A National Profile and Review of Services and Interventions for Children and Young People with High Support Needs in Australian Out-of-Home Care

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Abstract

One of the major challenges currently being faced by out-of-home care services is the issue of placement breakdown and multiple placements, and the psychological effects of these experiences. Previous longitudinal research by Barber and Delfabbro (2004) indicates that approximately 15-20% of young people in Australian out-of-home care have significant emotional and behavioural problems or 'high support needs' that often condemns them to a life of repeated placement instability and further psychosocial harm.

This thesis reports the findings of Australia's first national comparative study of 364 children with this placement profile in four Australian States (Queensland, South Australia, Victoria and Western Australia). Based on detailed interviews with case-workers, case-file reading, and comprehensive analysis of objective placement data, this study provides a detailed analysis of the social and family background of this population of children, their psychosocial profile, service history, and their placement experiences. It was found almost all of the children with high support needs in Australian out-of-home care had been subjected to traumatic, abusive, and highly unstable family backgrounds. A proportion of young people had experienced over 30 placement changes and approximately 70% scored in the clinical range of emotional and behavioural disturbance. The young people in the sample were generally very similar in their characteristics. Children within this population appear to form one single cluster based upon very common family experiences; namely, the combined effects of domestic violence, substance abuse, physical violence and neglect. Such findings suggest very strongly that out-of-home care policy cannot, and should not, be considered in isolation from other important areas of social policy and public health.

Following the review of the characteristics of the children, the thesis examined the range of therapeutic interventions and placement options that might be suitable to address their needs. This section involved a literature review, an extensive internet search of care and service options and a review of program information wherever this was available. It is clear from the review that it is very difficult to maintain this population of children and young people in stable family-based foster care arrangements within the existing out-of-home care system. This thesis highlights

the need for a greater integration of services and a greater focus on ensuring an ongoing commitment to addressing the entrenched psychological and social difficulties contributing to placement instability. There is also a great need for a re-structuring and re-thinking of the continuum of care services available to children in out-of-home care, including the possible development of professional foster care services and an increased use and availability of treatment group residential care options. Most importantly, a re-structuring of the way child protective services and family, social and mental health services are provided and coordinated by State governments is felt to be desperately needed.

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"Perhaps the greatest social service that can be rendered by anybody to this country and to mankind is to bring up a family". George Bernard Shaw

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General Introduction

Foster care is often referred to as the necessary evil, as it is acknowledged there will always be children who are unable to live at home with their parents for a whole host of reasons. Recent AIHW (2005) reports have shown that it appears the number of children requiring out-of-home care is increasing. One of the principal reasons for this increase has been the rapid increase in the prevalence of child abuse reported and investigated in Australia. To a large extent, these increases are very likely to be attributable to important legislative and policy changes, including mandatory reporting. However, it is also acknowledged that this increase in abuse reflects an intensification of the broader problems within Australian society, in particular, the concentration of poverty within specific geographical areas and cultural groups and the effects of economic hardship, domestic violence, substance abuse and mental health problems (Osborn & Delfabbro, 2006).

In addition to increases in the demand for placements, there have also been several factors that have made it more difficult to find placements for those children who receive referrals. The recruitment of suitable foster carers continues to be a major problem that plagues foster care systems around the world (Barbell, 1999; Barber & Gilbertson, 2001; Victorian Department of Human Services, June 2003). Carers have exited the system in great numbers, having been discouraged by the lack of social and Government support and the inadequacy of remuneration provided to them (Barber & Gilbertson, 2001). Placement options have also been reduced due to the substantial reduction in non-home-based forms of care, including residential care and group homes, across the country during the last two decades (Barber, 2001).

The consequences of the increasing numbers of children requiring care and a reduction in the availability of suitable placement options have been twofold. The first is the growing concern that out-of-home is now more likely to be used as a last option for children and families requiring support. Consequently, only those children whose needs are most serious will be placed into care. Also due to the limited placement options available, it is becoming increasingly difficult to find suitable placement for many children in care. Suitable placements are therefore becoming more difficult to obtain, and so placements will be at greater risk of placement

breakdown. Evidence in support of these changes has been obtained in a number of studies (Barber & Delfabbro, 2004; Delfabbro, Barber, & Cooper, 2000; Victorian Department of Human Services, 2003). Placement instability or foster care drift continues to be a challenging feature of most care systems in Australia and many other Western countries, and one of the strongest symptoms of the failure of current out-of-home care systems. Research has shown a bi-directional relationship between unstable placement histories and psychological disturbance (Delfabbro, Barber, & Cooper, 2000). Placement instability has been found to be associated with problems with attachment and behavioural and emotional problems in children (Fanshel, Finch, & Grundy, 1989b; Farmer, 1993; Palmer, 1996). Moreover, in support of the view that the intensification of family or background problems is linked to greater strain on the foster care system, Holland and Gorey (2004) in Ontario Canada found that "strong relationships have been observed between child developmental and mental health problems, their familial precursors and foster placement instability" (p. 119). Further compounding this issue is the fact that placement disruptions appear to make existing behavioural difficulties even worse for the foster children, resulting in a vicious cycle of repeated placement failure.

Recent longitudinal research in South Australia (Barber & Delfabbro, 2004) has found strong evidence for all of these phenomena. However, one encouraging feature of their findings was that these extreme levels of placement disruption were only confined to a subset of the overall population in out-of-home care. Whereas most children achieved stability within two years of a new referral, a smaller proportion (15-20%) experienced very high levels of instability. Barber et al.'s (2001) work found that outcomes for children in South Australian foster care could be very reliably and efficiently predicted based upon baseline child characteristics alone, and that clear thresholds (e.g., criterion levels of instability, conduct disorder scores) can be identified that suggest a very poor prognosis for longer-term outcomes. Not surprisingly, this finding that high rates of placement instability are disproportionately concentrated in a small percentage of children has led to a greater focus on this population of children. Often referred to as "high support needs" or "complex needs" children, children in this group are now recognised to be particularly unstable because they have more complex or challenging needs than others in the care system. Furthermore, there are a great many studies (Chu & Dill,

1990; Femina, Yaeger, & Lewis, 1990; Mullen, Martin, Anderson, Romans, & Herbison, 1996) that have shown that early exposure to abuse and trauma is associated with significantly poorer psychological and social functioning, a greater likelihood of substance abuse, inter-generational abuse, and poor employment and relationship outcomes. For these reasons, such outcomes have potentially very significant long-term psychological effects on the children and also broader economic and social costs for State and Federal governments. Thus, it is argued that if one could understand and address the needs of these children, one could therefore concentrate financial resources and services in a way that very efficiently targets the primary cause of strain in the care system.

To date, few studies have attempted to undertake this task. For example, Barber and Delfabbro's research has provided detailed information concerning the outcomes of high support needs children in out-of-home care, but their study was subject to several limitations. Their analyses were confined solely to the South Australian system, and only a small amount of information was obtained concerning the families from which they had come. A Victorian report by Morton, Clark, and Pead (1999) provided extremely detailed information in a series of case studies of young people in Victoria with high support needs, but their findings only involved a sample of ten children and were confined to Victoria. For these reasons, the aim of the current research project was to extend previous State research into children with high support needs placed into out-of-home care in four different Australian States. In the context of this research, 'high support needs' was operationalised in terms of Barber and Delfabbro's (2004) criteria for ongoing placement disruption derived from empirically based statistical models. Any children who had experienced two or more placement breakdowns due to their own behaviour within the previous two years were included in the research. Such children have been previously shown to have a very poor long term prognosis of placement stability and are thus difficult to accommodate in the existing care system. Therefore, it was concluded that it was essential to not only establish the extent of the problems for these high support needs children but also examine and review appropriate and effective treatment, placement and service options for them.

Thus, the main objectives of this project can be summarised as follows:

- *To obtain a national profile of high support needs children in Australia*. What is the current social and psychological well-being of high support needs children in Australia? What services are they currently receiving? Are their needs and family backgrounds similar across the country?

- *To review intervention options for high support needs children in out-of-home care*. What psychological and other interventions have been shown to be effective?

- *To review national and international programs for high support needs children with case studies*. What is the state of play in relation to current service and treatment options for high support needs children in Australia and around the world? What can we learn from particular case studies?

- *To examine two national examples of programs for high support needs children in out-of-home care in South Australia and Victoria*. Are these treatment options for children in Australia effective?

- To discuss the implications of these findings for assisting Government policy and service provision for high support needs children in Australian out-of-home care.

Overview of Thesis

To address each of these issues, this thesis is divided into four sections. The first section (Section A, Chapter 1) contains a detailed review of existing research relating to foster care and the psychosocial consequences of time in care, and, in particular, the consequences of placement instability. Within Chapter 1, the first sections (1.1 – 1.4) provide an introduction in relation to the need for out-of-home care services, the types of out-of-home care placements and a historical overview of Australian foster care services. The following section (1.5) discusses the rates of placement instability and the psychosocial consequences of placement instability.

The last sections of Chapter 1 (1.6 - 1.9) contain a review of the literature on the effects of early trauma, attachment theory, family contact and the general psychosocial consequences of foster care in adulthood.

Section B (Chapter 2) contains the national profile of high support needs children (*N* = 364) in four Australian States (South Australia (*N* = 113, 31.0%), Victoria (*N* = 99, 27.2%), Queensland (*N* = 80, 22.0%) and Western Australia (*N* = 72, 19.8%). In Chapter 2, the placement and care history of the children is presented, along with an analysis of the multiple family and complex social background contributing to their placement into care (section 2.4). The next sections of the Chapter profile the psychosocial well-being and functioning of the children. The education of the children is discussed in the following section (2.8), followed by Section 2.9, which relates the current behavioural and emotional functioning of the children to their placement histories and social and family background histories. The type and frequency of family contact in discussed in section 2.11, and this is related to the placement history of the children and their current behavioural and emotional functioning. Section 2.12 provides four individual case studies of children in the study. Extensive details on the services and intervention provided to both the children and their families since their first contact with the Department and during the children's time in out-of-home care are then presented. The next section provides an analysis of the types of children most likely to receive certain services and interventions. The final section (2.14) of this Chapter provides an overall discussion of the findings and discusses the implications for the Australian foster care system.

Section C (Chapters 3 & 4) contains extensive details on possible interventions for high support needs children, followed by a review of North American program designs with case studies (Chapter 4). Section 4.10 provides a review of broad European and United Kingdom trends in treatment services, with a few brief examples of particular program designs. A review of treatment services for children in Australian out-of-home care is presented in section 4.11, along with several case studies of programs in operation around the country.

The final Section D (Chapter 5) contains two main sections. The first section provides details of pilot evaluations of two different Australian programs for high

support needs children. The final part of the Chapter (Section 5.7) compares and contrasts the two programs. The final section of Chapter 5 (5.8) offers conclusions about the outcomes from the two program evaluations.

The final Chapter in this thesis (6) integrates the findings of the national profile study, the international and national review of programs, and the two pilot evaluations in order to consider the implications of this work for existing foster care services and for future services and research for high support needs children in Australian out-of-home care.

SECTION A

Chapter 1

Literature review

1.1 The need for out-of-home care in Australia

Despite recent improvements in the Australian economy, many families continue to experience significant social pressures. Broader economic factors such as poverty, unemployment, and homelessness plague many communities, and there has also been a substantial growth in non-traditional family structures (sole parent families, teenage parents, or reconstituted families) which have made people more vulnerable to broader social and economic pressures. Individually, many more families are now affected by substance abuse, domestic violence, and poorer physical and mental health, all of which have greatly affected their capacity to provide adequate care for children (Barber & Delfabbro, 2004; Department of Human Services, February, 2004; Layton, 2003; Victorian Department of Human Services, June 2003). The reason for the prevalence of such issues tends to be related to the families having limited economic resources and less stable support networks. Accordingly, most researchers agree that a substantial number of families will continue to require additional Government support to ensure the safety and well-being of their children and that out-of-home care remains one of the most important options that should be available (Des Semple & Associates, March 2002; Layton, 2003).

Consistent with this view are figures for Australia which show that the number of children in out-of-home care has continued to rise since the early 1990s (Barber & Gilbertson, 2001). For example, at June 30th 2005, there were 21,795 children in various forms of out-of-home care, and this compares with only 13,979 in 1996 (a 70% increase over that time). From 2004 to 2005, the growth rate was 9% (AIHW, 2005).The number of children in out-of-home care has increased each year since 1996, when there were 13,979 children. Since 1996, there has been a staggering 45% increase in the number of children in out-of-home care (AIHW, 2004). Indeed, as pointed out by Barbell and Freundlich (2001), there is evidence to suggest that there are now more children entering care than children exiting care, a greater proportion

of children who return to care, and a greater rate of placement of children in care through other systems such as the mental health and juvenile justice systems. Conversely, data reviewed by the Adoption and Foster Care Analysis and Reporting system (AFCARS report, 2006) in the US noted that the number of children entering between 2000 and 2005 has steadily decreased and the number of adoptions has been steadily increasing. In Australia, a higher percentage of children have been shown to be staying in the care system longer. For example, according to statistics from Australian Institute of Health and Welfare (2004), an audit of care systems across Australia showed that approximately a fifth of all children (22%) had been in care for five years or longer.

A further contributing factor in the increasing demand for out-of-home care services has been the growing prevalence of child abuse reported and investigated in Australia. For example, during the seven year period from 30th June 1997 to the 30th June 2003, there has been a 41% increase in the number of children on care and protection orders in all jurisdictions, from 15,178 to 22,130 (AIHW, 2004). The majority (85%) of children who were on care and protection orders at 30 June 2003 were on guardianship or custody orders (AIHW, 2004). Re-notifications and re-substantiations of abuse have also substantially increased in many jurisdictions (Layton, 2003). In South Australia, for example, the dramatic increase in re-notifications has reached the point where the percentage of notifications that related to new children is only 33%, or put another way, 67% of notifications related to children or young people who have already been notified before (Layton, 2003).

The Victorian Department of Human Services (June 2003) attributed these changes to several crucial factors, including low socio-economic status, substance abuse, mental health issues and problems associated with sole parenting which contributed to some families coming into contact with the child protection system. Similarly, the Layton review in South Australia (Layton, 2003) acknowledges that the high level of re-notifications is:

> just one social health measure that highlights the difficulty many agencies face in human service area when dealing with intractable long-term problems. Issues such as poverty, substance and alcohol abuse, mental health issues and domestic violence – these issues require long-term comprehensive and flexible approaches, that are coordinated and focused on increasing levels of safety and well-being for children, young people and their families (p. 9.32).

Although it is generally agreed that this increase in child abuse is due to many of the broader social and economic pressures described above, such figures have also attracted some competing explanations. One such explanation is that the definition of abuse has changed and broadened over the last decade to include such forms as emotional abuse that were not previously included (Cashmore, 2001). Another possibility is that mandatory reporting requirements have led to many incidences of abuse that might have previously gone unreported being identified for the first time. Nevertheless, the fact that national strategies and legislation are now in place to deal with abuse means that there is unlikely to be any foreseeable reduction in the number of children referred for out-of-home placements because of abuse in the near future (Layton, 2003).

In addition to increases in the demand for placements, there have also been several "supply" factors that have made it more difficult to find placements for those children who receive referrals. For example, a shortage of foster carers is evident throughout the Western world, including the UK, US and Australia (Barbell, 1999; Barber & Gilbertson, 2001; Victorian Department of Human Services, June 2003). In Australia, shortages have occurred through a number of factors, including smaller numbers of carers entering the system, the high levels of attrition of existing carers, and the changing and complex needs of children in foster care (Barber & Gilbertson, 2001). An important social factor that has impacted on the availability of foster carers is the increase in numbers of women who have entered the workforce over recent decades. As Barber and Delfabbro (2004) note, "in both its scale and its implications for society, the world has witnessed few other movements like it" (p. 49). According to the Australian Bureau of Statistics (2002), the workforce participation of married women has more than doubled since 1966, and close to half

(45%) of all employees are women (cited in Barber & Delfabbro, 2004). Another factor is the ageing of the population of western countries, which has led to an increasing number of men and women of working age having to provide care for elderly parents and relatives. Gibbs (1996) suggested that it will soon be the case that more Australian employees will have dependent elders than dependent children, meaning that these families are not in a position to care for more children. Furthermore, the capacity of families to accept children into their homes has diminished due to the increase of single-parent households that followed the introduction of the Family Law Act 1976. As reported in the review of Australian social trends by the Australian Bureau of Statistics (1999), ever since the Act made divorce an easier and more humane option, the national divorce rate has climbed, to close to 45 per cent for all marriages with a duration of under ten years.

In addition to the aforementioned social and demographic forces in the western world that reduce the number of available carers, the foster care system is also struggling to retain current foster carers. Much of this has been attributed to the poor relationship between carers and relevant government agencies or the lack of support provided to foster carers (Victorian Department of Human Services, June 2003). For instance, an American study of foster carers reported that 64% of foster parents stated their main reason for leaving was systemic reasons such as poor communication, insensitivity of the agency to foster family needs and lack of support. Many of the respondents noted that they were often not reimbursed for the true cost of caring for foster children (Barbell, 1999). Although there is research (Chamberlain, Moreland & Reid, 1992) to show that retention rates can be enhanced by increased payments, other research (Barber & Gilbertson, 2001; Rhodes, Orme, & Buehler, 2001; Victorian Department of Human Services, June 2003) has also found that there is no simple solution for improving foster carer retention rates and that money by no means is a sufficient incentive. The evidence suggests that foster carers are less likely to leave fostering in agencies that take a more professional approach and provide better remuneration in conjunction with carer preparation, training, support and full involvement of the carer in case planning (Social Work Research and Development Unit, 1999).

A number of studies have also indicated that many carers leave for reasons to do with caring for the child, including difficulties with the child or young person's behaviour (Victorian Department of Human Services, June 2003). In Australia, a major theme that was documented by the Victorian Department of Human Services (June, 2003) review of home-based care was many DHS staff felt the role of foster care had significantly changed over the past decade, and the foster care system was being asked to do a job it was never designed to do and is currently ill equipped to handle. The review states that "as a voluntary system set up historically to support other families in the local community, many feel that it is now being asked to cope with a totally different set of expectations with children who are no longer 'volunteered' by their parents but removed by state under protection orders" (p. 73). This finding goes hand-in-hand with the fact that children who are removed due to protection orders are more likely to have more complex needs and are subsequently much harder to find placements for and to care for. In other words, the system is now dealing with a new cohort of children and consequently asking foster parents to provide a different and more difficult service. Such pressures on carers are undoubtedly leading to increased levels of burnout and a higher likelihood of placement breakdown. According to the Victorian review (VDHS, June 2003), difficult children exhaust agency time and funding and are likely to have a negative effect on the image and appeal of foster care and thereby inadvertently discourage potential new carers.

Such pressures are further intensified when viewed in combination with the knowledge that the number of children in residential care is falling due to the reduction in residential care options. This trend towards the preference for home-based care is also evident in other countries such as the UK and US. Barber and Delfabbro (2004) conclude that all of these social and demographic forces are widening the gap between demand for and supply of foster carers.

1.2 How children come into care in Australia

In Australia, the State governments have primary responsibility for child protection, and consequently the Minister for each state must ensure that all children have a satisfactory place to live (Barber & Delfabbro, 2004). Currently, all States and Territories except Western Australia have legislation regarding the compulsory

reporting to community services departments of harm due to child abuse or neglect. Most States and Territories only require certain members of a few designated professions involved with children to report suspected cases of abuse and/or neglect. In the Northern Territory, any individual who has reason to believe that a child may be abused or neglected must report this to an appropriate authority. Although Western Australia does not have specific legislation in relation to mandatory notification, there are "protocols and guidelines in place that require certain occupational groups in government and funded agencies to report children who have been or are likely to be abused or neglected" (AIHW, 2004, p.15).

In some circumstances, parents can agree voluntarily to have their children placed into care for a short period. However, where this consent is not given, or where a longer placement is considered necessary, a court order is often required. For a child to be placed under an order, a court needs to determine whether the child is at risk and in need of care and/or protection. The legislation varies according to the definition of 'in need of care and protection' in each State and Territory. Application to the court is usually the last option and is used in circumstances where the family has resisted assistance and every avenue has been exhausted. However, not all children are placed on a care and protection order and/or in out-of-home care due to issues relating to abuse and neglect. In some cases family conflict is the driving cause, whereas in other instances a child may be a danger to himself or herself. In a small number of cases the parents may be ill and unable to care for the child (AIHW, 2004). For example, if the South Australian Youth Court is satisfied with the basis of the Department's Application, it can grant wide ranging orders including the two main forms of orders: custody orders for up to twelve months or guardianship orders for up to twelve months or until the child turns 18 years of age (Legal Services Commission of South Australia, 2004). The Court can also grant voluntary custody agreement orders (V.C.A's) when the parent(s) agree or choose to place their child under the custody of the Court for a set period of time.

1.3 The principal forms of out-of-home care in Australia

Throughout the literature, it is common for the term 'out-of-home care' to be used to describe all forms of care or just one specific form of home-based care. Indeed, it is not uncommon to observe the terms alternative care, substitute care and

out-of-home care used interchangeably to describe the system that provides care for children and young people who are unable to live with their birth parents (Des Semple & Associates, March 2002). The principal forms of care provided in Australia and included in these categories vary considerably both in terms of the nature of the care arrangement as well as its duration. However, in Australia, the two main categories are "home-based care" and "facility-based care". The Australian Institute of Health and Welfare (2004) classifies home-based care as: "where placement is in the home of a carer who is reimbursed for expenses for the care of the child including:

- Foster care/community care – general authorised caregiver who is reimbursed by the state/territory for the care of the child and supported by an approved agency.
- Relative/kinship care – family members other than parents or a person well known to the child and/or family (based on a pre-existing relationship) who are reimbursed for the care of the child
- Other home-based care – including private board" (AIHW, 2004, p.68 – Glossary)

By contrast, "facility-based care – includes care in a facility-based (residential) service whose purpose is to provide placements for children and where there are paid staff.

Placements in 'family group homes' are counted as facility-based care, even when the arrangement would appear to share many similarities with conventional family-based foster care. As in many other countries, foster carers are predominantly volunteer workers who are compensated for expenses incurred rather than paid an income. Furthermore, the majority (92%) of children placed into care are placed into home-based out-of-home care. Of those in home-based care, 51% were in foster care, 40% in relative/kinship care and 1% in some other type of home-based care" (AIHW, 2004, p.56).

Table 1.1 Percentage of children in out-of-home care, by living arrangements and State and Territory, at 30 June 2003

	NSW	Vic.	Qld	WA(a)	SA	Tas.	ACT	NT	Total
Foster Care	34	54	74	52	82	53	50	68	51
Relatives/Kin	57	30	25	38	14	15	35	21	40
Other home-based	-	5	-	-	1	1	-	-	1
Total home-based	**91**	**89**	**99**	**89**	**96**	**70**	**86**	**88**	**92**
Residential care	3	10	1	8	4	22	13	5	5
Independent living	1	1	-	2	-	5	-	1	1
Other (b)	4	-	-	-	-	3	1	5	2
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

(a) The data include a small number of children who were placed with relatives who were not reimbursed

(b) 'Other includes unknown living arrangements

(data from Table 4.4, p. 43, AIHW, 2004)

As demonstrated by the Australian Institute of Health and Welfare, the type of care arrangement that is favoured differs substantially across Australian States. As indicated in Table 1.1, Tasmania had the highest proportion of children living in residential care, and New South Wales had a relatively high proportion of children living with relatives and kin who were reimbursed (AIHW, 2004). However, it must be noted that the majority of children living in residential care in Tasmania were housed mainly in family group or cottage-style homes where approximately four children were placed with a live-in carer. South Australia had the highest proportion of children placed in foster care (82%) and the lowest percentage of children placed with relatives or kin (15%) (AIHW, 2004). Variations also exist in relation to the age of the child. Nationally, children aged less than one year of age are most likely to be either in family care (26%) or in home-based out-of-home care (66%). However, relatively high proportions of children aged 15-17 years are in residential care (12%) or are living independently (8%) (AIHW, 2004). Furthermore, the children in residential care are considerably older than children in home-based care. The findings suggest that as children get older in care, they are more likely to progress to more restrictive settings and experience greater levels of disturbance (Bath, 1998). Barber and Delfabbro (2004) provide support for this finding. Their study found that the longer children spend in care, the more likely they are to exhibit emotional and

behavioural disturbance and repeated placement moves and the more likely they are to be moved from family-based placements into residential care placements. This is often related to the fact that many foster parents are not trained adequately to care for these individuals and the young people are repeatedly moved to a new placement. Generally, once they have exhausted all home-based options, the adolescents end up in more restrictive settings, often because there is just not anything else available to meet their needs or because their behaviours can no longer be managed in a home-based environment.

The high proportion of children in home-based care reflects the current trend of the ever increasing use of foster, relative and kinship placements and reduction in the use of residential care placements (Johnstone, 2001a). These latter arrangements are usually used only if a family-based placement is inappropriate. However, these institutional-type placements are essentially diversionary programs for young offenders and as such are normally perceived as the last resort for children who are deemed 'unfosterable' (Barber & Delfabbro, 2004; Bath, 1998). According to Barber and Delfabbro (2004), this trend has been a deliberate policy because "… not only is foster care cheaper but at its best models the kind of nuclear family to which the State aims to return the child" (Barber & Delfabbro, 2004, p.46). Many researchers have differing views on what is considered the most suitable placement as opposed to the most preferred care option. Some researchers affirm that many children should be cared for in an environment that is as similar to a home environment as possible whereas others argue that children should be cared for in an environment that meets all of the their developmental, physical, psychological and emotional needs. In some cases, that means a group home or a residential placement with intensive supports. However, Australia, like the US and UK, has seen a dramatic decrease in children in residential care, which has previously been the option of choice for children who were difficult to care for in family homes (Barber & Delfabbro, 2004; Bath, 1998; Hudson, Nutter, & Galaway, 1994; Whittaker, 2000). For instance, in 1983, there were 7,410 children in residential care in Australia, but by 1993 the number had fallen to 2,455. Yet during that same period, the numbers of children in foster care remained relatively stable. In recent years, the numbers have fallen even more and, in 2000, there were only 1,222 children in residential care (Barber & Delfabbro, 2004).

However, given that family-based foster care is the cheapest out-of-home care option available, it is obviously appealing to all governments around the world. As mentioned above, the UK and US have also witnessed similar declines in their residential care (sometimes referred to as 'group' or congregate care) populations. For example, in Britain during 1996-2001, the number of children in foster care rose by 16 per cent whilst the number in residential care fell by 11 per cent during that same period (Department of Health, 2002). One of the main reasons for the decline in the use of residential care has been the view that the placement of a child or young person in residential care cannot provide the same quality of care as the placement of a child or young person in foster care. The argument for this view is based on the notion, which is reflected in policy around the world, that fundamentally children have the right to grow up in an environment that is as similar to a family environment as possible.

In recent years, governments have had to deal with the consequences of the decline in residential care options. Governments are now faced with the problem that they now have fewer options for placement of children and young people who cannot reside in family-based settings due to emotional and behavioural problems. Consequently, "increasingly difficult children are being foisted on reluctant foster parents, resulting in an alarming rate of placement breakdown as volunteer workers discover they have neither the skills nor the desire to deal with the children they are assigned" (Barber & Delfabbro, 2004, p. 48). In response to this problem, the Victorian review (Victorian Department of Human Services, June 2003) noted that governments have begun to reappraise the role that residential care can play in their continuum of care for certain types of children and young people in care. Research has provided evidence that residential care may not be as 'bad' for the child as previously thought. For example "studies have revealed that the achievements of foster care and residential care in terms of health and well-being outcomes for children and young people are broadly comparable" (Barber & Gilbertson, 2001; Victorian Department of Human Services, June 2003, p. 95). Research has further indicated that younger children without clinically significant levels of disorders fare better in home-based environments and that residential care is a realistic option for children and young people who exhibit major behavioural and emotional problems (Bath, 1998). Furthermore, conventional foster care appears to be more harmful than

beneficial for children and young people with serious behavioural problems (Barber & Delfabbro, 2004). For example, two Dutch studies (Scholte, 1997) both demonstrated that conventional foster care is much more successful for younger children without clinically significant levels of emotional or behavioural disorder**.** Studies in the UK and US (Fratter, Rowe, Sapsford, & Thoburn, 1991; Hudson et al., 1994; Whittaker, Tripodi, & Grasso, 1990) have revealed that group home settings staffed by family care workers may be the best alternative for this group of children and young people as they provide the necessary support, structure and therapeutic intervention that is required. Ultimately, these findings lead to the conclusion that best practice in foster care should be based on careful assessment of each individual child's suitability for placement, not based on a prescriptive 'one-fits-all' model (Barber & Gilbertson, 2001; Victorian Department of Human Services, June 2003).

1.4 Out-of-Home Policy: Then and Now

1.4.1 A Brief History of Australian Out-of-Home Care

The history of Australian child welfare reaches as far back as 1795 when a Female Orphan School on Norfolk Island was opened. However, as with many Australian institutions, the roots of Australian child welfare are embedded and moulded in early British tradition. In particular, the practice of the British Poor Laws informed the basis of the development of Australian child welfare, which was established on the philosophy of 'rescuing children' from their poor and itinerant parents (ACSWC Secretariat, August 1997). The design of the system was centred on a moral crusade of properly socialising these children, as the supposed immoral example set by the parents was thought to produce deviant behaviour in the children. Consequently, it was proposed that the only way to 'rescue' these children and to change their behaviour was to remove them from their families, and many were put out to work or were placed in orphanages (ACSWC Secretariat, August 1997; van Krieken, 1992).

In the second-half of the Nineteenth century, there was greater State involvement "in the regulation of childhood through the establishment of universal schooling, reformatories, industrial schools and boarding-out systems" (van Krieken, 1992, p. 61). A similar trend was evident throughout Western Europe, Britain, and North America. By 1890, a clear pattern of social policy emerged concerning the

State's dealings with children. It was during this time that 'boarding-out', which was an early form of contemporary foster care (Jamrozik & Sweeney, 1996), became the preferred care option, and this followed a Royal Commission into the merits of residential care. This method of out-of-home care continued until the 1930s when it decreased in value, again in favour of residential care (Liddell, February 2003).

The years between the late nineteenth and the early twentieth centuries were a time of great change and expansion of child welfare agencies. It was during this time that various Aboriginal Protection Acts were passed and the Children's Courts and probation systems were established. As a result, the numbers of children and families under some form of state supervision greatly increased. Consequently, social agencies began to implement care standards and supervise foster parents as well as develop documentation on children's individual needs when making referrals for placements. The Federal Government instigated inspections of family foster homes, and services were provided to natural families to enable the child to return home. Furthermore, foster parents were seen as part of a professional team working to find permanency for dependent children.

The period of the mid-twentieth century witnessed a shift back to institutional care once again. The move was associated with a combination of the increased numbers of children requiring care and also growing public distress about threats to the current social order (Jamrozik & Sweeney, 1996). Again it can be noted that the development of substitute care services in Australia was based primarily on social, political and economic forces rather than in response to the needs of children or the accumulation of professional knowledge. For example, during the late 1960s and the early 1970s, child welfare services were predominantly oriented towards the effects of poverty and inequality on families. There was greater importance placed on the structural causes of disadvantage in society, so that efforts were made to reduce the pressures on families that resulted in the need for substitute care. In other words, there was an emphasis on preventative services and enhancing the capacity of families through social skills training and community development (Jamrozik & Sweeney, 1996).

In 1972, the Whitlam government decided that the State's dealings with families would be less apparent and reduced the amount of State intervention. The government encouraged the provision of support for children and families, although this did not last for long due to the economic pressures of the mid-1970s recession. Later in the early 1980s, the Fraser government decided that intervention with families should be minimal and reduced its role in this area (Liddell, February 2003). This temporarily led to a substantial reduction in the number of children in care during this time. For example, during 1972 the total number of children in care was estimated at 26,846, but by 1982 the number had dropped to 16,395 and in 1985 the national figure further dropped to 12,308 (Boss, Edwards, & Pitman, 1995). However, at the same time, the late 1970s also was the starting point of what was to become a gradual increase in numbers because of the increasingly important role of child welfare services. Dr C. Henry Kempe, a paediatrician, pioneered the identification and recognition of child abuse more than forty years ago. Kempe and others identified what came to be known as the 'battered child syndrome', which resulted in a public outcry and States placing an increased emphasis on the protection of children (Liddell, February 2003). Child welfare services implemented procedures for detecting and notifying families where children may be at risk of abuse and/or neglect (Jamrozik & Sweeney, 1996).

In the years that have followed this period, the main focus of welfare agencies continues to revolve around the alarming amount of child abuse and child maltreatment. In the present day, relatively few children enter foster care only because of social disadvantage. Instead, as indicated above, it is much more likely that young people enter care because of dangerous circumstances or crises that significantly threaten their well-being and safety. These conclusions are supported by data from child protection services. Notifications in Australia show increases from 107,134 in 1999-2000 to 198,355 in 2002-2003, with similar increases being observed for substantiations (24,732 in 1999-2000 to 40,416) in 2002-2003 (AIHW, 2004). However, it is important to recognise that the increasing number of notifications may be related to mandatory reporting requirements. As Scott identifies, this results in overwhelmed Child Protection systems and trouble in locating the seriously at-risk children. She states it is akin to searching for the proverbial 'needle in the haystack' (Scott, 2006).

1.4.2 The modern policy environment

Child protection legislation in most States of Australia views alternative care as a short-term measure to ensure the safety of children or to assist parents. By contrast, adoption is relatively rare in Australia because the legislation encourages foster care to be a temporary solution, with the primary intention of reunifying the children with their biological families. These policy imperatives are reflected in comparisons of the relative proportion of young people in out-of-home care in Australia compared with other Westernised countries. For example, Bullock and Little (2002) and Parker (2000) point out that the majority of US states have much higher rates of children in care than European countries and that the proportion of children in care who are subsequently adopted is 40% greater in the US than in the UK. In comparison, the UK has lower rates of children in care than the US but higher rates of adoption from State care. However, Australia has low rates of both. For example, in America there are over half a million children in foster care (542,000 estimated as at 30th September 2001, U.S. Department of Health and Human Services, 2003), and in the UK there are close to 60,000 children in State care (Department of Health, April 2003). Canada also has high numbers of children receiving care from local authorities, with approximately 76,000 in care (Farris-Manning & Zandstra, March 2003). Bullock and Little (2002) assert that the net result is a rate of 462 per 100,000 children going into care and being adopted in the US, compared with 15.2 in the UK and 2.4 in Australia. Despite these differences, it is hard to know whether greater compulsion leads to better protection of children from maltreatment. Nevertheless, Australian authorities recognise that it may not always be safe to return the children home, and Australian child protection laws empower social workers to separate children from dangerous or negligent parents in these cases (Barber & Delfabbro, 2004).

The current Australian policy environment was strongly influenced by several key documents, including the 2001 Children and Young Persons (Care and Protection) Amendment (Permanency Planning) Act in New South Wales, which highlighted the importance of rearing children in a ‘family-setting’, preferably their biological family home. Although this policy shares much in common with American notions of permanency planning in the sense that there is an emphasis on the stability of placements and continuity of relationships to promote children’s

growth and functioning (Fein, Maluccio, Hamilton, & Ward, 1983), the policy makes more rigid assumptions concerning the primacy of biological parents.

In the United States, permanency planning received official sanction in the Adoption and Assistance Act in 1980. The legislation was introduced as a response to the increasing number of children who were experiencing repeated placement moves and long and often indeterminate stays in care. Prior to the introduction of the Act, many children were left in care for years on end with no plan, and many drifted through the system until their orders expired at 18 years of age (Barber & Delfabbro, 2004). Therefore, the primary intention of permanency planning is to provide stability for each and every child who enters the care system. Stability is based on a hierarchy of preferred options, beginning with reunification with the biological family as the most preferred option. This is followed by adoption by foster carers or others, long-term foster care, and residential placements as the least preferred option (Fein, Maluccio, & Kluger, 1990). The hierarchy of placement options conveys the high value placed on the importance of family and also the importance of providing a stable residence and stable relationships for children. The hierarchy of placement options further suggests that family-based options are fundamentally the preferred option for all children in care.

