to keep a child in foster care and $150-$220 US a day to have a child in residential care.

The Vera institute is interested in residential models that see children as partners such as in Missouri where children through the group are involved in setting the rules and look to create authenticity and responsibility through the programming.

There is a sense that in New York that funding for residential care is set by the State in way that gives you just enough to fail young people. Providers spoke of the how it was impossible to provide the treatment required and the short-sighted view of the outcomes for children and young people.

The alternative care environment is one that is complicated across countries. There are many competing demands and social complexities to address. Across all jurisdictions there has been a significant increase in the use of drugs by parental households where abuse is present. In Scotland alone their leading drug expert Neil McKegney released a study in 2006 that showed 60 000 Scottish children are living in drug dependent households where serious drug misuse is part of everyday lives. Further to this 300 babies are born a year with substance addiction.

Many children and young people are being left in situations of significant distress for much longer. One of the very distressing parts of doing this research was the amount of stories I heard of children and young people having been left in what I can only describe as horrific circumstances and the statutory bodies that were charged with protecting them failing to act. Many children then present with significant distress, trauma and mental health issues at very early ages.

In all of these different contexts visited a number of Key themes emerged. I have grouped these themes into issues and have tried to provide some coherent ideas across jurisdictions about residential care, its challenges and successes.

Key Issues Identified

The place of residential care

There are varying opinions about the place of residential care for children and young people. Many people believe that there is no place for residential care, this is often based on the sense that residential care is a restrictive environment that can impact negatively on children and young people through exposing them to other children and young people in distress.

However, it is evident that extremes of care environments never serve children and young people well. Everyone across the systems investigated believed that some level of residential care was needed to provide quality environments that meet a variety of needs for children and young people. Where residential care had been abandoned many people talked of the inability to provide stable care for children and young people. This had led often to the development of individualised care packages for young people that were struggling to deliver therapeutic outcomes for young people.

What is clear is that we need to better define what we mean by residential care and to identify the essential elements that residential care should incorporate. The variation in what is called residential care is great as already outlined in the definitions section.

Some jurisdictions spoke of some children and young people that had had up to 40 placements in foster care. At the very least the majority of children and young people in residential care had experienced 5 placements before coming into a residential program. The significant lack of continuity and stability being created for children and young people in care is concerning.

For many countries that had decreased residential care, foster care was often operating as small group homes without the resources or monitoring afforded to residential care. Where this was happening it became clear that residential care began to operate by default, so it could be inferred that the system needed some forms of group care that were resourced to manage to meet the needs of children and young people.

Due to residential care becoming used more restrictively in many jurisdictions the characteristics of young people entering these settings are an "extraordinarily challenging highly concentrated group of children and young people who tended to share histories of neglect and trauma as well as multiple placement disruptions and failures. Consequently they struggled with sever emotional and behavioural disturbances characterised by vulnerability to affective flooding under even minimal levels of stress, high levels of aggression towards others as well as themselves an significant cognitive deficits" (pg 4 Morris, Muehlbaurer, Francis, Naylor 2006)

Currently there are often low ambitions for residential care, with a limited sense of what people think residential care can achieve.

There was a sense residential care was needed due to foster care not coping with all the children and young people in care but still great reservations about its capacity to make change. In essence most systems still did not embrace residential care as a positive option for children and young people and as such it was often tentatively spoken about with a limited sense of the place it can play for children and young people.

Some of this is linked to the often vague ambitions for children and young people in care in general. It is evident that without a clear embracing of wanting to see children and young people in care do better, rather than the provision of basic care, then an examination of the system that cares for children and young people will be caught in a similar malaise.

The one difference in this picture was Scotland where in 1992 Angus Skinner undertook and examination of residential care in Scotland producing a land mark report called “Another kind of home”. To prepare this report Skinner examined evidence from over 100 organisations and visited approximately 20% of Scotland’s children’s homes sometimes staying overnight.

Skinner concluded that “The key to good quality care…is the calibre and effectiveness of staff. However, residential care workers cannot make effective provision without the support of managers and other professionals. Their have been long standing problems in providing good quality residential care. The reasons are complex but an important factor has been lack of clarity about the value of residential care as part of the strategy of provision for young people and children. Many residential care staff felt that the purpose of their work and their contribution are not sufficiently understood and valued.” (pg 14 Skinner 1992)

“Agency practices and procedures should recognise residential placement as an option to be considered positively, because of its particular benefits in appropriate circumstances. Guidelines and procedures should not imply that residential care is some form of last resort. The range of care options should be seen exactly as that – a range or continuum with different options appropriate for different circumstances. The continuum should not be viewed as a hierarchy, with an automatic preference for one form of care over another without regard for individual circumstances.” (Skinner 1992 pg 15)

Skinner (p19, 1992) identifies the following place for residential care:

- When young people are in need of emergency care
- When young people needs long term care and a family placement is not appropriate
- When a young person needs care with an additional specialist therapeutic or educational service provided on the same site
- When a young person has complex and special care and educational needs an their family requires short-term support in the care tasks
- When brothers and sisters require care which keeps them together and where placing in substitute families would see them separated from each other.

Adrian Ward at the Tavistock Clinic has hopefulness in relation to residential care. He believes that we need a focus on therapeutic care, that residential care can't just provide good care, such as a substitute parent. He says that given we are caring for children who have not had ordinary experiences we need something more. He believes it is a subtle art of creating difference.

Fred Wulczyn of Chapin Hall in Chicago believes that it is not helpful to demonise any form of care. He instead would ask what a reasonable supply of residential care is. This is somewhat dependent on the question of what is a reasonable model.

Given there has been little thoughtfulness about the types of residential care and the benefits of each type for children and young people, this is difficult to answer. Often there is a not a sense of evaluating the models as defined earlier in this paper and then looking at what types of these services you need across the system. How many young people need treatment vs. therapeutic care vs. a graduated down intensity of living to group care.

This also begs the question about how residential care is used – if it fails to become part of the system of care – an intervention that may even help families and young people live better together rather than an end in itself- then how much of it do we really need.

Currently in the US depending on the jurisdiction you live in the likelihood that you are placed in group care ranges from 10%-80%. Wulczyn believes that if a decision to place a child in group care was based on the clinical needs of the child then you would not have such significant variance in these ratios.

Jim Anglin of the Victoria University Canada believes that group care for children and young people should be a positive choice for children and young people. Anglin believes that residential care is not a destination but a transitional service of 1-2 years of intense work in a mindful way and that this type of care can assist young people to live better in their world.

What is clear from this research is that all jurisdictions need a range of options in alternative care to best meet the needs of children and young people in care. Systems that have tried to exist without residential care have failed to provide stability and continuity for children and young people in care. Residential care can be a very positive and successful intervention for children and young people, what is needed to ensure this will be explored further in this paper.

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

This is best demonstrated by a young woman involved in Who Cares Scotland evaluation of residential care (Whiteford, 2005) “Spread the word that it’s not children’s fault for being in children’s homes because they think it’s you and you’ve done something wrong, but for us it was our parents that had the problems and not us. The minute people look at you, they look with disgust, and they say that you’re in a bad boy’s or girl’s home, as if to say that you have done something really violent, and we haven’t done anything wrong” (female 15, pg 73 Crimmins and Milligan 2005)

Recommendation:

1. *Residential care can provide a significant intervention and a quality care environment. As Skinner (1992) concludes residential care should be embraced as a positive option for young people in meeting their needs, not simply as a last resort. Placement in residential care should be a mindful process. States in Australia must examine their practice and policy in this area and look to examine their relationship to needs based planning, this requires attention to the following two points.*

2. *Systems need to define the types of residential care required and work to develop a system of residential care options that matches the needs of children and young people within a range of out of home care and support options.*

3. *Children and young people entering residential care should have their needs identified to match the level of intensity of the service they require to meet their needs and should have available options that do not lead them to be in services that are either over-restrictive or under capacity to meet their needs.*

Evaluation

There were many gaps in the system to look at evaluation. There was certainly a lack of connection between providers and researchers. Often, whilst there were networks of providers or in Scotland a dedicated training and research body for residential care, there appeared little interface between providers and the centre except on an individual basis. Many services were undertaking evaluation of their effectiveness but often in the absence of external assistance.

It would be fair to say this would be to do with cost, but in many ways lots of money is getting used to accommodate children in the UK residential care costs between $1500 AUS and $8000 AUS a week. However, there is limited investment in evaluation of this care. As rightfully stated by Adrian Ward (2006) it is often difficult to look at evidence with residential care as it is difficult to know what element it is that makes the difference for children and young people. That is, was it the care that was offered, the program, the relationship with a particular carer or the therapy provided as part of the program.

There are a number of programs that are being driven by their evaluation and using this in program design such as the Maples Centre in Canada and their partnership with Simon Fraser University, where the researchers are a part of the care team and the longitudinal evidence being collected is used to evaluate and formulate program responses. Likewise the Saccs program in the UK uses the assessment and outcomes data of young people to map the progress of interventions and to inform practice development.

There is however, evidence of a lack of collecting data in a meaningful way across systems that would lead to trend analysis, evaluation of models and the possibility to see what works. Jim Anglin of the Victoria University British Columbia, Canada (2006) is unclear if we can evaluate models without a clear 3-5 year post study. He would classify outcome measures within 3 categories:

- Experiential
- Developmental
- Programmatic

Fred Wulczyn of Chapin Hall Children's research centre, Chicago (2006) believes that we need to look at the net contribution of the residential experience on the developmental trajectory of the young person that was underway when they entered residential care. We need to ask does the experience of living in residential care halt the spiral, reverse the spiral or further escalate the spiral.

Wulczyn believes that residential care may be a positive factor for children and young people but may not be enough of one given the risk factors that young people present with. This is also complicated by the skills and abilities of individual children and their ability to offset any negative experiences.

Wulczyn believes there are also methodogical problems in evaluating residential care because of both the selection affects (who is going into residential care) and the fact that you cannot do randomised trials. But it is evident that further research is needed that is clear in its theoretical design and that a thoughtful theory is used to construct the care that children and young people get provided. Wulczyn believes that research in this area needs to be a partnership between governments and providers.

In my opinion evaluation does need to have an external or impartial component as well. One of the complications in providing residential care is that it is expensive. Providers have much money tied up in the care of young people and if evaluation is not to be used to prove that something works, but also used to look at what does not work, then external bodies such as research centres and universities play an essential role in assisting in this domain. The danger in not having them involved is that evaluation could be used to protect financial or personal philosophy interests rather than the interests of children and young people.

It is very difficult to transport models from one part of the world to the next. Often cultural contexts are different, funding systems different, and the ways that they can be supported by different. That said investigating models that are seen to be affective and looking at what is affective about them is necessary.

Models that work tell us something about key ideas and program methodology that are apparent within these programs. In Anglin's opinion (2006) there is value in adapting the idea contained within the model, where it may not for cultural or funding reasons be wise to adapt the model itself.

Involvement of Young People

The opinions of young people are as divergent as any group of professionals in relation to residential care. It is imperative that we continue to find mechanisms for young people to give feedback about the care they experience.

Many researchers, public servants and providers spoke of the difficulty of being truly child centred and the capacity of the system to affect change based on the service user's responses.

I sat in on a consultation at the House of Lords in Britain of the young people in cares experience of being able to challenge decisions made about them by the statutory body. All young people spoke of not being included and when they complained about decisions and used an advocate service that they were seen as trouble makers and at times told this by their workers. The capacity of any system to hear feedback and act on it is a sign of the systems maturity.

Often we are operating systems that are so risk averse that we are making decisions on the basis of policy and not the needs of children and young people. In the words of Anglin (2006) you cannot raise children without some risks. You cannot therefore use tools or policies or procedures to nullify risk, they will certainly contain risk but it will never mitigate risk entirely.

Thus the opinions of young people need to be involved in all evaluations of service delivery. It is they that live and experience the services we provide. Young people are shaped good and bad by the services we offer. They are often the most powerful agents of change and have a way of making sense of practice in a way that grounds this for carers.

In the documentary Wards of the Crown, produced for the Federation of Children in Care in Canada, the young people who had been in group homes in this documentary highlighted significant issues in their experiences.

One young woman talked of the experience of not having had physical contact in 5 years in group care. She said no one can survive without touch and that love was inappropriate in group care. But it's not inappropriate for young people.

She said in all the years of her self harm people kept looking at her behaviour but they didn't ask "what is wrong with your heart or what's inside you". The power of the relationships is demonstrated in these statements and more powerfully probably than any of the words that I will offer on this topic in the rest of this paper.

Universities and External Evaluation
As already discussed universities and research centres have strong place to play in the evaluation of residential care. There were varying degrees to which residential care providers, policy officials and research intersected across the world. In parts of the world this was stronger than others. Chicago probably provided the best example of this.

The State of Illinois has undertaken significant development in their evaluation framework. The state has partnered with 3 research centres to assist them in designing and evaluating residential care (Chapin Hall Children's Centre, North Western University and the University of Illinois in Chicago) this began with the creation of a common language describing the types of residential care services available and a classification system. This allowed the system to map against identified needs of young people and the capacity of the current system to meet these needs.

Secondary to this the partnership created a profile of young people requiring residential services, by undertaking a profile of young people being referred to residential care this allowed the team to look at need versus current models of service delivery and capacity that had already been identified.

The group then set up a small group process where providers came together to discuss the outcomes of the above processes. These small groups also then allowed providers to share practice wisdom and to assist researchers in their classification and to make sense of the data that they were collecting. These groups also allow an intersection between practice and research that is often not evident in other systems in such a rigorous way.

Finally the group have developed a residential performance indicator called the dashboard. This performance measure was developed by a unique collaborative public private partnership consisting of IDCFS, university and provider members. A dashboard is generated for each program category within the classification system and compares like providers on a series of performance related items, highlighting strong and weak programs. The goal in compiling this information is to allow for meaningful, data driven comparisons among like providers and serve as a means to identify provider effectiveness along critical dimensions (Morris, Muehlbauer, Francis Naylor)

The capacity of this system to effectively over time look at their ability to meet young people's needs is assisted through the significant partnerships that have been formed in Chicago. As discussed with Dr Alan Morris (Institute of Juvenile Research) the difficulty is always in getting a balance in evaluation with an efficacy of the data and the amount of time it takes.

You do not want the infrastructure of evaluation to outweigh the infrastructure of what you are evaluating.

However, to move to evidence based systems it is clear that far more thoughtfulness needs to be given to this in Australia outside of individual programs evaluating their program. To ensure this as Ward, Bullock and Clough (2006 What Works in Residential Care) note we need to be clear about what we want residential care to achieve for children and young people, thus performance measures should reflect practice and priorities.

A comprehensive evaluation of data and trends is imperative in the face of significant social change. We must continue to learn and not become fractured by the social difficulties we live in. We have significant knowledge of trauma, attachment and brain development. We must continue to keep putting this together to assist young people to claim a life that is rightfully theirs. This therefore requires that we have a greater interface between research centres, universities and practitioners. During the course of this research it became apparent that often research undertaken was difficult to integrate with model development.

Partly this would be because the knowledge being gained through research is constantly evolving. To be able to integrate this into model development and find funding to do so is complicated and often involves lobbying and time delays to implement new ideas. Where residentials have access to their own endowment and funds then their ability to respond to the changes in research and develop new models of care is greatly enhanced. This is demonstrated by the Kibble program in Glasgow where a number of innovative program delivery components are being designed and driven by practice experience alongside research and thus there is an increased capacity to meet the needs of young people, within the changing environment within which we live.

Recommendation:

4. *That Australia contracts and enables the use of universities, research centres and partnerships with providers to establish evaluation models and methods in the residential care sector that allow for rigorous assessment of the functioning of residential care models and the capacity of their interventions to affect change*

5. *That any evaluation methodology designed incorporates the views and experiences of young people who have resided and continue to reside in residential care.*

6. *Outcomes of evaluation should be incorporated into ongoing professional development across the sector, not just individual programs, to provide opportunity for continuous improvement and a focus on what works and what does not thus ensuring high quality care environments for children and young people.*

Assessment

Often during this research across jurisdictions practitioners told me that it is not until a young person is in residential care that a comprehensive assessment has been undertaken of their needs and psychological well being. You would have to question that if such a process happened earlier that many young people may have had opportunities to be provided services that were targeted more directly to them, including access to residential care at an earlier stage.

Most therapeutic programs overseas had access to psychologists and other consultancy services including therapeutic teams that assisted care staff in their capacity to make sense of young people's behaviour and design an appropriate intervention. This ensured the care environment was one of therapy and change rather than of containment.

Further to this, assessment of educational needs appears paramount given the poor outcomes for young people in care within education.

It would appear often that a needs assessment of young people is at odds with a risk assessment. Needs assessment identifies more areas for actions and in budgetary driven system this is often not valued.

The danger in this is that assessment is done for assessments sake. In Canada often young people had had a number of assessments undertaken but no enacting of the assessments had occurred. Equally the importance of having a good assessment is balanced by needing to ensure that the assessments are used to shape care plans and to provide services to children and young people in consultation with them. Many psychologists spoken with during this trip, spoke of the relief for young people in understanding better why they did what they did, or their learning styles that were able to provide some opportunity to tailor schooling.

The implementation by the Maples program in Canada that ensured a care plan consultancy team that provides a skilled practitioner to assist a care team in their continued planning and implementation of an assessment was one of the few services with this capacity. The significance of an outside point of reference that supported an often stressed and overtaxed system to keep focus on a plan for a young person, and the extra support to the system to be enabled to provide a quality of care was born out of research, evaluation and experience.

Wulczyn would argue that assessment is often not undertaken to understand a child's needs but to ascertain if this is the right placement or rather to gate keep.

Children and young people should never become the sum of their assessments but having good assessment tools, rigorous thinking and planning about the needs of children and young people and using this to design indivualised care plans and an ability to map progress, defined those programs that were succeeding in affecting change and providing high quality care.

Recommendation:

7. *That young people entering residential care should have basic psychological assessments undertaken including an assessment of their learning needs to ensure that an adequate care plan and intervention is designed to meet children and young people's needs.*

8. *That processes are undertaken to ongoingly review assessments ensuring that staff are using the information in the ongoing care they are providing.*

9. *That Residential care systems have access to therapy and therapeutic consultancy to assist staff to better plan interventions and assist children and young people develop the skills to allow them a better life within our society.*

Family Work

All systems quoted the statistics of up to 80% of young people are found to return to their family on exiting care. However, very rarely was residential care working with the family system.

In the UK most young people in residential care were being taken from their community and moved sometimes long distances which made contact and work with the family near impossible. Due to funding arrangements where money goes with a young person much family work was not funded as a result. This was made worse by the budgetary driven systems that everybody outlined in the UK where decisions were made on local authority budget constraints not what was in the best needs of the child.

Whilst many residential staff told me that young people "vote with their feet" when old enough, few seemed to see a place for them in working with families and I wondered often about how sustainable outcomes for young people were in their lives if they repeatedly returned to a system that they had, little contact with and had been provided little opportunity to moderate or learn behaviours to manage. This is made more difficult where young people then move away from the supportive relationships they may have formed in residential care and return home miles from their support system.

Many residential services spoke of children and young people going home on family visits and for those who were based in the community of origin of young people this was reasonably frequently.

Some residentials also had strong family involvement. However, there was limited networking between the residential care staff and families. We know that family of origin issues are prevalent in all therapeutic work. Within the residential system many therapeutic programs were undertaking work with young people that assisted them to work through their family of origin issues. Sycamore in Scotland had mitigated their distance from families by providing two flats for families to be able to stay in so that children and young people got to have time with their family. These flats were attached to residential units allowing staff opportunities to work with families who are some distance from their children.

Some programs had been exceptionally thoughtful about families and one in Canada had attached a family therapist/counsellor. The responsibilities of this worker was to work with each young person on family of origin issues as well as conduct family work and group meetings for young people. The counsellor in this program stayed for dinner once a week so they could observe behaviour within the house. This was position was seen as very affective in assisting young people – however, was consistently under threat of loss of funding due to a lack of importance placed on these issues by funders. At the time of interview this position had been shifted to a foster care support worker.

What is evident is that all children and young people come from families. Their families are their first experience of attachment, often their first experience of trauma but also their first experience of belonging.

Residential care has a significant role to play in helping children and young people make sense of their family. Young people know that long after professionals have gone, family remains. Residential care can assist young people reconnect with lost connections, identify family or significant others to build relationship with. Even where family contact is seen to be dangerous or difficult young people need to be assisted to make sense of their family of origin and to work with the painful reality of this for them. “For practitioners and managers the theme of family contact might be summarised in terms of working with the family in mind which may mean very different things for different children.” (2006, Ward, Bullock Clough).

The Saccs residential programs in England had addressed family work through their life diary work with young people. In working on a life story book with children they also work with adults who the child has known including parents, brothers, sisters, aunts and uncles, grandparents, neighbours, the courts, the police,, foster carers, teachers, nursing and medical staff, social workers: people who have tried to help them and people who have harmed them. (2005, Rose and Philpot). These comprehensive interviews and searching for material assists children and young people to make sense of their story to make connections with lost people in their lives and to at times rebuild connections with family. In essence it also allows young people to celebrate parts of their lives that are often lost, with a focus on the negative and very little on the positive.

Often residential facilities struggle less with competitiveness with natural families. Strong therapeutic knowledge can bring a different sense to family's interactions. Residential care could be well placed to assist young people to learn new skills; this includes how to moderate their own relationships with families and learning ways to manage often very difficult and complex relationships within a supportive structure.

Residential services could also offer to families an alternative view of their young person. Residential care is often in the unique position of having cared for their young people with many more resources than families themselves had access to. Many of them struggle to care for the young people entrusted to them.

If Residential care services have a strong philosophical background and include therapists with good family therapy training and understanding then we are often underutilising the skills based within these services to assist children and young people make sense of their history and denying the possibility for change.

Often when young people enter residential care the family work is seen as divorced from the program. Often this is left to overworked case workers with limited time and often limited skills in this work. The failure to consistently look at the issues for children and young people within the context of family and the splitting of these systems you could surmise, causes splitting within children and families and is not helpful in assisting them to work through, heal or treat issues.

When we evaluate any programs without paying attention to the context then the fragmentation is difficult to evaluate effectiveness. It would be interesting to test out if family work was a greater component of residential care if shorter stays in care would therefore be evident as a result. The residential could then form part of the system that offered ongoing respite and response to families as they renegotiated their relationships, such as the Maples program in Vancouver has managed.

At the very least if the residential is unable , because of distance, to undertake family work then it would be best if an external family work provider is assigned to work with the residential over time to assist with this work. Leaving family work to the overworked statutory bodies does not give this work the significance it deserves.

Recommendation:

10. That family work/family therapy is incorporated into residential care models to ensure that the whole needs of children and young people are met and that children and young people are enabled to reconnect with family and kinship systems that will be important to them on leaving care.

17-18 Year old young people

All residential providers in the UK raised concerns about this age group. Most young people were leaving care at 16. Interestingly whilst the UK legislation says that young people in care must be supported until 23, there appeared limited understanding of how to do this. There were also budgetary systems that prevented local authorities. For instance young people aged 16-18 years were funded from a different budget to 0-11 year olds and 11-16 year olds. These age groups were also funded to different levels and it appeared that on the whole service delivery was driven by money available not the needs of the young people.

All residentials in the UK spoke of how young people were not ready at 16 and 17 to live alone, but where funding was tied to young people individually then the funding followed the child and when services were no longer funded they provided a much more limited service to young people, if at all. This could be argued may be because of the amount of 'for profits' in the market place – but appears more likely due to the unit cost way services had to manage funding, which meant they were likely to solicit a new child quickly to affectively manage program budgets. For young people already in residential care where many feel staff are only there because they are paid to be, this type of approach and funding package must make it difficult to attach and to feel there is a purpose to building a relationship to have to end it again.

In Canada young people as young as 16 were being placed on youth agreements that allowed them to access independent living and support but with conditions. Young people were provided with a flat and some subsidies for their income but had to sign a contract where they attend school, employment/training and drug programs (if relevant) or other conditions as per an agreement with a case worker. This often resulted in many young people living in low cost housing, in dubious neighbourhoods with some limited support.

Practitioners spoke of many examples of these young people from highly difficult backgrounds being unable to sustain the conditions of their contract and often found themselves homeless and having suffered another failure and placement move. You would have to argue that even a young person from the most stable background given a flat, an income and no adult supervision would struggle not to have friends around and maintain their tenancy in these conditions.