Another legislative attempt by Government in the United States was the introduction of the Omnibus Budget Reconciliation Act 1993, which increased funding for family preservation services across America. The Act was in response to the high number of children entering care, and the legislation was aimed at keeping children out of the care system altogether. Recently, the US Senate has provided additional legislative support for permanency planning via the Adoption and Safe Families Act 1997. The primary aim is to prevent children returning from foster care to unsafe homes and to find permanent homes for those where reunification is not possible. The Act has strict guidelines, and permanency planning hearings are held within the first twelve months of the child being placed and then annually. However, under this Act the State is required to petition for the termination of parental rights in cases where the child has been in care for fifteen of the preceding twenty-two months or if the parents have attempted or committed murder or voluntary manslaughter of one of their children or have committed felony or assault resulting in serious bodily

harm to one of their children (Lindsey, 2001). The Act also provided financial incentives to State welfare departments to increase the rate of children adopted. Predictably the number of children moving out of the system increased dramatically and in the first year the number of adoptions increased by close to 30 per cent (Barber & Delfabbro, 2004).

Similarly in the UK, the move toward permanency planning occurred back in the 1970s after a series of high profile tragedies such as the death of a child named Maria Cowell at the hands of her step-father after she had been returned from foster care to her mother. The Government realised during that time that many children were drifting in care for years on end with no plan for a permanent placement (Rath, 2001). In the UK, as in the US, the government views adoption as an important and under-utilised aspect of permanency planning. In recent years, the UK Government has put further emphasis on the importance of adoption and has proposed initiatives to increase the number of adoptions of "looked after" children (Rath, 2001). The proposals include increasing funding for services and support for children and their adoptive families, setting timescales for permanency plans and adoptive placements, and setting a target to increase by 40% by 2004-05 the number of adoptions of looked after children (Rath, 2001).

Canada, unlike the aforementioned countries, does not have a unifying piece of legislation concerning adoption. In Canada, the adoption laws are handled by the Provinces and Territories and tend to vary across jurisdictions (Trjynch, 2003). Like Australia, Canada does not have the same focus and funding for adoption as do America and Britain. Nevertheless, Ontario's Child and Family Services Act was amended on March 31 2000 and now focuses on establishing expeditious permanency plans for children in care. However, Canada still has relatively small numbers of children adopted (Ross, 2000).

Nevertheless, the policy changes witnessed throughout Australia, America, Britain and Canada were in response to current difficulties which are similarly reflected in the current state of the care systems in each of these countries. All of the systems have observed dramatic declines in children in residential care and an over-reliance on family-based care. Such movements have inherent consequences that the

system is currently dealing with: issues such as a lack of placement options for children and young people with complex needs. As such, the findings direct us to an inescapable conclusion that the out-of-home care system may not be sustainable in its present form and that legislative changes have not always had a beneficial effect on the outcomes for children in State care.

1.5 Foster Care 'Drift' or Placement Instability

Placement instability, placement breakdown or 'foster care drift', as it is commonly referred to in the literature, is an ever-present concern held by many child welfare professionals. The phenomenon of foster care 'drift' has come to the forefront of research recently due to the mounting evidence of its harmful effects on children's social and psychological development. The landmark study of Maas and Engler (1959) observed that a central theme of out-of-home care policy in the United States has been the elimination of 'foster care drift'. In that study and many others since (e.g. Barth & Berry, 1987; Bryce & Ehlert, 1971; Claburn, Magura, & Resnick, 1976; Katz, 1990; Maluccio, Fein, & Olmstrad, 1986), the researchers found that children who were placed in what was intended to be temporary foster care were often left there for years on end. Under these circumstances, the children tended to lose contact, and with it attachment, to their natural families. Compounding the problem was the finding that many of these children experience considerable 'foster care' drift. This term refers specifically to the process whereby children are moved from one placement to the next, often in very rapid succession, and where, even after months or years in care, children fail to develop a stable residence with any single family or household. The extent to which this problem pervades Australian foster care appears to be quite alarming. For example, a recent paper in *Children Australia* by Delfabbro, Barber and Cooper (2000) reported that over 40% of children coming into South Australian foster care had six or more previous placements and that almost a quarter had experienced ten or more. This disruption was often found to coincide with school changes and children being geographically separated from their birth families with little or no direct contact.

Many factors have been identified that may contribute to unexpected placement change or disruption. These factors include characteristics of the child or foster parent, issues related to the matching of the placement, social worker practice

behaviours and factors related to the placement agency (Teather, Davidson, & Pecora, 1994). More recently, the issue of child behaviour has also been identified in a number of Australian studies (Bath, 1997; Delfabbro, Barber & Cooper, 2002a) which have drawn attention to the increasing proportion of children with very challenging behaviours being referred into care. As Barber and Delfabbro (2004) have pointed out, a very noticeable difference between foster care in Australia and elsewhere is that Australian foster care is more selective. In Australia, only a relatively small proportion of children is referred for foster placements (3 in every 1000 children aged 0-17 years), compared with a rate of 8 per 1000 in the United States (Barber, Delfabbro, & Cooper, 2001). One symptom of this difference is that Australian foster care systems tend to select only those children who cannot be placed elsewhere. Thus, foster care is used much more as a last resort rather than as an option of choice, so that children with more challenging behaviours tend to be placed into care, whereas those who have fewer problems tend to be returned home. Barber and Delfabbro (2002) have found that between 15 and 20% of children currently being placed into care in Australia could be described as extremely challenging, and these children do not appear to be suitable for family-based foster care. Such children cannot be maintained in stable family foster placements and tend to experience considerable placement instability, with the number of placement changes varying from between three and four placements a year up to twenty or more (Delfabbro et al., 2000). According to Berrick, Courtney and Barth (1993) and Staff and Fein (1995), disruption rates in the United States, in traditional foster care, range from 38% to 57% during the first 12 to 18 months of placement, with percentages increasing with more time spent in care.

Placement instability has been found to be associated with problems with attachment and behavioural and emotional problems in children (Fanshel et al., 1989b). However, these problems are not only damaging to the children themselves but they also increase the risk of setting into sequence a cycle of placement instability that may be perpetuated (Fanshel et al., 1989b; Farmer, 1993; Palmer, 1996). Proch and Taber (1987) describe this phenomenon further. They found that there is a positive association of variables that characterise high-risk young people. Such variables include significant emotional and behavioural problems, running away, sexual acting out and length of time in care with multiple placements. They

showed that this population of adolescents tends to become locked into a pattern of placements characterised by increasingly shorter stays in increasingly restrictive settings.

According to many researchers (Halfon, Mendonca, & Berkowitz, 1995; Rosenfeld et al., 1997), the child welfare system is today dealing with children who are more medically fragile, behaviourally challenging and/or in need of special services. Haflon et al. (1995) noted that up to 84% of children in foster care exhibit emotional or developmental problems. Kates, Johnson, Rader and Streider (1991) observed that the increased risk is associated with the difficulties in attachment created by the traumatic conditions often characterising the child's developmental years. The risk of psychological disorders is also linked to the potentially traumatic separations occurring with placement changes. As a result, Rosenfeld et al. (1997) note, "the foster care system has become an open air mental hospital serving many disturbed children" (p. 454). As previously mentioned, more than twenty years ago, the US Congress recognised the importance of placement stability and passed the Adoption Assistance and Child Welfare Act (1980). The Act required agencies to develop permanency plans for each child. It further emphasised the need to move more quickly toward placement stability and permanence, if possible, for children in care (Redding, Fried, & Britner, 2000). However, multiple placements are more common than they were 20 years ago, and this may be due in part to the growing number of children in care, and the more serious emotional, behavioural and medical problems of children entering the system (Rosenfeld et al., 1997). For example, as Holland and Gorey (2004) recently asserted "strong relationships have been observed between child developmental and mental health problems, their familial precursors and foster placement instability" (p.119). They pointed out that among the strongest predictors of placement instability were parental substance abuse and the severity of the child's behavioural impairment. For example, "foster children whose parents used drugs or who have severe behavioural problems are 5 to 9 times more likely to experiences multiple foster placements over longer periods of time" (Holland & Gorey, 2004, p. 120).

In Australia, at a system or agency level, the principal consequence of these problems has been a substantial increase in the workload of case-workers, who have

reported increasing difficulty in managing the cases that they are allocated. For example, case plans that outline strategies and timelines for reunifying children with their birth families have been neglected. This has led to concerns that a substantial number of children who are currently in foster care may be very unlikely to be reunified with their families, and that they will continue to 'drift' through the foster care system until their orders expire at the age of 18. In addition, given the concomitant placement instability described above, there is concern that the experience of being in foster care may be increasingly psychologically harmful and that children's normal psychosocial development is being unduly disrupted. For these reasons, both at a policy and practice level, there has been greater emphasis given to the use, or development, of strategies that will enhance children's experiences in foster care and which will ensure that any potential harms will be minimised.

1.6 Psychosocial issues in foster care research: An overview

1.6.1 The effects of early trauma on child well-being

Today, 'trauma', 'traumatic events' or 'traumatised' are words frequently associated with children in foster care. The word trauma is borrowed from the ancient Greek meaning 'wound' and refers to a single event or series of events that overwhelm a person's existing defence structures and leaves a person exposed to living with unmanageable anxiety or mental pain (Cicchetti & Toth, 1995). Childhood trauma has been shown to have profound impact on the emotional, behavioural, cognitive, social and physical functioning of children (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Research in this area has also shown that traumatic events that involve intentional violence (i.e. emotional and physical abuse) are likely to be associated with symptoms of severe psychological distress and socio-cognitive problems as well as psychopathology in childhood and adulthood. It is well established that developmental experiences determine the organisational and functional status of the maturing brain (Perry et al., 1995), so that the identification and treatment of 'trauma' is crucial to enhancing children's long-term mental functioning. Depending on the severity, frequency, nature, and pattern of traumatic events, Schwarz and Perry (1994) showed that at least half of all children exposed to abuse are likely to develop significant neuropsychiatric symptomatology. One of the most common neuropsychiatric syndromes which develops following trauma is post-traumatic stress disorder (PTSD). Schwarz and Perry (1994) found that children

exposed to trauma often present with a range of PTSD symptoms, including conduct difficulties, anxiety, phobias, and depression (see Cicchetti & Toth, 1995). Children may react in a variety of ways, and these reactions are generally age related and specific. For example, younger children (aged 1 to 5 years) exposed to a traumatic event are more likely to feel helpless and experience an intense fear and insecurity because of their inability to protect themselves. Many children at this age lack the verbal skills and conceptual skills needed to cope effectively with sudden stress. School-age children, on the other hand, are more able to understand permanent changes or losses, but fears and anxieties are likely to predominate in this age group. Some children, however, become preoccupied with the details of the disaster and want to talk about it continuously, whereas preadolescent children are often more affected by peer reactions to the traumatic event as opposed to reactions by family members. Adolescents, in comparison, are more likely to have a combination of childlike reactions mixed with adult responses. Teenagers may show more risk-taking behaviour than normal and may be unable or unwilling to discuss their emotions with others.

More recently, researchers have focused on the neurophysiological processes associated with trauma. Much of this research has shown that, due to the considerable plasticity of the developing brain, children's neurological development is very much shaped and moulded by what happens in their external world. Perry et al. (1995) argue that it is the human brain that processes and internalises traumatic experiences and that mediates all emotional, cognitive, behavioural, social and physiological functioning. Furthermore, the authors emphasise that understanding the organisation, function and development of the human brain, and brain-mediated responses to threat, is essential to understanding the traumatised child. Several studies have shown that when exposed to a traumatic event, children's brain regions, including the hippocampus, the anterior cingulate, and the prefrontal cortex, interact or function in ways that are deviate from the norm (Bradley, 2000; LeDoux, 1996). These findings mirror those obtained in studies of adults with confirmed diagnoses of PTSD which showed quite different brain activation patterns from control samples without a similar history of trauma. For example, the amygdala and the anterior cingulate were found to be hyperactive when compared to a control group whenever memories regarding the abuse were probed, whereas the hippocampus and the

prefrontal cortex were hypoactive when compared to the control (Bremner et al., 1999; LeDoux, 1996; Shin et al., 1999). Similarly, the Committee on Early Childhood, Adoption, and Dependent Care (2000) further asserts that more children are entering foster care in the early years of life when brain growth and development are most active. The paper reports that during the first three to four years of life, the anatomic brain structures that govern personality traits, learning processes, and coping with stress and emotions are established and made permanent. If they are unused, they atrophy. The authors argue that the nerve connections and neurotransmitter networks that are developing during these early years are influenced by negative environmental conditions including neglect (lack of stimulation), abuse, or violence within the family. Furthermore, the authors assert that early cognitive and emotional disruptions in the early critical years have the potential to impair brain development. These findings signify and provide direct evidence for the real physical and psychological consequences of trauma on the developing child.

Other studies have focused on the relationship between trauma and cognitive processes in children. As stated by Holland and Gorey (2004), "it is well known that the first years of life are developmentally critical and the vast majority of foster children have spent these years in particularly difficult, even ugly circumstances" (p. 119). As such, infancy and childhood are crucial periods in which trauma can easily produce dysfunctional changes which can lead to psychopathology (Spataro, Mullen, Burgess, Wells, & Moss, 2004) and poor metacognitive development. According to Brown (1980), metacognition refers to one's awareness and control over one's cognitive process – a process or form of self-regulation. Lang (1977) proposed that fear, which is a part of all traumatic events, becomes embedded in memory and interferes with the processing of information. Foa, Riggs, Dancu and Rothbaum (1993) suggested that PTSD, like the other anxiety disorders, could be construed as reflecting a pathological fear structure that contains faulty associations and erroneous evaluations. They further proposed that traumatic events could be viewed as a fear structure. In other words, Foa and Kozak (1986) state that following a trauma, fear structures develop that contain mental representations of the traumatic experience and are characterised by excessive threat-related beliefs. Therefore, a child who has not yet fully developed a cognitive structure may learn to interpret the world through a fear structure. As a result, this leads to adaptational failure and maladaptive

behaviours. In a similar vein, Putnam (1997) pointed out that trauma can affect emotion regulation and metacognition or one's ability to have awareness or control over their cognitive processes. When trauma occurs, children's cognitive processes and information processing are compromised, and therefore a child's ability to develop a theory of mind (the ability to reflect on one's own and other's mental states and interpret the world) is compromised. In this way, traumatic events can have the potential to have an adverse impact on several areas of a child's cognitive development and functioning, which can have far-reaching effects into adulthood.

Perry et al. (1995) have recently observed the impact of trauma on neurological processes and development. The authors assert that understanding the neurodevelopmental consequences of trauma is important in that it has led to reconceptualisations of children's adaptation to adversity as often captured in the concept of 'resilience'. According to Perry and colleagues, it has become common to refer to children as resilient on the grounds that they are expected 'to get over' events. For example, Perry and his colleagues state that it is not uncommon for adults to recount traumatic events and describe how terrifying it was for them, but recount the child's reactions as their not seeming to be affected or as having unattached non-reactive behaviours. However, Perry et al. highlight that the children's unattached non-reactive behaviours are often not a sign of coping but of dissociation. Perry et al. refer to two primary adaptive response patterns in the face of extreme threat: the hyperarousal continuum (defense - fight or flight) and the dissociation continuum (freeze and 'surrender' response). Each of these adaptive responses activates a unique combination of the child's neural system, and it is the predominant adaptive style of an individual in acute traumatic situations which will determine what types of post-traumatic symptoms will develop: hyperarousal or dissociative. For example, adult males are more likely to use a hyperarousal (fight or flight) response, and young children are more likely to use a dissociative pattern (freeze and surrender) of responses. Perry et al. further emphasise that "a traumatic event experienced during infancy or childhood has the potential effect of influencing the permanent organisation and all future functional capabilities of the child" (p.277).

According to Perry et al. (1995), another implication of adopting a neurodevelopmental approach to working with maltreated children is the recognition

that early intervention can ameliorate the intensity and severity of a trauma response. Furthermore, early interventions are likely to reduce the probability of the child developing a sensitised neural system that could result in either persisting hyperarousal or dissociative symptoms, or both. As Perry and others affirm, the longer an individual is in a dissociative state, the more likely they are to exhibit dissociative symptomatology. In addition, the longer individuals are in a fear state, the more likely they are to carry around persistent symptoms of hyperarousal.

Another psychological theoretical perspective or approach to the consequences of trauma (i.e. abuse, neglect and abandonment) is referred to as developmental psychopathology. This area has been strongly influenced by the work of figures such as Sroufe and Rutter (1984) who defined the approach as "... the study of the origins and course of individual patterns of behavioural maladaptation, whatever the age of onset, whatever the causes, whatever the transformations in behavioural manifestation, and however complex the course of the developmental pattern may be" (p.18). For example, Manly, Cicchetti and Barnett (1994) showed that various forms of maltreatment influenced child functioning. The authors confirmed that, although maltreated children exhibited poorer adaptation than nonmaltreated children, a clearer picture of functioning emerged when the authors examined other aspects within the context of maltreatment. The authors examined the subtype, frequency, chronicity, and severity of child maltreatment on social competence and behaviour problems. Manly et al. argued that the severity of maltreatment, the frequency of child protective reports, and the interaction between severity and frequency were significant predictors of children's functioning. Manly et al. also showed that peer ratings of children's level of aggression could also be predicted from the chronicity of the maltreatment within the child's family. In addition, Manly and colleagues identified different sub-types of children. For example, children who had been sexually abused were found to be more socially competent than other maltreated children, whereas children who had been physically abused displayed more behavioural problems than the non-maltreated children.

Similar research was undertaken by Wolfe and McGee (1994), who investigated the underlying structure of maltreatment and its relation to adjustment, including the developmental period during which maltreatment occurred, the type of

maltreatment experienced, and gender differences in maltreated adolescents. The authors identified a number of interesting differences in the relationship between early maltreatment and adjustment. Specifically, they showed that the relationship between early maltreatment and adjustment was strengthened when interactions between physical and psychological abuse and between partner abuse and neglect were entered into the analysis. For example, the authors found that current psychological adjustment amongst females was significantly related to the developmental period during which neglect or psychological abuse occurred. Psychological adjustment problems were generally more severe when maltreatment increased during middle childhood as opposed to very early childhood.

Other research has focused specifically on the relationship between the types of abuse and subsequent symptomatology. For instance, physical abuse and neglect has been shown to be related to higher levels of child depressive symptomatology, (Kaufman, 1991) conduct disorder and delinquency in maltreated children than in nonmaltreated children (Kazdin, Moser, Colbus, & Bell, 1985). Maltreated children are also more likely to be diagnosed as having attention-deficit hyperactivity disorder, oppositional disorder, and posttraumatic stress disorder (Famularo, Kinscherff, & Fenton, 1992) and concomitant difficulties in social and cognitive functioning (Smetana & Kelly, 1989). Such experiences are also linked with negative outcomes during adolescence, including drug use, teenage pregnancy, and school failure (Thornberry, Ireland, & Smith, 2001). In their paper, Thornberry et al. reassessed the impact of maltreatment according to when the maltreatment occurred. Their data were drawn from the Rochester Youth Development Study, which is a broad-based longitudinal study of adolescent development. The authors found that maltreatment that occurs in adolescence and is of a persistent nature may have stronger and more consistent negative consequences during adolescence than does maltreatment experienced only in childhood. Such findings provide strong evidence for timely intervention for maltreated children.

Brown and colleagues (1999) studied 776 randomly selected children from a mean age of five years into adulthood (over a 17 year period) and found that adolescents and young adults with a history of childhood maltreatment were three times more likely to become depressed and suicidal compared with individuals with

no history of maltreatment. The authors acknowledged that the family circumstances in which abuse and neglect occur were often extremely complex and often involve a range of other potential risks for subsequent disorders in their offspring. Brown and colleagues classified these risk factors into four major domains: 1) risk factors in the child, such as handicap, chronic illness, or difficult temperament; 2) dysfunctional child-rearing and family relationships; 3) parental substance abuse, poor health or very young age; and, 4) poverty and related stresses in the family and the community. They suggested that these contextual factors often coexist, and it is unclear whether the negative outcomes observed in the children result from the abuse or from the broader factors, such as the environmental and familial context in which it occurs. The authors found that contextual factors such as parental substance abuse, low family contact and illegal activities significantly increased the risk of child psychopathology, including depressive disorders and suicide attempts. Childhood sexual abuse was found to have the largest effect and was the most independent of these contextual factors. Specifically, the authors found that the risk of repeated suicide attempts was eight times greater for youths with a sexual abuse history. Those children who were neglected were less likely to become depressed or suicidal if the families' problems were addressed or changed. This particular finding provides evidence for a broader focus for intervention in these cases; for example, an early intervention focus such as the Elmira nurse home visitation program (discussed in detail in Chapter 3).

A recent study by Ryan and Testa (2005) also examined the relationship between maltreatment and juvenile delinquency. The authors argue that it is important to understand that even though maltreatment,

> by definition, is an event occurring within the family or substitute care setting such as a foster home, day care centre, or group home, the physical abuse and neglect of children is best understood as the manifestation of an unfolding sequence of underlying problems that often are initiated prior to the family's formation and could be located as well in community and cultural conditions (Ryan & Testa, 2005, p. 229).

This broader ecological perspective, the authors argue, helps shift the focus away from parental psychopathology and family dysfunction and highlights how community and cultural conditions can influence "the development of the child, both inside the family and later on as the child moves into school, forms peer relationships, and matures into young adulthood" (Ryan & Testa, 2005, p. 229). The authors concluded, from their study of aggregate population data from the Illinois Criminal Justice Information Authority (N = 18, 676), that children who experience maltreatment are at increased risk of engaging in delinquent behaviour. Specifically, they found that children who were substantiated as victims of maltreatment had on average 47% higher delinquency rates relative to children not indicated for abuse or neglect. Furthermore, they noted that approximately 16% of children placed into substitute care experience at least one delinquency petition, compared to 7% of all maltreatment victims who are not removed from their family. The authors also found gender differences in the link between maltreatment and juvenile delinquency. For example, placement instability further increases the risk of delinquency for male foster children, but not for female foster children. The authors noted that children in substitute care are at an increased risk of delinquency (more than double the risk), compared with children not entering a substitute care setting.

The research findings described above provide evidence that maltreatment appears to pose an increased risk for a wide range of disturbances in functioning and varied forms of psychopathology during childhood and in later adulthood. However, as recognised by Cicchetti and Toth (1995), generalisations from existing data need to be made cautiously due to sample composition and co-occurring risk factors, including family and genetic risk factors. For example, research has identified that between 20 and 50 per cent of depressed children and adolescents have a family history of depression, so that it may be unclear as to whether childhood pathology is a reflection of differences in experience or genetic makeup (Todd, Neuman, Geller, Fox, & Hickok, 1993; Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997). Parental depression has often been found to increase the risk of anxiety disorders, conduct disorder and alcohol dependence (Weissman et al., 1997). Moreover, as mentioned above, there may be broader co-existent sociological and economic risk factors such as poverty, overcrowding, substance use, and poor housing and nutrition, all of which may make some children and adolescents more

susceptible to psychopathology.

Encouragingly, recent studies have indicated that early intervention can sometimes mediate the consequences of early trauma. For example, a recent French study examined the outcome for families whose children were followed in an out-patient treatment centre (Dumaret & Picchi, 2005). The treatment centre was designed to promote healthy parent-infant relationships and prevent difficulties for families exhibiting psycho-emotional and or psychiatric risks. The study selected 38 families, all of whom had a child aged less than 18 months, born between 1985 and 1990, and in care for more than one year; the other children received intervention after this age. Assessment of parents and children was made when the families had been out of treatment for at least five years. The authors argued that the impact of early therapeutic intervention is most strongly observed among children of the families at high risk who had received such care before the age of one. Dumaret and Picchi found that all these children had better social competences with peers, fewer behaviour problems, and less school failure than others who had not received the intervention. Given these results, the authors concluded that early therapeutic intervention mediates psychosocial risk in these families.

1.6.2 Attachment theory and out-of-home care placement

Bowlby (1969) defined attachment as the enduring affectional ties that children form with their primary caregivers. Bowlby described attachment behaviour as a desire for proximity to an attachment figure, and argued that this is necessary for children to develop a sense of security, confidence and acceptance. One of the key features of Bowlby's theory is his argument that children form only one strong attachment, usually to the mother – referred to as monotropy. Bowlby also asserted that, if attachment has not formed by age three, then it is too late, and even after six months it may be difficult to form. He further argued that the strength or "security" of these early attachment experiences lays the foundation for later psychosocial and cognitive development. The concept of attachment is based on the notion of "homeostasis". Bowlby argued that children strive to maintain physical proximity to the attachment figure and that, when this goal is threatened, the child will show signs of distress. Maternal deprivation is the term used by Bowlby to describe the serious developmental impairment that is caused by being separated from the mother in

infancy. Rutter (1981) criticised Bowlby's maternal deprivation theory on the grounds that these impairments could have been due to a range of different factors. Rutter argues instead that separation is not the crucial factor in emotional disturbance but the general family discord that underlies the emotional disturbances observed by Bowlby. In other words, Rutter argues that it may be the circumstances surrounding the loss that was most likely to determine the consequences rather than the 'loss' itself. Studies conducted by Rutter (1981) have shown that children are capable of forming multiple attachments and that it is the quality of care rather than just the continuity of care that is important. These findings have implications for children under State care.

As Ainsworth (1967) found, attachment-related behaviour becomes more prevalent gradually over the first several months of life and peaks during the second year of the child's life. The behaviour then diminishes in intensity as children become more confident in their independence. At a certain critical period of development, around six months of age, children will show signs of separation anxiety and display a common pattern of behaviours when the attachment figure leaves. In the short-term, this usually includes crying and throwing a tantrum, but over the long-term, the child may ultimately become detached and indifferent to the attachment figure. Ainsworth (1967; 1970; 1979; 1991) recognised that children differ in their reaction to separation. One example was in her famous 'strange situation' experiment. The experiment involved the mother leaving the young child (aged 12 to 18 months) alone in a room of toys. The child was then joined for a brief time by a friendly stranger, after which the mother returned and greeted the child. Ainsworth found an interesting pattern of reactions to the separation. Some infants (called securely attached) sought closeness to the mother when she returned, whereas others, whom she labelled insecurely attached either ignored or avoided the mother or displayed anger at the rejection. This rejection behaviour is simultaneously displayed with a clear desire to be close to the mother at the same time as rejecting her (an ambivalent or anxious-ambivalent style). Ainsworth argued that children with an avoidant style of attachment behaviour will appear unfazed by the mother's departure, whereas ambivalent children will become very upset. More recent research with infants in high-risk samples, such as those who have been maltreated, has discovered a fourth style of attachment, which is a variant of insecure

attachment, referred to as disorganised (Main & Soloman, 1986). Main and Soloman describe the disorganised child as one who displays contradictory actions, such as approaching the mother while simultaneously staring in the opposite direction. Such children may also appear disoriented and display rocking behaviours and dazed facial expressions.

Disrupted early attachments have been associated with severe personality disturbances in later life (Zanarini, Gunderson, Marino, Schwartz, & Frankenberg, 1989). Ricks et al. (1985) noted that children who experienced disrupted attachment often experience difficulty behaving appropriately as a parent with their own children. Such individuals are also likely to suffer from depression (Brown & Harris, 1978) or exhibit antisocial behaviour and adjustment problems (Tizard & Hodges, 1978). Not surprisingly, maltreated children who are removed from dangerous or neglectful environments, who then are confronted by further disruption through numerous placement failures, are likely to be particularly at risk of experiencing difficulties trusting adults and forming attachments with adults and children (Newton, Litrownik, & Landsverk, 2000). Newton et al. acknowledge that it is well known that such children exhibit behavioural and mental health problems, or are at a great risk for those problems. Furthermore, there is evidence to suggest that placement disruption and behaviour problems are associated, despite variations in the conditions responsible for placement disruption (Newton et al., 2000). For example, the interpersonal problems of behaviourally troubled children have been repeatedly documented in association with histories of anxious-avoidant attachment (Elicker et al. 1991; Putallaz & Heflin 1990; Sroufe & Egeland 1991; Sroufe & Rutter 1984, cited in Penzerro, 1995). Penzerro and Lain (1995) argue that such children “are more likely to behave aggressively toward peers, to misread environmental and interpersonal cues, and to engage in bullying and other hostile behavior” (Sroufe & Waters, 1977, cited in Penzerro & Lein, 1995, p. 352). Furthermore “teachers tend to respond with "angry control" to avoidantly attached children (Motti 1986; Sroufe & Fleeson 1988, cited in Penzerro, 1995, p. 352), and this may result in further problems at school.

Penzerro and Lein (1995) suggested that disordered attachments are directly responsible for placement disruption, and described a cohort of children who “display exceptionally clear patterns of alienation in relation to transitions from

placement to placement" (p. 351). Furthermore, the research demonstrated that emotionally disturbed adolescents in care are most likely to have histories of placement disruption, especially those adolescents with externalising disorders (Pardeck, 1983; Proch & Taber, 1987). Such externalising disorders include attention deficit hyperactivity disorder, oppositional-defiant disorder, and conduct disorder (American Psychiatric Association, 1994).

According to Penzerro and Lain (1995), the social development of a child is most severely affected by a lack of a stable caregiver. As attachments become more tenuous, children become much less selective regarding relationships. As a result, Penzerro and Lain state that "they are likely to drift into harmful relationships (Pardeck, 1983) or to repeat the pattern that has already been established of drifting through relationships" (Penzerro & Lein, 1995). Moreover, Penzerro and Lain (1995) argue that an individual's coping skills later in life are heavily influenced by their history of attachment. They suggest that a poor attachment history, subsequent attachment disorders and placement problems in maltreated children are often linked together in a vicious cycle. For example, abused children who develop avoidant attachments to cope with a hostile home life (Penzerro & Lein, 1995) often then experience multiple placements whilst placed in care, often in conjunction with externalising problems. Placement breakdowns then only serve to reinforce the avoidant coping style. Thus, as Penzerro and Lain (1995) point out, each time a placement breaks down, "the child's attachment system is activated and avoidant patterns are re-enacted" (p. 354). As McIntosh (2001) highlights,

> the distress of a child who is dealing with the loss or separation from an attachment figure is greatly amplified when they simultaneously find themselves in new surroundings, in the absence of personalised and familiar care (p. 4).

However, it is important to acknowledge that earlier research of institutionally-reared children conducted by Rutter, Quinton and Hill (1990) has shown that later good experiences of attachment can compensate for early disruptions or deprivation of the attachment relationship. However, other researchers have said that the longer children are deprived of adequate attachment, the greater

the risk of ability to achieve it (O'Connor et al., 2003).

1.7 Family contact and disconnection in foster care

The issue of family contact has continued to be contentious in foster care research. In South Australia, the Child Protection: Alternative Care Manual of Practice (1999) asserts that "family contact is a process of maintaining meaningful links between children in care and their families and networks of origin". Family contact is considered to be a way in which children maintain an ongoing association with their families and is deemed to be a right of every child in foster care. The South Australian Children's Protection Act 1993 also expresses this view in Section 4 (2) (b) where it states that: "serious consideration must be given…to the desirability of…preserving and strengthening family relationships between the child, the child' parents and other members of the child's family, whether or not the child is to reside within his or her family".

Family contact is considered essential to assist children in the resolution of grief and loss associated with being placed into care, and is seen as necessary to increase children's likelihood of being reunified with their birth families. For example, Fanshel (1975) reported that more frequent parental visitation strongly influenced the fate of children in care. In a 5 year longitudinal study, Fanshel showed that children who stayed longer in care were less likely to be visited by their parents and that the mean frequency of parental visitation decreased over time. Based upon these findings, Fanshel argued that "the visitation of the child should be carefully scrutinised as the best indicator we have concerning the long-term fate of the child in care" (p.513). Millham, Bullock, Hosie, and Haak (1985), like Fanshel and Shinn (1978), also found that ongoing contact was the best indicator of an early return home.

However, Fanshel's findings have been criticised by some authors (e.g., (Cantos, Gries, & Slis, 1997; Delfabbro, Barber, & Cooper, 2002b) who have drawn attention to several methodological limitations in the design of the Fanshel study. Although not questioning the importance of family contact in achieving reunification, Delfabbro et al., for example, question Fanshel's decision to base his analyses on successive cross-sectional analyses rather than a fixed cohort which

remained in care for the full five years. They point out that many children in care (for whom there was always an intent for them to go home) often have satisfactory relationships with their parents, and so it is not surprising that children with more frequent contact tend to go home earlier. This means that if one considers successive cohorts of children in care, they will very likely consist of an increasing proportion of children who always had poorer relationships or levels of contact with their parents. Such data, in itself, provide inconclusive proof that longer periods in care causes a reduction in family contact. To support Fanshel's argument, one needs to consider the contact rates of those who remain in care for the full duration of the study. A South Australian longitudinal study, conducted by Delfabbro et al. (2002b), provided little short-term evidence for the substantial decreases of contact described by Fanshel.

A further problem is the evidence supporting the putative causal relationship between the frequency of parental visitation and children's psychosocial well-being. Cantos et al. (1997) note that there have been several studies examining the benefits of parental visitation upon the emotional adjustment of the foster child. Weinstein (1960) demonstrated that the well-being of foster children is related to the awareness of their origins and position as a foster child. He found that the average well-being scores for children who were visited less were still significantly higher than those for children who were unvisited. These conclusions were also borne out by the finding of Aldgate (1980) who observed that parental contact is of great importance, not only because it facilitates reunification, but because it helps the child retain a sense of identity, which she considers to be related to emotional well-being and adjustment. However, as Cantos et al. point out, the majority of these previous studies provide little evidence that visitation influences well-being. Simply showing that visitation and well-being are linked is potentially circular in that children who are better adjusted may be more likely to have satisfactory and communicative relationships with their parents. One cannot therefore attribute improvements in well-being to the introduction of visits.

Further compounding this problem is the fact that these studies have not used standardised measures of behavioural adjustment, and many of the estimates of adjustment were often "derived from caseworker's anecdotal reports" (Cantos et al.,

1997, p. 311). Cantos et al. further argue that not all studies necessarily report a positive association between visitation and child well-being. In some studies, there is evidence that parental visits can be associated with inappropriate behaviours, an increase in separation anxiety and increased depression in the child. Gean, Gillmore and Dowler (1985) argued that visiting can involve considerable stress for all parties – the foster child, the biological parents, and the foster parents. The authors stated that foster children often feel a conflict of loyalties between the biological parents and their foster parents, and react in an angry and confused manner during and after visits. Schofield, Beek, and Sargent (2000) also found in their study that at least a third of children experienced stress and potential harm as a result of interacting with parents and grandparents during their time in care.

As described previously (Section 1.6.2), Bowlby asserted that humans have an innate need to form affectionate bonds with significant adults, in most cases their primary caregiver. Bowlby acknowledged that a child's unwilling loss or separation from their primary caregiver can give rise to many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment. This view was further underscored by McIntosh (2001) who stated that the distress of a child who is dealing with loss or separation from an attachment figure is likely to be greatly amplified when they simultaneously find themselves in the new and unfamiliar surrounds of a foster home. McIntosh points out that, in a child's life, attachment is not an 'optional extra' but a core need. The emotional, social, and cognitive development of a child can be greatly enhanced if an attachment figure is provided, but this is often given little consideration in foster care, and can have significant implications for the child's long-term well-being. Andersson (1999) postulates that for some children parental visiting may be the key to successful foster placement in that it demonstrates the parents' acceptance of the fostering arrangement and shows the child that both sides can accept each other. However, as Stevens (1997) points out, children's continued contact with their birth parents can create confusion, uncertainty and be upsetting. Furthermore, he argues that "non-rehabilitative contact will only confuse, disrupt and undermine the new carers' roles" (p.13).

Ainsworth has conducted extensive research into appropriate residential care practice in relation to family contact. His research aimed to build an empirically validated model of group care that is child centred and family affirming (Ainsworth, 1997b). His data came from the Trieschmann Carolinas training and consultancy project. The first phase of his analyses was a confirmatory factor analysis approach followed by the administration of a validated instrument to a self selected group of New England group care programs. The primary purpose of the research was to reconceptualise the purpose and function of group care programs. In addition, his research had a dual commitment to children and parents placed within an ecological perspective and as part of a complementary family preservation and family reunification paradigm. Ainsworth found that the group care programs significantly differed from each other in the extent to which they conformed to a model of Family Centred Group Care (FCGC). He proposed a second model, the key components of which were service availability, parental involvement, and staff attitudes. Ainsworth argued that if agencies are rated to reflect the extent to which they conform to this model of FCGC, then the referral and allocation of children and families most likely to meet their needs are slightly clearer. In a more recent study, Ainsworth (2001) drew from available literature on residential care in Australia, Europe and the United States. The study reports some positive findings on residential care for 'at-risk' youth and recommends that residential care is part of the continuum of services for young people in the care system. Importantly, Ainsworth reports findings on a study (Parmelee et al., 1995, cited by Ainsworth 2001) that found having family involvement during treatment was a factor that was predictive of a positive outcome for the young person. This is something that is often forgotten or ignored for many young people entering residential care. This finding was also reiterated in a review of residential care versus foster care that highlighted the success of family-centred residential care (see Barth, 2002).