Whilst everybody identified that attachment disorders and disruptions characterise young people in care, it appears that we continue to often provide systems that sustain, some would say worsen rather than challenge, treat or heal this damage.

As already identified many of the young people entering residential care have significant trauma and the research would illustrate often cognitive deficiencies given the high levels of neglect and trauma they have been subject to.

Many practitioners during the course of this research spoke of the severe emotional delays that young people in their care demonstrated from a lack of quality interactions over time. Yet, paradoxically, all systems some how expected that this group of young people in care, demonstrate a level of competence and independence that the general population was not expected to have.

These groups of young people are immensely vulnerable, have lacked good quality care over the course of many years and have not been offered any skill development in the areas of independence. For some residential services overseas this was compounded by the limits of their site and the sheer numbers of children involved in which resulted in the use of cooks and cleaners denying young people active involvement in the day to day living skills.

Skinner made recommendations in 1992 that young people in residential care should be well prepared for adult life and that young people should be supported into their early 20's. At the most vulnerable point for any young person, transitioning to independence we appear to provide limited support and a lack of recognition that some forms of group care with staffing may be necessary to assist young people begin their adult years with a positive experience.

Recommendation:

11. *There needs to be a renewed focus on the needs of older young people in this age range with further model development undertaken to better ensure positive options for young people leaving care*

12. *Continued higher levels of care should be available for this group if needed with specialist support offered*

13. *An independent living skills program needs development in all residential care facilities to ensure that young people leave with appropriate skills that equip them to live independently into the future.*

Relationships/Attachment

All services visited during the course of this research spoke of the central needs of children and young people of having good quality relationships and that it was the relationship they were able to establish with young people that made the difference to the outcomes.

It is also clear from the research that the best experiences of residential care are those where young people have caring relationships. Berridge (2002) said that you could measure successful residential care according to the interaction between young people and the adults and young people routinely used terms that included empathy, approachability, persistence, willingness to listen and reliability.

Whilst we know this is critical we are less sure how to produce a good quality relationship between children, young people and carers.

It is the relationship that carers establish with young people that assists them in understanding young people's behaviour within the context of their experiences. Without these relationships young people often disclose little of their experiences and thus limiting the capacity of carers to understand better the world view of the young people and therefore act accordingly.

Without a sense of attachment or investment young people have no motivation to change or act within the boundaries set by programs. We all know that when in trouble we turn to those that care most about us and will hold our distress respectfully and empathetically. We feel little need to connect or attend to those people within our contexts who have failed to build relationships with us. Young people will not respond positively to staff where they do not feel valued and cared for.

This is the key challenge for residential care because conversely they are often trying to build relationships with young people whose prior relationships have been characterised by distrust, pain and lack of care. Thus carers need extraordinary skills in building relationships. Primarily as Skinner noted (1992) a positive care experience can only be provided by staff who genuinely like young people and who feel personally involved and responsible.

All residentials visited placed significant emphasis on building and maintaining relationships with young people in their programs. All sites operated on a key worker model, identifying one worker who held the primary responsibility for building a relationship with young people and ensuring that their needs were met within the program. All services spoke about this relationship in the context of attachment and the centrality of this relationship for the young person and their experience of the program. Furthermore, it was this workers responsibility to advocate for the young person at team meetings. This sense of having someone go in to bat for you, someone whose primary responsibility is your sense of well being cannot be diminished for young people who have had very little experience of this in their life.

Many young people do not feel they are worth being cared for and that they are not able to establish relationships, this is significant in residential care where many children have experienced multiple placement breakdowns prior to entering a residential program. Thus the key worker model becomes essential in breaking this pattern and helping children and young people establish new patterns and experiences of themselves as valuable and likeable regardless of their behaviour.

As Skinner noted residential carers cannot exactly replicate a parent/child relationship but they have to fullfill the basic parenting experience for children and young people in their care, primarily the attendance to the physical and nurturing needs of children and young people. The need to have positive relationships with staff cannot be underestimated though.

It is in the day to day building and repairing of relationships that much of the therapy is undertaken with children and young people in residential care. However, often little support is offered to staff in understanding how to build relationships, how to build investment with children and young people and to focus on managing relationships with self and others in a highly charged emotional environment. (Anglin 2005)

The Sanctuary Model at the Andrus Children's centre in New York has established significant processes in their daily living environment that not only gave children and young people opportunities to learn affect regulation but also built a sense of relationship with staff and residents.

Community meetings were held at the beginning of each day allowing children and young people and staff to identify personal goals for the day and to discuss how they were feeling. I observed that this process, whilst skill building, also gave staff and young people an opportunity to build relationships and learn about each other. Children and young people were interested in what staff thought and insight was provided into each other and a sense of we are all in this together was generated. I witnessed high quality caring relationships that children and young people and carers were invested in, where children could express their fear, joy and sadness in a respectful and contained environment.

What was evident across all places visited was that many thoughtful and nurturing relationships were being established with young people. However, often these relationships were disrupted by the systems demands that relationships change with your placement. Many programs were not enabled to use well the relationships established to assist young people to transition to new environments, including their home. For children and young people who have battled to build quality relationships and whose short lives have been characterised by disruption and a lack of relationships, this is very disturbing.

Residential care cannot be a family there forever, but the relationships established could be used far more thoughtfully to assist young people to build new relationships and to support them in their growing understanding of how to relate to others. Often funding systems broke attachment processes for young people and relationships formed with residential carers were not always used to assist a young person to transition to a new placement be that home, foster care or independent living.

This issue has been picked up by Voice in the United Kingdom, an agency looking at the needs and the voice of young people in care. They have been advocating for what they have called a BFG (Big Friendly Giant). Voice are advocating that every child in care should have a person that remains in contact with them throughout their period of care and beyond. This person should be chosen by the young person and should be from an existing network (not necessarily a professional). However, they also advocate that children and young people should be allowed to keep in touch with people they have worked with in the past.

Given the amount of research and information written about the importance of relationships within the residential literature I found this curious. Many practitioners spoke of their desire to work further with young people but were not enabled by the systemic factors that had been created.

Recommendations:

14. *That models are developed in residential care that make use of the relationships established with children and young people and to use these relationships thoughtfully to assist young people transition to new care environments.*

15. *That children and young people are enabled to make use of the residential care relationships they have established for a period of time post the residential care experience to ensure that they have a sense of connectedness and value.*

Secure Care – Issues and Views

Secure Care in Scotland is used for 2 purposes, to provide interventions to young people who have offended (juvenile justice) and to provide interventions to those young people that may be a risk to themselves and others (drug use, physical aggression, self harm, prostitution).

All residentials spoke of how they had young people in their residentials that had been in secure care. Many raised concerns about secure care and its affectiveness of intervening or making change for young people. It appeared that for many services they felt that secure care contained the issues that brought young people into care but that it did not manage to ameliorate the issues.

Secure care is only for 3 mths and then young people must be reviewed. Many young people at this point are not demonstrating the issues that they were to have them qualify for secure care so they are released. Young people who leave secure care appear to do well for a while but then they become involved in the same issues that led them to secure care and they re-enter the system – often not at the same secure care site and some now not in secure care for welfare reasons but for reasons of criminal activity.

Many staff spoke of concerns for the attachment disorder this was creating within young people in Scotland and that young people were learning in the words of one provider “to lead a transient lifestyle, never learning the benefits of working through crisis and only ever having to survive 3 months at time, whereby you fix things by changing location.” You would have to question how much this is contributing to young people then becoming homeless and developing addiction to transience.

As the growth in secure care takes place (Scotland is due to increase secure care by 100 places taking the places to 235) there does not appear to have been a significant correlation in therapeutic input to residential care models.

Within secure care those units that are working more effectively are undertaking a comprehensive assessment of young people undertaking a social care, medical, educational and psychological assessment within 3 weeks. In the first 2 days assessment meetings are held with family, social workers and other relevant agencies to gather information that is already held including what significant life events have occurred for young people and the purpose of locking them up.

If significant psychological disorders show up in the assessment a Forensic Psychiatrist is brought in. Post the assessment being completed a meeting is reconvened with the family, local authority and young person and the assessment is presented and options for intervention discussed. This may include that the young person is not best met by secure care and alternative placement needs to be found.

The majority of young people coming into secure have some type of criminal activity although this varies markedly and young people can be in for minor offences vs. on remand or being kept for serious offences such as manslaughter and murder. Of the young people being referred to one unit, it would appear that a failure to intervene more affectively earlier with young people's challenging behaviours has led to them progressing to more criminal paths and ending up in secure care. Many young people appear to be entering secure care due to a failure of residential care services ability to undertake intervention. This is usually a direct result of a lack of funding to undertake more therapeutic interventions. More worryingly, a number or young people are coming straight from home to secure care and residential care is still being used as a last resort.

Many young people who are in secure care on the grounds of being a risk to themselves or others often progress well and are then able to be discharged in 3 months. However, the secure unit has limited capacity to undertake follow up and as young people are coming from all over Scotland then this can be some distance. Complexities of funding arrangements make other agencies involved in the case staying involved near impossible. As funding in Scotland goes with children then an agency that may have previously provided a service will lose their funding for that service when a young person goes into secure care, thus they are unable to continue to connect over this time and are likely to pick up other work to replace this work.

Thus continuity for young people is broken and vital work that may need to go into the assisting the home, peer group or foster carers is ceased and the young person returns to very similar conditions that led them into secure in the first place. This is more worrying where a young person in foster care if they go into secure loses their foster placement even if it is for short periods.

The secure units appear to be collecting substantial data on young people but there did not appear any comprehensive way of collating this.

One unit spoke of their statistics showing that for young people in secure care there were significantly high correlations for the following:

- Exposure to domestic violence
- Being a victim of domestic violence
- Parents who abuse alcohol
- Parents who abuse drugs.

These trajectory points are interesting to consider when looking at how we may prevent young people entering secure care, yet a lack of thoughtfulness about constructing environments is leading to an increase in the use of secure units rather than an opportunity to increase resources to tackle these problems.

British Columbia in Canada has explored secure care (or safe care as it is being referred to there) however they have not enacted the legislation that is present to provide this as yet. Alberta in Canada has had programs in secure care for some time specifically to deal with sexual exploited young people and they have the capacity to order young people into involuntary drug treatment programs.

Currently Alberta has the capacity with sexually exploited young people to apprehend them and place them in a protective safe house for up to 47 days. The long term outcomes have not been found to be good. Like in Scotland a number of young people upon being released return to their previous lifestyles. In the most part Alberta's assessment has shown that they manage to keep young people safe and make them healthy whilst in the secure unit. Whilst Alberta acknowledges the limited outcomes, they see the dollars well invested if one young person is safer.

When British Columbia began looking at safe care they examined it in relation to three groups:

- Young people with drug and alcohol issues
- Young people who are being sexually exploited
- Young people with significant mental health issues

As a part of this process a large consultation was held with the community to discuss secure/safe care. Community groups were vocal saying that secure care could not be an option in the absence of good mental health services and drug and alcohol detox services for young people.

As was rightly pointed out, services are needed for young people to voluntarily seek help. Many young people have had the experience of wanting to seek assistance for drug issues or mental health problems but have been faced with long waiting lists and an inability to find help. Most young people need an immediacy of service, ability for a service to respond timely and within the range of their motivation. If these do not exist and resources are placed in secure care then many young people who voluntarily would have in the past sought assistance are ending up in secure care. Any involuntary intervention should be based on risk not capacity to respond in any other way.

In British Columbia's opinion you need to strengthen your voluntary services before you explore secure care. This means strengthening for young people:

- Access to safe housing
- Employment
- Mental health services
- Drug and Alcohol services
- Educational opportunities

In this sense BC have moved to put an additional 12 million into drug addiction services and have constructed a 5 year mental health plan that has attracted significant investment.

If BC are to look at secure care it will now be a refined target group of young people who are at risk of sexual exploitation (prostitution). It will be time limited and based on individualised plans.

However, you could argue that where there is an inability to work with the systemic issues surrounding young people such as the foster carers, natural families or assist young people with significant transitional factors then this too will fail to provide anything other than a containment strategy. Safety without intervention and assisting the system to provide better for the young people will not benefit young people in the end.

Many practitioners in residential care spoke of their grave concerns for children and young people who were exposing themselves to significant danger. Many of them spoke of their concern in abandoning children and young people to the streets and to adults who were more interested in exploiting children and young people than caring for them. Many practitioners believed that it was negligent and at times criminal to be allowing significantly traumatised children and young people to be allowed to live in dangerous situations without intervening even if it was against their will. These are salient arguments and ones that resonate strongly when you care passionately for children and young people.

Recommendations:

16. *There is a need to develop a range of strategies in response to the needs of children and young people who are at significant risk of harm to themselves or to others.*

17. *Any model development in relation to young people at significant risk needs to consider the interface between other service systems, including substance abuse and treatment services, mental health, homelessness and youth justice.*

18. *There is a need to consider what role, if any, secure care may have in the range of responses based on thorough review of policy, practice and research in Australia and overseas and debate of the outcomes of this review.*

Restraint

As detailed many of the children and young people in care were exhibiting extremes of behaviour due to the immense trauma they had suffered and for many having lived too long without appropriate boundaries. Thus most residentials undertook some form of restraint when children and young people were uncontainable and were a risk to themselves and others.

Restraint has not been used widely in Australia but is used widely in all systems visited during this study. Nearly all Government jurisdictions visited on this research study provided significant guidance in relation to restraint, including policy directions that included safe restraint practices, identified preferred providers and restraint processes that organisations could use and monitoring procedures required. Restraint is a very serious issue; children and young people die in restraints every year in the US and the UK. A lot of thought needs to go into the use of restraint.

Most services undertaking restraint had well developed training regimes for staff and developed monitoring systems of all restraints used to be able to identify trends and patterns of restraints used within the service.

Use of restraint becomes an issue when too many restraints are used. Whilst the focus of most restraint practice such as TCI and CALM is on intervening at early stages to prevent behaviour, often staff struggled to move their focus from restraint to intervening earlier.

However, where restraint is not used and police are called children are being charged and we are seeing a criminalisation of children's behaviour (children being charged for swearing at staff etc..)

Many jurisdictions had seen a large push by the unions about safety conditions for staff led to staff being trained in restraint – staff being physically attacked. In Scotland there are national policies about restraint that have been developed by the central government.

Many people see the use of restraint as caring. Much concern was raised in Scotland about the failure to restrain resulting in young people not being assisted to gain control of their behaviour and ending up in a criminal justice setting. Many providers felt this was a failure of the service and replicated the neglect and failure to respond that many young people had experienced in their homes.

What is clear is that if the safety systems that surround you such as police undertake punitive measures when intervening with children in care, restraint is a far preferable option. In Chicago, services spoke of young people ending up in watch house overnight when police intervention was actioned, even if this was minor.

In many countries the staff did not get to choose what occurred when police intervened, there were automatic responses from the police system.

There are varying views from young people about restraint in the literature, many children and young people have expressed a lot of distress at the use of restraint. Many children have been injured and hurt through restraint. Other children and young people have expressed that where restraint is undertaken to keep them safe they have seen this as a caring gesture, whilst they did not like it.

Some children expressed that they only behaved so that they would not be restrained because they did not like it. Whiteford (2005) found that young people's criticisms of restraint were around "too many restraints when risk is not an issue, badly handled restraints and the use of too much force/aggression, including too many people holding them down." (pg 77 Crimmins and Milligan). In Whitefords's opinion some young people understood the concept of restraint if they posed a serious threat to themselves or others. However, children and young people felt this was not always the case. Children and young people have spoken of restraint hurting, creating feelings of humiliation and distress and creating stronger feelings of resentment of carers. (Morgan 2004)

During the course of this research I often witnessed the struggle for services in trying to assist young people live within boundaries and the extreme risks that services took in caring for young people who were having difficulty controlling themselves. This included carers regularly being harmed themselves in attempting to provide safe care for young people.

Restraint according to Milligan 2006 should not be seen absent from context, it is not a matter of not having restraint but what factors need to be present for restraint to be practised appropriately and well. There are significant factors according to Milligan that restraint should be considered within. There is a danger to separate out the control and care functions of your system. Control needs to be in the context of care. More regulations are often introduced to monitor restraint but this should not be without training of staff.

Restraint according to Milligan (Scottish Institute of Residential Care) should only occur in the following conditions:

- A high skilled staff group
- A philosophical and theoretical framework of care that looks at restraint within a therapeutic context
- Significant training and policy development
- A low restraint culture.

There is always a danger that if services privilege forms of intervention that is based on control are we privileging compliance over nurturing (Bryce 2006).

There is no doubt that without significantly supporting alternatives such as police and mental health systems to respond appropriately, to not restrain leaves children and young people incredibly vulnerable to trauma and/or being criminalised and I would have to question the impact of this on children and young people into the future. As adults charged to make these difficult decisions trying to honour all experiences and needs is difficult.

There are many examples overseas of comprehensive policy and research in this area, including the commission for social care inspection having undertaken a comprehensive study of children and young people's views on restraint (Morgan, 2004). Guidelines, policy directives and regulations alongside evidence of good practice are routine in those jurisdictions where restraint was practised which ensured that residential programs had more comprehensive guidance in their use of restraint and were constantly then able to evaluate the place of restraint within their programs. This is currently not the case in Australia.

Recommendations

19. *All States in Australia should have clear policy development about restraint and its place in caring for children and young people in care – this should include parameters and approved restraint practice within an overall framework of therapeutic care.*

20. *Significant training of residential carers must be undertaken in the use of restraint and restraint should only be practiced within the context of therapeutic care with a well developed therapeutic intervention model that ensures restraint is only ever a last resort.*

21. *All residential care providers need identified policy provision about restraint and a demonstrated capacity to monitor its use and develop alternatives that honour young people's experience.*

Mental Health of Young People

96% of young people in residential care have mental health problems, Sinclair and Gibbs (1996) found that there is strong denial about young people's mental health needs. A recent study in the UK found that 4 out of 10 young people in care had thought about suicide in the last month. Mental health appears to be an area that we have neglected and Ward (2006) believes that we are yet to get a practice and language for assessing children's emotional needs. There is a danger in being too diagnostic as young people can become the sum of their diagnosis.

The office for National Statistics recently did a study of 10,000 children aged 5-15 and their mental health across England, Wales and Scotland. Within the general population 8.5% of children displayed mental health issues this rose to 45% in the looked after population (5 times the average). Interestingly in the Scottish cohort children and young people at home, in foster care or residential care displayed the same level of concern across the spectrum regardless of where they resided.

In the 80's in Scotland, psychiatric and therapeutic services were attached to residential units. There were strong relationships that were seen now to have broken down and now relationships are mediated through referral mechanisms

The one bright light in this in Glasgow is the substantial investment in Mental Health services for young people who are looked after and the development of a multi-disciplinary team to undertake this work.

This team will see all children in residential and foster care and they will accept a referral if there is a concern in the system. This means that children and young people will not have to present with a diagnosable mental health issue but any one in the system can have a concern and the team will assess need and work with the system to assist, including seeing the child or maybe another part of the system.

Further to this, the unit will begin discussions with residential service providers to look at how they may be of assistance to them, including consultation that may take the form of a member of the team working alongside the residential service as an ongoing consultant. This means the service will move to a relationship based service one where relationships are valued.

This grew out of work that was undertaken by the team with Foster Carers. The team consulted foster carers and asked if they had a mental health service that you wanted what it would look like. The foster carers responded by saying:

- You would take our word that there is a problem
- You wouldn't be hung up on proving that young people didn't have a problem
- You wouldn't take the child away and not tell us what you have done
- You wouldn't dump us when a child moves and we may still need assistance.

There was a great sense from Dr Bryce of understanding the complex world of care including the sense that the people who have the most contact with vulnerable young people, have the least experience and we therefore need to value their role with those that are vulnerable and support them.

Service model development with Mental Health

Scotland have considered how to best meet the mental health needs of young people in out of home care and discussed some preliminary models of residential care which focused on how the mental health needs of young people might best be met. Dr Bryce detailed that they were interested in teasing out - in, for want of a better phrase, an academic way - a spectrum of mental health need and mapping it onto a spectrum of provision.

Assumptions about the spectrum of provision - all young people have mental health needs and so "mental health capacity" would be needed right across that. But at one end of the spectrum, mental health issues play a more prominent part. There is, of course, a language issue here, which plays into the discussion -illustrated by asking which terms we would want to use to indicate the "need" – disabled, vulnerable, excluded, disturbed, dangerous etc.

Bryce suggest that if we hold that question, we might suggest that, the richer the mixture of mental health need within the group of young people, the more one would want to build in mental health skills. A question arises, as this happens, of professional identities - and whether some of the provision would properly be a joint social work and health provision, with the employment of health professionals as part of the staffing establishment- rather than the current "visitor" role.

In Vancouver, Canada the ***Maples Adolescent service*** has provided a significant mental health treatment model to meet the needs of young people 12 and over with a multi-disciplinary team as Bryce described.

The Maples service is providing a mental health service that is both residentially based and one that is based on an outreach model within the home.

The residential component is only 3 months in length, but does provide some ongoing respite if this is needed as part of a care plan. Further to this, the program can be provided in the family or external home environment with a team that outreaches to the young person's context allowing for significant innovation and the ability to build on existing connections within the community.

The program overall has a strong theoretical framework, which is based around attachment and a family systems perspective. The multidisciplinary team consists of Psychiatrists, Psychologists, Nursing staff, Social Work and Child and Youth Care staff and a recreation team.

Most young people being provided care have significant behavioural difficulties and psychiatric problems including conduct disorders. Residential programs provide a period of clinical evaluation, stabilisation, and intervention and follow up in a structured setting as well as support for families/care givers and the development of a care plan.

Services provided include mental/psychiatric evaluation, multi-disciplinary assessment and plans of care, family therapy, education and support, educational opportunities, vocational and recreational opportunities and social interactive experiences, ongoing outreach and respite services and ongoing program evaluation.

There are a number of significant differences to this program. Firstly the strong emphasis on attachment as the guiding principles for all work unites the staff team at all levels. This provides staff regardless of role, a common language and filter through which to see young people's behaviour. This allows for more congruent and consistent planning and adds to the experience that young people and their families have through the fact that they hear the same messages from the staff team.

This emphasis on attachment has led to the development of an adolescent parenting group called the connect parent group. This group is based on attachment theory and teaches parents and caregivers attachment skills and empathic responses to their young people. It focuses on young people's needs for attachment and taps into caregivers own attachment issues. Most parenting courses are strategy based, this one is based on parents gaining new insights alongside some skill based sessions. It is a compulsory part of young people coming to the program both externally and internally.

The group has been based on significant research that found within multi-problem families that there were the following factors:

- Disengagement between families and young people
- High levels of criticism
- Parental psychopathology
- Ineffective parenting.

The group has had rigorous pre and post testing and evaluation by an external university (Dr Moretti) Simon Fraser University. Statistical evidence has been significant with parents and caregivers maintaining a changed attitude over time.

Further to this, the significant difference in the program is the conclusion. At the end of the internal and external assessments there is a care plan meeting. The care plan meeting brings together, the young person, care givers, case worker and any other relevant services with the multi-disciplinary team that have undertaken assessments over the course of the treatment, including, psychological, a family social history, educational assessments and psychiatric assessments. At the meeting the assessments are discussed with the group, including the young person. From this a care plan is presented to the team that is based on the assessments and designed to assist the young person live back in the community in a better way and for the community to be able to construct an environment that best meets the needs of the young person.

What is striking about this is that at the meeting is also a care plan consultant who has been assigned to set up a meeting post the discussion to assist the group in the community to enact the care plan and to act as a consultant to the group to keep on track in ensuring that they can think through creatively the care plan and construct environments in their community.

The Mental health needs of young people in residential care are complex and given the “river of pain” (Anglin 2002) that children and young people have experienced it is no wonder that children and young people are overwhelmed and distressed and developing significant mental health difficulties. The complexity of this is that often residential care staff are trying to provide care for this group of young people without the significant benefit of multi-disciplinary teams to guide their interventions.

Likewise the Institute of Juvenile Research of the Illinois University in Chicago has developed a significant in house treatment and consultation program for residential services in Chicago. This allows the team to undertake an assessment and treatment plan and to then work with the residential service provider in an ongoing consultancy role to assist them in constructing care environments that meet young people’s needs. This significant assistance is designed to preserve relationships with residential services but also ensures that young people are being provided an intervention that is least restrictive but well planned and supported. This type of model recognises the incredible job that residential services are undertaking in the care of children and young people.