Pinkerton, in Kelly and Gilligan's book (2002), has also highlighted the importance of birth families to care leavers and the importance of maintaining contact whilst children are in care. Kelly, in another chapter of Kelly and Gilligan's book, reviews the literature on outcome studies of foster care and family contact. Kelly states that there are two competing views about the advantages or disadvantages of family contact. Firstly, some researchers argue that children are

more likely to prosper in care if they remain in contact with their birth families, whereas others propose that it may be more advantageous for children to have a fresh start and commit themselves wholly to their foster parents (Kelly & Gilligan, 2002, p. 59-83). Unfortunately, this debate still continues today without clear answers.

Nevertheless, Fernandez (1996) noted that it was evident that younger foster children were more disadvantaged in terms of contact with their parents. Similarly, Delfabbro, Barber and Cooper (2002b) have shown that within the alternative care population, age and emotional disturbance are positively correlated,and they argue that this no doubt accounts for the world-wide phenomenon that foster placements are more stressful for young children than for adolescents. The above findings are in line with Bowlby's (1969) influential model of attachment and its potential implications for children placed into foster care.

Recent research by Barber and Delfabbro (2004) concluded there is little evidence to suggest that children who remain in care for longer periods experience a decrease in the frequency of family contact. Furthermore, they concluded, that in the longer term, there appears to be a small relationship between changes in the frequency of contact and the likelihood of reunification. However, in the early months after intake, the authors concluded that children with poorer levels of behavioural adjustment at intake are less likely to be visited, but the reverse was found to be true for children who had been in care for a period of two years. Nevertheless, the issue of family contact appears to continue to perplex both researchers and policy makers, as the evidence is not yet clear as to how the issue should be addressed. Either way, it appears that family contact is considered to be very important establishing in the longer-term for support for young people when they leave the care system. For example, Cashmore and Paxman (1996) noted that a high proportion of young people often return to live with birth parents after emancipating from care and feel that the relationship is very important to them. However, the logistics of how it occurs and the frequency of visitation needs to be dealt with on an individual basis, as each family relationship and the circumstances surrounding the child's entry into care are unique (Osborn, 2002). It is also important to remember that family contact, according to Barber and Delfabbro (2004), is only a corollary of good family relationships. In other words, often those families with

better relationships are the ones most likely to have ongoing positive family contact and most likely to be reunified. Nevertheless, the research base delineates that the issue of family contact is an important factor in the stability of foster placements and in the psychological functioning of the foster child.

1.8 Problems left untreated in care

As stated previously, although many children enter foster care with chronic medical, mental health or developmental problems, many do not receive adequate or appropriate care while in placement (Simms, Dubowitz, & Szilagyi, 2000). For example, the US General Accounting Office (1995) found that many significant health problems go undetected, or, if diagnosed, are unevaluated or treated. These concerns are by no means new features of care systems in that similar problems have been reported for over three decades. For example, in 1972 and 1973, Kavaler and Swire (1983) studied the health status of over 650 children who had been in foster care in New York City for at least one year. They found that close to half the children had one or more chronic medical problems and more than a third (37%) required a referral to a specialist for further evaluation and treatment. Nearly one-third (29%) of the preschool children were suspected of having borderline or retarded mental development, and at least 70% were found to have moderate to severe mental health problems (Simms et al., 2000).

As Simms et al. point out, the very significant concern for policy makers and practitioners is that such psychological and emotional problems brought into care may worsen rather than improve during the time children spend in care. The fact that many children spend a significant proportion of their childhoods in foster care and often without comprehensive therapy or general health care during this time led Simms et al. to conclude that foster care “remains a poor system for poor children” (p. 916). They argued that greater attention therefore needs to be placed upon foster care as a context in which treatment occurs, rather than merely an alternative place to live. One reason why this issue is so important is that many of the problems compounded by out-of-home care and, in particular, prolonged periods of placement instability, mean that health problems and disadvantage will often continue into adulthood.

1.9 General psychosocial consequences in adulthood of out-of-home care

As many researchers have acknowledged, a large percentage of the children entering care today experience significant emotional, behavioural and psychological disorders (Bath, 1997; Kupsinel & Dubsky, 1999; Landsverk & Garland, 2000; Sawyer, Sarris, Baghurst, Cornish, & Kalucy, 1990; Sheppard & Benjamin-Coleman, 2001). Numerous researchers have identified (Barber et al., 2001; 2002; Bath, 1998; Delfabbro et al., 2002a) problematic behaviours, ranging from acting out and general aggression towards others to sexually at-risk behaviours and serious substance abuse. Children also often have severe cognitive, emotional and behavioural problems that ultimately affect their academic functioning (Pelnick, 2000). Many are also highly traumatised as a result of abusive home environments, and these problems do not necessarily cease after they have been admitted to care. The children are placed at an increased risk of experiencing additional negative life events and are likely to undergo further trauma related to placement changes (Barber & Delfabbro, 2004). Many of these maltreated young people end up in the juvenile justice and mental health settings. According to Pecora, Williams, Kessler, Downs, O'Brien, Hiripi, and Morello (2003), child maltreatment costs governments billions of dollars in both direct and indirect costs. The direct costs include costs related to hospitalisation, chronic health problems, mental health care and law enforcement. The indirect costs of child maltreatment include special education, mental health, health care, juvenile delinquency, lost productivity to society and adult criminality (as cited in Pecora et al., 2003). For example, Buehler, Orme, Post and Patterson (2000) recently showed that **"**when compared with adults in randomly selected comparison groups, adults who experienced family foster care were less adjusted on 20 of 36 indicators, particularly in areas of education, economic well-being, marital relationships and community involvements" (Buehler et al., 2000 p. 595). Flynn and Biro (1998) also reported poorer educational outcomes and negative behaviour among Canadian children in care compared to those not in care, but they did not have worse outcomes on measures of identity, social and family relationships, or prosocial behaviour. Courtney and Piliavin (1998, cited in Taussig, 2002) recently reported that 12 to 18 months after leaving foster care (due to emancipation), 27% of male and 10% of females had been incarcerated, 37% had not finished high school, and 50% were unemployed.

Cashmore and Paxman's (1996) landmark Australian study on wards leaving care further identifies several life domains where young people who had spent time in care were substantially worse off. The young people often had problems getting access to appropriate accommodation and in some cases were homeless. For example, a study by Courtney, Piliavin, Grogan-Kaylor, and Nesmith (1998) of youth 12 to 18 months after leaving care found 14% of the men and 10% of the women were homeless at the time of interview or had been homeless in the previous 12 to 18 month period. Cashmore and Paxman reported that often the youth had achieved lower levels of education and also experienced difficulty gaining employment. A national study conducted in America reported that the percentage of youth in foster care who leave care with a high school diploma ranges from 37% to 60% (Burley & Halpern, 2001). In light of the educational disadvantage, it is not surprising that many young people are at risk for unemployment and underemployment (Freundlich & Avery, 2005). For example, Courtney et al. (1998) found that nearly 40% of youth were unemployed. Cashmore and Paxman also observed that youth were at an increased risk of economical disadvantage, as many did not have any skills regarding income and money management and many lacked sources of emotional and financial support. Cashmore and Paxman (1996) reported that many females had early pregnancies and often the young people fell into parenthood early on. The young people also showed signs of mental health problems and many reported low levels of happiness. Other studies have found similar findings (Green & Jones, 1999; Maunders, Liddell, Liddell, & Green, 1999; Mendes & Goddard, 1999; Owen et al., 2000).

A recent large population-based study (N = 13135) conducted in the United Kingdom by Viner and Taylor (2005) clearly showed that those individuals with "a history of public care were significantly less likely to achieve high social status and significantly more likely to be homeless, have a conviction, have psychological morbidity, and have poor general health" (p.895). Viner and Taylor also noted gender differences in the sample with a history of public care, with more men likely to be unemployed and have a history of mental health problems and less likely to attain higher education. Women, on the other hand, with a history of public care were more likely to be permanently expelled from school. Viner and Taylor concluded from their findings that poorer socioeconomic outcome in both genders confirms

earlier reports (see Biehal, Clayden, & Stein, 1995), and that being in public care is linked with later social exclusion. Their findings were also in agreement with a cross-sectional study of 142 children in public care (Williams et al., 2001) which reported similar findings in relation to a history of public care and later convictions. Viner and Taylor also found in their current study that individuals with a history of care have a greater than two fold higher risk for having a conviction by 30 years of age. Viner and Taylor's (2005) UK study concluded that public care in childhood is associated with a host of adverse problems later in life, including socioeconomic, educational, legal, and health outcomes. However, they were not able to confirm the high rates of mental health problems, unemployment and teenage pregnancy reported in many other studies. The authors of the study concluded that disadvantage associated with public care is less than reported by previous studies, for those who leave care at 16 to 17 years of age, and in cross-sectional research during adolescence that fails to account for other causes of disadvantage that might have preceded the time in care. Viner and Taylor recommend further research that examines the timing of placement, whether that affects the long-term outcomes, and whether treatment interventions can reduce adult disadvantage in those groups at high risk.

In contrast, Casey Family Programs, a large foster care provider in the United States, have found positive outcomes for former foster youth. Casey Family Services have conducted extensive research on young people leaving Casey services, who are referred to as alumni. One particular study (Pecora et al., 2003) researched 1,087 alumni who had been placed with a Casey foster family for 12 months or more, and found positive high school graduation rates and employment rates for many of the alumni. The study reported that the majority of the alumni, at the time of study, were in a stable and positive living situation, but that 22% had been homeless for one or more nights at any time within a year after leaving care. They also reported that among the risk factors facing youth in foster care, low educational attainment may have the most adverse affect on long-term adjustment. Youth who are at risk for school failure are also at an elevated risk for drug abuse, delinquency and violence. Casey Services have targeted educational services to improve educational attainment and overcome barriers to education for foster youths. The Casey Alumni study reported that a substantial proportion (72.5%) of their alumni had received a high

school diploma or GED (General Educational Development) by the time their case closed. The study also found that 88% of alumni aged 25 to 34 who were eligible for working were working at the time of the interview, but this rate is slightly lower than the national average. The researchers conducted analyses to determine which variables predicted success (a composite of educational attainment, income, mental and physical health, and relationship satisfaction) in adulthood for former foster youth. The variables that predicted success included: being male; completing a high school or GED before leaving care; being in a college/job training scholarship and support program; receiving life skills and independent living preparation; requiring less tutoring; participation in youth clubs or organisations; requiring less alcohol/drug treatment; not being homeless within one year of leaving care; and, less positive parenting from the last foster mother (the lower level of foster mother support may have helped motivate the youth to prepare for their emancipation).

All of the previous research indicates that the trauma associated with entering care, and the time in care, can have far reaching consequences for the individual's later life. The research into the outcomes of young people leaving care provides evidence that merely providing care is not enough and many young people need intensive therapeutic intervention and support. According to Morton, Clark and Pead (1999) and Clark (2000), many young people today require treatment to redress high levels of accumulating disadvantage in education, and in most cases therapy is required to address post traumatic stress, attachment-related problem behaviours and a range of health, emotional, cognitive and behavioural difficulties.

However, it is important to note that not all children entering care fare this badly. In fact, the majority of children fare reasonably well. For example, Martin and Jackson (2002) established an improvement in the foster children's academic functioning whilst in care. Pelnick (2000) also noted an increase in school attendance and academic functioning of children in foster care. Furthermore, Festinger's (1983) study of 227 children who had been in foster care in New York found that the majority of children who had been in long-term foster care became productive, law-abiding citizens in their early twenties. Such findings have been replicated by other researchers, such as Maluccio and Fein (1985). More recently, Barber, Delfabbro and Cooper (2002) in Australia showed that the majority of children in care settle into

their placements and display improved social and psychological adjustment. However, they also identified a small percentage of children who experience repeated placement failure and a deterioration of social adjustment. Amongst this latter group, there was little evidence of improvement over time. The findings suggest “that early placement disruption is not merely a symptom of adjusting to new surroundings, but a predictor of ongoing problems in the care system” (p. 211).

Therefore, in view of the numerous negative outcomes that can occur in the adult lives of foster children, it imperative that we are mindful of the effect placement instability has on the psychological and social development of children and young people in care. Current legislation regarding the placement of children in care further highlights this point. The South Australian legislation states, as does the legislation in most Western jurisdictions, that children should experience as little disruption as possible when placed into foster care (Barber & Delfabbro, 2004). The policy identifies that children require stable and continuous (if not permanent) placements so that successful development and normal attachment can be achieved. Yet, one of the greatest challenges of modern day children’s services is to provide stable placements that effectively meet all the needs of young people with high support needs. It is for these reasons that there is an increasing focus on addressing the needs of children who experience particularly high rates of placement instability.

SECTION B

Chapter 2

National Comparative Study of Children with High Support Needs

2.1 The Problem of Foster Care Drift or Placement Instability

Many researchers continue to debate the definition of foster care drift, placement instability, placement breakdown, placement disruption or placement termination (Smith, Stormshak, Chamberlain, & Bridges Whaley, 2001). However, in most cases, these terms refer to the unplanned termination of a foster care or residential care placement. Regardless of the terminology, placement instability (the term that will be used in this thesis) continues to be a challenging feature of most care systems in the Western world, with similarly high rates of disruption having been observed by several researchers in different countries (see Section 1.5 for detailed review).

In Chapter 1, it was pointed out that several researchers have attempted to identify and disentangle the factors that increase a child's risk of experiencing placement instability. For example, Pardeck (1984) and Pardeck, Murphy and Fitzwater (1985) examined individual child factors. Their research showed that increased age and the presence and severity of behavioural and emotional problems were significantly related to higher rates of placement instability. Palmer (1996) also found evidence boys may be at greater risk for instability than girls. In Australia, research by Delfabbro, Barber and Cooper (2000) found that gender, location and placement history were the three most important factors that predicted placement disruption. They found that boys were four times more likely to experience disruption, and children in the country were 3.35 times more likely to have this experience. Furthermore, if children had a history of previous multiple placement changes (6 or more), they were 3.38 times at greater risk of experiencing disruption. The results of this particular study suggest that problems increase as children grow older and the longer they remain in care.

Barber et al.'s (2000) work found that outcomes for children in South Australian foster care could be very reliably and efficiently predicted based upon

baseline child characteristics alone, and that clear thresholds (e.g., criterion levels of instability, conduct disorder scores) can be identified that suggest a very poor prognosis for longer-term outcomes. For example, children with high conduct disorder scores and aged 14+ years had almost an 80% chance of having a placement breakdown due to the child's behaviour after each new referral into care. If two or more such breakdowns occurred within a two year period, then children had only a 5% chance of finding a stable placement after two years and were clearly distinguishable from other children in care in terms of their placement history. Such children had between 10 to 20 or more placement changes in two years, including many in residential care, with relatives, and sometimes short periods at home.

Some researchers have also examined the social-interaction factors that can influence placements and result in disruption. Stone and Stone (1983), for example, identified several factors that were related to placement disruption, including a poor parent-child relationship, the child's inability to form positive attachments with caregivers, or previous experience of having lived in chronically abusive or neglectful homes. By contrast, Berrick, Needell, Barth, and Johnson-Reid (1998) placed greater emphasis on the relationship between the foster parent and the foster child or the fit between foster parent and foster child characteristics. In their view, these factors were more predictive of placement outcome than either child or foster parent characteristics alone. Other researchers have placed greater emphasis on system-level contextual factors, such as the degree of contact, rapport building and case-worker continuity (Pardeck, 1984). For example, Moore, Osgood, Larzelere and Chamberlain's (1994) research found an exponential relationship between the number of children placed per home and the number of daily problematic behaviours emitted per child, which ultimately contributed to an increased risk of placement breakdowns.

2.1.1 The need for further research into placement instability

Despite the recognition of the complex needs of many children in care, most foster care services have few, if any, systematic processes or methodologies in place to allow for the early identification and ongoing monitoring of their needs. As a consequence, these children 'at risk' impose considerable burdens on the foster care system and undermine its capacity to provide effective services for other children in

care. Although admittedly these problems occur because there are limited resources and alternative arrangements for very challenging children in many jurisdictions, there is a growing recognition of the need to find: (a) more effective ways to meet the needs of challenging children in alternative care, and (b) possible ways to identify these children when they enter foster care, so that more effective services and strategies can be put into place when children first come in contact with the service system.

Barber and Delfabbro's (2004) study provided detailed information concerning the outcomes of these children in out-of-home care, but their analyses were confined solely to the South Australian system. Furthermore, relatively little information was obtained concerning the services provided to these young people, and the families from which they had come. For these reasons, there is a need to extend this research so that the causes of the placement disruption are considered in a broader social and demographic context.

2.1.2 Aims of the National Comparative Study

Barber, Delfabbro and Cooper's (2001) recent work has tended to focus upon the characteristics of the children themselves and how this relates to outcomes, and how well the system has responded to their needs. It is important to recognise that many problems are brought into care, rather than being caused by it. Accordingly, there may be considerable value in documenting young people's pathways into care, so as to identify possible intervention points, or service responses that might have been useful in preventing young people's entry into care. In addition, there may be considerable value in understanding what services are currently being used by existing services so as to determine what is effective and ineffective in meeting the needs of these young people.

The first principal aim of this study was to extend Barber and Delfabbro's (2004) findings by conducting a more detailed national study of the needs, social background, and service responses to children who met the empirically derived criteria across four different Australian States. To do this, measures from the previous longitudinal study were supplemented by a wider range of measures, including the Strengths and Difficulties Questionnaire (SDQ) currently being used in

the Australian Institute of Family Studies' national longitudinal study of children (LSAC). The SDQ was included to estimate the proportion of children with placement instability who fell into the abnormal or clinical range on key indicators of psychological and social adjustment, so as to highlight the potential need for specialist therapeutic services for this population.

A second aim was to place a greater emphasis on the utilisation of services both at the entry point into care as well as during placement. As indicated by Bath (1998), while much is written about the characteristics of children who experience considerable placement instability, there is also a strong need to understand the implications of these characteristics for practice and service delivery in order for progress to be made in finding appropriate solutions for these children. For example, in considering young people's entry into care, it is important to determine what service responses were or could be utilised to reduce the likelihood of young people having to leave home. On the other hand, once young people are in the care system, there is a need to ascertain which services have been used, and whether these were effective or ineffective, so that recommendations can be made concerning future service and treatment responses.

A third aim was to provide a national reference point for evaluations of intervention strategies conducted in different States. At the present time, it may be difficult to make best practice recommendations for children with challenging needs because different programs or jurisdictions are dealing with children with a variety of different characteristics, age range and placement histories. National data using standardised measures will provide a means by which to compare the needs of children in different jurisdictions so that treatment options that prove effective in one State can be replicated or considered by others faced with children with similar profiles (Chapter 5 for program evaluations). In addition, because State Governments are often reluctant to publicise their own individual problems because of fear of condemnation by the local media and the public, the development of a national profile of these children may serve to strengthen national awareness and facilitate debate concerning these problems and the need to address them in a unified way across the country.

Although this research was primarily of an exploratory and descriptive nature, it was nonetheless possible to investigate several broad hypotheses relating to the association between child characteristics and system outcomes; namely that;

(a) Children with more complex family backgrounds would have poorer psychosocial functioning on a range of measures,

(b) Psychological and social functioning would be poorer in children with the most disrupted placement histories,

(c) Children with more complex needs would receive more services because of the tendency for greater amounts of resources to be directed towards the most difficult cases.

2.2 Overview of method and presentation of results

The findings from this study will be presented in a series of sections. The following section (2.4) will commence with a description of the placement history of the children and a description of their high support need as identified by their case-files. The next sections (2.5 - 2.7) will provide a psychosocial profile of the children based on standardised measures, followed by a section that will examine the relationship between psychosocial functioning and the children's placement history, social background and general high support needs (2.9.4). Section 2.10 will examine the relationship between certain measures. The following section (2.11) will examine the level and type of family contact and its relationship to child functioning. Section 2.12 provides four case studies of individual children in the study. The next section (2.13) will examine children's service history and how this relates to the social background of the families and child characteristics. The final section will discuss the conclusions, implications and recommendations arising from the results and relate the findings to the study aims and hypotheses.

2.2.1 Selection criteria

The national comparative profile study was undertaken in four States that agreed to participate (South Australia, Victoria, Queensland and Western Australia) between November 2003 and August 2005. This was the first national project of its type to be undertaken in Australia and was conducted to extend previous research conducted in South Australia (see Barber & Delfabbro, 2004; Barber et al., 2001; 2002; Delfabbro et al., 2000; 2002a; Delfabbro et al., 2002b). The selection of 'high-

support' children was based on the objective and empirically derived selection criteria identified in the longitudinal study of children in care (Barber et al., 2001; Delfabbro et al., 2002a). Using this method, it was therefore highly likely that that sample selected in the different States had a genuinely poor prognosis for achieving stability in care.

Children were selected if they were between 4 and 18 years of age and referred for emergency, short-term or long-term placements. The children were selected only if they had experienced two or more placement breakdowns in the previous two years or had experienced a placement breakdown during their first four months in care. According to Barber and Delfabbro (2004), placement instability was defined as two or more placement breakdowns due to behaviour, due to the danger of false positives recorded in case-files. They noted that it was common for social workers to record 'disruptive behaviour' as the reason for terminating a placement when the situation was either more complex than that or was merely a case of incompatibility between the child and foster care. However, when disruptive behaviour was mentioned as the cause on more than one occasion, false positives were extremely unlikely. Children less than four years of age were not selected because the measures employed in this research were not appropriate for this age group (Delfabbro et al., 2000). Children on detention orders or those referred for family preservation services were also excluded because the primary focus was on children who could not be currently and effectively accommodated in out-of-home care.

2.2.2 Sample characteristics

The study involved 364 children and young people purposively selected using Barber and Delfabbro's empirically derived objective criterion of placement instability from four Australian States (South Australia (*N* = 113, 31.0%), Victoria (*N* = 99, 27.2%), Queensland (*N* = 80, 22.0%) and Western Australia (*N* = 72, 19.8%). In South Australia and Western Australia the samples were purposive in nature and are thought to include all of the young people who fall into this category. The samples from Victoria and Queensland were random in nature due to the larger population of children in care in those respective States. Of the 364 children and young people, 58.2% were males and the mean age was 12.92 (*SD* = 3.28, range 4-17

years). The majority of the total sample was identified as non-Indigenous, 17.9% as Aboriginal/Torres Strait Islander, and 4.1% of 'other' nationality. Just over 70.0 % of the sample were placed on Guardianship of the Minister orders, 4.4% were on Care and Protection orders, 0.8% were on Voluntary orders and 24.7% were on 'other' court orders. Analysis of the order duration showed that just under half of the children were on Guardianship of the Minister orders until the age of 18 years (45.1%), 39.3% were on 'other' length orders and 15.7% of the sample were on twelve month orders.

2.2.3 State differences in sample characteristics

Table 2.1 summarises the significant differences in age, gender and ethnicity of children from the four Australian States. A significant difference was found between the age of the children from three States (F (3, 364) = 6.03, $p < 0.05$). The children from South Australia were found to be significantly younger than the children from Western Australia and the children from Victoria. It was also found that the children from Queensland were significantly younger than the children from Western Australia. Pearson's chi-squared analyses revealed significant gender differences across the States (χ^2 (1, N = 364) = 8.12, $p < 0.05$). The sample from Victoria had a higher percentage of male children than the South Australian sample. Pearson's chi-square cross-tabs also revealed significant ethnicity differences between the States, χ^2 (1, N = 364) = 28.20, $p < 0.05$. The Victorian sample was found to have a significantly higher proportion of non-Indigenous children than the South Australian, Queensland and Western Australian samples.

Table 2.1 Summary of State differences of age, gender and ethnicity of children

	SA	VIC	QLD	WA
	(*N* =113)	(*N* = 99)	(*N* = 80)	(*N* = 72)
Mean age (*SD*)	12.20 (3.49)	13.21 (3.50)	12.48 (3.14)	14.13 (2.29)
N (%) male	56 (49.6)	68 (68.7)	45 (56.3)	43 (59.7)
Ethnicity *n* (%)				
Non-Indigenous	87 (77.0)	91 (91.9)	56 (70.0)	50 (69.4)
Aboriginal	21 (18.6)	6 (6.1)	17 (21.3)	21 (29.2)
Other	5 (4.4)	2 (2.0)	7 (8.8)	1 (1.4)

2.2.4 Method of data collection

The data for this study were collected from case-files and face-to-face interviews with case-workers at community service departments in South Australia, (formerly the Department of Human Services (DHS), now known as Department for Families and Communities (DFC), Victoria (Department of Human Services (DHS), Queensland (Department for Families), and Western Australia (Department for Community Development) between November 2003 and August 2005. The principal investigator (Alexandra Osborn) conducted approximately 120 face-to-face interviews (over 100 hours in total, not including travel time) and coordinated data collection in each of the four States. The principal investigator also liaised with the others collecting the data on a frequent basis (weekly) and provided guidance and instruction. Due to the privacy act (Privacy Amendment (Private Sector) Act, 2000), the case-file readings were only permitted to be undertaken by a paid employee (Children Services Practitioner with a minimum three year University Bachelor degree in Social Work or Psychology) of each of the community service departments. The project consisted of multiple studies conducted across the four States. The data were then combined to form the national sample. The principal investigator entered and analysed all the data from each of the four States.

Records at the central referral agency were monitored over a number of months in order to identify a sample of children meeting the specified selection criteria. A target sample of 100 was sought for each State. In the case of Western Australia and South Australia, it was possible to sample almost all children in the

metropolitan area falling into this category, whereas a random selection was taken in Queensland and Victoria. The data collection was purposive in nature. Children were selected if the child had two or more placement breakdowns in the previous two years. If the child met the inclusion criteria, the respective case-worker at the district centre or non-Government agency was contacted with the intention of conducting a short interview, and for the purposes of gaining access to case-files. The list of children who were identified as being suitable for inclusion in the study was recorded along with the contact details and location of the child's allocated case-worker. This information was collected from the central agency records, Government databases and verified with case-workers in interviews. Children selected using the method described above have been clearly shown to have greater difficulty in being accommodated than other children in care (Barber, Delfabbro & Cooper, 2001; Barber & Delfabbro, 2004).

Using both qualitative and quantitative methods, a social history of each of the children was compiled from reviews and coding of case-file information (case-plans) developed when children first came into care. The information examined included: abuse and neglect notifications, alternative care history, reasons for being placed into care, family background, situation at time of referral (behavioural issues, needs, interventions, school attendance), and previous services. A second phase in the data recording involved documentation of the child's long-term placement history from both computer records (where these were available) and an interview with the child's case-worker, with a focus upon identifying the reasons for placement changes. To validate the information quickly, a sample of case-workers was asked to indicate how often they had telephone and direct contact with the children during the relevant period (i.e. the last 12 months, see section 2.2.6).

2.2.5 General survey design

A standardised protocol was developed in consultation with the Department of Human Services (DFC in South Australia), and in light of preliminary inspections of case-files to ascertain the validity of items. Previous research by Delfabbro in conjunction with FAYS (Forward & Carver, 1999) suggests that case-file data is of variable quality and protocols need to be developed very carefully (Munro, 1999), and that the best quality data is obtained by a combination of case-file reading and

interviews with well-informed case-workers. Barber and Delfabbro (2004a) have previously demonstrated the relationship between the ratings/self reports of case-workers and foster carers and shown consistent reports and ratings of the children and young people. It should be noted here that much of the information contained in the case-files was very detailed (multiple case-files for each young person) and so it was not possible for two independent people to read the file separately.

2.2.6 Frequency of case-worker contact with child and foster carers/staff

The respective State governments Human Research Ethics Committee members (HREC) in each of the four States did not allow direct contact (i.e. for interview) between the researcher and foster children due to privacy and anonymity reasons. Taking this into account, we felt that due to the high needs of the children, the case-workers were in a good position to comment on the level of social and psychological functioning of the children. To confirm that case-workers were a reliable source of information, for a small proportion of children (N = 49, 13.46%) from South Australia only, information was collected concerning the type and frequency of contact that case-workers were having with the children and foster carers/unit staff in the previous six months. As can be seen in Table 2.2, over a third of case-workers were having telephone contact with the child 2 to 6 times per week; whereas, just over half of case-workers were having telephone contact with the foster carer/unit staff 2 to 6 times per week and 18.3% were having daily telephone contact. In respect to direct face-to-face contact, case-workers were seeing approximately a third of the children on a weekly basis, and the case-workers were having direct face-to-face contact with the foster carers/unit staff at a similar rate to the children. The results therefore provide evidence that case-workers have a relatively high level of both telephone and direct contact with both the children and foster carers/unit staff and therefore should be in a good position to comment on the general social and psychological well-being of the foster children.

Table 2.2 Type and frequency of case-worker contact with children and foster carers/unit staff in the previous six months, (*N* = 49)

Contact type	Never (%)	1-3 times per month (%)	2-6 times per week (%)	Daily (%)
Telephone – Child	8.2	51.0	36.7	4.1
Telephone – Foster Carer/Unit staff	2.0	20.4	59.1	18.3
Direct – Child	0.0	65.3	34.7	0.0
Direct- Foster carer/ Unit staff	4.1	68.4	26.5	0.0

2.3 Measures

2.3.1 Case-file Audit

a) Demographics

Records were taken of the child's age, gender, ethnicity, and type and duration of order (e.g., Guardianship to 18).

b) Biological family/social background

Information was collected regarding the child and biological family's background and factors that were documented in the case-file that contributed to the child being placed into care. These factors included; financial problems, domestic violence, parental substance abuse, and parental physical illness and/or disability. Records were also taken on the forms of abuse or neglect that the child may have experienced, the number of siblings under 18 residing in the biological home and number of siblings also in the same placement as the child in question.

c) Critical events in the child and family's life

Extensive information was collected concerning the circumstances that contributed to the child's first contact with the Department, and what circumstances appeared to contribute to the child first being placed into care.

d) Care history

This section recorded the child's age at first entry to care; the primary reason for entry to care; number of all types of foster placements prior to entering current placement or program; the years spent in care; the number of previous reunifications with family; and whether the child had previously been placed in residential or relative care; the duration of longest reunification with the child's birth family; and the reasons for re-entry into care. Case-workers were asked to comment on the factor(s) they felt that made it most difficult for the child to return to their biological parents.

e) Child's needs

This section related to high support needs of the child identified in their case-file. Such high support needs included; conduct disorder, hyperactivity, depression, anxiety, attention deficit hyperactivity disorder (ADHD), personality disorder/mental illness, physical/intellectual disability, and any other needs. If the case-file identified that the child was diagnosed with conduct disorder, then a specific section on conduct disorder symptoms was also completed. This section included items such as; damaging or destroying property, offending, substance abuse, temper tantrums, lying and cheating, fighting with or physically attacking others, persistent disobedience, severe school problems, school refusal, running away, harm to self, inappropriate sexualised behaviours towards others, sexually at-risk behaviour, interpersonal conflict, attachment disorder and any other relevant information.

f) School/education based interventions before or since contact with the Department

This section included items relating to whether the child was attending school at the time of the first placement into care and whether they were currently attending school at the time of data collection. The section also had a checklist of possible service supports that the child may have received in the past or may currently be receiving. Such service supports included; periodic meetings between teachers and carer(s), individually tailored curriculum, private tutor (at home or school), or general education worker at location, or any other educational support services.

g) Specific therapies or interventions provided to child or biological family since or before they came into contact with the Department

Extensive information was collected in regard to any specific therapies or interventions that the child or biological parents may have received before the child came into care or during the child's time in care. Information was collected on the type of therapy or intervention, when it was provided and who actually provided the service. A checklist was developed so that information could be systematically extracted from the case-files (see Appendix A). The checklist included such services as; assertiveness training, self-esteem building, psychiatrist, psychologist, treatment for specific mental health issues, anger management, social skills training, dealing with grief and loss, behaviour management, employment training/apprenticeship, independent living, substance abuse treatment, safe sex practices, family mediation, family support worker visits home, mentor and any other services.

2.3.2 Psychosocial assessment - Interview with child's case-worker

a) The Child Behaviour Checklist (CBC) – (Boyle et al., 1987)

Psychosocial adjustment was measured using three sub-scales derived from Boyle's et al's (1987) child behaviour checklist. The Child Behaviour Checklist is an empirically designed measure of child behavioural problems and social competencies. The items are scored on a three-point scale ranging from 0 = "Never", to 1 = "Sometimes", to 2 = "Often". The questions were administered to the child's allocated case-worker who was asked to rate the child's behaviour over the last six months using the three response categories. The three main constructs that were measured included conduct, hyperactivity, and emotionality.

Conduct disorder scale

An abbreviated conduct disorder scale was used from Boyle et al.'s (1987) Child Behaviour Checklist. The items were those used by Barber and Delfabbro in their three-year longitudinal study (see Barber & Delfabbro, 2004). The items included satisfied the key criteria of the DSM classification for conduct disorder and each was scored (0 = "Never", 1 = "Sometimes", 2 = "Often") giving a score range of 0 (no problems) up to 12 (very severe problems). The six items referred to: "destroying property", "damaging property", "defiance at school", "lying and cheating", "stealing from outside the home" and "physically assaulting others". The

Cronbach's Alpha for the conduct subscale (6 items) was acceptable at 0.79.

Hyperactivity scale

An abbreviated hyperactivity scale was also used based upon three items from Boyle et al.'s (1987) CBC. The three items included the key elements of the DSM classification for hyperactivity disorder and each item was scored the same way as the conduct disorder scale. The three items were: "couldn't sit still, restless or hyperactive"; "could not concentrate or pay attention for long"; "distractible, has trouble sticking to things". The score range for the hyperactivity scale (3 items) was 0 (no problems) up to 6 (very severe problems). The Cronbach's Alpha for the hyperactivity (3 items) was 0.87.

Emotionality scale

An emotionality scale was again constructed from 5 items from Boyle et al.'s (1987) CBC. These items captured the key elements of DSM classification of 'overanxious disorder' and 'affective disorder'. Each of the five items was scored in the same way as the conduct disorder and hyperactivity scales. The total possible score for the scale was between 0 (no problems) and 10 (very severe problems). The items included: "not as happy as other children"; "unhappy, sad or depressed"; "too fearful or anxious"; "nervous highly strung or tense"; "worried a lot". Reliability analyses confirmed that the Cronbach's Alpha for the emotionality (5 items) sub-scale was also acceptable (0.71).

As discussed by Barber and Delfabbro (2004), the items selected from Boyle et al's. (1987) CBC to measure conduct disorder, hyperactivity and emotionality are those that were found to have the highest item-total correlations with their relevant sub-scales in a study of over two thousand Canadian adolescents (Barber, Bolitho, & Betrand, 1999a, 1999b). All three scales were used extensively by Barber and Delfabbro (2004) and have found to have very good psychometric properties in Australian foster care samples and to be highly predictive of relevant system outcomes, including the probability of placement breakdowns and the effects on sustained placement instability.

b) Strengths and Difficulties Questionnaire (SDQ)(Goodman, 1997).

The SDQ is a short behavioural screening questionnaire for children and young people 3-16 years of age. It comprises a mixture of 25 positive and negative attributes of the child. The attributes are divided between 4 sub-scales: Conduct problems (5 items), Emotional symptoms (5 items), Hyperactivity/inattention (5 items), and Peer Relationship Problems (5 items). Together the 20 items generate a Total Difficulties Score. Each item is scored on a 3-point scale, where 0 = "Never", 1 = "Sometimes", and 2 = "Often". The scale ranges for each of the four sub-scales was 0 -10 and the Total Difficulties Scores is a sum of the four sub-scales to give a score out of 40. Reliability analyses were also performed on Goodman's SDQ scales to ensure they possessed adequate levels of internal consistency. The Cronbach's alpha for the conduct problems scale (5 items) was slightly lower than Boyle's conduct scale at 0.73. Hyperactivity scale alpha was acceptable at 0.78 (5 items), but again was lower than Boyle's hyperactivity scale. The scale alpha for the emotionality problems scale (5 items) was acceptable at 0.79, which was higher than Boyle et al's. emotionality scale. The Alpha value for the peer problems (5 items) subscale was only just acceptable (0.66).