Recommendations:

22. *Models of care should be developed in all states in Australia that provide specialised care for children and young people who exhibit highly complex behaviours.*

23. *Service delivery models within mental health systems in Australia need further development to provide services to residential care providers and recognise the significant place of residential care in providing care for young people with mental health issues. This includes greater respect and acknowledgement of residential services place within the mental health system.*

Trauma

It has been evident that all of the young people in residential environments across the world have experienced significant trauma in their lives. Every body I met on this trip had horrific stories to share of things that have happened to young people in their care, not withstanding often the number of placements that young people had had prior to their current one.

However, often the philosophical understanding of trauma and its impact was lacking in the residential care environments. It was not making up a large component of understanding and without this young people’s behaviour is easily seen as bad and not adaptive as it would be in this context.

At the very minimum children and young people have experienced significant loss coming into care. It is easy to forget this. The loss of family, friends, hope, dreams, power, and connections ideas of what they want represents the least trauma that children and young people have endured.

Add to this abuse, neglect and often incredibly distressing events and this is a powerful mix of trauma that many children and young people experience. This does not often take into account the multiple placements that children and young people in residential care have had to endure.

Perry's research (Bloom 2005) in the neuroscience area evidences changes in brain function in adaptation to trauma. Perry and his colleagues have observed persistent hyperarousal and hyperactivity, changes in muscle tone, temperature regulation, startle response and cardiovascular regulation as well as profound sleep disturbances, affect dysregulation, specific and generalised anxiety and behavioural impulsivity in children who have been traumatised.

On some occasions I heard staff talk of children who had experienced up to 40 placements before children were placed within their program. Trauma of any kind is often neglected when thinking of children and young people's behaviour and how we work with them to assist them deal with these losses. It is often more evident for children and young people who have survived multiple placements, but loss needs to inform our thinking for all children and young people in care. Little children may express this in tears and distress (as I often witnessed) but often children and young people display this within what is classed as oppositional behaviour.

As Anglin references (2002 pg 55) "Responding to pain and pain based behaviour is the primary challenge for carework staff….Perhaps more than any other dimension the ongoing challenge of dealing with such primary pain without unnecessarily inflicting secondary pain experiences on the residents through punitive or controlling reactions can be seen to be the central problematic for the carework staff."

Most programs incorporated a sense of the importance of trauma through their use of structure predictability, safety and security in their program design. Whilst this was followed through when young people were in the care of the service, little thought again was given to these elements when looking at transitional arrangements for children and young people upon leaving the residential.

Ward (2006) raised concern about the over-reliance on restraint and cognitive behavioural based programs that appear to address only behaviour and not trauma or distress. These programs attest good research basis but are often based on small samples and in his assessment are packaged up and duplicated everywhere. In Wards opinion these things occurred for the following reasons:

a) To make a difficult task appear manageable
b) To make something expensive appear cheap
c) To make a long task seem short.

Most programs visited on this study continued to struggle to find the balance between addressing behaviour and treating trauma. A lot of programs worked daily to address these issues, because holding a trauma framework does not mean that we negate addressing behaviour either. It is not an either or debate.

This is one of the key struggles of residential care. The Sanctuary Model of Care within the Andrus Children's Centre had put this debate at the centre of their model development using a trauma based frame in the context of both their school and residential program. This saw them have a social worker placed in each residential care unit who could assist residential care staff make sense of behaviour and address the needs of children whilst assisting children and young people to change behaviour.

This included significant training of staff in understanding trauma but in a variation of this, the model also assisted young people to understand the impact of trauma on themselves through a social educational model. I had the experience of talking with some young people of their experience of this model and they told me that the groups had helped them understand not only their behaviour, but the behaviour of other young people they lived with. They described the groups also giving them an idea that they could act differently and providing them with new skills and ideas in managing their distress. There was a sense for me of these children and young people having a great sense of their own ability to create change and that they did not have to beholden to the past.

Relationships are key to residential care. Building relationships based on trust and within the confines of what a child or young person can manage is key to having an understanding of trauma. Coupled with this many staff that work in residential care have their own histories of abuse and distress, with many having not had an opportunity to address their own pasts.

What is therefore evident, that many staff will suffer from hearing these stories and living alongside this pain based behaviour that is not easy to withstand at times. All staff spoke of being spat on, kicked, abused and at times significantly physically attacked, watching the home they had created being destroyed. I know myself that as I had to hear of the despairing stories of children and young people around the world, I experienced significant distress and depression about the state of the world.

Without a framework of trauma and understanding of young people's behaviour as adaptive for the environments in which they have had to live and survive, and then we continue to have young people to conform to the structure we design, rather than the structure conform to their needs (McCoy 2006). What was clear in this study was that many children and young people had experienced much pain in their short lives.

Further to this, an understanding of the immense pain and trauma associated in these living environments compels us to look at how we support the staff caring for children and young people and simultaneously give them the capacity to deal with their own pain and gain greater understanding of how to care compassionately and affectively with young people who are traumatised.

As Anglin points out (2002) “Given the severity of the difficulties encountered by the young residents in their daily lives and the depth and pervasiveness of their psycho emotional pain, it seems imprudent at best and negligent at worst to place inexperienced untrained staff in such a demanding and complex environment. Furthermore it cannot be in the resident children’s best interests to be exposed to ineffective or repressive staff reactions to the resident’s painful attempts to take action, however, misguided within their often incomprehensible and frightening situations.” (pg 114)

Recommendations:

24. *That trauma theory and practice is incorporated in all residential care staff training and that staff are provided practical measures to respond to pain based behaviour in young people*

25. *That responding to trauma and pain based behaviour is a central part of all models of residential care*

26. *That children and young are provided opportunities and information to understand the impact of trauma on themselves and others so to be provided with an opportunity for change.*

Staffing

Staffing levels, within residential care are significant. If staffing levels are too low, the capacity to manage the residential by placing an emphasis on intervention rather than putting out fires is not possible. Conversely, having too many staff can give negative messages to young people about their capacity to manage their own behaviour. Staffing should not been seen in numbers alone. Although staffing levels need to be appropriate and safe, staffing should also be seen in the context of supervision, training, and professional development.

Good staffing ratios allow young people to build relationships with staff and these relationships are the context within which intervention will occur for young people. In turn it is in these relationships that young people have an opportunity to influence the care they receive as demonstrated by the young people in the Who Cares study in Scotland (Whiteford 2005) where one young woman said “I have a key worker she is really good…..She’ll sit down and let me talk. She helps me understand the decisions that have been made about me” This is not possible without the resources to ensure the time is able to be made available.

This was demonstrated in the visit to a residential that had only 2 staff to up to eight young people. The young people ranged from 9-15 years and staff spoke repeatedly of their struggle to get time as a key worker to spend time with their children and to do things with them that would assist in building relationships.

Further to this staffing levels are about safety, providing a safe environment for young people and staff. Where staffing levels are low and needs of young people high this creates significant issues. Many young people talk of feeling unsafe in their residential, subject to bullying and not having staff around to assist(Whiteford 2005). Whilst this can also be about how staff interact and see their role, (which will be discussed in the training section further) it is impossible to address issues or prevent issues occurring if not enough staff are present.

In the majority of services visited staffing levels were 1 staff to 2 children or young people. At peak periods of after school, dinner, bed times this was often increased to 1.5 staff to 2 children or in a 4-5 bed residential 3 staff were on at these points.

In one residential the staff told me that they could see a young person might benefit from leaving the residential for a period of time, going for a drive or spending some time one on one with a worker but they could not achieve this as there were 8 young people to care for and only 2 staff and you could not leave one staff member with 7 children. This inevitably means that sometimes young people are escalating acting out behaviour and then having to be restrained or have a police intervention where with better staffing this may have been prevented.

Many people during the course of this trip spoke of the concern of the low status of residential carers. Many said that other youth work was paid at a higher rate, yet residential workers had to work in highly traumatic environments, where verbal and physical abuse was part of the everyday life and they were expected to undertake therapeutic care and reflection and yet often overseas staff were paid less than waiters at times. They were required to have significant education but then they were left with debts that on low wages that were difficult to pay off.

Anglin 2006 believes that an upgrade in status of residential carers is needed, he says “we owe it to children – they need to know they are cared for by someone who is respected.” “Good care is not produced by tools – it’s provided by people and investing in carers is investing in the heart and soul of children.”

As demonstrated by the Sycamore Service (Helping people grow) “The task for us as staff is to value ourselves and those around us – to supply the conditions that are conducive to this growth and development; to provide opportunities and the facility for this growth to occur.”

According to Foley this requires organisations to place a significant emphasis on supporting, training and providing conditions for staff that allow them to being able to access all their energy to care for children and young people.

The majority of people believed that a new deal was needed for residential staff, that they should be paid at higher levels than other youth work and that this was in recognition of their exceptional skills and care required. It is evident this will not occur unless the value of residential care is recognised for children and young people. Unless we see that residential care can be a quality option, we will not provide it with quality status.

Recommendations

27. *As Skinner noted the "key to good quality care is the calibre and effectiveness of staff". Residential care staff need to be valued by the system they belong to and remuneration levels need to be assessed against the care they are required to provide.*

28. *Staffing levels of residential care facilities needs to be adequate to provide safe care for children, young people and staff. Staffing models should be mapped against the types of care environments being provided and the levels needed to provide quality outcomes for children and young people.*

Training and support

In Anglin's study of residential care in 2002, he noted the fact that those who had the most complex and demanding role in caring for traumatised children have the least and in many cases no training to assist them in this role (pg 113 Anglin 2002). In Anglin's study this meant "that many workers are being hired to work in the midst of this river of pain without having engaged in a process to identify, understand and come to terms with the unresolved trauma and pain in their own backgrounds leaving them vulnerable to defensive actions towards youth when the youth's pain emerges…." (pg 113 Anglin 2002)

Unfortunately this was still the case for many residential carers across the jurisdictions visited on this study tour.

Carers need to have a good understanding of trauma, its impact on young people and effective strategies for intervention that sit alongside behaviour management. It can not be an either or approach. We need to move from a position of what are we going to do to stop this behaviour, to a positions that asks what is causing this behaviour. We need to reclaim curiosity (Bryce 2006) and ensure that it forms the basis of all of our practice in residential care.

Scotland through the Scottish Institute for Residential care at the University of Strathclyde was making a significant impact on training of residential carers in all the places visited.

The dedication of a research and training centre for residential care that was assisting to professionalise the care offered was significant. It gives significant status to residential care within Social work and was offering degrees and master's qualifications for managers and carers in residential care specifically.

An increase in training and the status of residential carers will give an increase to the status of children and young people in residential care.

Many issues were raised about the levels of training and requirements for residential carers. All concerned felt that specific training needs to be developed for residential care specifically that current training models do not lend themselves to assist carers to care more professionally. Given the complexities of how residential care has been seen this is not surprising. Gallagher (2002) discovered that where training and support of staff is low there is correlations with low educational outcomes for children and young people. This attests to the lack of a learning culture being present and a lack of congruence as suggested by Anglin.

This was in stark contrast to that at the Kibble Residential Program in Scotland where an organisational ethos exists of investing in staff and investing in children. The CEO believed that children and young people needed to see their value in their staff being valued. There was also a belief that children and young people would not value education if they did not see their staff engaging in further education. 80% of staff had undertaken further training and many were engaged in further education.

It was clear across the board in all sites visited that we need qualifications for staff in residential care but we are struggling to find what system works best. Worryingly although there has been an increase in training in the UK there has not been a correlating increase in the standards of care offered. This would indicate that training is one part of the sum of residential care and that improving training alone will not improve the care or outcomes overall.

Pat Petrie from the UK has been exploring the concepts of social pedagogy that form the basis of residential care in Denmark and Germany. The social pedagogy relates to overall support for child development – in pedagogy care and education meet. Petrie (2006 pg 116) found that "Pedagogy implied work with the whole child – body, mind, feelings, spirit and creativity – the child is seen as a social being connected to others and at the same time with his or her own experiences and knowledge."

Clearly the overall emphasis of this approach on overall child development and the whole child is immensely useful. When looking at Maslow's hierarchy of needs it is evident that we are often in residential care only meeting the basic needs of children and young people and sometimes fail to meet the aesthetic and cognitive needs of children and young people. To be honest, it has been some time since I looked more closely at the hierarchy of needs and was reminded of so many needs for young people.