SDQ Conduct disorder scale

The conduct disorder scale comprised 5 items giving a score range of 0 (no problems up to 10 (very severe problems). The total possible score of 10 was divided by the total number of items (five) to yield a mean conduct score of between 0 and 2. The five items referred to: temper tantrums; general obedience; fighting with or bulling other children; lying and cheating; and, stealing from outside the home, school or elsewhere.

SDQ Hyperactivity scale

The hyperactivity scale consisted 5 items giving a score range of 0 (no problems up to 10 (very severe problems). The total possible score of 10 was divided by the total number of items (five) to yield a mean conduct score of between 0 and 2. The five items included: 'restless or overactive, cannot sit still for long'; 'constantly fidgeting or squirming'; 'easily distracted, concentration wanders'; 'thinks things out before acting'; and 'see tasks through to the end, good attention span'.

SDQ Emotionality scale

The emotionality scale also consisted of 5 items with a score range of 0 (no problems up to 10 (very severe problems). The total possible score of 10 was divided by the total number of items (five) to yield a mean conduct score of between 0 and 2. The items included: 'often complains of headaches, stomaches or sickness'; 'many worries, often seems worried'; 'often unhappy, downhearted or tearful'; 'nervous or clingy in new situations, easily loses confidence'; and 'many fears, easily scared'.

SDQ Peer functioning scale

The peer functioning scale comprised 5 items with the same score range and total possible score as the previous three scales. The items included: 'shares readily with other children, e.g., toys, treats, pencils'; 'rather solitary tends to play alone'; 'has at least one good friend'; 'generally liked by other children'; and 'gets on better with adults than with other children'.

The questions were administered to the child's allocated case-worker who was asked to rate the child's behaviour over the last six months using the three response categories. Even though the Boyle et al. (1987) checklist and the SDQ are similar clinical instruments, they were both included in the interview so as to allow comparisons with the findings of those of Barber and Delfabbro (2004) that relied solely on the Boyle et al. scales.

c) Social adjustment

The case-workers were also asked to comment on the child's social adjustment in the previous six months using a four-point scale with 7 items ranging from 1 = "Never", 2 = "Rarely" 3 = "Sometimes" and 4 = "Often". This scale was previously used and validated by Barber and Delfabbro (2004). The scale consisted of five items relating to social relationships ("Has been getting along well with people", "Has resented people telling him/her what to do", "Has felt persecuted or picked on", "Has been inconsiderate of other people's needs or feelings", and "Has blamed others for his/her mistakes"), and two items measuring social confidence ("Has looked forward to mixing with others" and "Has been willing to talk and express feelings"). Items were recoded so that lower scores on all items represented a

better level of social adjustment. This generated a scale with a score range between 7 (high adjustment) and 28 (low adjustment). The Cronbach's alpha for the social adjustment scale (7 items) was acceptable at 0.71.

d) Educational adjustment

Information regarding the child's attendance at school or an education-based program was also gathered, including the current grade or achievement level. The case-worker was also asked to indicate whether the child had been suspended or excluded from the school or education program in the previous six months and, if so, the number of times.

e) General health issues

Information regarding the child's weight and physical coordination was collected along with whether the child had had any physical health problems (including dental) that had required attention in the previous six months and whether any action had been taken. The case-workers were also asked to indicate whether the child had any diagnosed psychological health problems and whether any action had been taken to address them.

f) Attachment disorder checklist

The attachment disorder checklist was developed based on the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 1994) classification for this disorder. Case-workers were asked to indicate how often children had exhibited certain behaviours in the previous six months based on 10 items on a four-point scale ranging from 1 = "Never", 2 = "Rarely", 3 = "Sometimes" to 4 = "Often", giving a possible total score of between 0 – 40. The checklist included statements such as; "makes very little eye contact", "has been indiscriminately affectionate towards strangers", and "has produced incessant nonsense speech". The items were scored so that a high score on the scale indicated a higher level of attachment-related problem behaviours. Cronbach's alpha for the attachment disorder scale (10 items) was acceptable at 0.68.

g) Family Contact

The frequency and type of family contact the child had experienced in the previous six months was also recorded. Case-workers were asked to indicate how often the child had telephone, face to face supervised contact, face to face unsupervised contact and/or overnight stays with their biological mother, father or relatives.

h) Placement history

Case-workers were asked to indicate how many placement terminations the child had had in the previous two years and also to specify the primary reasons for these decisions. In addition, the case-workers were asked how many of the moves were requested by carers due to the child's behaviour and what the main behaviours were that had been the primary cause of the breakdowns. Case-workers were also asked to describe what critical incidents had led to recent placement breakdowns.

i) Frequency of case-worker contact with foster carer and child

Information was also collected concerning the type (telephone/ direct face-to face contact) and frequency of contact between case-workers and the foster carer/unit staff and the child in the previous six months. The case-workers were asked to indicate the frequency of each form of contact with each person on a six-point scale: 0 = "Never", 1 = "Once per month or less often", 2 = "2 - 3 times per month", 3 = "Weekly", 4 = "2 - 6 times per week" and 5 = "Daily".

2.3.3 Ethical Considerations

All information obtained from case-files, case-workers and computer records remained completely anonymous and confidential through the process of de-identification of all records by internal Departmental employees. The case-files were only viewed on site at the agency and were never removed by the researcher. Appropriate consent and approval procedures were followed in relation to obtaining information about the cases included. Managers and supervisors were contacted to inform them of the project prior to any attempt being made to contact individual case-workers.

Statistical note

Although some researchers support the use of correction methods such as Bonferroni corrections to reduce the probability of Type I errors in situations where large numbers of tests are conducted, such corrections are not included based on recommendations of Nakagawa (2004).

2.4 Placement and care history

2.4.1 Introduction

The purpose of this chapter is to provide a national profile of the placement and care histories of those children with the highest levels of placement instability in four Australian States. As indicated earlier, one of the main reasons for doing so is the fact that much research has tended to focus solely on the characteristics of the children and their outcomes in care; however, it is also critical to recognise and provide evidence that many problems are brought into care, rather than being caused by it (Barber et al., 2001; Pecora. Kessler, Williams, O'Brien, Downs, English, White, Hiripi, White, Wiggins & Holmes, 2005). For this reason, there is considerable value in documenting young people's pathways into care, and this Chapter will report the young people's pathways into care, their placement and care histories, their biological and social background factors, and a multiple high-support needs analysis.

2.4.2 Care history

As indicated, information concerning the care history of each of the children was collected in each of the four States. The mean age at entry into care of the total sample was 7.48 years (*SD* = 4.21), with a range of 0 to 16 years. On average, the number of years the children had spent in care was 4.80 years (*SD* = 3.76), with a range of 0 to 18 years in care. The mean number of previous placements (all types: foster, residential and/or relative) the children had experienced prior to their current placement was just under eleven placements (*M* = 10.53, *SD* = 7.80), with a range of 2 to 55 placements.

Further analyses were conducted to establish whether there were any age, gender or State differences in regard to the children's care history. No significant gender differences were noted for the age at first entry to care, the years spent in care

or the number of previous placements. As can be observed in Table 2.3, the Indigenous children entered care at a significantly younger age and had spent a significantly longer period of time in care in comparison to the non-Indigenous children. The Indigenous children did not differ from the non-Indigenous children in terms of the number of previous placements or number or duration of reunification attempts.

Table 2.3 Indigenous status and care history, M (SD)

	Non-Indigenous children (N = 285)	Indigenous children (N = 65)	t
Age at entry to care	7.70 (4.23)	6.30 (4.02)	2.41*
Years spent in care	4.62 (3.82)	5.78 (3.45)	2.20*
Number of previous placements	9.99 (6.71)	11.72 (8.50)	1.77
Number of previous reunification attempts	0.87 (1.49)	0.78 (1.47)	< 1
Duration of longest reunification (months)	9.37 (13.58)	5.47 (10.42)	1.50

*$p < 0.05$

As can be seen in Table 2.4, Fisher's LSD post-hoc comparisons revealed significant State differences for the mean age at which children had entered care (F (3, 361) = 5.24, $p < 0.01$), the number of previous placements (F (3, 358) = 8.62, $p < 0.01$), and the mean number of years spent in care (F (3, 359) = 6.75, $p < 0.01$).

Table 2.4 State differences in children's care histories, M (SD)

	SA	QLD	WA	VIC
Age at entry to care	6.23 (4.04)	7.92 (4.06)	7.68 (3.91)	8.36 (4.44)
Number of previous placements	13.56 (10.32)	8.72 (5.83)	9.45 (4.75)	9.39 (6.74)
Years spent in care	5.42 (4.36)	3.76 (3.23)	5.96 (3.63)	4.11 (3.19)
Number of previous reunification attempts	0.52 (1.69)	0.56 (1.05)	0.98 (1.36)	1.35 (1.41)
Duration of longest reunification (months)	2.83 (5.32)	7.24 (11.12)	8.53 (11.90)	13.07 (16.15)

Inspection of Table 2.4 shows that SA sample entered care at a significantly younger age than Victoria and QLD samples. The SA and WA samples had spent significantly longer time in care than the QLD and VIC samples, whereas th QLD sample had significantly spent the lowest number of years in care than the SA and WA samples. Overall, the SA sample had a significantly higher number of previous placements than the other three States, whereas QLD sample was observed as having had the lowest number of previous placements.

2.4.3 Reunification attempts

The mean number of reunification attempts on average experienced by the sample was relatively low, 0.85 (SD = 1.46), with a range of 0 to 16 attempts. The mean duration of the children's longest reunification attempt was 8.46 months (SD = 12.92), with a range of 0 to 60 months. A one-way ANOVA revealed significant differences between the State samples in regard to the mean number of previous reunification attempts (F (3, 330) = 7.06, $p < 0.01$) and the duration of the longest reunification (F (3, 183) = 6.82, $p < 0.01$). The Western Australian and the Victorian samples had the highest number of previous reunification attempts and the South Australian sample had the lowest number (see Table 2.2). However, it should be noted that the differences that were observed may be due to the different legislation and policies operating in each of the States. No significant gender differences were noted in relation to the number of previous reunification attempts or the period of reunification.

2.4.4 Reasons for re-entry into the care system

The reasons attributed to the re-entry of 132 (36.3% of the total sample) children back into the care system included parent(s) inability to cope with the child's behaviour (33.4%), parental problems (28.8%), abuse (24.2%), neglect (7.6%), and other reasons such as the death of a parent (6.1%).

2.4.5 Relative care and residential care

Just under half of the total sample (47.3%) was identified as previously having been placed in relative care. Further analyses were conducted to determine whether the State samples differed in regard to placement into relative care. Pearson chi-square analyses revealed significant State differences ($\chi 2$ (3, N = 352) = 81.54, p < 0.01). It was found that placement into relative care was higher in Western Australia and Victoria. This finding is not surprising considering that previous research has noted the South Australia care system as having the lowest level of relative care placements in Australia (Layton, 2003).

Just over half of the total sample (56.5%) had previously experienced a placement in a residential/group care. Significant State differences were observed in relation to the frequency with which children had been placed into residential care ($\chi 2$ (3, N = 360) = 64.07, p < 0.01). Residential care was more widely utilised in Victoria and Western Australia than in South Australia and Queensland. There were no associations between gender and the frequency of relative or residential care placements or any differences between the Indigenous sample and the non-Indigenous sample.

2.4.6 Family structure

Information was collected on the mean number of siblings and the number of siblings (under 18 years) still residing in the family home and whether siblings were currently placed in the same placement or program. The mean number of siblings under the age of 18 years was M = 2.59 (SD = 2.39) with a range of 0 to 20 siblings. The average number of siblings currently in the same placement was 0.90 (SD = 1.47), with a range of 0 to 9 siblings (including a group home placement that housed all ten children). The mean number of siblings identified as still residing at home with the biological parent(s) was 0.96 (SD = 1.36). A one-way ANOVA was conducted to determine whether any within or between group differences existed. No

within group differences were found, but significant differences were noted between the four States on the mean number of siblings under 18 (F (3, 364) = 3.53, p < 0.05). The South Australian sample (M = 3.16, SD = 3.27) was found to have a significantly higher mean number of siblings under 18 than the Queensland (M = 2.11, SD = 1.69), Western Australian (M = 2.42, SD = 1.84), and Victorian (M = 2.43, SD = 1.88) samples. A significant between group difference was found between the States on the mean number of siblings in the same placement with the child (F (1, 3) = 14.44, p < 0.01). It was found that the South Australian sample (M = 1.30, SD = 2.27) had the highest mean number of siblings in the same placement in comparison to Queensland (M = 0.15, SD = 0.45), Western Australian (M = 0.18, SD = 0.45) and Victorian (M = 0.48, SD = 1.00) samples. A significant between groups difference was also noted on the mean number of siblings still residing at home with the biological parents (F (3, 364) = 8.15, p < 0.01). The Victorian sample (M = 1.37, SD = 1.63) was noted as having a higher mean number of siblings currently residing at home than the Western Australian (M = 0.73, SD = 1.06), South Australian (M = 0.79, SD = 1.16) and Queensland (M = 0.86, SD = 1.38) samples.

2.4.7 Reason for first contact with department

Information was collected concerning the circumstances that contributed to the child and families' first contact and dealings with the department and the number of notifications the department received. The reason for collecting this data was to determine whether early dealings or contact with the department were then reflected in the reason for later entry into care. For example, was the presentation or allegations of problems similar to the presentation or allegations that actually led to removal of the child from the family home? The time interval between first contact and entry to care was also examined.

The mean age of children's first contact with the department was relatively young at 3.66 (SD = 3.67), with a range of 0 (birth) to 15 years of age, compared with a mean age of 7.48 (SD = 4.21) when the child entered care. Table 2.5 indicates that the families came to the attention of the department for a variety of serious problems, issues and needs and that there was usually a considerable delay between the time of this initial contact and when children actually entered care. A paired samples t-test revealed a significant difference between when the children first had

contact with the department to when they actually first entered care (t (1) = 19.86, p < 0.001). The mean number of notifications (all types), where it was possible to obtain this information (N = 210, 57.7%), was 5.87 (SD = 5.02), with a range of 1 to 29 notifications. As can be seen below (Table 2.5), a variety of reasons were initially noted, ranging from financial problems to allegations of neglect and abuse.

Table 2.5 Primary or main reason for first dealings/contact with department, *N* = 364

	N (%)
Abuse (physical and/or emotional and/or sexual)	93 (25.6)
Neglect	81 (22.3)
Abuse and neglect	72 (19.8)
Child's very difficult behaviours (and/or sexualised behaviours)	29 (8.0)
Domestic violence	27 (7.4)
Parental mental health problems	19 (5.2)
Parental substance abuse	16 (4.4)
Financial problems and/or homelessness	11 (3.0)
Parents not coping with child	6 (1.6)
Parental intellectual disability	2 (0.5)
Parents imprisoned	1 (0.3)

Further analyses were conducted to determine if any gender or State differences existed in relation to when the children first had contact with their respective departments. No gender differences were observed. A one-way ANOVA revealed a significant State difference (F (3, 355) = 6.14, $p < 0.001$). Fisher's LSD post-hoc comparisons showed that the Victorian sample first had contact with their department at a significantly older age than South Australian, or Queensland or Western Australian children (Table 2.6).

Table 2.6 Mean age of children in years at first contact with department

	M (*SD*)
South Australia	2.96 (3.31)
Queensland	3.00 (3.62)
Western Australia	3.78 (3.79)
Victoria	4.91 (3.72)

2.4.8 Reason for entry to care and social background

Information was collected concerning the children's biological family and social background that may have contributed to the child being placed into care (Table 2.5). Although it is well known that children in care suffer from various

experiences and forms of abuse, there is very little information available concerning multiple forms of abuse. Much debate had also surrounded whether children who suffer from one form of abuse are more likely to suffer or be victims of other types of abuse. In the following analyses, the frequency of different forms of abuse and also the prevalence of multiple forms of abuse in the Australian care system will be examined.

As indicated in Table 2.7, a high proportion of children and families had histories of domestic violence and physical abuse of children by the parents. Just under 70% of families were noted as having parental substance abuse problems and a variety of other reasons (emotional abuse, death of a parent) that resulted in the placement of the child into care. Over half of the children had entered care due to neglect, financial problems and parental mental health problems. Homelessness or inadequate housing, sexual abuse and imprisonment of parent(s) also affected approximately half of the children and families. Physical illnesses or parental intellectual disabilities were less commonly identified in the children's case files.

Table 2.7 Biological family and social background factors associated with child's placement into care for total sample, (*N* =364)

Biological family/social background	*N* (%)
Domestic violence	270 (74.2)
Physical abuse	267 (73.4)
Parental substance abuse	240 (65.9)
Other reasons	224 (61.6)
Neglect	212 (58.2)
Financial problems	193 (53.0)
Parental mental health problems	183 (50.3)
Homelessness/Inadequate housing	178 (48.9)
Sexual abuse	175 (48.1)
Parental imprisonment	127 (34.9)
Parental physical illness	61 (16.8)
Parental intellectual disability	48 (13.2)
Parental physical disability	34 (9.3)

The primary or main reason for the child's entry into care as identified by case-workers in the children's case-files included: neglect (33.8%); abuse (all forms, 31.3%); parents unable to cope with the child's behaviour (15.4%); other reasons (14.3%); parental mental health problems (4.1%); or parental imprisonment (0.3%).

Pearson's chi-square analyses were conducted to determine whether the non-Indigenous children differed from the Indigenous children in respect to their social and family background histories. The Indigenous children differed significantly to the non-Indigenous sample on a number of social background variables including: parental homelessness, parental imprisonment, parental substance abuse, parental mental health problems, parental homelessness, exposure to domestic violence, and victim of physical abuse (see Table 2.8 below). The Indigenous children were observed to have a significantly higher prevalence of all the social background variables except for physical abuse and parental mental health problems.

Table 2.8 Prevalence of family and social background factors in Indigenous and non-Indigenous children

Biological family/social background	Non-Indigenous *N* (%)	Indigenous *N* (%)	χ^2 (*df* = 2, *N* = 364)
Domestic violence	204 (71.6)	60 (92.3)	19.33**
Physical abuse	215 (75.4)	40 (61.5)	6.37*
Parental substance abuse	179 (63.0)	58 (89.2)	29.29**
Parental mental health problems	160 (56.1)	17 (26.2)	19.36**
Homelessness/Inadequate housing	127 (44.6)	48 (73.8)	22.56**
Parental imprisonment	90 (31.6)	35 (53.8)	14.27**

*$p < 0.05$, **$p < 0.01$

Further analyses were conducted to investigate whether the factors that contributed to the children's involvement with the care system were similar across the country (Table 2.9). As can be observed, the children and families in different

States experienced a similar range of problems across the country.

Table 2.9 Summary of State differences of children and their social and family background, *N* (%)

	SA (*N* =113)	VIC (*N* = 99)	QLD (*N*= 80)	WA (*N* = 72)
Financial problems	69 (61.1)	60 (60.6)	32 (40.0)	32 (44.4)
Homeless	56 (49.6)	55 (55.6)	33 (41.3)	34 (47.2)
Domestic Violence	89 (78.8)	85 (85.9)	47 (58.8)	49 (68.1)
Parents imprisoned	32 (28.3)	36 (36.4)	19 (23.8)	40 (55.6)
Parental substance abuse	73 (64.6)	73 (73.7)	44 (55.0)	50 (69.4)
Sexual abuse	57 (50.4)	56 (56.6)	29 (36.3)	33 (45.8)
Physical abuse	82 (72.6)	87 (87.9)	56 (70.0)	42 (58.3)
Parental mental health problems	53 (46.9)	76 (76.8)	26 (32.5)	28 (38.9)
Parental physical illness	13 (11.5)	26 (26.3)	7 (8.8)	15 (20.8)
Parental physical disability	7 (6.2)	17 (17.2)	7 (8.8)	3 (4.2)
Parental intellectual disability	15 (13.3)	21 (21.2)	6 (7.5)	6 (8.3)
Neglect	83 (73.5)	63 (63.6)	42 (52.5)	24 (33.3)
Other	34 (31.0)	76 (76.8)	9 (11.3)	25 (38.9)

Several significant State differences were observed in relation to the children's social and family backgrounds. Pearson chi-square analyses revealed that the States significantly differed on a number of family and social background variables including: financial problems (χ^2 (3, N = 364) = 12.79, $p < 0.01$), domestic violence (χ^2 (3, N = 364) = 19.64, $p < 0.001$), physical abuse of children (χ^2 (3, N = 364) = 19.49, $p < 0.001$), neglect of children (χ^2 (3, N = 364) = 31.39, $p < 0.001$), parental imprisonment (χ^2 (3, N = 364) = 20.15, $p < 0.001$), parental mental health issues (χ^2 (3, N = 364) = 42.15, $p < 0.001$), parental physical illness (χ2 (3, N = 364) = 13.18, $p < 0.01$) and disability (χ^2 (3, N = 364) = 10.80, $p < 0.05$), parental intellectual disability (χ^2 (3, N = 362) = 9.51, $p < 0.05$) and a range of additional 'other' problems and issues (χ^2 (3, N = 364) = 88.37, $p < 0.001$). No significant differences were found between the male and female children for the prevalence of social and background characteristics nor were any significant differences observed

between the male and female children for the prevalence of abuse and neglect.

Overall, the findings indicate that the South Australian and Victorian samples had much higher rates of abuse, the Western Australian sample appeared to suffer from higher rates of parental imprisonment whereas the Queensland sample appeared to have a lower prevalence of most social background factors listed in Table 2.9.

2.4.9 Multiple familial and social high-support needs analysis

Table 2.10 summarises the prevalence of multiple familial and social background factors identified as contributing to the placement of the child in the care system.

Table 2.10 Prevalence of multiple familial and social background factors coinciding with placement into care

No. of factors	*N* (%)
0	8 (2.2)
1-3	126 (34.6)
4-6	176 (48.3)
7-10	54 (14.8)

As can be observed, a high proportion of children were experiencing multiple problems. For example, only 8 children were noted as not experiencing any problematic family or social background factors, and close to half of the children and families were suffering from between 4 to 6 social background problems and issues.

Table 2.11 Prevalence of physical abuse, sexual abuse and neglect

Multiple forms	*N* (%)
0	36 (9.9)
1	94 (25.8)
2	142 (39.0)
3	92 (25.3)

Similar trends are evidenced in Table 2.11, which summarises the prevalence of multiple forms of abuse and neglect experienced by children. Only a small number of children were identified as having experienced no form of abuse or neglect, whereas the majority of the sample had experienced at least one form of abuse or neglect.

Further analyses were conducted to ascertain the prevalence of a combination of abuse and/or neglect variables. It was found that a high percentage of children had experienced a combination of abuse and neglect. For example 164 (45.1%) of children had experienced both neglect and physical abuse, 143 (39.3%) children had experienced physical and sexual abuse, and just under a third of the sample had been victims of both neglect and sexual abuse (N = 111, 30.5%). Just over a quarter of the children had experienced all forms of maltreatment, as noted in their case-files.

2.4.10 Conclusion

The current results highlight the extent to which families and children are suffering from multiple problems. Previous research, in particular, has indicated that children who live with domestic violence face an increased risk of exposure to traumatic events, neglect, of being directly abused and the risk of losing one or both of their parents (Carlson, 2000; Edleson, 1999; Rossman, 2001). However, the prevalence of domestic violence in the families of the children in the study is of concern, as is the similar prevalence of abuse and neglect. Many researchers have directed attention to the relationship between domestic violence and subsequent abuse of children. For example, McKay (1994) found that children from homes where domestic violence occurs are physically or sexually abused and/or seriously neglected at a rate 15 times the national average. Straus and Gelles (1990) found that between 53% and 70% of males who engage in physical abuse against their wives in America also frequently abused their children. Furthermore, other research has shown that women who have been hit by their husbands were twice as likely as other women to abuse a child (Child Welfare Partnership, 1995).

The co-morbidity of domestic violence and abuse is not the only major concern, but it is the adverse consequences of children's exposure and subsequent reactions to the violence in their home. For example, younger children often do not

understand the meaning of the abuse and tend to believe they have done something wrong, or are to blame. As a result, children experience feelings of guilt, depression and anxiety. Furthermore, younger children generally do not have adequate verbal skills to express their feelings, so these emotions are often interpreted as challenging behaviours. Such children may also exhibit behaviours such as withdrawal, regressed behaviours, eating and sleeping difficulties, concentration problems, anxiety, and physical complaints. In contrast, pre-adolescent children typically have better verbal skills and are therefore more likely to externalise negative emotions. Along with the symptoms commonly seen in younger children, pre-adolescent children may show signs of low self-esteem, poor peer relationships, delinquent and oppositional behaviour and school problems. Adolescents, on the other hand, are at a greater risk of experiencing severe school problems (delinquency, poor attendance and/or drop out) and substance abuse, and these adverse consequences may continue into later life. Long-term problems include higher levels of adult depression and trauma symptoms and increased tolerance for and use of violence in adult relationships (Carlson, 2000; Edleson, 1999; Hughes, Graham-Bermann, & Gruber, 2001). The consequences of early trauma and abuse are further explored in the following section, which examines the psychosocial well-being of children in the sample.

2.5 Psychosocial well-being

This chapter examines the physical, psychosocial and educational status of children with high support needs in Australian out-of-home care. Included in the results are a summary of overall functioning scores, comparisons with relevant Australian normative data and other studies of out-of-home care, and State comparisons. In the chapters following this one, more detailed analyses are provided of the relationship between psychosocial outcomes, placement history, service history and the children's social background.

2.5.1 Health issues

2.5.2 Physical health problems

The health issues of the children in care were obtained along with their current social and psychological functioning, so that comparisons could be made with current Australian population norms wherever possible. The results showed that close to sixty percent of the sample (59.1%) were identified by their case-workers as

falling into the normal health weight range. 20.3 % of the sample were noted as ‘slightly to very underweight’ and 18.9 % as ‘slightly to very overweight’. According to the Australian Bureau of Statistics (2005), Australian child obesity rates are among developed nations, with approximately 25% considered overweight or obese. Although these observations would need to be confirmed medically and using established indicators of weight status (e.g., Body Mass Indices), the current sample nevertheless appears likely to have a similar weight distribution to the rest of Australian child population.

Over half of the sample (58.2%) were identified by their case-workers as requiring some form of professional attention for physical health problems in the previous six months. A variety of health issues required attention, such as a range of ‘other’ health problems (56.8% including chronic disabilities and disorders); dental problems (17.6%); eye problems (6.0%); allergies (2.1%); and pregnancies (1.4%). A number of health services were also accessed during this time period due to associated health problems. As can be seen in Table 2.12, almost half of the children had received services from general practitioners. Several children had received dental services in the previous six months and other general health services and supports including assistance and treatments from STD clinics.

A number of children had received optical services and a similar number of children had received attention from a medical specialist (i.e. cardiologist, urologist etc) and/or a paediatrician due to chronic health problems, disorders or developmental irregularities. It should be noted that not all physical health problems identified by case-workers had received attention, as many case-workers indicated that children refused to engage with services.

Table 2.12 The percentage of children accessing services in previous six months

Health service	*N* (%)
General practitioner	165 (45.3)
Dentist/Orthodontist	61 (16.8)
Other general health services (including STD clinics etc)	33 (9.1)
Optometrist	22 (6.0)
Medical specialist	21 (5.8)
Paediatrician	20 (5.5)

2.5.3 Psychological health problems

During the interview, case-workers were asked to indicate whether the children had any psychological health problems based on psychiatric and psychological reports that required attention in the previous six months. The vast majority of children (89.5%) were noted as having some form of diagnosed psychological health problem that required attention in the past six months. Several psychological health problems were noted by the case-workers, including a variety of non-specific or undiagnosed psychological health problems (59.6%), behavioural issues/conduct disorder (35.7%), emotional issues (17.8%), attachment disorder (17.6%), depression (14.2%), trauma (13.5%), anxiety (9.6%), sexualised behaviours (7.4%), suicidal ideation (6.3%), post-traumatic stress disorder (5.4%), and oppositional defiance disorder (3.2%).

A number of psychological health services were accessed in the previous six months due to the presentation of psychological health problems. These included private psychologist/psychiatrist/counsellor services (54.6%); 'Other' psychological health services (48.5%, i.e. non-Government treatment programs such as NADA in South Australia, day programs, school-run initiatives); Child and Adolescent Mental Health Services or equivalent (38.2%); hospital Mental Health Unit (8.7%); Services provided specifically through District Offices (6.0%, i.e. psychological assessments, mentors, any form of assistance); and sexual health clinic or family planning service (0.6%, i.e. Second Storey in South Australia).

It should be noted here that not all identified psychological and physical health problems received attention during that time period. A limitation of the data is

that the percentage of children that were not receiving required services was not collected so that it is difficult to draw any firm conclusions about the undersupply of services. Nevertheless, it is of interest to see the type and variety of services accessed by this subpopulation of children and young people. It would be of interest in future research to examine the proportion of children in care receiving and not receiving required health and psychological services.

2.5.4 High support needs and family and social background

As part of the case-file reading, information was collected concerning the child's characteristics and high support needs. A high percentage of children were identified in their case-files as exhibiting symptoms associated with conduct disorder (65.4%), depression and/or anxiety (33.8%), Attention Deficit Hyperactivity Disorder (32.4%), an intellectual disability (30.5%), a personality disorder and/or mental illness (15.7%), hyperactivity (15.4%), a physical disability (12.9%), and other high support needs such as emotional issues (7.7%).

Analyses were conducted to determine whether the Indigenous children differed on any of the above mentioned child characteristics and high support needs in comparison to the non-Indigenous sample. A significantly lower proportion of Indigenous children were found to have depression/anxiety, ADHD and personality disorder/ mental illness.

Table 2.13 Comparison of Indigenous and non-Indigenous children on prevalence of high needs as noted in children's case-files

	Non-Indigenous *N* (%)	Indigenous *N* (%)	χ^2 (2, *N* = 360)
Depression/Anxiety	110 (39.0)	11 (17.2)	13.60**
ADHD	108 (38.3)	10 (15.6)	19.27***
Personality disorder/ mental illness	53 (18.8)	3 (4.7)	8.62*

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$

Analyses were conducted to establish whether the children from each State were experiencing a similar frequency and level of needs. Pearson chi-square analyses revealed significant State differences on the frequency of several high support needs (see Table 2.13). These included conduct disorder (χ^2 (3, N = 359) = 97.82, $p < 0.01$), personality disorder/mental illness (χ^2 (3, N = 360) = 12.37, $p < 0.05$), physical disability (χ^2 (3, N = 360) = 20.36, $p < 0.05$), and intellectual disability (χ^2 (3, N = 360) = 16.07, $p < 0.05$).

Table 2.14 Prevalence of high support needs by State as identified in children's case-files, N (%)

	SA (N = 109)	QLD (N = 79)	WA (N = 72)	VIC (N = 99)
Diagnosed Conduct disorder	77 (70.6)	75 (94.9)	15 (20.8)	71 (71.7)
Personality disorder/Mental illness	7 (6.4)	17 (21.5)	11 (15.3)	22 (22.2)
Physical disability	9 (8.2)	2 (2.5)	17 (23.6)	19 (19.2)
Intellectual disability	29 (26.4)	32 (40.5)	11 (15.3)	39 (39.4)

As can be seen in Table 2.14, the Western Australian sample had the lowest percentage of conduct disorder in comparison to the other three States. The Queensland sample was noted to have the highest prevalence of conduct disorder in comparison to Western Australian, Victorian and South Australian samples. The diagnosis of a personality disorder/mental illness of a child was less likely in the South Australian sample than the other three State samples. Physical disabilities were more likely to be noted in Victorian and Western Australian samples than the South Australian and Queensland samples. The Western Australian sample had a lower proportion of intellectual disability than was noted in Queensland and Victorian samples. Furthermore, the Queensland sample was noted as having a higher proportion of intellectual disability than the South Australian sample.

2.5.5 Social and family background and child characteristics

The previous section provides extensive information of the high support needs and characteristics of the children. A considerable amount of research has

argued that maltreated children fare badly later in life as a direct result of early abusive and traumatic experiences. Due to this association, several of the social and family background factors were collapsed to form more general factors and then compared to child characteristics (conduct disorder, hyperactivity, depression/anxiety, ADHD, personality disorder/mental illness, physical disability and intellectual disability/developmental delay) for the purposes of the analyses below. The four general factors were: economic deprivation (financial problems and homeless or no adequate housing); parental incapacity (mental health problems, intellectual disability and physical disability and/or illness); abusive (physical abuse, sexual abuse and neglect); and antisocial behaviours (substance abuse and domestic violence). Table 2.15 provides a summary of the frequency of occurrence of one or more variables in each of the four parental factors.

Table 2.15 Prevalence of broad social background problems

	N (%)
Economic deprivation	244 (67.0)
Parental incapacity	233 (64.0)
Abusive	328 (90.1)
Antisocial behaviours	318 (87.4)

As indicated in Table 2.15, the vast majority of children and families were experiencing, or had experienced, a multitude of problems and issues. Over two-thirds of the sample had experienced some form of economic deprivation and/or parental incapacity that contributed to their placement into the care system. Furthermore, the majority of the sample had experienced some form of abuse and/or neglect and previously resided with parents involved in some sort of antisocial behaviour.

Analyses were conducted to determine whether the Indigenous children differed on the four social background difficulties in comparison to the non-Indigenous children. A significantly higher proportion of Indigenous children (*N* = 59, 90.8%) were found to have experienced some form of economic deprivation in comparison to the non-Indigenous children (*N* = 178, 62.5%), χ^2 (2, *N* = 364) =

21.11, $p < 0.001$). A higher proportion of Indigenous children ($N = 63$, 96.9%) were also found to have parents that were involved in antisocial behaviours in comparison to the non-Indigenous children ($N = 248$, 87.0%) that contributed to their placement into care (χ^2 (2, $N = 364$) = 23.11, $p < 0.001$). A higher proportion of the non-Indigenous ($N = 198$, 69.5%) sample was found to have experienced some form of parental incapacity that contributed to their placement into care in comparison with the Indigenous sample ($N = 28$, 43.1%), χ^2 (2, $N = 364$) = 17.25, $p < 0.001$.

The four parental factors were compared to certain child characteristics, as listed above, to determine if any relationships existed between the variables. A significant relationship was noted between the parental economic deprivation factor and ADHD in children (χ^2 (1, $N = 360$) = 7.72, $p < 0.05$). ADHD in children was also significantly related to parental incapacity (χ^2 (1, $N = 360$) = 4.72, $p < 0.05$). Parental incapacity was also related to intellectual disability in children χ^2 (1, $N = 360$) = 7.85), $p < 0.05$). The antisocial behaviour parental factor was significantly related to conduct disorder, χ^2 (1, $N = 360$) = 7.14, $p < 0.05$). Parental abuse was not significantly related to any of the child characteristics. The findings indicate a significant relationship between ADHD in children and a number of family and social background factors, but it does not identify whether this relationship is causal. The only other child characteristic that was significantly related to the parental factors was intellectual disability. Intellectual disability of a child was related to the parental incapacity factor but it was also related to parental antisocial behaviours. Parents of intellectually disabled children may be more likely to be prone to antisocial behaviours, or may be more likely to suffer from an intellectual disability or mental illness that makes them more vulnerable to involvement in substance abuse, and to have a history of domestic violence in the home (i.e., parental antisocial behaviour factor).

Based on the above four factors, a hierarchical cluster analysis was conducted to determine whether children and families differed in their background histories and subsequent psychosocial functioning. It was hypothesised that four distinct clusters or ‘profiles’ of children would emerge. For example: 1) children who had histories of abuse and neglect; 2) children with a history of parental incapacity; 3) children with a history of economic deprivation; and 4) children with parent(s) with antisocial

behaviours. For a cluster analysis to be capable of generating a cluster there must be a statistical basis for cases to form distinct clusters. Unfortunately, due to the similarity between the children and their background histories, no clearly identifiable and meaningful cluster solutions could be developed (see Hair, Anderson, Tatham & Black, 1995).

2.5.6 Standardised measure of behavioural and emotional functioning

The following section presents findings using two standardised measures of emotional and behavioural functioning, namely Boyle et al's. CBC and Goodman's SDQ. As mentioned earlier, even though the Boyle et al. (1987) checklist and the SDQ are similar clinical instruments, they were both included in the interview so as to allow comparisons with the findings of those of Barber and Delfabbro's (2004) longitudinal study of disruptive children identified using the same selection criteria and same measures (i.e., 2 or more behaviour breakdowns due to behaviour within two years). The purpose of collecting data on the behavioural and emotional functioning of the children was to determine whether the functioning of Australian children in foster care was as severe as other studies conducted in different States (Barber & Delfabbro, 2004; Layton, 2003; Victorian Department of Human Services, June 2003). Furthermore, the findings presented provide the first national profile of emotional and behavioural functioning of Australian children and young people in care.