Social Pedagogy has something to offer given their training focus that looks at assisting carers to help young people connect through art, sport and the sensual parts of their world. We should explore the strengths of this model to incorporate training. Petrie identifies the following training areas (2006 pg 118)

1. theoretical subjects in behaviour and social sciences
2. skills training such as group work, working with conflict and challenging behaviours and team work
3. creative and practical subjects such as art, drama, wood work, gardening, music – media through which they can relate to children
4. arts and practical subjects are valued for their general therapeutic effect – helping children enjoy life
5. optional study modules and placement for specific settings.

In Canada, the schools of child and youth care have combined the expertise of early childhood, social work, psychology and education to provide a course for students with a particular focus on students gaining an understanding of the life world of the child and viewing interventions through the life space of the child.

This would mirror a lot of the pedagogues view, with a strong emphasis on life span development. There is also a particular emphasis on the use of self and therapeutic self awareness. Students are encouraged to understand their own values and beliefs, assumptions, how this shows up in their thoughts and learning to ask for feedback without personalising this. There is a strong emphasis on laboratory work and testing out skills through role playing.

Child and Youth care degrees and diplomas were offering skills in the following areas:

- group work
- recreations skills
- behaviour management
- family systems theory
- life span development
- psycho-educational models

There are strong practicum components and in many of the courses significant screening to get accepted to the course, including in one course a weekend away to assess suitability for the program.

Practitioners consistently spoke of the need of training to be practice based. Theory needs application in reality. It is all good and well to understand trauma, but when faced with an aggressive young person what do I do? What should I say? Any training needed to provide students with the capacity to apply their theory in practice.

Further to this far greater training in mental health is required. Statistics as detailed from Scotland and from Mc Cann (1996) work in Oxfordshire that found 96% of adolescents in residential care showed some form of psychiatric

disorder a significant number that had gone undetected and 23% of young people had a major depressive illness, requires much more thoughtfulness about the mental health training and support given to residential carers.

All residential facilities visited and spoken with have young people exhibiting significant distress and that they are concerned with their mental health. Residential care workers routinely spoke of the lack of consultation an interest of the mental health professionals in their knowledge and skill. The diversions in these systems are contributing to the ongoing poor outcomes for children and young people in care.

Routinely those residentials providing high quality service provision had significant access to consultants. Staff were learning on the job and there is a continued focus on young people's needs and a questioning of how we could best meet these needs. This could be either in house or external therapeutic consultancy. The use of multi-disciplinary teams in residential care and the benefit of significant input via consultancy and increasing support and training to carers were routinely seen in a number of residentials in this study.

Recommendations:

29. *Minimum standards for training of Residential care staff should be developed within Australia*

30. *Any training developed should incorporate an emphasis on mental health, attachment, trauma, life span development and loss and grief*

31. *All training should have a focus on assisting residential carers to develop personal reflective skills*

Environment and space

Attention to the environment residential care was conducted in varied across settings. Some settings were wedded to the building in which they conducted their work. The building had existed long before the new program had been designed.

Often services had been conducting care for over 100 years on these sites and many started as orphanages many years ago. Some of the difficulty with this is that if large sums of money are tied up with the building then it is difficult to consider the best environment in which to provide residential care . It becomes improbable to think of selling the history of an organisation or problematic to cost wise to completely renovate a building to better provide the contemporary models of residential care.

Further to this, sometimes staff that were thoughtful about the environment were prevented from taking appropriate action to rectify its short comings due to budgetary constraints, or an inability to do much to change the physical lay out or setting within which they existed.

What is clear is that the environment you live in has a significant impact on you and vice versa. If the environment is shabby, unkempt and uncared for then it is likely that young people feel this way about how they are treated by staff and the system as a whole.

Furthermore, there is little incentive to invest emotionally in keeping a poor environment clean or friendly for staff or young people. Aesthetics are important to consider in their impact on experience. We invest large amounts of money in creating cultural spaces – parks, theatres, urban upgrades - (and I had the joy of visiting many of these on this trip) due to our understanding of how the environment shapes our community.

So it is natural that the environment that young people live in will influence them. It would be my belief then that living in an environment that is an old institution gives a physical sense of being institutionalised regardless of the type of care offered. This was certainly my experience.

There is little evidence to suggest that when evaluating the outcomes of residential care that much attention has been paid to the quality of the physical environment in which the care exists.

Defining what environments physically are best and what works well for different populations of children and young people is difficult. However, further evaluation and thought need to be given to this area.

Many practitioners and providers of residential care spoke with me during the course of this study about the environment, often discussing how they manipulated the environment and space to create harmony, physical space and capacity to monitor children and young people. This was often as thoughtful as what colours were used within the service to paint the walls.

Many practitioners spoke of their sense that in providing a comfortable and inviting home environment they were inviting young people to feel comfortable and at home. They spoke of the affects of a nice home and investing children and young people in keeping it nice. Many spoke of working in other services where the environment had been paid little attention and they had seen the result in young people's negative behaviour.

It would be evident therefore that further evaluation of these interactional affects for residential care is required.

Often young people were still sharing bedrooms within residential services, which in a family environment is more than acceptable. I would question its value when children and young people are forced to live together with limited influence over who will be living alongside them. In these environments young people had limited input in who they had to share with, an in often what was also limited physical space not to have your own haven to retreat to has to have a significant impact on the psyche.

Residential care could be seen as a luxury given many of the environments that young people are coming from, and no doubt for some young people there are benefits in sharing. However, we need further investigation of young people's views on this, for many young people in this study it caused significant distress, and where your life is already out of your control in the most part, this is an added burden.

Overall, the lack of focus on environment goes to the core of viewing residential care negatively overall, not by providers but often by funders who are forced to often find the money to operate the service they know children and young people need.

Recommendations:

32. Further research into residential care should incorporate some study of the impact of the environment and space so that greater emphasis can be placed on this area.

What makes residential care successful? Key factors in the delivery of high quality residential care

1. **A well developed philosophy and model development that is thoughtful, reflects theory and can be demonstrated at all levels of the organisation. Key elements in the theory development that include at a minimum a framework that incorporates, trauma, attachment and loss. This includes appropriate access to resources including multi-disciplinary teams of therapists, psychologists and consultant physiatrists to make this work.**

2. **Young people at the centre of service delivery and firmly embraced by all staff as the most important client group including administrative and auxiliary staff**

3. **A sense of creating a home for young people – sense of belonging, importance and care by all staff. Young people being claimed.**

4. **A commitment to training and a significant investment in all those caring for young people – creative and at all levels including administrative and auxiliary staff**

5. **A commitment to continuous learning, evaluation and research demonstrated through the involvement of staff in projects across the residential and with the input of consultants and universities**

6. **The development of a continuum approach that ensures a suite of programs, living environments and interventions are available for**

young people that meet their needs and is able to track with them over time. This includes a capacity to meet educational needs, family work, foster care and residential care within an integrated approach.

7. **A belief in residential care and its place for children and young people as a positive option not a last resort**

8. **A resourced system to ensure that residential care is a positive option, with staffing models, environments and accesses to resources demonstrating this to staff and young people.**

9. **Support through training and development and centres dedicated to the training, research and resourcing of the residential sector.**

10. **Congruence in the supporting literature from governments including articulated policies well developed standards that are easy to understand and target young people (see example of Scottish standards) and consistent monitoring systems.**

11. **Congruence within the residential between stated aims, model of care, engagement and treatment of staff and delivery of services to young people and their families.**

12. **Funding arrangements that allow for adequate staffing and significant holistic interventions including supporting education, psychological and therapeutic interventions, specialist assessments and recreational input.**

13. **Integration with the systems that support children, young people and families including mental health and treatment services – ones that operate on concern and not are not diagnostically driven, giving opportunities for early intervention and assistance to carers who are dealing with our most vulnerable children with the least training and support.**

14. **Residential care can be used effectively for younger children if it is therapeutic, healing wounds and actively addressing distress for young children that prepares them for foster care. This type of model could prevent many younger children from undertaking too many foster placements and successfully transitioning to a new family. This should be short term and have foster care linked to the program or significant family intervention models. Children under 6 should not be placed in this type of program. You could argue that it should be time limited from the start 1 year at most with an exit strategy built in at the beginning.**

15. **A focus on family and community work allowing the residential to outreach and assist young people connect to the systems that are important to them. Focusing on continuity of relationships and continuing attachments, learning new skills in a supported environment to be able to moderate their connections over time.**

Conclusion

This research tour was by no means a comprehensive study of residential care, many more learned people than me have undertaken research in residential care over the years, many of them referenced in this paper and I walk in their footsteps. This study did allow me to spend time reflecting though on how we provide good quality care within a residential system.

I am of the belief that residential care does have a positive place in the lives of children and young people in out of home care. I am not sure that we are clear about how to do this in the best way at this time, but what is evident is that many people are providing good experiences to children and young people in residential care around the western world. It is important that we learn from each other and continue to strive to make residential care a place that children and young people can be proud to have belonged to.

It became clear to me during this research that one of the central factors in any care of children and young people in out of home care is the need to be claimed and to belong. For too long we have had an ambivalent relationship to children and young people in out of home care. We, including statutory departments, have seen our place in their lives as transitory. For some children and young people this will be the case and we will be just a short part of their journey but there will remain a cohort of children and young people where this will not be the case.

No relationships in own lives are ever black and white. Grandparents, aunts, family friends and other relatives and friends play key roles in the caring function for us over time. Some have stronger roles than others in our lives but in the main they claim us as theirs, we know where we belong and the importance of these relationships.

We must stop pretending this is not the case for children and young people in care, we must take responsibility, see them as belonging to us and work to provide the input and care that they need.

As I was working in Vancouver an article appeared in the local paper about abuse in a past institutional care environment. This was a sober reminder of what can happen to children and young people when we are not diligent, when we do not have in place good systems of care without trained staff, thoughtful programming and monitoring.

But it was also a reminder that the residential care referred to in this paper is not institutional care. We need to reclaim residential care as a positive option. Bad things happen to children and young people in all situations, their home, community, foster care, kinship care and we do not dismantle these systems completely, nor let them carry the negative connation that residential care has been allowed to.

Good quality care needs thoughtful, reflective environments. We need to reclaim residential care to allow children and young people to have positive experiences of themselves. Being in a residential program should not be a punishment. Many times I have heard children and young people refer to themselves as resi-kids – in reference to themselves being bad. Where we let children and young people fail into residential care this is the system we create.

Coupled with this we should not let past horrors such as physical and sexual abuse that happened in institutional care stop us loving children and young people in residential care. We must also reclaim good and safe touch and affection. Children and young people cannot live without this and we must not let fear stop us providing what is essential in children and young people's lives.

It is clear that children and young people in care need choices in the care environments offered to them. One program in Canada told me of how one young person they had worked with and had spoken of how family care was the 'F' word for her. This young woman spoke of how she did not do family well and she preferred to live in residential care. For us to be responsive to children and young people we need to therefore be able to offer care systems that meet their needs.

To not replicate the past then we must be ever diligent in the care we provide, it is my hope that this paper contributes to the ongoing debate about what good quality residential care looks like and the factors that we need to address to ensure this.

Lisa Hillan

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APPENDIX A

Places visited during research trip

Scotland Feb 2006

1. Scottish Institute for Residential Child Care, Glasgow School of Social Work, University of Strathclyde – Contact Ian Milligan
2. Kibble Residential school, Paisley Glasgow – Contact Graham Bell
3. Sycamore Children's Service – Kircaldy, Fife – Contact Tim Foley
4. St Mary's Kenmure, East Dunbartonshire, Glasgow – Contact Neil Sharpe
5. Children's and Young People looked after Mental Health Team, Glasgow – contact Dr Graham Bryce
6. Blairvardach Residential – Rhu Shannon – Contact Jean Cockburn

England March 2006

1. Adrian Ward – Tavistock Clinic – London
2. National Centre for Residential Care, National Children's Bureau London – Contact – Jonathon Stanley
3. SACCS – Therapeutic Residential services, Shropshire – Contact Richard Rose
4. All Parliamentary meeting on Children Looked after – House of Lords England
5. Caldecott Community – Residential care – Kent – Contact Clive Lee
6. Voice of Young People in Care

Vancouver March 2006

1. Maples Adolescent Treatment Centre, Vancouver – contact Jim Brown
2. The Children's Foundation, Vancouver – Contact Jim McLaughlin
3. The School of Children and Youth Douglas College, Vancouver – Contact Doug Estergarrd
4. Professor Jim Anglin Victoria University, Victoria
5. The School of Child and Youth Care Victoria University – Contact Daniel Scott
6. Federation of Child and Family Services, Victoria -Contact Craig Meredith
7. Ministry of Children's Services – Contact Annette Harding
8. Touchstone Family Services – Contact Michael McCoy

Chicago March 2006

1. Chapin Hall Children's Centre Chicago, Contact Mark Courtney
2. Department of Children and Family Services Illinois, Contact – Ron Davidson
3. Federation of Children's Agencies – Contact Marge Bergland
4. Uhlich Children's Advantage, Chicago, Contact – Kim Schmidt
5. Northwestern University – Contact Catherine Francis and Wanda Tracy
6. Institute of Juvenile Research, Illinois University in Chicago – Contact Dr Alan Morris
7. Lawrence Hall Youth Services, Chicago – Contact – Mary Hollie

New York April 2006

1. Vera Institute, New York - Contact Tim Ross
2. Andrus Children's Centre, Yonkers New York – Contact Brian Farragher

Appendix B
Models of Residential Care

Kibble Residential School
Paisley Glasgow

Kibble residential school is a large campus style operation in Paisley about 20 minutes from central Glasgow. The residential is based on a continuum model of service delivery. It provides only for boys aged 12-16 and has a school on site. Around 60 boys are accommodated with 40 boys attending the school within the context of a day program.