Table 2.16 Mean (SD) of CBC sub-scales based on previous six months compared with Barber and Delfabbro's (2004) disruptive group

	Total	*M* (*SD*) as divided by item number	Barber & Delfabbro (2004)	Barber & Delfabbro (2004)
	M (*SD*)	*M* (*SD*)	*M* (*SD*) at intake	*M* (*SD*) at 2 years
Conduct	5.32 (2.98)	0.89 (0.50)	1.04 (0.33)	0.72 (0.52)
Hyperactivity	3.81 (1.89)	1.27 (0.63)	1.41 (0.50)	1.33 (0.66)
Emotionality	5.71 (2.63)	1.15 (0.57)	1.11 (0.38)	1.07 (0.57)

Table 2.16 presents mean item scores on the CBC sub-scales based on the child's behaviour in the previous six months, according to their case-worker. The table presents the total mean scores for each of the three sub-scales in addition to the mean score which is the total mean score divided by the number of items in each of the sub-scales (the method used by Barber and Delfabbro, 2004 to present the results using the same score range for individual items). The abbreviated measure used in the research (14 items) had a total possible score range of 0 to 28, the total CBC mean score for the total sample was found to be 14.78 (*SD* = 5.43), which indicates a relatively high level of problems in the total sample based on this particular standardised measure. Table 3.4 also summarises the mean scores at intake and after two years in care for the group of 'disruptive' children identified in Barber and Delfabbro's (2004) longitudinal study of children in South Australian foster care. As can be seen, if one considers the two scores obtained for South Australian children at intake and at the two year follow-up, the total Australian sample obtained in the current study had very similar scores. These findings indicate that the national sample, selected using the same selection criteria, was well matched to the Barber and Delfabbro study in terms of general psychosocial adjustment. The importance of this comparison is that it provides an indication of the likely placement trajectory of this cross-sectional sample of children if they were to be tracked longitudinally.

Further analyses were conducted to establish whether any gender or State differences existed between or within each of the States on Boyle et al's. CBC. No significant gender differences were found and no within group differences were found on each of the three sub-scales; however, a significant between group difference (F (3, 352) = 6.06, $p < 0.05$) was noted for the hyperactivity subscale. Fisher's LSD post-hoc comparison revealed a significant difference between the South Australian (*M* = 4.08, *SD* = 1.75) and Victorian samples (*M* = 3.38, *SD* = 1.93), with the South Australian sample exhibiting a significantly higher level of hyperactivity problems. Apart from this, the results showed that the children drawn from different States were generally well matched on the Boyle et al. measures.

Further analysis of these findings by ethnicity showed a significant difference for the CBC emotionality sub-scale with the non-Indigenous sample (*M* = 5.92, *SD* = 2.60) scoring higher on this measure than the Indigenous sample (*M* = 5.11, *SD* =

2.71), t (1) = 2.19), $p < 0.05$. No other significant Indigenous differences were observed.

A similar series of analyses was undertaken using SDQ scores. As indicated in previous chapters, the SDQ is becoming the most widely used or "gold-standard" of psychosocial adjustment in Australia and has been included in the Federal Government's national longitudinal study of children (LSAC). A second advantage of the SDQ is that recent normative data have been published by Mellor (2005) and therefore allow comparisons of children in the current sample with children in the general Australian population. A third advantage is that normative data are available for different informants (self-report, parents and teachers). Teacher reports are probably the most similar to the case-worker reports used in the current study because of the greater similarity of knowledge and frequency of verbal contact between children and the informant.

Table 2.17 displays the mean scores for each of the 20 items of the SDQ and the mean score for each of the four sub-scales. In accordance with the standard scoring of the SDQ, five of the positive items have been reverse scored so that a higher mean score denotes a greater level of problem on the subscale, consistent with the other fifteen negative items. According to Mellor (2005), 20% of Australian children aged 7 to 17 years fall into a borderline or 'query' range and 10% fall into the abnormal or 'of concern' range. Mellor provides age and gender norms for children aged 7 to 17 years in Victoria, Australia. Each of the mean scores for the four sub-scales indicates that, in comparison to a teacher-rated sample of Australian children aged 7 to 17 years (Mellor, 2005), the national sample scored consistently higher on all four sub-scales and the Total Difficulties score (all independent t-test values, $p < 0.001$). Similarly, when the national sample is compared to the non-clinical parent-rated American sample of 9878 4 to 17 year olds (National Center for Health Statistics, 2001), the national Australian sample of high supports needs children scored significantly higher on all four sub-scales. The American norms were: Conduct (M = 1.30, SD = 1.60), hyperactivity/inattention (M = 2.80, SD = 2.50); peer functioning (M = 1.40, SD = 1.50); and emotionality problems (M = 1.60, SD = 1.80) sub-scales.

Table 2.17 Mean (SD) of SDQ sub-scales based on previous six months compared with Australian population norms (Mellor, 2005)

Mean score (SD)	*M* (*SD*) (*N* = 319-356)	*M* (*SD*) Australian population norms (*N* = 910)*
Conduct scale	5.37 (2.42)	1.00 (1.50)
Hyperactivity scale	6.21 (2.60)	2.50 (2.60)
Emotionality scale	4.24 (2.76)	1.40 (1.70)
Peer Functioning scale	5.06 (2.49)	1.60 (1.80)
Total Difficulties Score (N = 306)	21.07 (6.88)	6.51 (6.03)

*As the only available Australian normative data was available from Mellor's study, teacher reports were used as the most valid comparison values for this sample

Additional analyses were conducted to determine the percentage of children that fell into the normal, borderline and abnormal range for each of the four sub-scales of the SDQ and the SDQ Total Difficulties score. Close to three quarters of the sample (77.7%) fell into the abnormal range for the conduct problems sub-scale and the peer problems subscale (61.5%), whereas under half of the sample were in the abnormal range for both the hyperactivity/inattention subscale (45.9%) and the emotional problems subscale (41.5%). Overall, close to two-thirds (61.8%) of the sample fell into the abnormal range for the Total difficulties score (see Table 2.18).

Table 2.18 Distribution of sample in normal, borderline and abnormal ranges for SDQ

	N (%)
Conduct problems (N = 346)	
Normal (0-2)	44 (12.1)
Borderline (3)	19 (5.2)
Abnormal (4-10)	283 (77.7)
Hyperactivity/Inattention (N = 355)	
Normal (0-5)	141 (38.7)
Borderline (6)	48 (13.2)
Abnormal (7-10)	167 (45.9)
Emotionality problems (N = 351)	
Normal (0-3)	153 (42.0)
Borderline (4)	47 (12.9)
Abnormal (5-10)	151 (41.5)
Peer problems (N = 320)	
Normal (0-2)	60 (16.5)
Borderline (3)	35 (9.6)
Abnormal (4-10)	224 (61.5)
Total Difficulties Score (N = 306)	
Normal (0-13)	43 (11.8)
Borderline (14-16)	38 (10.4)
Abnormal (17-40)	225 (61.8)

Independent samples t-tests were conducted to ascertain whether any significant gender differences existed or any differences existed between the Indigenous and non-Indigenous children on the SDQ measure. No significant gender differences were noted on the SDQ conduct sub-scale or the peer functioning sub-scale; however, significant gender differences were noted on the hyperactivity (t (1) = -3.02, $p < 0.01$) and emotionality (t (1) = 3.69, $p < 0.01$) sub-scales. Girls (M = 5.73, SD = 2.74) were found to perform better on the hyperactivity sub-scale than boys (M = 6.56, SD = 2.44) but worse on the emotionality sub-scale (Female: M = 4.86, SD = 2.68; Male: M = 3.78, SD = 2.73). An independent samples t-test also

revealed that the Indigenous sample (M = 4.05, SD = 2.31) scored significantly lower on the SDQ peer problems sub-scale in comparison to the non-Indigenous sample (M = 5.32, SD = 2.50), t (1) = 3.51, $p < 0.01$). Indigenous children (M = 19.33, SD = 8.01) also scored significantly lower on the Total Difficulties Score in comparison to the non-Indigenous sample (M = 21.69, SD = 6.57), t (1) = 2.29, $p < 0.05$. These findings suggest that the current functioning of the Indigenous sample in respect to peer functioning and overall behavioural and emotional functioning was significantly better at the time of review than the non-Indigenous sample.

A one-way ANOVA was conducted to ascertain whether any differences existed between the four States on the standardised SDQ measure. No significant differences were found within each State for all States or between the States on three of the four sub-scales (hyperactivity problems, emotional problems and peer functioning). A significant difference was found between States on the conduct disorder sub-scale, F (3, 346) = 3.45, $p < 0.05$. Fisher's LSD post-hoc comparisons revealed a significant difference between the South Australian (M = 5.15, SD = 2.54) and Western Australian (M = 6.14, SD = 2.25) samples on the conduct disorder subscale, with Western Australian sample exhibiting a higher level of conduct disorder problems. A significant difference was also noted between the Western Australian and Victorian (M = 4.97, SD = 2.46) samples, with the Western Australian sample again exhibiting a higher level of conduct disorder problems and behaviours. However, no significant differences were found within or between each of the four States on the Total difficulties score, which indicates that each of the States are dealing with a similar level of behavioural and emotional disturbance as assessed by the SDQ.

A potential criticism of these analyses is that the age profile of the current study differs significantly from that of Mellor (2005). In Mellor's normative sample, 39% of the sample were aged 7-10 years (vs. 18% in the current sample), 24% were 11-13 (vs. 24%) and 29% were 14-17 years (vs. 49%). A question therefore arises as to how much of the difference between the two samples is due to age. Careful inspection of Mellor's results shows that this age difference was unlikely to have greatly influenced the results for two reasons. First, if one examines the mean sub-scale scores for the different ages and genders, the scores in Mellor's sample differ

by only a few decimal points. For example, the mean conduct score for 7-19 year old boys is 1.49 vs. 1.30 for 14-17 year old boys. The current comparisons reveal differences of 3-4 entire points. Second, Mellor showed that the age differences for teacher report data were generally non-significant for all sub-scales except hyperactivity. Hyperactivity scores were, in fact, higher in young children, which is in the opposite direction observed in the comparison of the current sample with the normative sample. In other words, the greater proportion of older children in the current sample is unlikely to explain the sheer magnitude of differences observed.

2.6 Social functioning

As discussed in the background to this report, good social functioning and adjustment of children in care is imperative to protect the child against future problems later in life. Many studies have identified the far reaching consequences of poor social functioning in childhood and adolescence. For example, Buehler, Orme, Post and Patterson (2000) recently showed that **"**when compared with adults in randomly selected comparison groups, adults who experienced family foster care were less adjusted on 20 of 36 indicators, particularly in areas of education, economic well-being, marital relationships and community involvements" (Buehler et al., 2000, p.595). Taussig (2002) also recently reported previous findings that 12-18 months after leaving foster care (due to emancipation), 27% of male and 10% of females had been incarcerated, 37% had not finished high school and 50% were unemployed.

Delfabbro, Barber and Cooper (2001) in Australia showed that the majority of children in care settle into their placements and display improved social and psychological adjustment. However, they also identified a small percentage of children who experience repeated placement failure and a deterioration of social adjustment. Amongst this sub-group of children there was little evidence of improvement over time. The findings suggest that those individuals displaying poor social functioning also are experiencing high levels of placement disruption. Barber, Delfabbro and Cooper (2001) "suggest that early placement disruption is not merely a symptom of adjusting to new surroundings, but a predictor of ongoing problems in the care system" (p. 211).

Information was collected on the children's level of social functioning and adjustment in the previous six months. As mentioned previously, the social adjustment measures used in the current study have been used and validated in several earlier studies conducted by a collection of researchers (see Barber et al., 2001; 2002; Barber & Delfabbro, 2004; Delfabbro et al., 2000; 2002a). Each item on the 7-item social adjustment scale is scored on a 4-point Likert scale that ranges from 1 = "Never", 2 = "Rarely", 3 = "Sometimes" and 4 = "Often". The total possible score range for the 7-item measure is 0 = No problems to 28 = Very high level of problems.

The table below (2.19) presents the mean scores on the social adjustment measure compared to Barber and Delfabbro's 'disruptive' group of children (N = 34) in the longitudinal study. As can be seen, the current sample is quite similar to their disruptive group and shares a similarly poor level of social functioning.

Table 2.19 Mean (*SD*) of social adjustment on previous six months compared with Barber and Delfabbro's (2004) disruptive group

	Total	Total Score/ No. of items	Barber & Delfabbro (2004)	Barber & Delfabbro (2004)
	M (*SD*)	*M* (*SD*)	*M* (*SD*) at intake	*M* (*SD*) at 2 years
Social adjustment	15.48 (3.43)	2.21 (0.49)	3.11 (0.36)	2.47 (0.46)

Table 2.19 indicates that the majority of children displayed a high rate of negative or poor social functioning behaviours, including often "resenting people telling them what to do" and "blaming others for their mistakes". The overall mean for this measure indicates only a modest level of social adjustment functioning for the total sample (see Table 2.19). Table 2.19 also presents mean scores for a normative sample of children in South Australia. Barber and Delfabbro's (2004) study coded their data in the opposite direction to the current study whereby higher scores on all items indicated a better level of social adjustment. As can be observed in Table 2.19, the national sample had a lower mean score for this measure than Barber and Delfabbro's disruptive sample, indicating that the disruptive sample had a

better level of social functioning than the national sample.

The scoring was also reversed for these measures so that comparisons could be made with Barber and Delfabbro's (2000) data. As can be observed in Table 2.20, the national sample has significantly lowers mean on all the negative social adjustment behaviours, indicating poorer social functioning than Barber and Delfabbro's (2000b) normative sample of children randomly selected from the general Australian population.

Table 2.20 Frequency and mean scores for negative social adjustment behaviours in previous six months compared with Barber & Delfabbro's (2000) normative data*

Social adjustment	'Never'-'Rarely' (%)	'Sometimes' (%)	'Often' (%)	*N = 354-360* *M* (*SD*)	*N* = 374 *M* (*SD*)*	*t***
Resented being told what to do	5.0	31.0	61.5	1.44 (0.63)	2.00 (0.83)	9.82
Felt persecuted or picked on	14.3	36.3	47.8	1.70 (0.83)	2.70 (0.97)	14.08
Blamed others for his/her mistakes	16.8	31.6	50.0	1.71 (0.87)	2.80 (0.98)	15.35
Inconsiderate of other people's needs or feelings	17.8	43.4	36.5	1.85 (0.82)	2.50 (0.88)	9.85

* based upon Parent ratings on a 1-4 scale where: 1="Often", 2= "Sometimes", 3= "Rarely", 4= "Never", ** all *t* scores significant at $p < 0.001$

The Table (2.21) below highlights the frequency of positive social adjustment behaviours present in the previous six months. In a high percentage of cases, the children were infrequently ("never to rarely") displaying positive social functioning behaviours such as "getting along well with people", "looking forward to mixing with others" and "willing to talk and express their feelings".

Table 2.21 Frequency and mean scores for positive social adjustment behaviours in previous six months compared with Barber & Delfabbro's (2000) normative data*

Social adjustment	'Never'-'Rarely' (%)	'Sometimes' (%)	'Often' (%)	*N* = 354 - 360 *M* (*SD*)	*N* = 374 *M* (*SD*)*	*t***
Getting along well with people	79.4	16.8	2.5	3.05 (0.73)	1.30 (0.52)	35.71
Looked forward to mixing with others	77.5	15.7	4.9	3.12 (0.85)	1.20 (0.49)	36.23
Willing to talk and express his/her feelings	55.0	32.4	11.5	2.60 (0.91)	1.60 (0.70)	15.87

*based upon Parent ratings on a 1-4 scale where: 1="Often", 2= "Sometimes", 3= "Rarely", 4= "Never", **all *t* scores significant at $p < 0.001$

Again, the scoring was reversed for these measures so that comparisons could be made with Barber and Delfabbro's (2000) data. As can be observed in the table above (2.21), the current national sample had a significantly lower level of positive social functioning when compared to the Australian normative data.

An independent samples t-test revealed no significant gender or age differences for the social adjustment measure. A significant difference was observed between the Indigenous children (M =18.44, SD = 3.74) and the non-Indigenous children (M = 19.76, SD = 3.33) with the non-Indigenous scoring significantly poorer on this measure, t (1) = 2.74, $p < 0.05$.

Further analyses were conducted to determine whether there were any significant State differences in relation to the social adjustment measure. A one-way ANOVA revealed a significant between group difference (F (3, 354) =2.78, $p <$ 0.05). Fisher's LSD post-hoc comparisons revealed a significant difference between the Queensland sample (M = 20.25, SD = 2.88) and Victorian samples (M = 18.89, SD = 3.44). The Queensland sample was found to have a higher level of social functioning problems compared with the Victorian sample, but did not differ

significantly from the South Australian (*M* = 19.27, *SD* = 3.67) and Western Australian (*M* = 19.94, *SD* = 3.48) samples.

2.7 Disrupted attachment-related problem behaviours

Attachment refers to the enduring affectional ties that children form with their primary caregivers (Bowlby, 1969). Bowlby argues that the strength or "security" of these early attachment experiences lays the foundation for later psychosocial and cognitive development. More recent research has identified the link between disrupted attachment and placement instability. Drury-Hudson (1994) states that the "loss of principal attachment figures in infancy and childhood is thought to be a major influence in the genesis of later behavioural difficulties" (p. 20). Newton (2000) also suggests that there is evidence to suggest that placement disruption and behaviour problems are associated, despite variations in the conditions responsible for placement disruption. For example, researchers have demonstrated that the problems of behaviourally troubled children have been repeatedly documented in association with histories of anxious-avoidant attachment (see Penzerro & Lein, 1995). Furthermore, Penzerro and Lain (1995) state that such children "are more likely to behave aggressively toward peers, to misread environmental and interpersonal cues, and to engage in bullying and other hostile behavior" (Sroufe & Rutter, 1984, cited in Penzerro & Lein, 1995, p. 352). Penzerro and Lein (1995) recently observed disordered attachments being directly responsible for placement disruption and describe a cohort of children who "display exceptionally clear patterns of alienation in relation to transitions from placement to placement" (p. 351). For these reasons, the current study aimed to collect data on the current functioning of children in respect to their attachment-related problem behaviours.

The attachment disorder checklist comprised ten positive and negative items related to attachment-related problem behaviours on a four-point scale ranging from 1 = "Never", 2 = "Rarely", 3 = "Sometimes", 4 = "Often". The three positive items were recoded to give a total score range of 0 = "No problems" to 40 = "Severe problems". Table 2.22 summarises the mean scores on each of the ten items for the total sample (*N* = 336).

Table 2.22 Attachment-related behaviour scores for total sample

	M (*SD*)
Makes very little eye contact	2.36 (1.02)
Shows little guilt or remorse for actions	3.01 (1.00)
Has been indiscriminately affectionate towards strangers	2.09 (1.16)
Deliberately provokes anger in others	2.90 (0.94)
Produces theatrical displays of emotion	2.82 (1.12)
Has produced incessant nonsense speech	1.92 (1.11)
Has been excessively demanding or bossy	3.20 (0.89)
Has been able to give and receive affection*	2.12 (0.85)
Has been willing to seek comfort from others when frightened or hurt*	2.19 (0.90)
Is able to trust others*	2.45 (0.82)
M (*SD*)	25.07 (5.01)

* items have been reversed scored

The overall mean score for the attachment disorder checklist indicates a relatively high level of attachment-related problem behaviours in the total sample. The highest score was noted on the items “has been excessively demanding or bossy” and “shows little guilt or remorse for actions”, which indicates that on average these behaviours are occurring frequently. Further analyses were conducted to establish whether any gender, ethnicity or State differences existed on this particular measure and no significant gender differences were found nor were within or between group differences found.

Table 2.23 Attachment-related problem behaviour scores compared to normal, borderline and abnormal SDQ Total difficulties score (higher scores indicate poorer attachment)

	Normal	Borderline	Abnormal	χ^2 (2, *N* = 336)
Attachment (0-24)	38	24	77	
Attachment (25-40)	5	15	147	47.11***

***p < 0.001

Further analysis was conducted to determine whether any relationships existed between clinical scores on behavioural and emotional problems (SDQ) and scores on the attachment disorder checklist (see Table 2.23). Chi-square tests revealed that those children who scored higher than 25 (out of a possible score of 40) were significantly more likely to fall into the abnormal range for SDQ Total difficulties score. This finding indicates that those children who display behaviours that are symptomatic of attachment disorder also display poor emotional and behavioural functioning. Previous research has indicated that poor attachment to their primary caregivers often occurs because of early abuse or neglect and that this early trauma then contributes to poorer emotional and behavioural functioning in later years. Furthermore, Newton (2000) states that maltreated children who are removed from dangerous or neglectful environments, who then are confronted by further disruption through numerous placement failures, are likely to be particularly at risk of experiencing difficulties trusting adults and forming attachments with adults and children (Rutter, 1981)**.**

The findings are therefore consistent with previous research showing that children with disrupted attachment also have co-morbid emotional and behavioural problems. For example, Pardeck (1983) noted that emotionally disturbed adolescents in care are most likely to have histories of placement disruption, especially those adolescents with externalising disorders (Proch & Taber, 1987). Such externalising disorders include attention deficit hyperactivity disorder, oppositional-defiant disorder, and conduct disorder (American Psychiatric Association, 1994).

2.8 Education

Numerous studies have confirmed that children in care perform significantly worse in school than do children in the general population (see Cashmore & Paxman, 1996). Such studies have shown that the education deficits of foster children often result in higher rates of unemployment, criminality, substance abuse and homelessness (Buehler et al., 2000). The main reason advanced to explain such deficits is the many placement changes and subsequent school changes experienced commonly by foster children. Children also often have severe cognitive, emotional and behavioural problems that ultimately affect their academic functioning (Pelnick, 2000). Therefore, considering that the children selected for this study had high levels

of placement instability it was important to ascertain the percentage of children in this sub-group who were attending school and to determine what sort of education-based supports or services they were receiving, if any.

A high percentage of children were attending school (69.8%) at the time of first placement into the care system. At the time of review, a slightly higher percentage of children and young people were attending school or some form of TAFE/apprentice program (73.1%). The distribution of children and young people in different grade levels was reasonably consistent. Approximately a third (37.3%) of the sample were in Primary school (Reception – Grade 7), 31.7% of the sample were in High/Secondary school (Year 8 -12) at the time of review, and 4.1% of the sample were in TAFE or an apprentice program. The highest proportions of children in the study were in Grade 9 at the time of the review (14.3%). No significant differences were found between the States in respect to school attendance at time of first placements or current school attendance.

A proportion of the sample were receiving a number of school service supports, including periodic meetings between teachers and carers (54.4%); individually tailored curricula (41.4%); general education support worker at location (24.7%); a range of other services such as special day programs or specially designed educational interventions (28.0%); a private tutor at home (14.6%); and a private tutor at school (6.9%).

Table 2.24 State differences in utilisation of school support services

	SA *N* (%)	QLD *N* (%)	WA *N* (%)	VIC *N* (%)	χ^2
Periodic meetings	58 (52.7)	37 (48.7)	41 (57.7)	62 (62.6)	7.36
Tailored curricula	38 (34.5)	23 (30.3)	44 (62.0)	46 (46.5)	19.17*
Tutor (school)	9 (8.2)	4 (5.3)	5 (7.0)	7 (7.1)	4.61
Tutor (home)	11 (10.0)	11 (14.5)	10 (14.1)	21 (21.2)	5.25
Support worker	29 (26.4)	11 (14.5)	8 (11.3)	42 (42.9)	28.12*
Other services	8 (7.4)	1 (1.3)	46 (64.8)	47 (47.5)	113.75*

* $p < 0.001$

Pearson's chi-square analyses were conducted to determine whether State differences existed in the proportion of children receiving school support services. Significant State differences were observed for three school service supports, namely individually tailored curricula, general education support worker, and other general support services. As can be observed in Table 2.24, individually tailored curricula were more frequently observed in Western Australian samples than the Queensland and South Australian samples. In addition, individually tailored curricula were observed more frequently in the Victorian sample than the Queensland sample. General education support workers were more commonly noted in Victorian sample than the South Australian and Queensland samples. Furthermore, general education workers were more commonly noted in the South Australian sample than the Western Australian sample but higher in Western Australian than the Victorian sample. Other general education support services were also more frequently observed in the Western Australian and Victorian samples than the South Australian and Queensland samples.

At the time of the interview, 34% of the total sample had been suspended from school in the previous six months, with a mean number of 1.13 times (*SD* = 2.80) and a range of 0 to 25 suspensions during the time period. No significant differences in the frequency of suspensions or the mean number of suspensions in the previous six months were found between the four States (see Table 2.25).

Table 2.25 Frequency of school suspensions and exclusions

	SA	QLD	WA	VIC	χ^2
	N (%)	*N* (%)	*N* (%)	*N* (%)	(3, *N* = 357)
Suspensions	43 (38.4)	26 (33.3)	26 (36.1)	27 (28.4)	7.11
Exclusions	11 (9.8)	6 (7.7)	7 (9.7)	21 (22.1)	12.96*

*$p < 0.05$

A smaller percentage of the sample (12.7%) had been excluded from school, with a mean number of 0.49 (*SD* = 2.45) exclusions in the previous six months (range 0 to 25). A significant difference was found between the State samples in respect to the frequency of exclusions from school. An independent samples t-test

revealed that the Victorian sample had a significantly higher frequency of exclusions from school in the previous six months in comparison to the Queensland sample, t (1) = 2.64, $p < 0.05$. A one-way ANOVA also revealed a significant between groups not within groups difference between the four States (F (3, 353) = 4.23, $p < 0.05$). Fisher's LSD post-hoc comparisons revealed that the Victorian (M = 1.23, SD = 3.81) sample had a significantly higher mean number of exclusions than the South Australian (M = 0.34, SD = 2.39), Western Australian (M = 0.21, SD = 0.84) and Queensland (M = 0.08, SD = 0.27) samples.

The results suggest that this sample of children have low levels of school attendance and high levels of suspensions and exclusions, and these features appear to be similar across the four States. As previously indicated, education is essential for good outcomes later in life including employment, and as a protective measure against risk factors, such as substance abuse, homelessness and criminality. Therefore, it is essential that education is given priority within the care system so that children and young people are not placed in a position that is likely to lead to negative life outcomes.

2.9 Psychological outcomes in relationship to placement background

This chapter builds on the previous two sections and examines the relationship between current psychological functioning and children's placement histories. Extensive information was collected on the placement histories (including the nature, type, frequency and reasons for breakdown) of the children from both case-files, interviews with case-workers, and system data from the central databases. This chapter will provide details on the relationship between psychological outcomes and social and placement background, including the frequency of family contact, considered as a social variable. The chapter aims to determine whether children who have experienced a high level of placement instability are exhibiting poor levels of psychological functioning.

2.9.1 Placement history

As mentioned previously, the children had experienced on average just under 11 previous placements (M = 10.53, SD = 7.80) prior to entering their current placement or program. Analysis of placement changes revealed that 64 (17.6%)

children had experienced between 2 to 4 placements since entering care, 86 (23.6%) children had experienced 5 to 7 placements, 71 (19.5%) children had experienced between 8 and 10 placements, and 110 children (30.2%) had experienced 10 to 15 placements since entering care. A smaller proportion of children had experienced very high number of placement changes: 30 children (8.2%) had experienced between 16 and 20 placements, another 19 (5.1%) children had experienced 21 to 30 placements and 10 (6.9%) children had experienced 31 to 55 placements since entering the care system. A selection of children in the total sample had also experienced placements in both residential/group care (56.6%) and relative care (47.3%) and a number of previous reunification attempts (M = 0.85, SD = 1.46).

Table 2.26 Range and frequency of placement breakdowns in previous two years (N = 359)

Number of placement breakdowns	*N* (%)
2 –5	252 (69.3)
6-10	80 (22.0)
11-14	17 (4.7)
15-30	8 (2.2)

Information was also collected on the number, type and reasons for placement breakdown. On average, the number of placement breakdowns experienced by the children in the previous two years was 4.95 (SD = 3.99), with a range of 2 to 30 breakdowns during that time period. As can be seen in Table 2.26, a large proportion of children had experienced a high number of placement breakdowns or unplanned placement terminations during that time period. The majority of children (69.3%) had experienced between 2 and 5 placement breakdowns and a further 22.0% had experienced between 6 and 10 breakdowns during the previous two years. A smaller number of children had experienced between 11 and 14 breakdowns and eight children had experienced between 15 and 30 breakdowns during the same time period. The mean number of placement breakdowns identified by case-workers as being requested by carers because of the child's behaviour was 3.01 (SD = 3.05), with a range of 0 to 20 changes requested specifically by carers due to the child's behaviour.

Table 2.27 Age differences in frequency of placement breakdowns in previous two years

	N	*M* (*SD*)
Younger (4-12 years)	139	4.32 (3.05)
Older (13-18 years)	220	5.35 (4.45)

No significant gender differences or differences between the Indigenous sample and non-Indigenous sample were noted for the number of placement breakdowns in the previous two years, but a significant age difference was observed. As might be expected, the older children (13-18 years) were found to have a significantly greater number of placement breakdowns in the previous two years than the younger children (4-12 years), t (1) = 2.49, $p < 0.05$ (see Table 2.27).

2.9.2 Psychological outcomes and placement background

Analyses were undertaken to determine whether children with more severe levels of behavioural and emotional problems (as based on SDQ scales) had higher levels of placement instability in the previous two years (see Table 2.28). Firstl, one-way ANOVAs were conducted on each of the four SDQ sub-scales (Conduct disorder, Hyperactivity, Emotionality and Peer problems) and then the Total difficulties score (sum of the four sub-scales). Significant between groups differences were found for the conduct disorder (F (2, 342) = 3.41, $p < 0.05$) and peer problems (F (2, 315) = 3.42, $p < 0.05$) sub-scales but not for the hyperactivity and emotionality sub-scales. Fisher's LSD post-hoc comparisons revealed that those children who fell into the abnormal range for conduct disorder sub-scale had a significantly higher number of placement breakdowns than those children that fell into the borderline clinical range (d = 0.80). Children who fell into the normal range for conduct disorder also had a higher mean number of placement breakdowns in the last two years than the borderline group of children (d = 0.52), but did not differ significantly from those in the abnormal range (d = 0.11). This finding indicates that there was not a linear relationship evident between conduct disorder and the number of placement breakdowns.

Table 2.28 Placement breakdowns according to clinical score on Conduct disorder, Peer problems and Total Difficulties Scale (SDQ), M (SD)

	Conduct disorder	Peer problems	Total difficulties score
Normal	4.69 (5.13)	3.90 (2.47)	3.74 (2.48)
Borderline	2.96 (1.55)	6.00 (4.96)	3.95 (4.68)
Abnormal	5.18 (3.99)	5.02 (4.08)	5.31 (4.10)

In relation to the peer problems sub-scale, post hoc comparisons (Fisher's LSD) revealed that those children who fell into the borderline range for the scale had a significantly higher number of placement breakdowns in the last two years than those children who fell into the normal range ($d = 0.56$). Those children who fell into the abnormal range also had a significantly higher number of placement breakdowns than those children that fell into the normal range ($d = 0.35$). There was no significant differences observed between the children who fell into the borderline and abnormal group ($d = 0.21$).

A one-way ANOVA revealed a significant difference between the groups of children in the normal and abnormal ranges for SDQ Total difficulties score (F (2, 302) = 4.05, $p < 0.05$), showing that children in the abnormal range had a significantly higher number of placement breakdowns than those children that fell into the normal ($d = 0.48$) and borderline range ($d = 0.31$) for this scale.

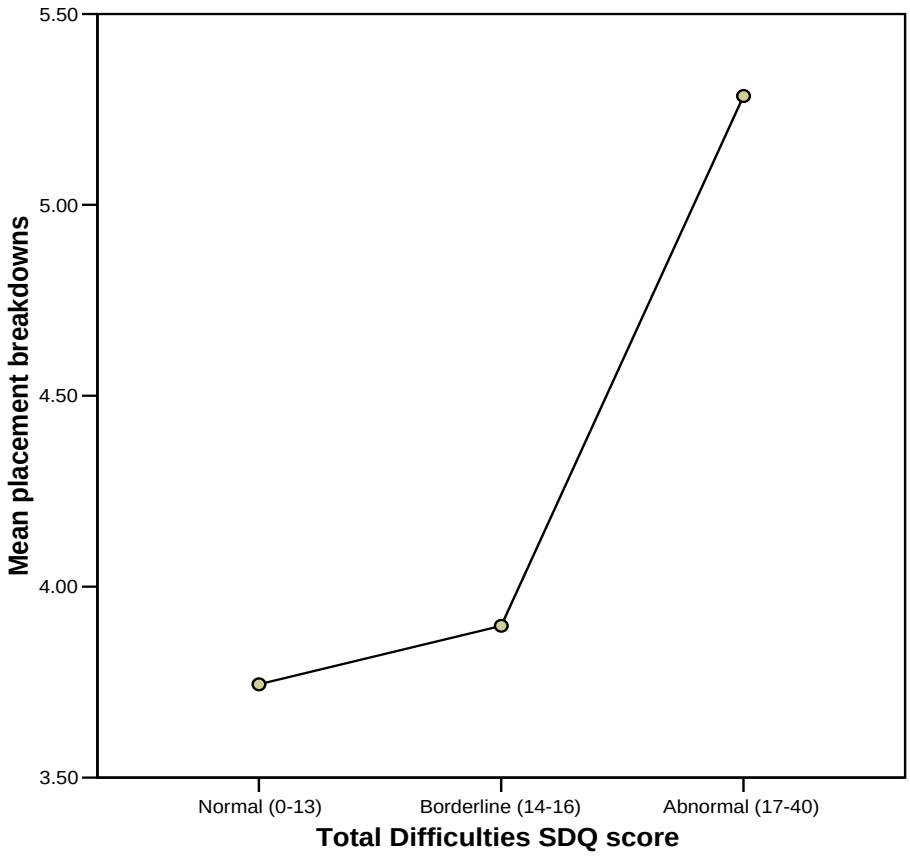

Figure 2.1 Relationship between SDQ Total difficulties score and placement breakdowns in previous two years

As can be observed in Figure 2.1, a positive curvilinear relationship is evident with respect to the Total difficulties score; those children with the poorest levels of functioning experienced the greatest number of placement breakdowns.

2.9.3 State comparisons

Analyses were conducted to determine whether State differences existed in the number of placement breakdowns. A one-way ANOVA revealed a significant difference between the four States (F (3, 355) = 4.71, $p < 0.01$).

Table 2.29 State comparisons of placement breakdowns in previous two years

	M (*SD*)
SA	5.20 (4.68)
QLD	5.42 (3.87)
WA	5.72 (4.32)
VIC	3.70 (2.48)

Fisher's LSD post-hoc comparisons revealed that the Victorian sample had a significantly lower number of placement breakdowns than the other three State samples in the last two years (see Table 2.29). The table highlights the similarity in the other three State samples in respect to the number of placement breakdowns.

The results above suggest that those children with the most severe levels of behavioural and emotional problems do indeed suffer the highest numbers of placement breakdowns. Although some inconsistencies were observed in the sense that higher rates of placement breakdown were not always associated with children in the abnormal range of scores on the SDQ, it is important to remember that this sample does not represent the full range of children in out-of-home care. Instead, the children were purposively sampled to identify those who had more disrupted placement histories. For this reason, it is likely that a clearer relationship between psychosocial dysfunction and placement disruption (of the nature observed by Barber & Delfabbro, 2004) would have been observed if the same analyses had been undertaken using a sample drawn from the general population of children in care.

2.10 Correlations between measures

Analyses were conducted to ascertain whether any correlations existed between the psychosocial adjustment measures, namely Boyle's CBC, Goodman's SDQ, Social Adjustment measure and the Attachment disorder checklist, and the number of placements and placement breakdowns the children had experienced.

No significant correlations ($r \geq 0.30$) were found between the age, gender and ethnicity of the children and any of the other variables. This finding very likely highlights the homogeneity of the sample in relation to the level and complexity of

problems in that the limited range of scores may have attenuated the correlations.

As one would expect, a small significant correlation was found between the number of placements the children had previously had and the number of placement breakdowns in the previous two years ($r = 0.30$, $p < 0.01$). Higher scores on the social adjustment (Socad) measure were significantly correlated with a higher score on a number of variables, including the attachment disorder (Att) measure, the CBC conduct (CBCC) sub-scale, the SDQ conduct (SDQC) and hyperactivity (SDQH) sub-scales. Higher scores on the attachment disorder measure were also significantly correlated with higher scores on a number of variables, including the CBC conduct sub-scale, and the SDQ conduct and hyperactivity sub-scales. Higher scores on a number of CBC and SDQ sub-scales were significantly correlated with higher scores on several other variables (see Table 2.30 below).

Table 2.30 Correlation matrix for SDQ sub-scales, CBC scales, attachment checklist and social functioning scale

	Att	Socad	SDQC	SDQH	SDQE	SDQP	CBCC	CBCH
Attachment								
Social adjustment	0.63							
SDQ Conduct	0.58	0.60						
SDQ Hyperactivity	0.36	0.34	0.36					
SDQ Emotionality	0.23	0.20	0.15	0.26				
SDQ Peer problems								
	0.45	0.45	0.27	0.41	0.27			
CBC Conduct	0.51	0.48	0.78	0.39	0.12	0.32		
CBC Hyperactivity	0.25	0.21	0.28	0.75	0.18	0.30	0.37	
CBC Emotionality	0.29	0.27	0.19	0.30	0.75	0.29	0.19	0.24

All correlations (two-tailed) are significant at $p < 0.01$

2.11 Family contact

Several researchers have attempted to investigate the effects of family contact in the lives of foster children. Some of the main reasons or arguments for family contact include maintaining relationships and improving the chances of reunification. For example, Poulin (1992) argues that family contact is essential to maintain long-

term attachments between children and their families, especially when they leave care and require a support network. Fanshel (1975) also argues that family contact is essential as it increases the chance of reunification. Cantos, Gries and Slis (1997) further emphasised that family contact enhances the psychological well-being of foster children by mitigating the negative psychological consequences of removal and maintaining the child's sense of continuity and identity. One of the reasons for collecting data on frequency of family contact was to determine whether any age, gender or State differences existed within or between the samples, and whether high support needs children maintain adequate connections with their families. Furthermore, family contact was considered as a social variable (i.e., as a positive sign of social functioning) and therefore it was important to examine whether those children with high levels of placement instability had low levels of contact and whether family contact was related to general difficulties in psychosocial functioning.

In the current study, case-workers were asked to rate how often the children had been in contact with their birth parents and/or other relatives during the previous six months. Three types of contact were considered: (1) indirect (i.e., telephone), (2) direct face-to-face supervised or unsupervised contact and (3) overnight stays. The frequency of each form of contact was measured on six-point scales: 0 = "Never", 1 = "Monthly or less often", 2 = "2-3 times per month", 3 = "Once per week", 4 = "2-6 times per week", and 5 = "Daily or more often". As can be seen in Table 2.31, the majority of children were having no telephone contact or direct (supervised, unsupervised face-to-face contact and overnight stays) contact with their mother, father or relatives. Only a quarter of the sample (24.4%) were having weekly telephone contact with their mother, while only 9.3% of the sample were having weekly telephone contact with their father. Approximately a fifth of the sample (18.7%) were having monthly telephone contact with their mother and 9.3% having telephone contact with their father. Approximately a fifth of the sample were having direct supervised (24.4%) and unsupervised (19.0%) contact with their mother on a monthly basis, and only 9.6% of the sample were having monthly overnight stays. A smaller percentage of children were having direct supervised (9.9%) and unsupervised (13.5%) monthly contact with their fathers and only 6.9% were having monthly overnight stays. A higher percentage of children were having unsupervised

direct monthly contact (30.5%) with relatives and 11.3% of the children were having monthly (11.2%) overnight stays with relatives (such as grandparents, aunties, uncles and other siblings). A percentage of children were also having weekly telephone (11.0%) and direct unsupervised contact (11.3%) with relatives.

Table 2.31 Frequency of telephone and direct (supervised, unsupervised and overnight stays) contact with mother, father and relatives in previous six months

Contact type (%)	Never	Monthly	Weekly	Daily
Mother				
Telephone	48.9	18.7	24.4	6.6
Direct – supervised	65.1	24.4	7.9	1.4
Direct – unsupervised	60.7	19.0	13.7	5.2
Overnight stays	78.3	9.6	4.4	6.6
Father				
Telephone	77.7	9.3	9.3	2.5
Direct – supervised	86.3	9.9	2.1	0.5
Direct – unsupervised	80.2	13.5	2.7	2.5
Overnight stays	88.7	6.9	0.8	2.5
Relatives				
Telephone	64.3	18.1	11.0	5.5
Direct – supervised	76.9	6.3	2.5	0.0
Direct – unsupervised	50.5	30.5	11.3	6.6
Overnight stays	78.0	11.2	3.3	6.3

Family contact with biological mother and father and other relatives was then broken down into six variables (never, monthly or weekly telephone or direct contact, see Table 2.32) so that age, gender and State comparisons could then be conducted.

Table 2.32 Telephone and direct family contact in previous six months, N (%)

	Never	Monthly	Weekly
Mother – telephone	178 (48.9)	68 (18.7)	113 (31.0)
Mother - direct	237 (65.1)	89 (24.5)	34 (9.3)
Father- telephone	283 (77.7)	34 (9.3)	43 (11.8)
Father - direct	314 (86.3)	36 (9.9)	10 (2.7)
Relatives-telephone	234 (64.3)	66 (18.1)	60 (16.5)
Relatives - direct	280 (76.9)	65 (17.9)	14 (3.8)

These analyses revealed no significant gender differences in the frequency of children's contact with their mothers, fathers or other relatives, but a significant age difference between younger (4-12 years) and older (13-18 years) children was observed. As can be seen in Table 2.33, older children had significantly less frequent telephone contact with their fathers and relatives than younger children ($\chi 2$ (2, N = 359) = 11.17, $p < 0.01$), and they also had significantly less frequent direct contact with their mothers ($\chi 2$ (2, N = 360) = 39.70, $p < 0.001$), and fathers ($\chi 2$ (2, N = 359) = 11.03, $p < 0.01$),. On the other hand, older children had significantly more frequent phone ($\chi 2$ (2, N = 360) = 15.69, $p < 0.001$), and direct contact ($\chi 2$ (2, N = 359) = 10.41, $p < 0.05$), with their relatives (siblings, grandparents, aunts and uncles) than younger children.

Table 2.33 Age differences in family contact in previous six months, N (%)

	Younger (4 -12 years)			Older (13-18 years)		
	Never	Monthly	Weekly	Never	Monthly	Weekly
	N (%)	*N* (%)	*N* (%)	*N* (%)	*N* (%)	*N* (%)
Mother phone	71 (51.1)	26 (18.7)	42 (30.2)	107 (48.6)	42 (19.1)	71 (30.2)
Mother direct	64 (46.0)	53 (38.1)	22 (15.8)	173 (78.3)	36 (16.3)	12 (5.4)
Father phone	112 (80.6)	5 (3.6)	22 (15.8)	171 (77.4)	29 (13.1)	21 (9.5)
Father direct	111 (79.9)	22 (15.8)	6 (4.3)	203 (91.9)	14 (6.3)	4 (1.8)
Relative phone	107 (77.0)	20 (14.4)	48 (21.7)	127 (57.5)	46 (20.8)	12 (8.6)
Relative direct	102 (73.4)	35 (25.2)	2 (1.4)	178 (80.9)	30 (13.6)	12 (5.5.)

2.11.1 State comparisons

Analyses were conducted to determine whether State differences existed in the frequency of family contact in the previous six month period. Pearson chi-square analyses revealed significant State differences in the frequency of telephone contact with biological father ($\chi 2$ (6, N = 360) = 23.91, $p < 0.01$) and with relatives ($\chi 2$ (6, N = 360) = 40.15, $p < 0.001$). The results showed that children in South Australia had significantly lower levels of telephone contact with biological fathers and relatives than the other three States. However, no other significant differences were observed, suggesting that the low levels of family contact described above for the sample as a whole were generally consistent across all the States.

2.11.2 Family contact and social background history

Analyses were conducted to examine the relationship between frequency of contact and family and social background variables (i.e. abuse, neglect, parental mental health problems, imprisonment etc.). Several significant relationships were observed between frequency of contact with both mothers and fathers and certain

social background variables (see Table 2.34). Specifically, a relationship was observed between children's telephone contact with mothers and parental mental health problems. Children were more likely to be having weekly telephone contact if their mothers did have mental health problems. Furthermore, children were more likely to be having weekly direct supervised contact with their mother if she did have a physical or intellectual disability.

Table 2.34 Significant variations in telephone and direct supervised contact with mother in relation to social background

	Never *N* (%)	Monthly *N* (%)	Weekly *N* (%)	χ^2 (2)
Telephone				
Mental health problems	76 (42.0)	37 (20.4)	68 (37.6)	8.94*
No mental health problems	102 (57.3)	31 (17.4)	45 (25.3)	
Direct supervised				
Physical disability	19 (59.4)	6 (18.8)	7 (21.9)	6.48*
No physical disability	218 (66.5)	83 (25.3)	27 (8.2)	
Intellectual disability	27 (56.3)	11 (22.9)	10 (20.8)	8.33*
No intellectual disability	208 (67.1)	78 (25.2)	24 (7.7)	

*$p < 0.05$, N =358-359

There were also relationships observed between the likelihood of contact with fathers and several social background variables. As indicated in Table 2.35, a greater proportion of children were having monthly telephone contact with their fathers if their fathers had not been imprisoned or who had no history of sexual abuse of the child. A greater proportion of children were having weekly direct unsupervised

contact or overnight stays with their father if they did not have a parent who had been or was currently imprisoned. A greater proportion of children were observed to be having weekly direct contact with their father if they had a parent with mental health problems.

Table 2.35 Significant variations in telephone and direct unsupervised contact with fathers in relation to social background

	Never *N* (%)	Monthly *N* (%)	Weekly *N* (%)	χ^2 (2)
Telephone				
Past or present imprisonment	108 (85.7)	5 (4.0)	13 (10.3)	7.83*
No imprisonment	175 (74.8)	29 (12.4)	30 (12.8)	
Sexual abuse history of child in care	146 (83.4)	10 (5.7)	19 (10.9)	6.36*
No history of sexual abuse	137 (74.1)	24 (13.0)	24 (13.0)	
Unsupervised/ overnight stays				
Past or present imprisonment	113 (89.7)	10 (7.9)	3 (2.4)	13.60**
No imprisonment	171 (73.1)	45 (19.2)	18 (7.7)	
Parental mental health problems	136 (74.7)	30 (16.5)	16 (8.8)	6.68*
No mental health problems	148 (83.1)	25 (14.0)	5 (2.8)	

*$p < 0.05$, **$p < 0.01$, N =360

These findings highlight possibly the contextual and pragmatic reasons that may affect the frequency of certain kinds of contact. For example, parental imprisonment may make it more difficult to organise ongoing contact between the children and their parents. However it appears for those children whose parents suffer from a mental illness or a physical or intellectual disability, a greater proportion of the children were having more frequent telephone and direct contact than those children whose parents did not have a mental illness or disability. This finding is similar to that reported by Barber & Delfabbro (2004), who identified that children who enter care for reasons related to parental incapacity are more likely to have ongoing contact than those who enter due to protective reasons such as abuse.

2.11.3 Family contact and placement instability

An analysis was undertaken to determine whether children with greater placement disruption were more likely to have lost contact with their parents. The results revealed no significant differences between the frequency and type of family contact and mean number of previous placements during their time in care or the mean number of placement breakdowns in the previous two years.

2.11.4 Family contact and psychosocial functioning

Following the findings of Barber and Delfabbro (2004), it was also hypothesised that children with the highest level of emotional and behavioural problems, as based on clinical scores from SDQ, would also have the lowest level of contact with family members (see Table 2.36).

Table 2.36 Frequency of contact with biological mother and SDQ scores, M (SD)

	Telephone			Direct supervised			Direct and overnight stays		
	Never	Monthly	Weekly	Never	Monthly	Weekly	Never	Monthly	Weekly
SDQ cond.	5.38 (2.46)	5.29 (2.37)	5.40 (2.33)	5.45 (2.47)	5.26 (2.44)	5.12 (1.76)	5.33 (2.38)	5.35 (2.38)	5.58 (2.43)
SDQ hyper.	6.02 (2.59)	6.66 (2.55)	6.27 (2.62)	6.15 (2.62)	6.35 (2.72)	6.41 (2.09)	6.08 (2.68)	6. 79 (2.14)	6.11 (2.68)
SDQ emot.	4.18 (2.79)	4.78 (2.86)	4.20 (2.68)	4.11 (2.71)	4.13 (2.92)	5.53 (2.49)	4.38 (2.76)	4.00 (2.67)	4.12 (2.89)
SDQ peer	4.93 (2.48)	4.86 (2.40)	5.39 (2.56)	4.83 (2.37)	5.23 (2.68)	6.36 (2.53)	5.15 (2.57)	4.82 (2.56)	5.06 (2.27)
Total diff. score	20.61 (7.38)	21.15 (6.43)	21.79 (6.31)	20.73 (6.95)	20.87 (6.96)	24.38 (5.47)	20.98 (7.20)	21.12 (6.18)	21.47 (6.65)

One-way ANOVAs were conducted to examine whether SDQ scores and the Total Difficulties SDQ score differed according to the frequency of contact (telephone, direct supervised, direct unsupervised and overnight stays) with their biological mothers. A significant difference was observed for emotional problems sub-scale and direct supervised contact with the mother, F (2, 346) = 3.86, $p < 0.05$. Fisher's LSD post-hoc comparisons revealed that those children that were having weekly direct supervised contact with their mothers had a significantly higher score on the emotional problems sub-scale than those children who were having monthly direct supervised ($d = 0.52$) or no direct supervised contact ($d = 0.55$). A significant between groups difference was also observed for the peer problems sub-scale and direct supervised contact with the mother, F (2, 315) = 5.02, $p < 0.05$. Fisher's LSD post-hoc comparisons revealed that those children who were having the most frequent level of direct supervised contact with their mothers also had a significantly higher score on the SDQ peer problems than those children who were only having less frequent ($d = 0.43$) or no direct supervised contact ($d = 0.62$). No significant differences were noted for the SDQ sub-scales and the other types of contact with the mother. However a significant difference was noted for the Total difficulties score and direct supervised contact with mothers, F (2, 302) = 3.34, $p < 0.05$. Fisher's LSD post-hoc comparisons revealed that those children with the most frequent levels of contact (weekly) also had the highest score on the SDQ in comparison to those children having monthly direct supervised contact ($d = 0.56$) or no direct supervised contact ($d = 0.59$). As can be observed in Figure 2.2, a positive relationship was evident between the frequency of direct supervised contact with biological mother and the SDQ Total difficulties score. No significant differences in the children's behavioural and emotional functioning and the frequency of contact with biological fathers were observed.

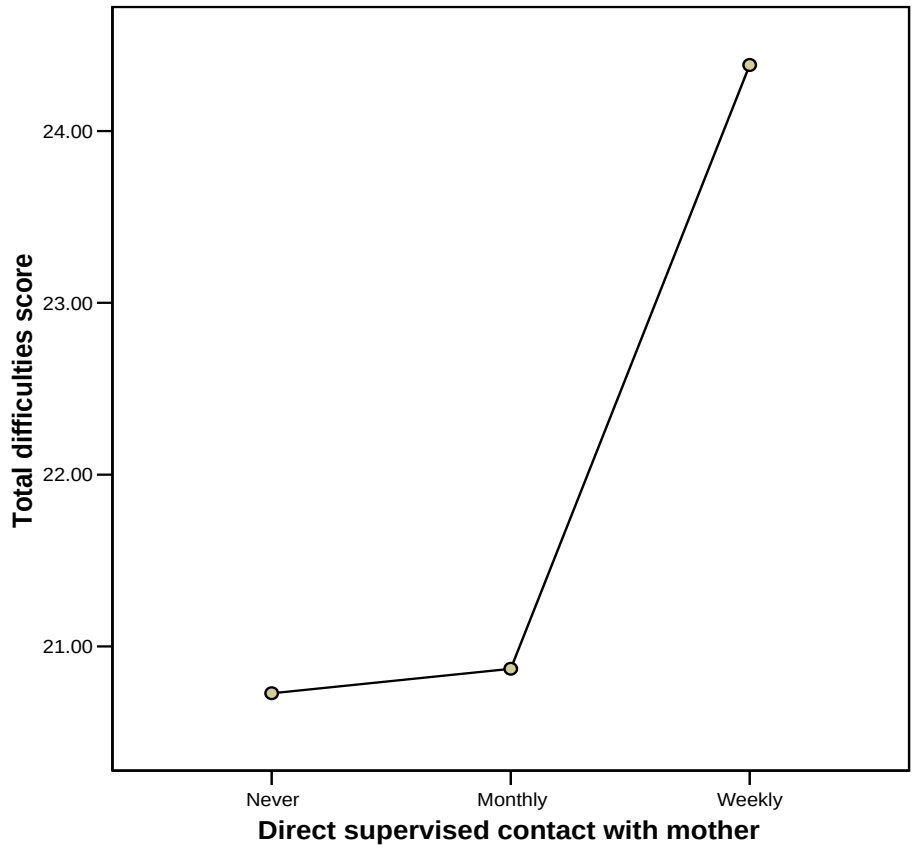

Figure 2.2 Relationship between direct supervised contact with mother and SDQ Total difficulties score

The findings differ from those reported by Barber and Delfabbro (2004). It appears that those children with the highest level of direct supervised contact with their mothers also have the highest emotional symptoms and peer problems scores and the overall Total difficulties score for the SDQ. It is hard to determine whether this is a causal relationship in that the high frequency of contact is affecting their behavioural and emotional functioning. The fact that the only relationship that was evident for direct supervised contact with mothers is also interesting, as no other relationships were found between the frequency of other types of contact (telephone or direct unsupervised contact and/or overnight stays) and the SDQ sub-scales. This may be related to the fact that those children who need to have supervised contact with their mothers are systematically different from those children who do not need to have supervised contact (i.e., the reasons for entry to care) or it may be that supervised contact is a very stressful event in the lives of the children and this may impact on their behavioural and emotional functioning. This finding therefore

warrants further investigation.

Nevertheless, the main findings from these analyses demonstrate that the majority of this sub-population of children in care have very low levels of family contact. These results are concerning in that previous research (Cashmore & Paxman, 1996; Delfabbro et al., 2002b; Fanshel, 1975) has demonstrated the importance of family contact for children, especially in their adult lives. The current findings differ substantially from the results observed in Barber and Delfabbro's (2004) study in South Australian foster care which found that the vast majority of children in general in out-of-home care in their study were having relatively frequent contact with their families. However, these findings contrast with previous research that showed that better adjusted children and families are more likely to remain in contact (Cantos et al., 1997; Delfabbro et al., 2002b). They show that this relationship may vary according to the type of contact: supervised versus unsupervised.

2.11.5 Conclusion

Several researchers have attempted to identify the factors that increase a child's risk of experiencing placement instability. The current study findings are in line with previous research (Pardeck, 1984; Pardeck et al., 1985) that demonstrated increased age and the presence and severity of behavioural and emotional problems are significantly related to higher rates of placement instability. Palmer's (1996) research found some evidence that boys may be at greater risk for instability than girls, although she suggests that this may only be because boys are typically more likely to experience the sorts of behavioural problems that are the cause of placement instability.

Delfabbro, Barber and Cooper (2000) argued that child factors may play a role in placement disruption. They found that gender, location and placement history were important predictors of disruption. In respect to placement history, they found that if children had a history of previous multiple placement changes (6 or more), they were at 3.38 times greater risk of experiencing disruption. Considering that on average the children had been in care for just under five years and had experienced close to 11 placement changes during their time it is not surprising that placement disruption is so extreme in this sample of children. The results of the current study

support their previous findings that suggest problems increase as children grow older and the longer they remain in care.

Research has also been conducted on the social-interaction factors that may influence placements and result in disruption. For example, Stone and Stone (1983) found several factors that were related to placement disruption and these included poor parent-child relationship, child's inability to form positive attachments to caregivers, or prior experience of living in chronically abusive or neglectful homes. The vast majority of the sample were noted to have attachment difficulties and had experienced living in chronically abusive and neglectful homes prior to entering care. Therefore, it is highly likely these factors may have contributed to ongoing behavioural and emotional problems and made it more difficult for children to form stable attachments with new caregivers.

2.12 Case studies

The following four case studies provide an overview of the multiple problems of each child and their family who were involved with community service departments across Australia. The purpose of providing the case studies is to give the reader an opportunity to understand the individual histories of the child and families and to comprehend the level of difficulties and multiple problems that the departments are faced with on a daily basis.

Case study 1: Male 14 years
This particular boy entered care at age 11 years after a history of allegations of physical, sexual, and emotional abuse and ongoing neglect concerns. The reason for entry was the child's self-harming behaviours and the parents requesting the child be removed from their home. Since his time in care he has experienced 16 foster placements including several residential care placements. His parents have a history of mental health issues and substance abuse and intellectual disability. The child's father was previously his primary caregiver until four years ago when he passed away. The boy subsequently lived with his mother and step-father where he suffered physical and emotional abuse and severe neglect. The boy suffers from mental health issues, a physical disability (hydrocephalus), a moderate intellectual disability, difficult behaviours and poor peer functioning, poor social functioning and poor attachment to others. He is very underweight and has poor physical coordination. The boy also has a history of severe school problems and he is currently attending a specialist school. In the last two years he has experienced eight placement breakdowns.

Case study 2: female 16 years
This teenage girl entered care at the age of 11 years after first notifications to the department of allegations of physical and severe sexual abuse were substantiated. During her time in care she has had four foster placements including an unsuccessful relative placement. Her family has a history of domestic violence, intellectual disability, imprisonment, and sexual and physical abuse. The girl has been diagnosed with conduct disorder and also exhibits sexualised behaviours. She is aggressive to others, frequently runs away and is involved in self-harming behaviours. She also displays poor social functioning and poor attachment to others. She is currently attending a specialist school. In the previous two years she has experienced two placement breakdowns.

Case study 3: Male 11 years

This young boy entered care just over twelve months ago. The first notification to the department was related to his mother's inability to cope or deal with the child's difficult behaviours. The family has a history of domestic violence and mental health issues, physical illness and intellectual disability. There is also a family history of substance abuse, financial problems, and imprisonment. The child eventually entered care due to emotional abuse, medical neglect and the child being at risk of physical harm in the home. The boy has experienced four foster placements, including a residential placement since entering care. The boy displays disruptive and aggressive behaviour and sexualised behaviours. He also has poor social functioning and very poor attachment to others. He has been diagnosed with ADHD and is having great difficulties at school. In the last twelve months he had experienced three placement breakdowns.

Case study 4: Female 7 years

This young girl entered care at age one. The first notifications to the department included concerns about domestic violence, mental health problems of the parents, severe neglect and emotional, physical abuse of the child. The mother has an acquired brain injury as a result of domestic violence and was having difficulty managing seven children at home. During her time in care the young girl has experienced 11 foster placements including two reunifications, five residential placements and one relative placement. The young girl suffers from an intellectual disability and developmental delay and displays aggressive and sexualised behaviours in her current placement. She is having difficulty at school and exhibits poor social functioning and poor ability to attach to others. In the previous two years she has experienced four placement breakdowns.

2.13 Service history

An important feature of the current study, which extended previous Australian research in the area of child welfare, was the collection of data on the early and ongoing service response for children and their families. The main purpose for collecting this information was to help identify when and what type of services that were provided to families and children and to help identify service responses that may have been important. This information may help inform the appropriate use of early intervention services for families and children with multiple needs and possibly prevent the traumatic journeys experienced by this subpopulation of children and their families.

2.13.1 Early and ongoing service responses for children and their families

Extensive information was collected on the specific therapies or interventions the children and/or the biological families had received before or since they came into contact with the department. As illustrated in Table 2.37, a higher proportion of children were receiving or had previously received services than the biological parents. Very complete data was able to be collected on placement history from both computer database sources and case-worker interviews. However, information concerning which services were provided to children and families was much more influenced by the varying quality of the case-files; therefore, these findings need to be treated with caution.

Table 2.37 Frequency of services accessed by children and/or biological parents before or after entering care system

Services	Children *N* (%)	Biological parent(s) *N* (%)
Assertion training	10 (2.7)	6 (1.6)
Self-esteem building	104 (28.6)	23 (6.3)
Psychiatrist	128 (35.2)	76 (20.9)
Psychologist	279 (76.6)	107 (29.4)
Treatment for specific mental health issues	67 (18.4)	53 (14.6)
Anger management	125 (34.3)	57 (15.7)
Social skills training	116 (31.9)	24 (6.6)
Dealing with grief and loss	135 (37.1)	29 (8.0)
Behaviour management	203 (55.8)	89 (24.5)
Employment training/apprenticeship	61 (16.8)	6 (1.6)
Independent living/Short periods away from home	70 (19.2)	8 (2.2)
Substance abuse treatment	35 (9.6)	78 (21.4)
Safe sex practices	69 (19.0)	n/a
Family mediation	80 (22.0)	71 (19.5)
Family support worker visits	n/a	150 (41.2)
Mentor	141 (38.7)	n/a
Other services	247 (67.9)	265 (72.8)

Table 2.37 above highlights the range and diversity of services and interventions offered to the children and families prior to entering care and during their time in care. Services from a psychologist were the most frequently accessed intervention by both children and their families, but this may not indicate treatment but rather only assessment of the individuals. This finding is also not surprising, as psychological assessment is mandated as part of a child's case plan in some Australian States such as South Australia.

The services and interventions listed above were collapsed into six general services for children and families.

The six services for children and the frequency of provision were:

1) Child psychological services (*N* = 317, 87.1% = psychologist, psychiatrist, treatment for mental health issues, and/or grief and loss counselling);
2) Child personal and social services (*N* = 231, 63.5% = assertion training, self-esteem building, social skills training, anger management, substance abuse treatment and/or safe sex practices training);
3) Child behaviour management (*N* = 203, 55.8% = any type of behavioural management intervention);
4) child vocational support and guidance (*N* = 185, 50.8% = employment training/apprenticeships, independent living services, and/or mentor services);
5) Child and family services (*N* = 80, 22.0% = family mediation services); and,
6) any other services or interventions (*N* = 158, 43.4%).

The six general services for families and the frequency of provision were:

1) family psychological services (*N* = 182, 50.0% = psychologist, psychiatrist, treatment for mental health issues, and/or grief and loss counselling);
2) Family personal and social services (*N* = 89, 24.5% = assertion training, self-esteem building, social skills training, anger management and/or substance abuse treatment);
3) family behavioural management (*N* = 89, 24.5% = any type of behavioural management training for parents);
4) family vocational support and guidance (*N* = 13, 3.6% = employment training/apprenticeships and/or independent living services);
5) Child and family services (*N* = 179, 49.2% = family mediation services and/or family support workers visits); and
6) any other services or interventions (*N* = 176, 48.4%).

Analyses were conducted to determine which children and families were most likely to receive services according to age, gender, level of psychological adjustment and which State the child resided. Several significant differences were found between the age of the children and the services they received. The children were divided into 2 groups; younger children (4 -12 years, *N* = 223, 61.3%) and older children (13-18 years, *N* = 141, 38.7%). A significantly higher proportion of the older children had received services and interventions than the younger children, including child psychological services, child personal and social services, child vocational support and guidance, and child and family services. Interestingly, no significant differences were noted between the younger and older children on the provision of behavioural management intervention services (see Table 2.38).

Two significant gender differences were noted. First, boys were found to have received more behaviour management intervention services than girls, and boys were also noted as receiving more child vocational support and guidance services than girls. This finding may highlight the gender difference in presentation of problems, as males generally present with more externalising behavioural problems whereas females' problems often tend to be more internalised (Barber & Delfabbro, 2004). The provision of more child vocational support and guidance to the males may indicate that the services (i.e. independent living services and employment training/apprenticeships) were either more available for the male children or possibly considered more suitable for males because of behavioural problems that had made them less suitable for conventional schooling.

Table 2.38 Age and gender differences in service provision for children

	Age			Gender		
	Younger *N* (%)	Older *N* (%)	$\chi 2$ (1)	Male *N* (%)	Female *N* (%)	$\chi 2$ (1)
Child psychological services	117 (83.0)	200 (89.7)	3.46*	186 (87.7)	131 (86.2)	< 1
Child personal and social services	69 (48.9)	162 (72.6)	20.94***	135 (63.7)	96 (63.2)	< 1
Child behaviour management services	78 (55.3)	125 (56.1)	< 1	136 (64.2)	67 (44.1)	14.46***
Child vocational guidance and support services	33 (23.4)	152 (68.2)	69.24***	117 (55.2)	68 (44.7)	3.87*
Child and family services	22 (15.6)	58 (26.0)	5.46*	47 (22.2)	33 (21.7)	< 1
Child 'other' services	55 (39.0)	103 (46.2)	1.81	93 (43.9)	65 (42.8)	< 1

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$, *N* range = 306-364

Several State differences were noted in the provision of certain services and interventions to the children. Child psychological services were found to be provided more frequently to South Australian children than those in Queensland, whereas child behavioural management services were more frequently provided to children in Victoria than in Queensland. A similar trend was observed for child and family services. The provision of a variety of 'other' services was more likely to be observed in the Victorian sample than the Western Australian sample. Child personal and social services was noted to be less frequently provided to the Western Australian sample than all the other States and child vocational guidance and support services were noted to be less commonly provided to the Queensland sample in

comparison to children in the other States (see Table 2.39).

Table 2.39 State differences in service provision for families and children

	SA *N* (%)	VIC *N* (%)	WA *N* (%)	QLD *N* (%)	$\chi 2$ (3)
Child psychological services	103 (91.2)	94 (94.9)	58 (80.6)	62 (77.5)	16.37**
Child personal and social services	75 (66.4)	73 (73.7)	4 (47.2)	49 (61.3)	13.28**
Child behaviour management services	58 (51.3)	79 (79.8)	26 (36.1)	40 (50.0)	36.44***
Child vocational guidance and support services	57 (50.4)	54 (54.5)	49 (68.1)	25 (31.3)	21.37***
Child and family services	17 (15.0)	44 (44.4)	2 (2.8)	17 (21.3)	47.81***
Child 'other' services	31 (27.4)	90 (90.9)	16 (22.2)	21 (26.3)	125.41***
Family psychological services	56 (49.6)	74 (74.7)	30 (41.7)	22 (27.5)	42.46***
Family personal and social services	17 (15.0)	37 (37.4)	16 (22.2)	19 (23.8)	14.58**
Family behaviour management services	14 (12.4)	47 (47.5)	3 (4.2)	25 (31.3)	55.35***
Family vocational guidance and support services	1 (0.9)	9 (9.1)	2 (2.8)	1 (1.3)	12.51*
Family and child services	54 (47.8)	80 (80.8)	11 (15.3)	34 (42.5)	74.25***
Family 'other' services	55 (48.7)	80 (80.8)	29 (40.3)	12 (15.0)	79.28***

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$, *N* range = 306 – 364

Several States differences were also noted in the provision of certain services and interventions to the families (see Table 2.40). The Victorian sample was found to have received a higer proportion of services than all of the other three States; however, this finding may be reflective of the more detailed data available that was collected in Victoria. Family psychological services were more commonly provided to the Victorian than the Queensland sample. Family personal and social services, family behaviour management training, family vocational support and guidance, family and child services and other services were more frequently noted as having been provided to the Victorian sample than those in the other three States. These State differences in child and family service provision may reflect differences in demand and availability of services in the different States or differences in the quality of source records monitored by the different Departments.

Table 2.40 Differences in service provision for children based on clinical scores for Conduct disorder sub-scale for SDQ

	Normal	Borderline	Abnormal	$\chi 2$ (2)
Child psychological services	35 (83.3)	23 (95.8)	246 (87.9)	2.24
Child personal and social services	19 (45.2)	11 (45.8)	191 (68.2)	11.99*
Child behaviour management services	16 (38.1)	13 (54.2)	165 (58.9)	6.47*
Child vocational guidance and support services	13 (31.0)	7 (29.2)	157 (56.1)	14.21**
Child and family services	6 (14.3)	4 (16.7)	66 (23.6)	2.26
Child 'other' services	14 (33.3)	11 (45.8)	124 (44.3)	1.87

*$p < 0.05$, **$p < 0.01$, $N = 346$

Analyses were conducted to determine if any differences existed in the provision of services to children depending on their level of functioning on the SDQ. The six child services and interventions were compared to the level of child functioning on the four sub-scales of SDQ (Conduct problems, Hyperactivity/Inattention, Emotionality and Peer problems) and the Total difficulties score. The three levels of functioning were based on the clinical levels of functioning

on the SDQ (i.e. normal, borderline and abnormal ranges of functioning, see Table 2.41). A significant difference was found in the service provision for children who fell into the abnormal range for Conduct problems for child personal and social services, child behaviour management intervention services and child vocational support and guidance. Surprisingly, no significant differences were observed in relation to the provision of psychological services based on the child's level of conduct problems. However, there was some evidence for appropriate matching of services. Children who fell into the abnormal range for conduct problems were more likely to receive behaviour management intervention services, whereas children with emotionality problems (depression and anxiety) in the abnormal range had received significantly more child psychological services ($\chi 2$ (2, N = 351) = 9.81, $p < 0.05$).

Table 2.41 Differences in service provision for children based on clinical scores for Peer Functioning sub-scale for SDQ, N (%)

	Normal	Borderline	Abnormal	$\chi 2$ (2)
Child psychological services	54 (90.0)	26 (74.3)	205 (91.5)	9.47*
Child personal and social services	39 (65.0)	22 (62.9)	147 (65.5)	< 1
Child behaviour management services	31 (51.7)	14 (14.0)	140 (62.5)	7.51*
Child vocational guidance and support services	36 (60.0)	21 (60.0)	109 (48.7)	3.44
Child and family services	18 (30.0)	2 (5.7)	57 (25.4)	7.82*
Child 'other' services	26 (43.3)	12 (34.3)	99 (44.2)	1.22

*$p < 0.05$, N = 319

No significant differences in service provision were noted for those children that fell into the different ranges on the hyperactivity/inattention subscale of the SDQ. However, significant differences were noted in the provision of child psychological services for children who fell into the abnormal range for peer problems ($\chi 2$ (2, N = 319) = 9.47, $p < 0.05$), child behaviour management intervention services ($\chi 2$ (2, N = 319) = 7.51, $p < 0.05$) and child and family services ($\chi 2$ (2, N = 319) = 7.82, $p < 0.05$).

There were two significant differences in service provision for those children who fell into the abnormal range for Total Difficulties Score. These children were significantly more likely to receive psychological services ($\chi 2$ (2, N = 306) = 6.67, p < 0.05) and also more likely to receive personal and social services ($\chi 2$ (2, N = 306) = 6.06, p < 0.05) than those children who fell into the normal and borderline range for the SDQ. These findings are encouraging as it appears that those children that fell into the abnormal clinical range for psychological functioning as measured by the SDQ were the most likely to receive services and interventions.

2.13.2 Conclusion

The findings on the provision of services to children and families demonstrate that those children with the highest level of problems appear to be the most likely to receive services and interventions. Several State differences in service provision were observed; specifically, the Victorian sample received a significantly higher number of family services and interventions. However, it is important to recognise that the observed State differences in the frequency of service provision may not be a true reflection because of the variations in the quality of records collected from different States. The State differences in service provision could also be attributed to differences in the children and families themselves. For example, the Victorian sample was observed to have a significantly higher proportion of males and to have had their first contact with the department at a significantly older age than the other three States. As a result the children may have entered care with more behavioural problems and hence received more behavioural intervention services. The families of the Victorian sample were also observed to have received a higher proportion of services and interventions and the South Australian sample was also observed to have received a significantly higher number of child psychological services but this may reflect differences in demand and availability in each of the four States. Nevertheless, the findings demonstrate that nationally the children and families are currently receiving or had previously received a wide variety of services and interventions.

But it may be a little too late for the majority of these children that have been in care for many years. They may be receiving the attention only now that was needed when they first came to the attention of community service departments at a

much younger age. Therefore, the findings suggest, as many studies have previously, that early intervention services are essential to prevent or limit the number of children entering care that end up drifting from placement to placement until they age out of the system.