Kibble had undertaken a research study of young people and where they moved on to post accommodation. The residential found that most young people went home or alternative residential care, but there was difficulty sustaining young people at home. The residential had moved to the continuum model over 10 years ago in response to the research. In the coming months the residential will begin to address this further with the use of the Youth Advocates Program from Pennsylvania in the US – this is a wrap around model that will have intensive work with families – it would be hoped that this may shorten young people's stay in residential care and possibly even prevent some young people coming into residential care.

The residential invests heavily in training for all staff with a significant sense of the importance of training. Nearly 80-90% of staff have been overseas for training and development and there is a training team involved in the mapping of service training needs, delivery of training and the contracting of consultants to undertake training where need be. Many staff are undertaking higher education such as masters, and PhD's paid for by the organisation.

The school provides residential care models that move from intensive support to independent living and work ready programs. Included in this is access to intensive foster care that the school recruits, trains and monitors to assist young people to transition to family based care where appropriate.

Classes within the school are small (4-5) based on the national curriculum and are assisted with extra curricular activities such as music, drama, sport. All young people participate in school or work education programs.

The organisation has recently begun a social entrepreneurs scheme to be incorporated within programs (this will be discussed further under residential programs section). The organisation has moved to have a significant investment in staff, young people and the fabric of the residential. Surpluses are reinvested in these areas and grants are matched by the organisations own investment. The philosophical underpinnings would see that if staff see they are a part of something dynamic then this flows on to young people.

Residential Programs

Intensive support programs

These programs were begun in response to the concerns of young people being released from secure care. They were seen to be a very vulnerable group of young people – (drug use, chronic absconding, prostitution), the transience of secure care (see section on secure care later in report) led to the development of a model that emphasised the value of solving crisis and where support will not be terminated.

Herbert's Psychology for social workers was incorporated where a look at the cycle for transitions of change was applied to young people within the residential. Depression – anger resentment – testing out – letting go. Young people in distress constantly going through the cycle – need to look at how we can break the cycle.

Model

- 4 young people live in the model with 3 staff (one to one)
- Each young person has a key worker who works with them
- Each young person has a co-key worker (can take over when key worker not on shift, on leave)
- Staff meeting every week – whole team
- Access to the psychologist and forensic psychologist
- Group programs for young people
- All young people have an assessment on arrival (psychologist) – shapes care plan
- Safety plan also undertaken for safe crisis management (restraint)
- Each young person's needs understood
- Risk assessment undertaken of behaviour what will increase or decrease risk
- All staff debriefed following any restraint – life space interviewing with young people
- Physical intervention monitoring group meets quarterly – looking at the number of restraints used, duration, type, young people involved, staff involved – from this look at training, personnel issues, changes that may need to be made to safety plans
- All staff participate in refresher restraint training every 6-12 months
- Culture of positive reinforcement
- Close support 2-1
- General support 3-1
- Community house 4 – staffed
- Through care service with one worker who can spend up to 10 hours

Issues for consideration after care 18-21 – this group still seen to be poorly catered for.

Intensive Fostering

Foster carers are recruited separately for young people within the residential.

Currently the service has four foster carers

Intensive foster carers are paid around $37 000 pounds with allowances and fees - $27 000 base wage – around a level 3 worker

The agency is paid around $112 000 pounds per placement??

Carers are trained to the same level as res care workers (HNC) and receive around 36-50 hours of training before assessment. One carer is expected to be available full time for the care and support of the young person (i.e. not to work) in a couple the other carer is seen as a secondary carer.

All placements are single placements, carers cannot have any young children and their own children must be at least 2 years older than the young person placed.

All IFC attend a weekly team meeting on a Monday morning to discuss young people, to assist with support and planning, this is also attended by professional staff including the young person's key worker within the school. The IFC are supervised by a senior practitioner and are provided supervision individually and as a couple.

Res care staff take young people out on weekends and evenings to give carers a break and respite care is also provided.

Carers sign a service agreement with the agency in relation to the expectations and processes that are required of them. All young people come to the school and the primary residential carer is expected to bring them daily to provide an opportunity to talk to the key worker with constant feedback going between the school and the carer.

Carers are required to go to a Foster Care Panel – the panel is arrangement of about 8 professionals who every 12 mths (and the first 3 months of new carers) make an assessment of the carer's capacity to care and whether the service is prepared to continue to employ them. On the Panel sits a Doctor, Psychologist and other professional representatives. Reports are prepared for the panel by the following people:

- Foster Carer
- Young Person
- Birth parent
- Key worker
- Senior Practitioner

The Panel assess the reports and then prepares questions of concern or needing clarification to discuss with the foster carers and the senior practitioner.

The panel then considers the responses and makes a decision on whether a carer is able to continue caring. The panel will also make recommendations for development and support that may need to be enacted in the coming 12 months, and sets a time for another review.

Foster Carers are not able to smoke inside their home as part of their agreement.

Practice development sessions are run ongoingly and all f/c are trained in restraint

Programs Development

The Programs Team consists of 3 psychologists, one part-time forensic psychologist.

All young people participate in a comprehensive assessment at the beginning of their stay – the team have found that often that the level of assessment before was poor, very general and no intervention strategy had been developed.

The team undertake a range of assessments including the LAC assessment; youth level service assessment, and emotional well being screening – a more comprehensive psychological testing is done by referral.

An educational assessment is also undertaken. Care Plans are then constructed for young people from these assessments.

Forensic assessment is only automatic with sexually aggressive behaviours

The assessment is completed within the first 3 weeks of a young person coming to the residential, 6 weeks at the latest.

Group and individual programs are also run as part of a treatment process. The team have trained staff in each area within the residential on programs and assessments so that the knowledge is transferred across the campus and that there are champions of programs and interventions across the residential.

The team can deliver programs that they have been trained in but staff are debriefed by the team consultant after each session, the programs are manualised and the manual followed to keep rigour in the programs.

Key workers for young people are given feedback and also given assignments to undertake with young people – including structured assessments and reports given. Each individual session young people each young person is provided with a report of their progress, this is shared with the key worker.

Programs run are:

- Ross offending program
- Anger management program – keeping cool – thinking smart
- Fire safe program
- Offending's not the only choice
- Individual therapy for young people

All young people are pre and post tested.

Addictions work is undertaken and motivational counselling.

Cognitive Behavioural approaches would be the most significant counselling style and intervention style undertaken.

Within the sexually aggressive behaviours work and consultant is used to undertake program development and treatment – these are specialist units constructed differently (office in the middle of the unit so that all young people can be viewed, alarms on the doors.)

Gaps would be the family based work and connection with families given that young people come from all over Scotland this is very difficult to achieve. Additionally getting all staff to work with the young people within a common language that is part of the treatment is often difficult due to the size of the staff and the smallness of the team.

Education

The school works on national curriculum with supplementary exercises such as wood work, and mechanics.

Class sizes are small (4-5) allowing for an indivualised service delivery and teachers are supported in classes by key workers and link workers that assist with young people's behaviour and play a link between the school and the residential.

Classes are short in duration and work to engage young people in a variety of ways and the flexibility of the approach leads to young people being engaged in the process. It is an expectation that all young people go to school and the school operates things that all schools do including assembly, plays, and concerts. Boys are invited to participate in these not forced.

Kibble works – business development

Kibble works provides a business development arm of Kibble. The organisation has started three businesses that are run for profit. These also have an element of business community partnership. Staff employed in the businesses have both technical expertise required for their business and also need to attain the HNC qualification in residential care.

Young People are then offered traineeships, paid a wage and trained within the business section. Young people and staff participate in staff meetings and all staff are reminded of their efforts making or breaking the business. Hence all staff including young people are learning significant skills in the contribution to the success of a business operation.

Young people then leave the program with qualifications and experience and the ability to get employment.

Currently the businesses are:

- Catering
- Furniture storage and disposal (green company platform)
- Mechanical workshop

The business development has been assisted by a number of foundational grants that have paid for storage space. But in a short period of time the success of the business is fast growing and demand currently outstrips capacity.

Young people have been seen to improve in their literacy and numeracy skills and have been keen to participate. Young people are included as staff and therefore are expected to live up to workplace conditions. This has seen many young people step up to the plate. Young people who have not been successful in school have been incredibly successful in this area, participating and keen.

This type of model is trying to redress the outcomes for young people in care that typically continue to be poor especially in the area of employment. Young people are learning alongside their adult work mates and much therapeutic input occurs within the context of the work place and not a counselling session. This is grounded in real life experiences for young people and young people are learning social skills, work skills and the operation of a work place within this context.

The fact that this is a business model and not a community one means that young people must contribute to the business or there will be no work for them. Many models that have existed that are based on work placement rather than contribution to the business have not been successful. Many young people in care are now part of a range of generations of families that have not worked. This type of program seeks to redress this and offer alternatives.

SYCAMORE Residential Services

Sycamore residential services provide 4 residential units in the county of FIFE. They are a national service and take young people from across Scotland. A number of the residential services are located in Kirkcaldy a seaside town about 1.5 hours from Glasgow.

Sycamore residential units are small 4-6 children or young people and are broken into the following units

Children 10-12 - 6 beds
Young People 12-16 - 6 beds
Independent/Supported Living 15-17 4 beds

A key worker model is undertaken in the residential

There are 3 staff on at all key times including a staff member on from 3pm - 11pm, staff are on rostered sleep overs and undertake 24 hour shifts.

Intensive Foster Care services (4 families specifically recruited for exit points for children and young people in the residential) The families are paid the equivalent of a working wage, with one member of the household required to not work and be the primary carer. The families are paid the allowance for the duration of the placement.

The units are essentially houses in the community some are owned by the organisation and others are rented from the local authority. Interestingly all but one has a family unit extension – this is a one bedroom flat with sitting room and kitchen, bathroom which is attached to the residential but allows families to come and stay to assist with visits between young people and their families. Family work and intervention is undertaken by residential staff.

There is significant documentation and planning undertaken with an assessment undertaken, treatment plan devised and strategies for behaviour management undertaken. In each planning tool staff are asked to identify the probable cause and speculative cause of behaviour, consistently re-emphasising family history and links to behaviour. All of this is reviewed regularly and updated.

Education
There is a strong emphasis on education and attendance at school. To assist with this the organisation has educational support staff. These staff go into school alongside a young person, they receive specialist training. They are seen as a resource to the class and the school not just the young person and thus participate in the class. If the young person's behaviour is disruptive the educational support worker and young person will have devised a plan in how this will be addressed i.e. maybe a signal word from the support worker if the young person is escalating or a walk outside etc…

By having the worker as support to the class they may take reading classes for a small group, or assist with maths etc it means this is less stigmatising for the individual young person.

Close links are maintained with schools and given the extra resources and support offered to the schools excellent relationships with the schools in their efforts to meet young people's needs is enabled. Schools don't feel they are being left with a problem

Overall organisational structure

Sycamore has a strong philosophical framework that is based on humanist principles. This framework defines what is acceptable and unacceptable. The humanist framework defines that all people are valuable and are only limited by their own potential. This framework is used to define the service in relation to how staff are treated and young people. Followed by this a behaviourist approach is taken with young people with strong Rogerian principles this is seen in the care provided in the following ways:

- Focus on boundaries
- Consequences
- Social helping learning theory
- Role modelling
- Quality relationships
- Relationships for children and young people fit within the context of their history
- Sense of staff owning the service
- Reaching out to young people prior to placement in the context of their environment.