2.14 General conclusions

The results of this national study show that children within this population (i.e. children who have been referred for emergency, short-term or long-term placements, had experienced two or more placement breakdowns in the previous two years or had experienced a placement breakdown during their first four months in care) are usually around 12 to 13 years of age and have typically experienced ten or more previous placements in their lifetime, with many having experienced over 20 or 30. Most first came into contact with the Departments at around the age of three but usually did not finally enter care until four years later. On average, these children had been in the care system for five years, but there had been few attempts to reunify them with their families. Compared with the Australian out-of-home population in general (AIHW, 2005), this group contained an over-representation of boys (60% vs. 50%), and an under-representation of Indigenous children (17% vs. 24% in the general out-of-home care population), suggesting that non-Indigenous boys are the group in Australia most likely to be at risk of significant ongoing placement disruption. Almost all of the children had been subjected to traumatic, abusive, and highly unstable family backgrounds. In every State, domestic violence, physical abuse and substance abuse were the three most prevalent problems, with parental mental health problems and neglect also observed in at least half of the sample. Over half of the sample had experienced four or more family background problems, and this included 15% of the sample who had experienced nearly all of the problems identified. Specific analysis of children who had been subjected to abuse showed that one third of children had been exposed to every type of abuse: physical, sexual and neglect.

Further comparative State analyses showed that there were some subtle differences in the profiles of children in each of the different States.

- South Australian children with high levels of placement instability were more likely to be female than in other States; had the highest levels of placement instability; tended to enter care somewhat earlier; were more likely to be subject to neglect; and had low rates of reunification success.

- Victorian children were less likely to be Indigenous; were generally more likely to be male; came into care somewhat later; were more likely to have parents with mental health issues; had been subjected to particularly high levels of domestic violence and physical abuse; but had greater reunification success.

- Western Australian children were more likely to be Indigenous. Compared with South Australian and Victorian children, they were less likely to be neglected, to have experienced physical abuse or to have parents with mental health problems; however, their parents were more likely to be imprisoned.

- In Queensland, there was a greater likelihood of attempts to reunify children with their birth families and children tended to come into care older than in South Australia or Victoria. Compared with the other States, Queensland children were generally less likely to have experienced domestic violence, physical or sexual abuse; to have parents who were imprisoned, or to have parents with mental health problems.

Without further and more extensive investigation, it is difficult to determine whether these differences reflect broader social and economic differences between the States, differences in the implementation of child protection policy, the availability of placement opportunities, diversity in practice, or differences in the nature of the records maintained by the respective Departments. For example, the particularly high level of placement instability in South Australia may only reflect a greater use of short-term emergency placements to assist in the planning for longer

term placements. Barber and Delfabbro (2004), for example, found using longitudinal tracking that most placement changes in South Australia were intended rather than due to genuine breakdowns in the placement. Alternatively, this finding may reflect the relatively low availability of non-family-based forms of care in South Australia, and the greater reliance on family foster care, a placement option that may be particularly unsuitable for this population of children and young people. Similarly, the greater proportion of parents imprisoned in Western Australia may reflect the greater proportion of Indigenous children, whose parents may have a greater likelihood of being highly represented in the correctional system (Aboriginal Affairs Department, 1995).

Nevertheless, despite these differences between the States, the results show that the young people in the sample shared many more similarities than differences in their characteristics, suggesting that it is possible to adopt a national perspective when discussing policies and services suitable to meet the needs of this population. Another important finding in this research is the fact that this population of children does not appear to fall into neat subgroups or clusters as might be expected based on the range of different background variables. Instead, children within this population appear to form one single cluster based upon very common family experiences, namely, the combined effects of domestic violence, substance abuse and physical violence and neglect. Such findings suggest very strongly that out-of-home care policy cannot, and should not, be considered in isolation from other important areas of social policy and public health. Any policies which are successful in reducing levels of substance abuse, domestic violence and the problems of adult mental health are likely to have significant impacts upon the out-of-home care system. Although much of the research in this field, including this thesis, has emphasised the ongoing psychological harm resulting from unsuccessful placement experiences, it is also almost certainly true that many of the children displaying significant emotional and behavioural difficulties when they are older had already suffered significant, possibly irreparable physical and psychological harm during their early years and before they were born (e.g., via the effects of substance abuse, poor parental nutrition and stress on foetal development).

As emphasised previously in Chapter 1, there are a great many studies (for example Chu & Dill, 1990; Femina et al., 1990; Mullen et al., 1996) that have shown that early exposure to abuse and trauma is associated with significantly poorer psychological and social functioning, a greater likelihood of substance abuse, inter-generational abuse, and poor employment and relationship outcomes. The young people in this current study were generally too young for many of these longer term issues to be investigated. However, there was clear evidence that bears out many of these previous findings within this population of children. As shown particularly in relation to the scores obtained on the SDQ, the vast majority of the young people had abnormally high levels of conduct disorder, difficulty with peers, and other social behaviours often associated with disruptions to early attachment experiences. Almost half suffered from clinical depression and anxiety, and many also appeared to have considerable difficulty in regulating and expressing their emotions in a way that would be conducive to healthy peer relationships and the formation of bonds with adults who might act as parents towards them.

In other words, one of the most important implications of these results is that any attempt to assist this population of young people needs to be undertaken with a clear understanding of the links between the child's current behavioural and emotional functioning and their previous family and placement history. Therapeutic interventions involving the treatment of trauma, the establishment of better attachments and social functioning, must therefore be emphasised in addition to interventions that seek to stabilise and control the behaviours contributing to placement breakdowns (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993; Hughes, 2004).

In Chapter 2, several hypotheses were advanced concerning the putative links between children's psychosocial functioning and their family and placement history:

(a) Children with more complex family backgrounds would have poorer psychosocial functioning on a range of measures;

(b) Psychological and social functioning would be poorer in children with the most disrupted placement histories;

(c) Children with more complex needs would receive more services because of the tendency for greater amounts of resources to be directed towards the most difficult cases.

The results confirmed that children with more complex family backgrounds had poorer psychosocial functioning on a range of measures. Secondly, overall psychological and social functioning was found to be poorer in children with the most disrupted placement histories. Finally, it was confirmed that children with more complex needs received more services because of the tendency for greater amounts of resources to be directed towards the most difficult cases. The study also demonstrated that the children and young people in care with the highest levels of placement instability, in the different States, were similar in both their family and social backgrounds and their current psychosocial well-being.

The major aim of the current study was to extend previous research by conducting a more detailed national study of the needs, social background, and service responses to children who met the empirically derived criteria across four different Australian States. The second aim was to place a greater emphasis on the utilisation of services both at the entry point into care as well during placement. The two primary aims were achieved.

However, an overriding purpose was to understand the implications of these findings for interventions and service delivery in order for progress to be made in finding appropriate solutions for these children (see Bath, 1998). The following Chapters (3 & 4) will provide an extensive review of international interventions and services and their applicability for children with high support needs in Australia.

SECTION C

Chapter 3

Specialised Interventions and Service Models for Children with High Support Needs

3.1 Overview

Although it would be theoretically possible to discuss a very wide range of interventions for children in out-of-home care, the purpose of this Chapter is to consider those interventions and services which may be specifically beneficial to children who have significant emotional, social and/or behavioural difficulties that make it difficult for them to find stable placements in conventional family-based foster care. As indicated in Section B, a high proportion of these children were identified as suffering from clinically abnormal levels of emotional and behavioural disorder, high levels of attachment-problem related behaviours, poor social functioning, depression, anxiety, and ADHD, which appears to be linked to high levels of placement disruption and instability. Educational difficulties were also evidenced in the high suspension and exclusion rates. More importantly, the genesis of many of these problems appears to arise in the earlier abusive, chaotic and traumatic life histories of these children and their families. As described in the previous Chapter, the majority of the families had histories of domestic violence, substance abuse, physical violence and neglect. Thus, based on these findings, it is clear that effective interventions must have the capacity to address not only the problems directly displayed by children but also be cognisant of the significant and complex family histories that underlie their problems and impede the capacity of the care system to achieve successful reunifications with families.

Although many interventions cannot be easily categorised into any single category, this chapter discusses some of the more commonly utilised approaches available to agencies in terms of two main categories; (1) child focused interventions and 2) family/parent-child/parent-focused interventions. This division is generally consistent with other significant and recent reviews such as that undertaken by Saunders, Berliner and Hanson (2004), who extensively reviewed treatment programs in America for children who had been physically and sexually abused.

Such a division recognises the difficulty of classifying programs or interventions by singular diagnoses (i.e. anxiety/ depression/conduct disorder) or by general issues (abuse/educational difficulties/ family discord), due to the prevalence of co-morbidity of psychological problems and the multiple co-occurring familial and social background issues as identified in the national profile study. The interventions that were considered were identified as possible best practice examples in several leading reviews of services for children with similar profiles to those in the national comparative study (see Chadwick Center for Children and Families, 2004; Saunders et al., 2004). A summary of some of the principal types of intervention is provided below:

Child focused interventions

- Behaviour modification / Token Economies
- Multidimensional Treatment Foster Care (MTFC)
- Cognitive-behavioural therapy (CBT and Dynamic Play, Cognitive processing therapy (CPT), Eye Movement Desensitisation and Reprocessing (EMDR), Abuse-focused CBT)
- Trauma counselling (Trauma-focused CBT, Trauma-focused Integrative-Eclectic Therapy, TF-IET)
- Activity scheduling (e.g. Play therapy, Trauma-focused play therapy, Art and Music therapy)

Family, parent-child and parent-focused interventions

- Attachment therapy
- Milieu therapy
- Personal and Social Skills Training
- Parent-Child Interaction therapy (PCIT)
- Parent management training (PMT)
- Multisystemic therapy (MST)
- Families First
- Triple P – Positive Parenting Program
- Elmira Nurse Home Visitation program
- Wraparound

3.2 Main intervention approaches in out-of-home care

3.2.1 Child-focused interventions

3.2.1.1 Behaviour modification/Token economies

As established in the previous chapter, a very large number of foster children appear to be entering the care system with complex behavioural, social, psychological and emotional difficulties. As a result, behaviour modification or behavioural therapy is one of the most common forms of intervention employed in programs to address such problems. Child behaviour therapy has a very extensive and well established history (Hersen, 1989). Many of the innovative ideas that were developed several decades ago to treat child behaviour form part of the majority of behavioural treatment programs operating today. Even though there are many methods of behaviour modification, there are two which prevail in the research literature. The first of these methods involves the systematic reinforcement and punishment of responses to produce more desirable behaviours. The principles of this technique are based on the notion that behaviour can be changed through rewards and punishments and the assumption that children are capable of learning the relationship (or contingency) between their behaviours and consequences (Fahlberg, 1991). The aim of the intervention is to teach children to form new habits or behavioural contingencies. The therapist or caregiver (parent, foster parent or residential staff) will apply positive reinforcement or rewards for positive behaviours and will punish or ignore (fail to reward) undesirable behaviours, thereby reducing the incidence of bad behaviour and increasing desirable behaviour (Meadowcroft & Grealish, 1990). In most cases, very simple rewards and punishments are used during the modification process. For example, a young child who acts out is ignored or punished by a carer raising his or her voice, whereas any positive behaviour is immediately rewarded by praise and affection. Most research in this area indicates that negative punishment (or the withholding of reward or attention) is preferred over positive punishment (raising one's voice to the child), because positive punishment is generally less effective or desirable and may have negative consequences such as the child acting out more by escalating his or her behaviour.

Programs for older children that employ this form of behavioural modification usually supplement the process of reinforcement with the use of

behavioural contracts. Behavioural contracts are, in most cases, mutually negotiated obligations established between the young person and their caregiver (parent, foster parent, residential youth worker, therapist, etc). There are several ways that the contract can be established: first, the young person may verbally negotiate the terms in the presence or their therapist, parent, foster parent or residential youth worker; or second, the young person and their particular caregiver may be asked to sign a document as an official sign of their mutual obligations and responsibility to each other; or third, the young person may be asked to sign an established contract on entry to a program or service (Patterson, 1974).

The second common form of behaviour modification is based upon the principle of conditioned reinforcement. The principles are based upon the fact that people can often be encouraged to perform behaviours to achieve specific outcomes (secondary reinforcers) which can then be used to obtain highly desirable outcomes (primary reinforcers). Primary reinforcers usually include such things as money, privileges, and luxuries, whereas secondary reinforcers usually take the form of points, tickets or tokens. The principles of operant conditioning are behind what is referred to as the "token economy" procedure (Chamberlain, 1990). A token economy is a system whereby tokens are used as reinforcers to increase desirable behaviour in individuals (for examples see Kelly & Gilligan, 2002). Such methods were, for example, employed in Achievement Place, a community based family style centre in Texas that used behaviour modification for delinquents using token (points) reinforcement procedures. Phillips, Phillips, Fixsen and Wolf (1971) found that pre-delinquent behaviours are amenable to modification procedures and that a token reinforcement system provides a practical means of modifying these behaviours. Although, the term 'token economy' is often not used in out-of-home literature because of its long association with mental health interventions and juvenile justice, many programs around the world nonetheless employ systems that are very similar.

3.2.1.2 Multidimensional Treatment Foster Care- MTFC

An example of a program that utilises token economies as part of its intervention with children is known as Multidimensional Treatment Foster Care. MTFC is a widely-utilised treatment program model for foster children in America (discussed in detail in Chapter 4). It is designed to decrease problem behaviour and

to increase developmentally appropriate normative and prosocial behaviour in children and adolescents. The treatment goals are accomplished by providing close supervision, fair and consistent limits, predictable consequences for rule breaking, a supportive relationship with at least one mentoring adult, and reduced exposure to peers with similar problems. As part of MTFC, when young people enter the program they are given very few possessions and privileges and then over time, their behaviour is monitored and as it improves they accumulate points which can then be exchanged for things that they desire (e.g., more furniture, a radio). Conversely, in some programs, young people might not be deprived initially but have the option to accumulate more points to obtain additional luxuries, greater responsibilities or variations in the level of freedom in the program. Such accumulation of points is often referred to in terms of "levels" or "stages", so that as the young person accumulates the points they are then able to graduate to a higher level or stage in the program. Eventually, once the young person graduates from each of the levels, they are then able to be discharged from the program, in most cases to a less restrictive setting. Often these techniques are employed in programs for juvenile offenders, especially in the United States. Four studies were conducted on the effectiveness of the behavioural intervention named Multidimensional treatment foster care (MTFC). The first study used a matched comparison design whereby youths were matched by age, sex and date of entry to a State training school (Chamberlain, 1990). A second randomised control study compared the effectiveness of TFC with typical community treatment for youths aged 9 to 18 years leaving a State mental hospital (Chamberlain & Reid, 1991). The measures used by the researchers included the PDR checklist, which examined the rates of problem behaviours, the Behaviour Symptom Inventory, which examined the presence/absence of psychiatric symptoms and the tracking of re-hospitalisations. A third study randomised 70 foster parents to three groups: 1) assessment only (parents were neither paid nor given enhanced training and support, 2) payment only (parents were paid for their participation but did not receive enhanced training or support), and 3) enhanced training and support (parents did not receive payment but did receive enhanced training and support) (Chamberlain, Moreland & Reid, 1992). The fourth study was a full-scale randomised clinical trial conducted from 1990 to 1996 and involved 79 male juvenile offenders aged 12 to 17 years (Chamberlain, & Reid, 1998). The participants were randomly assigned to treatment in TFC or Group Care (GC, lived with 6 to 15 other

males with similar histories of delinquency) for an average of seven months. The study collected data on official arrests and confidential reports of criminal activity, number of days incarcerated, school attendance, academic advancement and mental health. The clinical trial found that TFC participants, in comparison to the control group (GC), spent 60 percent fewer days in incarceration during the 12 month follow-up, had significantly fewer subsequent arrests, and had less hard-drug use. The TFC participants also reported significantly fewer psychiatric symptoms, had better school adjustment and rated their lives as happier compared to boys in Group Care. Overall, this particular technique has proven to be quite effective: the youth have shown significant reductions in antisocial behaviour (Chamberlain & Reid, 1991) and significant decreases in criminal referrals and days spent in detention facilities (Chamberlain, & Reid, 1998). It appears to be a cost effective alternative to residential treatment and led to better outcomes for children and families.

Although there are many positive features of this technique, there are several limitations that should be identified. For example, the technique can be very labour intensive and time-consuming (due to the high amount of monitoring and documentation of behaviours that is required). The technique also does not address the underlying emotions and attitudes that may be driving the behaviour. In addition, Levy and Orlans (1998) suggest that such transactional styles of interaction may inhibit young people's capacity to form more emotionally fulfilling relationships with adults, in that it may reinforce the young people's view of adults as rigid and authoritarian.

3.2.1.3 Cognitive behaviour therapy (CBT)

Programs and services also employ the use of behavioural modification techniques as one component of their overall therapeutic intervention with both children and biological families. For example, several individually focused interventions include cognitive behavioural treatments for a range of children's anxiety problems (Ollendick & King, 1998). Cognitive behavioural therapy or CBT involves the combination of cognitive therapy and behavioural therapy and is one of the most extensively researched forms of therapeutic intervention. CBT involves, in addition to the aforementioned behavioural therapy techniques, the therapist employing the use of cognitive therapy that focuses on teaching the child or young

person the link between how certain thinking patterns can cause certain symptoms. The therapist teaches the child how to change their thought patterns from ones that lead to maladaptive behaviour to ones that produce adaptive behaviour and positive feelings. The technique has been used to treat a variety of symptoms such as improving self-esteem, coping skills, problem solving skills, social skills, school attendance, post-traumatic stress disorder, conduct disorder, delinquency, depression and anxiety (see review of findings in Hodges, 2004). In one study CBT was found to be helpful in helping hyperactive boys develop anger control when compared to control training and was more successful in enhancing the boys' level of self-control and their use of specific coping strategies (Hinswaw, Henker, & Whalen, 1984).

A recent review of programs for children who had been physically and sexually abused conducted by Saunders et al. (2004) identified three programs that employ cognitive treatment components along with other interventions: Cognitive Behavioural therapy and Dynamic Play therapy for children with Sexual problems and their caregivers; Cognitive Processing therapy (CPT); Eye Movement Desensitisation and Reprocessing (EMDR); Individual child and parent physical-abuse focused Cognitive-behavioural Treatment (or Abuse-focused- AF-CBT); and, Trauma-focused cognitive-behavioural therapy (TF-CBT) that will be discussed in the Trauma intervention section.

Cognitive Behavioural therapy and Dynamic Play therapy

Cognitive Behavioural therapy and Dynamic Play therapy are two group treatment approaches, designed for younger children (6-12 years) who exhibit sexual behaviour beyond normal child sexuality and their caregivers, that are intended to reduce the occurrence of inappropriate and/or aggressive sexual behaviour in children (Bonner, 2004). The children attend twelve weekly sessions that involves both cognitive-behavioural therapy and dynamic therapy components, including impulse control; learning and applying sexual behaviour rules for children; cognitive reframing to prevent re-abuse of or by the child; weekly assessment of acquisition of information; positive reinforcing of appropriate behaviour; reflection to increase child's self understanding; acceptance to convey positive regard for child and improve child's self-esteem; and, facilitating group interaction to improve peer relationships (Bonner, 2004). A report by Bonner, Walker and Berliner (2000) noted

that both treatment approaches were found to be equally effective in reducing children's sexual behaviour problems at two-year follow-up. However, Saunders et al. in their report noted that only one evaluation on the program had been conducted.

Cognitive Processing Therapy (CPT)

Another example of a cognitive-based program is referred to as Cognitive Processing therapy. It is a brief cognitive-behavioural treatment designed to treat posttraumatic stress and other associated features (e.g., depression) (Resick & Clum, 2004). CPT consists of 12-16 weekly sessions that involve exposure to the traumatic memory and training in cognitive restructuring. CPT is based on exposure-based and cognitive therapies that are often used to treat trauma victims. The therapy is designed to help trauma victims "1) understand how thoughts and emotions are interconnected, 2) accept and integrate the traumatic experience as an event that actually occurred and cannot be ignored or discarded, 3) experience fully the range of emotions attached to the event, 4) analyse and confront maladaptive beliefs, and (5) explore how prior experiences and beliefs affected reactions and were affected by the trauma" (cited in Saunders et al., 2004, p. 37). Saunders et al. report that in a clinical study, in a group format for sexual assault victims, CPT was superior to wait list control for both PTSD and depression at post-treatment and at a 6-month follow-up (Resick & Schnicke, 1992). Again, Saunders and his colleagues classified the program as supported and acceptable but not efficacious for maltreated children.

Eye Movement Desensitisation and Reprocessing (EMDR)

EMDR is a relatively new multi-component brief (2-3 sessions) therapeutic approach for the treatment of traumatic memories and PTSD. According to Shapiro (2001), EMDR integrates elements of many effective psychotherapies, including psychodynamic, cognitive behavioural, interpersonal, experiential, and body-centred therapies. EMDR is an information processing therapy and uses an eight phase treatment approach. The therapy claims to restart and facilitate blocked processing of the traumatic memory, to promote more adaptive cognitions in regard to the trauma to establish alternate positive cognitions, coping strategies and adaptive behaviours (Chemtob, 2004). The theory of EMDR is grounded in adaptive cognitive network theories of learning and emotion and argues that traumatic memories are not fully assimilated into a person's pre-existing cognitive schemas and thus exert a

disequilibrating influence on subsequent information processing. During EMDR the client attends to past and present experiences whilst simultaneously focusing on an external stimulus and the client is instructed to let new material become the focus of the next set of dual attention (Shapiro, 2001).

The first phase of EMDR involves a history taking session, followed by a second phase that identifies whether the client has adequate methods of handling emotional distress and good coping skills. If further stabilisation is required or additional coping skills are needed, these are worked on before undertaking the next treatment phase. In the following three phases (3 to 6), a target is identified, and this involves the client identifying the most vivid visual image related to the memory and the related emotions and body sensations. At the same time the client also identifies a preferred positive belief. After this, Shapiro explains, the client is instructed to focus on the image, the negative thought, and body sensations while simultaneously moving their eyes back and forth, following the therapist's fingers, for a period of 20-30 seconds or more. Eye movements are the most commonly used external stimulus but other stimuli include auditory tones, tapping or other types of tactile stimulation. During this process, which is repeated several times, the client is instructed to just notice what happens and then is instructed to let their mind go blank and to notice whatever thought, feeling, image or memory comes to mind. When the client reports no distress related to the targeted traumatic memory, the therapist then asks the client to think of the preferred positive belief and to focus on this while again engaging in the eye movements. During the seventh phase, the client is asked to keep a journal to document any related material that may arise. In the final phase, the clients undergo a re-evaluation of all of the previous work and discuss their progress. According to Shapiro, after EMDR the clients generally report an elimination of, or a great reduction in, the emotional distress related to the memory and that they have gained important cognitive insights. Finally, Shapiro asserts that it is the emotional and cognitive changes in the clients that generally result in spontaneous behavioural and personal change.

EMDR theory proposes that an intrinsic self-healing mechanism is activated by the EMDR procedure and that this accounts for rapid treatment related changes, but this proposition in regard to the actual mode of action has not been confirmed

(Chemtob, 2004). Many studies have been conducted with other populations which have shown very positive outcomes in relation to processing trauma associated with war veterans, disaster-related PTSD and rape victims (Rothbaum, 1997), but Saunders et al. (2004) reported that only a few controlled studies have been conducted on EMDR with traumatised children or adolescents. They reported that compared to a wait-list condition, three sessions of EMDR was effective for disaster-related PTSD (Chemtob, Nakashima, & Carlson, 2002). Another study of conduct-disordered children found that EMDR produced superior results on measures of memory-related distress (Soberman, Greenwald, & Rule, 2002) as well as other outcomes including problem behaviours. Again, Saunders and colleagues refer to EMDR as a supported and acceptable therapy but not efficacious for maltreated children.

Abuse-focused Cognitive Behavioural Therapy (AF-CBT)

Individual Child and Parent Physical Abuse-focused Cognitive Behavioural Treatment, also referred to as Abuse-focused CBT, is another treatment specifically designed to target beliefs and attributions about abuse and violence (Kolko, 2004). The treatment of between 12 and 16 sessions also aims to teach skills to children and parents to enhance their emotional control and reduce violent behaviour. Again, this approach uses cognitive behavioural techniques but with a specific abuse focus. Both child and parent have different therapists who implement parallel protocols based upon social learning principles. The child treatment components include introduction to models of stress and CBT; understanding and cognitive processing of the child's hostility/violence and abusive experiences; psychoeducation about child abuse laws, child safety/welfare and common abuse-related attributions; training in affect identification, expression and management skills (e.g. relaxation training and anger control), coping skills discussions and training to address everyday problems; and, development of social support plans and interpersonal skills training to enhance social competence. The parent treatment components include introduction to models of stress and CBT; understanding family contributors to coercive behaviours; cognitive processing/challenging of caregiver's views on hostility/violence, child-related developmental expectations, and attributions that may promote coercive interactions; affect-regulation interventions to manage reactions to abuse-specific triggers (e.g. escalating anger, anxiety, depression); training in behaviour

management principles and techniques to promote use of non-physical but effective disciplinary practices; and, discussion of, or training in, any of the procedures described in the child treatment components.

The individual and family approaches in AF-CBT were evaluated in comparison to routine community services (RCS) in a clinical trial that evaluated key outcomes through a one year follow-up assessment (Kolko, 1996). Kolko reported that both the individual CBT and family therapy conditions reported greater improvements than RCS on certain conditions (i.e. less child-to-parent aggression, child externalising behaviour), parents (child abuse potential, psychological distress, drug use) and family outcomes (i.e. less conflict, more cohesion). Saunders et al. refer to this program as a supported and acceptable therapy but not efficacious. However, recently, the Chadwick Center for Children and Families report (2004) considered Abuse-focused CBT (AF-CBT) to be one of three intervention protocols as a "best practice" intervention for the treatment of child abuse. The report argued that one of the most robust caregiver outcomes has been in the area of parenting skills or practices specifically: "increased use of positive management practices and reductions in the use of harsh or coercive discipline" (p. 13). The authors of the report also commented that, despite the demonstrated efficacy of this intervention, it has not yet been widely used in America to assist abused children and their families.

3.2.1.4 Trauma counselling

The majority of children that enter care do so as a result of a single or series of traumatic experiences such as abuse and/or neglect. In recent years, a large part of the work done by therapists is focused on helping people affected by traumatic experiences through trauma counselling. In the last three decades trauma-caused psychological reactions, including post-traumatic stress disorder, have been studied extensively, and this research has lead to developments in therapy (Spiers, 2001). Trauma counselling is similar to any other general form of counselling in that it is conducted between an individual and a therapist or in a group therapy context. Furthermore, in contrast to psychotherapy, trauma counselling is conducted from an empathetic, client-centred and non-judgemental perspective. Trauma counselling has become a common component of therapeutic intervention in out-of-home care treatment programs because it has been recognised that behavioural programs only

act to reduce symptomatic behaviours rather than necessarily address the psychological problems often underlying problematic behaviours.

The majority of trauma counselling programs share many fundamental assumptions. The first is that superficial or overt problems and behaviours can only be addressed by examining problems that occurred previously and helping the individuals come to terms with the past trauma. Therapists will therefore encourage the individuals to discuss their previous experiences and how they may have led to their current circumstances. The therapist also helps them understand why and what happened to them and how this can affect the way that they function today. Furthermore, the therapist helps the individual understand that they need to come to terms with the past experiences so that they are able to function better now and later in life.

Saunders and colleagues refer to several trauma-based interventions in their extensive review of programs for physically and sexually abused children including: Trauma-focused Cognitive-Behavioural Therapy (TF-CBT); Trauma-focused Integrative-Eclectic Therapy (IET); and Trauma-focused Play Therapy (discussed in next section).

Trauma-focused Cognitive Behavioural Therapy (TF-CBT)

According to Cohen and Deblinger (2004), Trauma-focused CBT is an intervention based on learning and cognitive theories designed to reduce children's negative emotional and behavioural responses related to abuse experiences. It also provides support and training to non-offending parents in coping and parenting skills. The treatment components include: psychoeducation about child abuse; gradual exposure techniques of abusive events (i.e., utilising dolls, puppets, etc.); cognitive reframing, consisting of exploration and correction of inaccurate attributions about the abuse; stress management techniques; parental participation in parallel or conjoint treatment; parental instruction in child behaviour management strategies; family work to enhance communication and create opportunities for therapeutic discussion regarding the abuse. Cohen and Deblinger report that Trauma-focused CBT has been used in individual, family and group therapy and in office-based and school-based settings. Furthermore "it has been proven effective for children exposed

to a variety of traumatic events and has received the strongest empirical support from studies with abused children" (American Academy of Child and Adolescent Psychiatry, 1998, cited in Saunders et al., 2004, p. 49). According to Saunders et al., it was classified with the highest rating of all 24 program reviewed in their report and is considered as a well-supported and efficacious treatment model for physically and sexually abused children (see Saunders et al. review for all outcome studies). The Chadwick report (2004) also considered TF-CBT as one of three "best practices" interventions for the treatment of child abuse. The report stated that "TF-CBT has proven to be an efficacious treatment for PTSD symptoms for sexually abused children" (p. 9).

Trauma-focused Integrative-Eclectic Therapy (IET)

Another example of a trauma based treatment model is Trauma-focused Integrative-Eclectic therapy (IET). According to Friedrich (2004), IET "is a psychosocial intervention based on data suggesting that persistent effects of trauma and maltreatment are best understood as a function of both the child and the child's relationships and living context" (p. 52). IET draws on the principles of developmental psychopathology and Parent-Child Interaction Therapy (PCIT, discussed in detail later in Chapter) principles. The components of treatment include coordinated treatment plans, specific goals in areas of parent-child attachment and safety in the home, enhancing parent-child relationship via child-directed interaction, correcting inaccurate perceptions the parent has of the child, teaching alternate strategies for coping including relaxation, imagery and self-talk and teaching parents developmentally appropriate behaviour management strategies (Friedrich, 2004). According to Saunders and colleagues, IET is a supported and acceptable treatment model but is not considered efficacious due to the lack of evaluation studies.

3.2.1.5 Activity scheduling (e.g., play, art, music therapy)

Activity scheduling is another treatment approach that forms a large part of treatment programs for many children in out-of-home care who have been victims of abuse. Some of the more common approaches that are utilised include play therapy, art therapy and music therapy. These techniques rely on the children's natural means of expression, such as play, and this is then used as a therapeutic method to assist them in coping with emotional stress or trauma. Play therapy, in particular, has been

employed by therapists for many years and is often combined with Freudian psychoanalytic child therapy. Psychoanalytic play therapy was introduced into the psychological arena because therapists could not rely on the verbal communication skills of young children and the combination of the two approaches enabled the therapist and the patient to understand and work through the child's problem (Morris, 1976). Play therapy is today recognised as a developmentally appropriate intervention for children experiencing a broad range of problems, especially psychic trauma, and was originally introduced by Virginia Axline in the 1940s. Play therapy can be implemented in a variety of formats including sensorimotor, art, fantasy, and game play (Hall, Kaduson, & Schaefer, 2002). Play therapy has also been applied to initiate change and help children in transition, especially those children experiencing multiple moves in the care system. Play therapists use the therapeutic powers of play (e.g. relationship enhancement, role-playing, catharsis, attachment formation, etc.) to help clients prevent or resolve psychological difficulties (Hall et al., 2002). The therapists believe that this method allows the child to manipulate their world on a small scale. Therefore, by playing with specially selected materials (e.g., crayons, painting supplies, dolls and figures of various sizes and ages, toy cars, toy guns, stuffed animals) and with the guidance of the therapist, the child can play out their feelings, bringing them to the surface where they can face them and cope with them. The therapist also works from a non-judgemental, non-punitive position and creates an environment whereby children feel safe to express themselves in any manner they wish.

Research on play therapy has proven that the approach is an effective intervention for a broad range of children's problems (behavioural and emotional disturbance, depression, anxiety and social maladjustment), in various settings and across modalities, age and gender (Ray, Bratton, Rhine, & Jones, 2001). Many researchers have also demonstrated the effectiveness of play therapy for a variety of ages. For example, Johnson and Nelson (1978) reported that male juvenile delinquents who participated in counselling involving the use of a role-playing simulation game, a variant form of play therapy for older children, demonstrated an increased willingness to communicate. Wong, Morgan, Crowley & Baker (1996), with a small sample of 16-17 year old conduct disordered males, demonstrated that a table game "Stacking the Deck" improved the social skills of the boys; however, no

generalisation of trained skills was tested outside of the therapy setting. Recent outcome research indicates that therapeutic gains are maximised when the parents are actively involved in the treatment and when an optimal number of sessions is provided to the family (Hall et al., 2002).

Trauma-focused Play Therapy

Trauma-focused Play therapy is a model of treatment that uses play but also focuses on the traumatic event. It is a psychotherapeutic intervention that allows abused children to use symbols (toys) in play to externalise their internal world and to process potentially overwhelming emotional and cognitive material from a safe distance (Gil, 2004). Trauma-focused play therapists carefully select toys that will enable the child to recreate literal elements of the trauma experience, so as to provide children with a naturalistic way to reveal the traumatic experience. The treatment components include: selection and display of appropriate toys based on the particular child's traumatic situation; observation and recording of the child's post-trauma play; assistance with clarification, processing of idiosyncratic meaning, affect discharge, sequential organisations and integration of difficult cognitions and affect; assistance with child's anxiety and coping mechanisms; provision of parent support and education; collateral individual therapy for parents. No outcomes studies have been conducted to date but Saunders et al. considered it to be a promising and acceptable treatment model.

Despite these positive features, play therapy has also been criticised by many researchers. For example, Moreno (1985) points out that too much of the theory of play therapy seems to be based upon pragmatic judgements rather than evaluations. Furthermore, Moreno (1985) points out the "self-healing" nature of play, but that the process and the basic structure of play therapy and the reasons for its effectiveness remain unclear. As a result, the therapy may be difficult to implement and replicate in the same manner on each occasion.

Art and music therapy is another expressive form of treatment that enables children and youth to get in touch with their emotions and assists them to begin to deal with emotions and past experiences. Both therapies have a modern history of being used in the treatment of children who are mentally, physically or multiply

handicapped (Aldridge, Gustroff, & Neugebauer, 1995). Music therapy stimulates children without language and encourages them to communicate and helps to promote development. The theoretical basis for the therapy rests on the fact that at birth, children are most responsive to the human voice through hearing, and the theory proposes that such a relationship is essentially 'musical' (Aldridge et al., 1995). Furthermore, Aldridge et al. assert that "rhythmic interaction is important for the development of language and social communication in the infant" (p.198). For example, Aldridge et al. (1995) researched 12 children who were randomly allocated into two groups. The treatment group received individual music therapy and a non-treatment group served as a waiting-list control group who received therapy after three months, while the previously treated group had a break from therapy. The approach used in the study was based on Nordoff and Robbins (1977) design that is based primarily on the musical relationship where a child is encouraged to play, while accompanied by a therapist, on a variety of instruments, and also to sing or vocalise. The children in the treatment group demonstrated an improvement in hearing and speech, hand-eye coordination and personal-social interaction. However, music therapy is still subject to some scepticism because of the lack of empirical evidence for its effectiveness as well as a lack of a clear theoretical foundation.

3.3.1 Family, parent-child, parent-focused interventions

3.3.1.1 Attachment therapy

As discussed earlier in Chapter 1, attachment refers to the enduring ties that children form with their primary caregivers during early development (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969). Importantly, it is the quality of these earliest relationships that lays the foundation for later psychosocial and cognitive development (Bowlby, 1969; Fahlberg, 1991). The healthy early development of attachment relationships plays an important role in the psychological development of children and young people. According to Delaney (1998) and Levy and Orlans (1998) effective attachments enhance conscience development, the ability to empathise with others, the ability to trust others, inner feelings of security, the ability to express a range of emotions and the internal regulation of emotions and impulses. Children develop healthy attachment relationships when they are provided with an environment that is consistent, predictable and safe and where they freely receive

physical affection, comfort and protection. This type of environment facilitates the development of a sense of security, the ability to trust in caregivers and the feeling of competence and self control (Fahlberg, 1991; Levy & Orlans, 1998).

On the other hand, insecure attachments form when children are abused and/or neglected by their primary caregivers, are subject to chronic or abrupt separations from their primary caregiver, or are exposed to multiple changes in caregivers without the opportunity to develop attachment (Delaney & Kunstal, 1997; Levy & Orlans, 1998). As a consequence of such earlier negative experiences, various forms and degrees of psychological impairment may result, often referred to in the literature as 'attachment disorder'. For example, many young people may feel rejected and worthless and may not have the ability to form productive relationships with others. Young people may also be unable to regulate or control their own emotions, behaviours and impulses. They may also be incapable of understanding the emotional needs of others and themselves (Diagnostic and Statistical Manual of Mental Disorders, 1994). Accordingly, these children many present as either very withdrawn or mistrustful, or conversely, overly controlling and demanding due to their inability to negotiate with others, or understand what should be expected of others. Others may be lacking in empathy or indiscriminately affectionate (absence of stranger anxiety) (Delaney, 1998) because they have not learnt to differentiate between adults in general and appropriate attachment figures. Levy and Orlans (1998) also pointed out that many children may display temper tantrums or other uncontrollable displays of emotion, as well as engage in aggressive antisocial or impulsive behaviours, or even self-harming behaviours.