There is a strong understanding of trauma and behaviour in the context of pain. All interactions are thoughtful including how the house is set up with an emphasis on how the environment is constructed. The houses were pleasant homes, inviting warm well maintained, with young people having individual bed rooms and good communal spaces.

There is strong emphasis on staff development and training with many staff being encouraged and assisted to complete higher education. Staff are encouraged to have initiative and are provided with significant support in doing so.

The service has a well developed usage of consultants who are drawn from a number of backgrounds including:

- Psychologist with a specialisation in sexually aggressive behaviours
- Child psychiatrist
- Therapeutic group work
- Client centred practice
- Education consultant
- Fostering consultant

The service has also developed its own training to ensure staff are inducted into the Sycamore way. This is four day training and all new staff including admin participates in this. The group that comes out of this form a practice forum who continue to meet over the next year to discuss any issues arising.

The consultants groups are set up at the beginning of the year and all staff can request to attend groups or to present cases.

Further to this the service offers a creative therapy's service that has an art therapist, play therapist, and drama therapist. These services are provided to children and young people within the residential but also to children from the community.

SACCS Therapeutic service UK

Saccs began as an organisation that undertook training and consultancy on trauma. They were also undertaking assessments of children young people in care. The directors were very concerned with the limited impact they had on children and as such decided to set up a children's residential

SACCS have a significant focus on trauma and take children from 4 years - 13years to essentially prepare them for Foster Care.

SACCS provide a holistic service that includes:

- Therapeutic Parenting (residential care)
- Life story work
- Therapy teams
- Foster Care

The residential are placed in Shropshire and Staffordshire and the service takes children and young people from all over the UK and Ireland. The service can provide for 60 children currently (in small residences of 4- 5 children, some have only 3) and is looking to expand to other areas and will have up to 90 children accommodated.

The service sees they deliver recovery for children and young people. They take children who have disrupted attachments, multiple placements (one young child had 40 placements by the time he was nine)

The average stay of children in the program is 3years and 2 months. The service is looking for permanency for children seeing that the residential is their last placement before a foster carer can be found. Only about 50% of children are having contact with their parents.

Between 19998-2004 all children had been provided a foster carer and had stabilised.

The organisation has a strong emphasis on training of staff. All staff hold the nationally required NVQ3 however, staff will be working towards a foundation degree in residential child care (2 year degree) and staff will be funded to take this to a higher degree if they wish to enrol further.

On top of this the staff have training in the SACS recovery process. This is 24 1 hr subjects and lectures that are provided. Currently these topics are:

- Communicating with traumatised children
- Life story work
- Induction and foundation training
- Child protection
- Professional personal development
- Observation and assessment
- Sex and sexuality
- Attachment grief and loss
- Emotional intelligence
- Children's physical development
- Neuro – biology
- Working with children in a therapeutic way

The organisation has well developed assessment processes that are filled out on each child every 3 months by all members of the recovery team. There are 6 key areas that are focused on and 4-5 questions per area. The six key outcomes sought for children are learning, physical development, emotional development, attachment, identity and social, community development. The staff are asked to make a judgement on children in each key area between a scale of 1-4 ranging from acute difficulty to no difficulty and then to provide evidence of their findings – behaviour and thinking. The 3 reports are then mapped against each other and these are used to develop a recovery plan – identify areas for development, and treatment ideas for each program area to address.

There is also a practice research and development team (4 staff) who works on policy, training and evaluation. This team looks at 10-12 assessments of children a month, checking the previous assessments and see if there is a growth or decline in children's functioning. Analysis is done of this information, looking for patterns and the organisational delivery – is what we are doing working.

There is a strong focus on learning, development, training and evaluation.

Program

The program provides three essential elements

Therapeutic Parenting

Children are accommodated within a residential service that has rostered staff on 24 hour shift patterns with a sleep over. There is 10 staff for the 4-5 children, with 3 senior practitioners, a deputy manager and a manager and 3 staff on at any one time.

All children are assigned a key carer and a supportive carer.

There is a strong focus on therapy and recovery and a recovery team (therapist, life story worker and key carer and supportive carer meet every month for 2 hours to talk about each child). This is supplementary to other training and support offered.

The key carer takes the child to therapy and meets with the therapist to discuss key issues relevant for care after each session. There are also communication sheets filled out by the residential staff and the child to take back to therapy between sessions.

On arrival there is an assessment of children's needs. The assessment information gather includes:

- History
- Legal status
- Education needs
- Health needs
- Contact issues
- Information from parents
- Presenting issues
- Lac assessment and case plan

The service looks at what does it need to do to assist children manage their relationships from the past, in the present and into the future. The service aims to give children a voice and to provide predictability and consistency. In the first 6 months treatment is not provided, working to manage the behaviours and get a better picture of the child.

There is a strong focus on information sharing and demonstrated systemic thought about how to integrate practice in all areas of work offered to young people.All residential staff has access to consultancy (psychotherapist, and child psychiatrist) to assist with working with children.

On top of this staff have access to their own consultancy – a consultant looks at issues for staff with staff being asked to focus on their own self awareness. If staff are struggling with a child then managers can direct staff into counselling.

Therapy

There are 7 therapists employed across 2 sites. Each therapist would work with around 12 children. Therapists have a number of backgrounds including play, art, dance and cbt.

There are therapy suites where children go that are set up to provide a separate space for children to undertake work in. Therapists design a program to meet identified issues that are drawn from the assessment; res care staff, life story work and the child.

Life story work

This work is different from the work traditionally done in the life story work done with children. This is an in depth look at a child's life that includes interviews and gathering of information and opinions by a trained team of life story specialists. The team then works a child through their history during the process in an attempt to assist young people come to terms with their past and to better understand it.

Life story work is built on a strong theoretical background and

This includes the team undertaking the following

- A look at all files that are relevant for the child
- A look at the life of the child, parent and grandparents if alive – this is trying to gather important indicators of culture, values and personality traits.
- Interviews with other relevant persons including ex foster carers, family friends, neighbours
- Sharing of information with the child in conjunction with therapy and residential care workers

There is five staff employed to undertake life story work across 2 sites.
In at least 90% of cases life story workers work with families.

Foster Care

Foster carers are recruited, trained and supported by the organisation. In the majority of cases foster carers have only one placement unless determined by therapy that a child would benefit from another child present.

Foster carers have their own foster care support worker with whom they meet regularly.

In some cases carers may be recruited for specific children.

Foster carers continue to have access to therapists for the children, consultancy for themselves and the life story work.

CALDECOTT FOUNDATION

Set in Kent in England the Caldecott foundation has seven residential homes that provide a safe and contained environment and range in size preparing children to return to a foster or birth family. The Foundation can house up to 50 children and young people.

A case plan is designed for each child on entry to the program. Houses are staffed under a key worker model with staffing ratio being on average 1 staff for every 2 children.

School

The foundation runs their own school recognising that many children in care have poor educational experiences and are not succeeding within a mainstream system. The school has had some success in assisting children and young people to transition from their school back to mainstream school, but they have undertaken this through ongoing support from the Caldecott School that includes liaison by the Principal with the new school. This level of support and liaison is significant.

Class sizes are small with a maximum of eight students per class with a high teacher pupil ratio. School maximises achievement through the following structure:

Nurture
Admission phase where children are given space and time to build self-esteem and confidence – nurture class is divided into areas for formal teaching, quiet reading, play and homely corner.

Junior
Based on primary education – structured classrooms, stretching children while covering deficits in each child's learning – children encouraged to work as a group

Middle
Children who have reached secondary age but require additional coaching

Secondary
Formally time-tabled education with specialist subjects taught in dedicated classrooms

Special Education Needs
Baseline assessments identify educational deficits, weaknesses and strengths are developed for every child who needs them. Staff work on a 1:1 basis to maximise learning

The school also incorporates practical classes such as horticulture, woodwork, cookery with a focus on sport and other extra-curricular activities including concerts, children and young people are encouraged to join local sporting clubs.

Residential Units

Assessment Unit

The Caldecott Foundation runs a specialist unit for the assessment of children and young people in urgent need of care. Children and Young People stay in this unit for between 3-6 months – the team reports on each individual child's daily life – noting their needs, desires, ambitions, abilities and strengths and weaknesses.

In the unit psychological and psychometric and intelligence tests are undertaken shortly after admission providing the basis for a care package and planning. Psychiatric assistance is available if required. This assessment unit has its own internal school. Post time in the assessment unit a placement is sought in an appropriate care environment to assist in this transition the service has a through care social worker to liaise with the local authorities own social workers ensuring the placement aims are monitored and satisfied.

Residential care in general

Every child in the residential program is assigned their own social worker and receives a psychological assessment to ascertain the types of therapy if appropriate that are useful in assisting the child. Psychiatric assessments can also be accessed if needed.

Therapy services are extensive and include drama, art, music and play therapy. The therapy links to key workers and local authority staff to ensure that a comprehensive treatment program is introduced that allows young people to meet their emotional well being.

The therapy is also integrated into the living environment in the residential to ensure that the home environment reflects new learning's and ideas – sometimes therapists might undertake therapeutic work with key workers. Group programs are also run for children and young people.

Andrus Children's Centre
Yonkers New York

Much has been written about the Andrus Children's Centre's Sanctuary Model of care that has been developed in partnership with Dr Sandra Bloom. You can find out a lot of information on their website which is ……The model is well documented and the focus on trauma as the basis for programming.

However, I want to focus on a number of the implementations of this model that I witnessed within the residential.

School
The school like other schools within models documented within this paper had small student to teacher ratio's with approximately 8 students to one teacher. The school was characterised by a lot of flexibility for students, capacity to provide one on one interaction in the classroom and an sense of encouraging children and young people to participate rather than forcing a rule structure as such.

Within the school as within the residential all children, young people and staff had developed a safety plan. The safety plan was a document that young people and staff had to outline strategies for calming themselves when they felt that they were not in control. This plan was carried by all staff and young people and outlined a number of strategies that if a young person felt that their behaviour was getting out of control they could look to their safety plan and work with their teacher to implement this plan to assist them to stay in control and to not have negative consequences.

It was a requirement to carry the plan with you at all times and at a number of times during the day a safety check is done to ensure you know where the plan is. This has a two fold strategy one to remind young people and staff they have a plan and secondly to reinforce its use. The difference in this program is that staff are equal participants with young people in this strategy, it is not one based on young people only participating, so the school operates as a community. One of the teachers that I spent some time with told me of an incident where she was becoming stressed in the class and the young people could see this and one young woman put up her hand and encouraged the teacher to use her safety plan.

Further to this staff and young people participate in what is termed community meetings within the classroom. These are facilitated by an outside trained facilitator and once a week the team come together to discuss the impact of their actions on each other. Young people and staff are encouraged to openly discuss if their actions are inconsiderate of themselves and others and to acknowledge within a supportive context the impact of themselves on others. These meetings are strongly formatted and give a young person a chance to clarify their perceived actions and to accept or reject the information provided by the group. The group must agree or decline interruptions and new participants (including myself).

The group is also used as an opportunity to give the participants homework in trying out new affect and emotional growth activities. In the group I participated in the young people had to have helped someone in the proceeding week and discussed what they had done to help and what this felt like for them. Given many young people who have experienced trauma have difficulty with empathy these tasks are significant and give an opportunity to highlight strengths of each individual. Again the significant difference is that teaching and support staff are also responsible for undertaking the homework and for reporting to the group their progress.

Residential

Similarly within the residential the residential operates community meetings in the morning and the afternoon for each team of children with a key worker. In the morning young people are encouraged to identify how they are feeling and key goals they have for the day. Again staff are equal partners and must model their capacity to do likewise with young people.

In the afternoon when young people return from school another community meeting is held to talk about how young people are feeling at this point and also how they felt they went in achieving their goal. This meeting again provides two fold opportunities, one to get a picture about where young people are at and therefore be able to plan interventions that may assist with their current emotional state and secondly to assist young people to be in touch with their own feelings and experiences. Further to this it also provides an opportunity for staff to talk with young people about how they might achieve their goals and to celebrate achievement, which can be overlooked in highly charged emotional environments.