Attachment therapy therefore aims to address the early trauma experiences of the child and address the resulting consequences of the early negative attachment relationships. Through the process of therapy, they are taught to regulate their emotions and behaviours and develop more productive and fulfilling relationships with other people (Hughes, 2004). Therefore, the aim of therapy is to help the child form the emotional attachments that they did not form in their early years and to re-establish trust and begin to repair damage to the child's ability to experience intimacy and appropriate interaction with others.

In recent years, the term “attachment therapy” has been subject to considerable controversy, as it has often been associated with unorthodox forms of interventions such as “holding therapy”. Holding therapy refers to a process of physically restraining children who are unable to control their behaviours or who are unwilling to be held or receive any form of physical contact from an adult. The theory behind the intervention is that the “therapists” believe that children are only able to “resist” holding for a certain period of time, after which they eventually submit and therefore become more responsive to interactions with others. The process has been criticised, as many practitioners argue that the child usually submits due to them no longer having the energy to fight or resist as opposed to the child realising that they have nothing to fear when their usual defences are removed. Also, in the case of the notorious Evergreen treatment model in the United States, the use of holding therapy was implicated in several child deaths (Mercer, Sarner, & Rosa, 2003). Nevertheless, many agencies argue that holding therapy is an effective method for treating attachment disorder and the approach is used in many agencies throughout America. Saunders et al., in their review of treatment programs for abused children, gave this particular treatment model the lowest rating as it considers this model to be a potentially dangerous treatment.

As indicated by Moretti et al. (1997), attachment therapy does not specify that any single style of intervention is best at addressing the varied needs of adolescents with emotional or behavioural disorders. Rather, the purpose is to emphasise the importance of parent-child relationships and how the low quality of such relationships can impact greatly on the development of a wide range of social, cognitive and emotional impairments. Moreover, this actuality must be taken into account in the design of appropriate interventions for children with attachment disorder.

There are many theoretically grounded approaches for children and young people with attachment disorder. The theoretically grounded approaches to attachment disorder recognise that the disorder is complex and multifaceted with behavioural, emotional, social and cognitive components (Beck & Michaels, 2004). Moretti et al. (1997) argue that interventions need to be diverse and individually tailored to meet each child’s particular needs. Therefore, the therapist and caregiver

need to create an environment in which the young person feels protected and cared for to reduce their anxiety and uncertainty and to know what is expected of them. As opposed to behavioural modification techniques that involve strict duties and obligations, attachment therapy focuses on providing the young person with opportunities and choices, as attachment disordered children do not generally respond to the same rewards as other children. In most cases, attachment disordered children are motivated by a desire to manipulate and control the behaviour and feelings of others. This symptom is likely to have arisen from few limits being previously placed on their behaviour, or because they are unable to place their trust or safety in the hands of others. For that reason, a better strategy is to encourage appropriate behaviours by giving children additional privileges and opportunities when they engage in appropriate behaviours.

There is evidence to suggest that patterns of attachment can change and can be influenced by a variety of factors. According to Thompson (2000), these factors can include changes in family stresses and living conditions, changes in the quality of parental care, and changes in secondary attachment relationships. However, treating attachment disorder can be a difficult and long-term process. Furthermore, few empirical studies have been conducted on treating the disorder (Zeanah & Boris, 2000). Traditional forms of therapy have proved ineffective as they rely on the child's ability to form relationships, which is something the majority of children are unable to do. Rather, therapy that encourages the development of physical touch, eye contact and safety with the child's primary caregiver have shown to have beneficial effects on children's behaviour and social interactions (Hughes, 2004). Cognitive-behavioural interventions have also proven effective when the therapist targets symptoms that stem from the experiences of abuse (Hanson & Spratt, 2000). For example, Hughes (2004) states that cognitive-behavioural interventions have proven to be effective in helping some children resolve the effects of trauma and other psychological symptoms but are more likely to be beneficial if they follow the interventions that establish the conditions of safety, co-regulation of affect, and co-construction of meaning (see his paper for detailed review on Dyadic Developmental Psychotherapy).

Other reviews suggest that therapy can only be attempted once the child's environment has been stabilised (O'Connor & Rutter, 2000; Steinhauser, Osmond, Palmer, MacMillan, & Perlman, 1999; Zeanah & Boris, 2000). However, since the majority of children suffering from the disorder often exhibit extreme conduct problems, they are more prone to placement instability (Steinhauser et al., 1999). Children with attachment disorder will respond positively to a safe, consistent and predictable environment with clear boundaries, expectations and routines and this must be established prior to therapeutic intervention with the child. Therapeutic intervention needs to be presented in a non-directive or non-authoritarian manner, with a focus on providing the young person with opportunities and choices so that they do not feel pressured or threatened. Children with attachment disorder do not respond to the same rewards as other children and are generally motivated by a desire to manipulate and the control the behaviours and feelings to their own benefit and needs (Hughes, 1997). Rather, the children respond better to a process whereby they are taught the consequences of their actions and behaviours through drawing attention to the benefits and disadvantages (i.e., not being able to watch television until their homework is done). In this way, they learn to enjoy certain activities so that these activities can later be used as reinforcers (Hughes, 1997). Therefore, it is important to encourage appropriate behaviours by providing children with additional privileges and opportunities for them to engage in appropriate behaviours (e.g., being allowed to stay up later if they clean their room). Furthermore, problematic or inappropriate behaviours can be treated in a similar manner. For example Levy and Orlans (1998) suggest that if a child breaks items in the home, they should be told to do extra chores to cover the cost of the items. This approach to the behaviour assists the child to understand the link between the behaviour and the consequences of that behaviour.

A fundamental element of attachment therapy is to teach the child empathy and emotional regulation two parts of social development that the child with attachment disorder often fails to acquire. During therapy it is imperative that the child goes through a process of self-reflection whereby they are better able to understand their own actions and also understand how certain behaviours influence the emotional states for others. Also during this process they are taught self

regulation of their own emotional expression and to recognise what is appropriate or inappropriate behaviour with certain people and in certain environments.

Fahlberg (1991) has also commented on the importance of teaching young people to engage in positive interactions and activities undertaken on their own whereby they learn how to gain satisfaction from their own actions as well as doing things with others. Fahlberg suggests this can be achieved by creating activity schedules or by providing special outings, playing games, or getting the child involved in team activities or sports. By engaging in activities that the young person is interested in, the expectation is that their confidence in their own abilities will increase in conjunction with their level of trust in other people. Also, their level of ability to interact with others without the need to manipulate or control them is also likely to improve.

James and Sitterle (2004), in Saunders et al.'s review, discuss a multidimensional intervention referred to as Attachment-Trauma therapy model. This model is similar to Hughes' model described above. The therapy is based on the premise that children need to experience safety in an attachment relationship in order to adequately cope with traumatising experiences (James & Sitterle, 2004, p. 59). The treatment components include psychoeducation about attachment, development, trauma, adaptive and survival behaviours; directed positive affective and sensori-motor activities between caregiver and child in session and at home; use of drama, metaphor, and movement interventions; stress management and focusing techniques, including yoga, deep breathing, muscle relaxation and imagery; cognitive and expressive arts interventions; family play and behavioural interventions; focused trauma-loss work using play therapy; family ritual and commemoration interventions when a relationship has been lost. A treatment manual is available but no outcome studies have been conducted on this model. Saunders et al. concluded that this is a promising and acceptable approach.

It must be recognised that attachment disorders are complex and can arise from a variety of traumatic experiences. As such, interventions need to be individually tailored and sensitive to the child's age, needs and circumstances. As mentioned previously, attachment therapy, in contrast to behavioural approaches, are

more likely to address the problems underlying the behaviours, rather than just bringing the child's behaviour under control. Research has also indicated that a combination of attachment family-based therapy with cognitive-behavioural elements has proven to be effective in reducing anxiety and depressive symptoms in anxious adolescents (Siqueland, Rynn, & Diamond, 2005).

3.3.1.2 Milieu therapy

The term milieu therapy is another common form of therapy mentioned in descriptions of treatment programs for children and young people in out-of-home care. Milieu therapy has its roots in the therapeutic community movement, which stressed the role of social relationships in the development, maintenance and amelioration of mental illness and its symptoms. Many of the governing principles of milieu therapy are derived from Freudian ideas concerning ego-enhancement and the importance of the development of a functional sense of self through interacting with others. Milieu therapists work with clients and encourage them to practice new ways of engaging with others and the world. The therapists also help clients to recognise existing ego resources and to expand and strengthen them. Therefore, there is no specific form of intervention; rather, it is an overall approach to improve people's capacity to socially and physically adapt to the world. Thus, milieu therapy is defined as a type of treatment in which the child's social environment is manipulated for their benefit. One form of this therapy is referred to as the "therapeutic community" whereby the children live at a residence (commonly a residential or institutional setting) that has a highly structured and planned environment designed to enhance the development of the individuals (Sanders & Duncan, 1995). The concept of the "therapeutic community" originated in psychiatric settings where it was claimed that patients required a continuously structured, predictable environment that enabled them to realise their own potential and develop effective relationships with others. This form of therapy has been proven to be effective for at-risk youth who have severe disorders that impair or limit their ability to function in a normal living environment. The design of the therapeutic community has a focus on both specified routines and activities and on personal growth and reflection. The milieu or "life space" provides the client with a safe environment that is full of learning opportunities and immediate feedback and reinforcement from staff. In this

environment, the individuals are encouraged to talk about their emotions, difficulties and choices, and this may occur in an individual or group therapy context.

A governing principle of milieu therapy rests on the assumption that a client's difficulties are both expressed in, and arise in, relationships with other people. A second principle or belief is that therapy is a learning process that involves both the client and staff. As such, for a therapist to be effective they must be personally available to be affected by their interactions with the client. Therefore, the therapeutic process is essentially a self-reflecting teaching design and rests on the understanding that both client and staff share the same psychological processes and can learn from one another. The therapeutic team and clients also meet on a regular basis (at least weekly) to discuss the client's progress and establish future plans. This forum also allows clients to share experiences and learn from one another.

Since the design of milieu therapy can be quite flexible, depending on the client's needs, it can take many forms, and every component described above does not necessarily need to be present for a program to profess the use of this approach. For instance many programs claim that they provide a therapeutic milieu for their clients but do not adhere to any Freudian theories or use the group counselling and self-reflection depicted above. In such cases, changes observed in the children may be due to them being placed in a safe and nurturing environment that is free of abuse and unhealthy peer influences rather than as a direct response to the other therapeutic components of milieu therapy. Furthermore, the general assumption of milieu therapy that people may develop better social skills by interacting with others in a safe and predictable environment is an instinctively obvious one that could be easily justified using other theoretical explanations (for example, social learning theory) that make no reference to deeper processes (i.e., processes involving the internal conflicts arising from early childhood).

Overall, milieu therapy appears to offer an important focus on skill development and resolution of past traumatic experiences. Nevertheless, there are inherent problems with milieu therapy particularly in the context of campus-based residential programs. In such contexts, the design of the therapy is such that it requires a strict adherence to the provision of a very stable social and physical

environment, something that may not be able to be provided in these particular environments at all times. As the majority of residential programs have rostered staff and often a very high rate of staff turnover, many of the young people in such programs exhibit unpredictable and changeable behaviour. For these reasons, the idea of creating a stable and predictable environment may be very difficult to achieve in these circumstances. Additionally Van der Ven (1998), suggests that the very controlled environment of many residential programs may act to have the opposite effect on the children's behaviour. For example, Van der Ben asserts that it may result in an intensification of problematic behaviours and resentment towards authority figures.

Sheehan (2004), in the review by Saunders et al. (2004), discusses a milieu based intervention , the Therapeutic Child Development program which is an intervention for maltreated preschool children that aims to reduce risk factors and enhance protective factors through providing a safe, consistent, monitored environment. The duration of treatment can span from months to years. The treatment components include transportation of the child to and from the program each day; treatment milieu environment of 9 to 15 children; emotionally-attuned and responsive caregivers; developmental therapies (i.e., physical therapy, special education, speech therapy); case management; parent education and support groups; and applied parenting instruction. The program is run by Childhaven Incorporated agency in Alabama. Sheehan (2004) reported that in a long-term follow-up, the treated children were significantly less aggressive, had fewer internalising problems, were less frequently arrested for violent and non-violent crimes, and were often less identified as violent by caregivers (see Moore, Armsden, & Gogerty, 1998). However, according to Saunders and colleagues, more evidence is required to support the efficacy of this model.

3.3.1.3 Personal and Social skills training

The majority of therapeutic interventions for both children and adults have elements related to the development of appropriate social behaviours. This is important, considering that children with peer problems are at risk for future impaired social functioning (Evans, Axelrod, & Sapia, 2000). As such, today more and more programs, especially for children in out-of-home care, employ specialised

interventions relating to specific forms of behaviour, social skills and social interaction. Some of the more common examples include anger management, social skills training, personal skill development, and assertiveness training. Many of these interventions use behavioural principles, but there is a much greater focus on the development of skills and strengths of children rather than controlling or removing problematic behaviours. Furthermore, these interventions generally do not subscribe to just one theoretical model but often incorporate a broader range of theoretical approaches, including cognitive therapy, social learning theory and general counselling techniques.

Many out-of-home programs today utilise anger management training as just one part of their intervention with the children, and it can be provided in a variety of formats. In conventional behaviourally-based anger management programs, the therapist generally assists the client with recognising the nature, causes and consequences of their anger and then helps identify situations when the person is vulnerable and identifies strategies and techniques to overcome their anger. For instance, the techniques might include simple relaxation, behavioural, or social methods for dealing with the situation and their anger. Furthermore, the therapist might teach the client the connection between anger, breathing control and physiological arousal and that the client can learn to avoid the escalation of their anger by relaxing, taking deep breaths or simply by counting to ten before making a response. The therapist may also use social learning strategies such as role-playing, modelling and rehearsal to teach the client effective and appropriate ways to respond in anger-inducing situations. The client may practice such strategies with the therapist or may practice in a group therapy context with others who share similar problems.

On the other hand, cognitive approaches may assist the client to understand the ways in which the person perceives anger-inducing situations and the thoughts that lead to the aggressive behaviour. Often individuals who struggle with the management of their anger interpret situations in a way that evokes angry responses and they perceive situations or responses by others as more threatening or insulting than really is the case. Therefore, cognitive therapy helps the client recognise and understand the thought patterns that lead to aggressive responses and assists them

identify ways to negate or distract them before the anger escalates. As with the behaviourally-based approaches, cognitive approaches can also be provided in one-on-one therapy consultations or a group therapy context with others suffering from similar problems.

Unfortunately, an inherent flaw or limitation of this type of therapy is that it is assumed that the strategies and techniques learnt in the therapy context have been learnt by the children and will be generalised to other situations. In addition, many children and young people often quickly learn the appropriate responses that they know the therapist wants to hear but fail to internalise any of the learnt strategies and do not make any genuine commitment to alter their behaviour outside of the therapist's office. Therefore, the gains that the therapist sees in the client may often be a false indication of the efficacy of the program.

Similar methods as those described above are often used to enhance young people's general social functioning. Yet, the intensity of any social skills training program will vary depending upon the child's age, mental capacity and the nature of the young person's behaviour. As such, programs designed for very young children generally focus their training on very simple behaviours, such as being able to produce appropriate emotional responses (e.g., making eye-contact, taking turns in conversation and in tasks, sharing toys with other children, controlling tantrums or being able to ask for assistance when required). By contrast, programs for older children commonly focus on improving communication skills (e.g., how to talk respectfully to adults, how to make requests or express certain ideas or how to initiate conversations and keep them going). There may also be a greater emphasis on limit setting or "boundaries" of behaviours, including appropriate standards of personal attire or personal hygiene for different situations; appropriate emotional or physical boundaries (who can be approached, touched or contacted), and an understanding of social rules and obligations (e.g., what is impolite, inappropriate, or selfish). Central to this approach is enabling the young people to come to terms with their own emotions and the emotions of other people so that they are able to fully develop socially. Therefore, individual or group therapy sessions will assist young people to feel comfortable in being able to articulate their problems and emotions rather than to act them out.

Another very important approach for teaching young people appropriate social behaviours is through the process of social learning or role-modelling, in which young people are placed into a safe-predictable environment in which they are able to observe adults engaged in appropriate social interactions (see milieu therapy, above). Bandura (1977), one of the main proponents of social learning theory, asserts that human beings learn by observing others. Thus, the aim of social learning or role-modelling is to expose the child to situations and experiences whereby they begin to learn and understand the way people should interact and behave towards one another. Furthermore, during this process, the child is also given opportunities to demonstrate and practise the social skills observed in others, and subtle reinforcements (praise, positive affective responses) can be used to encourage repetition of these behaviours. Through this process, the young person may then come to believe that he or she is capable of interacting with others in a way that evokes positive responses (Bandura, 1977).

A further common component of social skills training programs involves an emphasis on assertiveness training (Thompson, 2000; Wise, Bundy, Bundy, & Wise, 1991). The function or objective of assertiveness training is to teach young people to recognise their rights and obligations and how to interact effectively with other people so as to protect their own interests. Many of the programs were designed to help young children learn how to protect themselves from bullying, especially in the school environment, but there is also a focus on enabling the child to interact with others in an appropriate and non-aggressive manner. The majority of programs provide the children with clear guidelines concerning the appropriate rights and obligations of young people and why it is necessary for people to assert themselves on occasion. In some cases, the children may be provided with presentations and role play activities (via slides, videos or cards) that set out situations where assertiveness might be required (e.g., one needs to ask for the return of property, or refuse an invitation to engage in an activity that is potentially harmful). Furthermore training may involve the discussion of responses or response styles that are most effective or least effective in dealing with the situation concerned. Role-playing exercises are provided that allow young people to practise effective responses and, in particular, how to develop the correct phrasing and intonation that make it convincing and sufficiently assertive. Some programs (e.g., Thompson, 2000) achieve this by

videotaping or audiotaping young people's responses (or those produced by others engaged in role-plays) and asking participants to listen to the responses and comment on how they might be improved.

An additional important program element combined with general social skills training is teaching young people self-discipline and about the obligations and responsibilities that they owe to themselves and to others. For example, during the time children in out-of-home care progress toward emancipation and independent living, it is important that they develop basic living skills as well as learn how to share duties and responsibilities with other people. Several programs, principally those involving young people about to leave care, specialise in life-skills training, but these skills are also developed and encouraged in more general programs in residential care or home-based care. The design of such programs is to set up well-formulated daily routines in which young people are given specific tasks or obligations that they are expected to perform. These tasks might include cleaning their room, completing their homework, cleaning the house or dishes, engaging in activities with others, or completing specific courses of therapy or education. All of these activities will be set out in terms of very detailed daily activity schedules or rosters, combined with explicit statements about what is expected of each individual residing in the home. The program objective is to help young people learn how to function effectively, not only as an individual but also with others and as a member of their community.

3.3.1.4 Parent-Child Interaction Therapy (PCIT)

In recent years, Parent-Child Interaction therapy (PCIT), an empirically-supported therapy, has been introduced as a treatment for young children (2 to 8 years) who have suffered abuse. According to Urquiza (2004), PCIT theory is predicated on the assumption that there are many underlying factors that contribute to the development of physically abusive families, and the foremost factor is the nature of the parent-child relationship. "Abusive parents are characterised by high rates of negative interaction, low rates of positive interaction, and limited and ineffective parental disciplining strategies" (Urquiza, 2004, p. 80). The theory which underlies PCIT was developed by Sheila Eyberg and is based on Baumrind's development research that examined the association between parenting practices and

child outcomes. The aim of the therapy is to place a new emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Baumrind's developmental approach identified the importance of parents meeting young children's dual needs for nurturance and for limits, which she described as 'authoritative parenting' (Baumrind, 1966). Baumrind's research showed that to enhance child outcomes, a therapy must focus on promoting optimal parenting styles and parent-child interactions. PCIT therefore draws on both attachment and social learning theories to facilitate the development of a more authoritative style of parenting. As discussed previously, attachment theory asserts that sensitive and responsive parenting provides the foundation for the child's sense of knowing that he or she will be responded to when necessary. As a result of this, children are then more likely to develop a secure sense of their relationships and more effective emotional and behavioural regulation.

The first phase of PCIT is Child-Directed Interaction (CDI), which aims to restructure the parent-child relationship and provide the child with a secure attachment to his or her parent. The CDI phase is similar to play therapy in that parents engage with their children in play to help strengthen their relationship with the child. The second phase of PCIT is based on social learning theory and emphasises the contingencies that shape interactions of conduct-disordered children and their parents; referred to as the Parent-Directed Interaction (PDI). The PDI phase specifically aims to address the processes by which contingencies are established and maintained and aims to establish consistent contingencies for child behaviour. The duration of treatment is usually 12 sessions, six sessions on relationship enhancement and six sessions on disciplinary practices. PCIT is a step-by-step, live-coached behavioural parent training model. It provides the parents with immediate prompts from the therapist in an observation room, who instructs the parent while they are interacting with their child through an ear-mounted receiver worn by the parent.

Research into PCIT has found statistically and significant improvements in the conduct-disordered behaviour of preschool children (Bell & Eyberg, 2002). In addition, other studies have documented the superiority of PCIT to waitlist control and to parent group didactic training (see Eyberg & Matarazzo, 1980). Positive outcomes have also been reported for the parents. For example, significant changes

have been noted on parent's self-report measures of psychopathology, personal distress, and parenting locus of control (Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). A recent study conducted by Ware, Forston and McNeil (2003) demonstrated the effectiveness of PCIT as a promising intervention for abusive families that offers an effective intervention to modify maladaptive parent-child interactions. Other researchers have also confirmed that PCIT treatment gains are maintained for several years post-treatment (Neary & Eyberg, 2002). In contrast, Funderburk, Eyberg, Newcomb, McNeil, Hembree-Kigin and Capage (1998) observed that behavioural gains which had generalised to the classroom setting immediately following treatment had generally reverted to pre-treatment levels by the 18-month follow-up. Saunders and colleagues (2004) concluded that PCIT was a supported and acceptable, but not efficacious, treatment model for physically abused children and their families. However, recently the Chadwick report (2004) concluded that PCIT was one of three intervention protocols that was considered as "best practice" for the treatment of child abuse. Authors of the report stated that "reductions in child behaviour problems related to PCIT have been found to be robust and durable over time, and generalisable from home to school environments" (p. 14).

3.3.1.5 Parent management training (PMT)

Today, there is a greater focus on the importance of including and assisting the biological parents of children in out-of-home care and improving the environment to which the child will be returning. For these reasons, parent management and parenting skills training programs now are a significant element of overall interventions to assist children. At the heart of behavioural parent training programs is a focus on teaching parents the skills that will enable them to change the antecedent events and consequences that are eliciting and maintaining problematic child behaviour (Skinner, 1959). Accordingly, the majority of such programs teach parents behavioural management techniques to assist them in managing the children's behaviours and also provide them with more appropriate and effective forms of communicating and disciplining the children. In a lot of the cases, the parents will also be asked to undergo both individual therapy and family therapy with the children. Through the inclusion of principles derived from Social Learning and Systems Theories, traditional contingency management techniques are now being

supplemented with methods which take into account parental cognition and which place the child within a systemic context (family and community). As a result, many programs today have a holistic approach to treatment and combine a variety of methods.

Kazdin, Esveldt-Dawson, French and Unis (1987) and Patterson and his colleagues at the Oregon Social Learning Centre (OSLC), after extensive work with children and their families, contributed to the generation of a treatment modality, referred to as “Parent Management Training” (Patterson, Chamberlain, & Reid, 1982). PMT is one of the most influential parent training programs. In this particular form of parental training, attempts are made to (1) reduce coercion, (2) reinforce desired behaviours through rewards, (3) emphasise monitoring of the child’s activities and tracking of their behaviour, (4) promote positive involvement with the child, and (5) teach problem solving skills (Reid, Patterson, & Snyder, 2002). The theoretical underpinnings of PMT include Coercion theory, Social Interaction theory and Operant theory. Coercion theory asserts that people with antisocial behaviours generally fulfil their social desires by treating other people negatively so that they gain advantage over others. Aversive behaviour is used to manipulate the social environment (Patterson, Reid, & Dishion, 1992), and people come to believe that this is the only effective way to interact with others. The therapists teach parents to pinpoint problematic child behaviours and to use positive reinforcement techniques such as praise or a points system. They also teach parents how to use discipline methods such as the removal of privileges and “time-out”. The therapists also teach parents negotiation and problem-solving strategies. The families work with the therapists for approximately 20 hours and the therapists will also make visits to the home to encourage the generalisation of skills.

Several studies have evaluated PMT. Firstly, Patterson, Chamberlain and Reid (1982) conducted a comparative evaluation of the training program, randomly assigning nineteen families (children aged 3 to 12 years) to parent training treatment which consisted of 17 hours of therapy, or to community referral. The children in the community referral group received active treatments from community-based practitioners. The study showed that children in the parent training treatment group were significantly less aggressive, and 90% of the parents in the parent training

group reported that treatment was “very effective” compared to 25% for the community referral group. Another study by Bank, Hicks Marlowe, Reid, Patterson & Weinrott (1991) looked at outcomes for families of chronic delinquents. Fifty families of court-referred youth under 16 years of age who had had two or more recorded juvenile offences were randomly assigned to a parent training treatment group at OSLC or a community comparison (intensive family treatment and other services). The OSLC group received treatment that was based on therapeutic techniques described in Patterson and Forgatch (1987) and Forgatch and Patterson (1989). The OSLC group displayed a much more rapid decline in the average number of offences but by two years there were no significant differences in the average number of non-status offences between the two groups. However, the OSLC group did spend fewer days in institutional confinement, although by the final follow-up, the difference was not significant. Still, between intake and termination, the OSLC group had significant reductions in antisocial behaviours and stealing as reported by their parents.

More recently, PMT has been modified to address delinquent adolescent problems, and the results from two studies have been encouraging. The participants showed both an improvement in behaviour and a reduction in rates of offending (Patterson & Forgatch, 1995; Webster-Stratton, 1991). Brestan and Payne (2004) reported that PMT, combined with Kazdin’s Cognitive-Behavioural Problem-Solving Skills Training (PSST) (see Saunders et al. for review), which is a manual based treatment for children with antisocial behaviour, was more effective at the follow-up assessment. Saunders et al. concluded that PMT was an accepted and supported treatment model but not necessarily efficacious.

3.3.1.6 The Incredible Years

The Incredible Years programs were developed by Carolyn Webster-Stratton for children (aged 2 to 10 years) who are highly aggressive, disobedient, hyperactive and inattentive. The program has also been used with parents at risk for abusing or neglecting their children. Patterson’s early work on child aggression strongly influenced the development of the Incredible Years program (Patterson, 1982). The program includes a parent, teacher and child training series that is designed to promote social competence and prevent, reduce and treat aggression and related

conduct problems in young children. The program uses group discussion, videotape modelling, and rehearsal intervention techniques to help adults living and working with children.

The interventions that make up this series (parent training, teacher training, and child training programs) are guided by developmental theory concerning the role of multiple interacting risk and protective factors (child, family, and school) in the development of conduct problems. The parent training intervention is focused on strengthening parenting competencies (monitoring, positive discipline, confidence) and developing parents' involvement in children's school experiences in order to promote children's academic and social competencies and reduce conduct problems. The child social skills and problem-solving training programs involve strengthening children's social and emotional competencies (i.e., effective problem-solving strategies, managing anger, practicing friendship and conversational skills) as well as appropriate classroom behaviours. The teacher training program is focused on strengthening teacher classroom management strategies, promoting children's prosocial behaviour and school readiness (reading skills), and reducing classroom aggression and non-cooperation with peers and teachers. Additionally, the intervention focuses on ways teachers can effectively collaborate with parents to support their school involvement and promote consistency from home to school.

The series has been subjected to numerous randomised control evaluations (see full-list of all evaluations on Incredible Years website), and recently the Incredible Years was selected by the U.S. Office of Juvenile Justice and Delinquency Prevention as an "exemplary" best practice program and as a "Blueprints" program (Webster-Stratton, 2000).The program has been recommended by the American Psychological Division 12 Task force as a well-established treatment for children with conduct problems.

3.3.1.7 Multisystemic therapy (MST)

Multisystemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), developed in the late 1970s, is currently one of the more popular and efficacious treatment models in America that has a major focus on parent management and skills training. Essentially, MST is an intensive family and

community-based treatment that views individuals as being nested within a complex network of interconnected systems that include individual, family and extra-familial (i.e., peer, school and neighbourhood) factors. The MST approach to treatment considers that intervention may be necessary in any one, or a combination of these systems and views this ecology of interconnected systems as the "client". Originally designed to treat chronic, violent or substance abusing offenders at high-risk of out-of-home placement, MST is now being tested and used with a variety of populations, including children and young people with emotional and behavioural disturbance (Huey, Henggeler, Brondino, & Pickrel, 2000), abused and neglected youth (Brunk, Henggeler, & Whelan, 1987), and substance abusing or dependent adolescent offenders (Henggeler, Pickrel, & Brondino, 1999; Schoenwald, Ward, Henggeler, Pickrel, & Patel, 1996). MST has also served as an alternative to hospitalisation for youths in psychiatric crisis (Henggeler, Rowland et al., 1999). MST is based on two behavioural theories, systems theory and social ecology and on causal modelling studies of serious anti-social youth (Burns, Schoenwald, Burchard, Faw, & Santos, 2000). The first behavioural theory, systems theory, states that various systems interact to determine individual behaviour (Plas, 1992). The second, social ecology theory, stresses the reciprocal relationship between those systems and the individual (Brofenbrenner, 1979). Based on the two theories, MST works to intervene in a way that alters both the surrounding environment and the individual's behaviour. As such, MST is a strengths-focused approach in that it endeavours to promote behaviour change in the youth's natural environment through using existing strengths within each system (e.g., family, peers, school, neighbourhood, informal support networks). The ultimate goal of MST is to empower parents with the skills and resources needed to address the difficulties that may arise in the home with the youth and also enable the youth to cope with the family, peer, school, and neighbourhood problems. As opposed to traditional services that remove youths from their environment and in many cases place them with other youths that have similar problems, MST helps the family to function more successfully in their immediate environment (Burns et al., 2000). The therapist works with the youth and family within a context of support and skill building and places developmentally appropriate demands on both the youth and the family for responsible behaviour. Interventions are integrated into a social ecological context and include a variety of approaches such as strategic family therapy, structural family therapy, behavioural parent training, and cognitive

behaviour therapies. MST is provided to families using a home-based model of services delivery. The reason for this type of service delivery model is to help overcome barriers to service access, increase family retention in treatment, and provide intensive services, and enhance the maintenance of treatment gains.

The design and implementation of MST are based on nine core treatment principles. The nine principles serve to operationalise MST, and evaluations of treatment fidelity are based on parent and child ratings of the therapists' adherence to the principles. The nine principles of MST drive how the intervention is implemented and provide a structured guide for both the therapist and the family to follow and adhere to. Henggeler, Schoenwald, Rowland and Cunningham (2002) assert that a critical element of MST interventions is ensuring treatment gains are maintained and generalised. The nine principles are as follows:

1. The primary purpose of assessment is to understand the fit between the identified problem and their broader systemic context.
2. Therapeutic contacts emphasise the positive and should use systemic strengths as levers for change.
3. Interventions are designed to promote responsible behaviour and decrease irresponsible behaviour among family members.
4. Interventions are present-focused and action-oriented, targeting specific and well-defined problems.
5. Interventions target sequences of behaviour within and between multiple systems that maintain identified problems.
6. Interventions are developmentally appropriate and fit the developmental needs of the youth.
7. Interventions are designed to require daily or weekly effort by family members.
8. Intervention effectiveness is evaluated continuously from multiple perspectives, with providers assuming accountability for overcoming barriers to successful outcomes.
9. Interventions are designed to promote treatment generalisation and long-term maintenance of therapeutic change by empowering care givers to address family members' needs across multiple systemic contexts (Henggeler et al., 2002, p. 117).

The nine principles guide the MST assessment and evaluation process and therapists' adherence to the principles is paramount for the treatment to be effective. Evaluations of MST have demonstrated reduced long-term rates of criminal offending in serious juvenile offenders, reduced rates of out-of-home placements for serious juvenile offenders (Henggeler et al., 1993) brought about extensive improvements in family functioning, and decreased mental health problems for serious juvenile offenders (Henggeler et al., 1997). Furthermore, controlled studies that focused on chronic juvenile offenders have demonstrated that MST is equally effective with African-American and White families and with male and female youth across the adolescent age range (i.e., 12-17 years; Borduin et al., 1995). MST is also one of the few interventions to demonstrate long-term effectiveness with youth presenting with serious clinical problems and their families (Schoenwald, Ward, Henggeler, & Rowland, 2000). A study conducted by the Washington State Institute on Public Policy recognised MST as the most cost-effective intervention for juvenile offenders among 16 programs evaluated (Aos, Phipps, Barnoski, & Lieb, 1999). However, it must be noted that a recent systematic review of effects of multisystemic therapy (Littell, 2004) issued caution about these efficacy studies on the grounds that the majority of outcome studies have been authored or co-authored by the developers of MST and have lacked empirical rigour. More recently, Littell, Popa and Forsythe (2006) conducted a systematic review of eight randomised controlled trials of Multisystemic Therapy (MST) conducted in the USA, Canada, and Norway. The authors concluded it is not clear whether MST has clinically significant advantages over other services. They stated that the results were inconsistent across studies, which varied in quality and context. There is no information from the eight studies about the effects of MST compared with no treatment. However, they concluded that there is no evidence that MST has harmful effects. Similarly, Saunders et al. (2004) concluded that MST was a supported and acceptable treatment model but is not necessarily an efficacious model specifically for children who have been physically and sexually abused.

Although MST is a family-based treatment model that shares many similarities with other family therapies, it has several distinguishing features. First, MST places considerable emphasis and attention on the systems that the youth and the family are interconnected with and therefore ensures that support networks are

put in place to enable the family to maintain therapeutic gains. Second, the model has a strong commitment to reducing or removing barriers to service access. Finally, MST services are much more intensive than traditional family therapies. For example, the typical program duration is four months and consists of several hours of treatment each week.

One study to date has evaluated the effectiveness of MST versus parent training with abusive and neglectful families (Brunk et al., 1987). Brunk et al. found that MST was superior to parent training for improving parent-child interactions. Abusive parents showed greater progress in controlling their child's behaviour, maltreated children exhibited less passive non-compliance, and neglecting parents become more responsive to their child's behaviour. However, parent training was found to be superior to MST on decreasing social problems.

Overall, the well-documented efficacy of MST suggests that it is a promising intervention for children in out-of-home care and their families. An obvious and inherent limitation of the program, however is that it relies on the assumption that the child has a viable family that is willing to be involved in the therapeutic process. Despite this, MST could still be an option if the child is in a long-term foster placement or is adopted. MST services, in recent years, have been incorporated into out-of-home care programs and are being utilised as part of a continuum of care (i.e. MST-outpatient, MST home-based, MST treatment foster care and an MST short-term secure setting). For instance, if children are being discharged from a group residential program, one to two months prior to them returning home, the MST therapist works with the family to prepare the parents and then works with the child and parents for several months after the child is returned home. This broader application of MST appears to be a good option for potentially addressing a variety of out-of-home populations. However, it must be noted that for an agency to implement MST, they need to buy the training manuals and be provided extensive training directly through MST Services Incorporated.

Currently, MST is being run by agencies all over the world including the United States of America, Canada, Australia, New Zealand, United Kingdom, Ireland, Denmark, Netherlands, Norway and Sweden.

3.3.1.8 Families First

Families First is a family preservation program that is gaining a lot of recent attention by researchers.. The model has been in existence for many decades, and several studies have shown that programs that use the HOMEBUILDERS model safely prevent placement in foster care. The HOMEBUILDERS program uses a cognitive behavioural framework to explain the variety of behavioural dysfunctions. The model consists of individualised in-home application of a variety of cognitive and skill-building strategies that target specific problems in the family that make their children at-risk of out-of-home placement. The first studies that were conducted in the early seventies and eighties were primarily non-experimental and often showed positive outcomes. On average, it was demonstrated that approximately two-thirds to three-quarters of the children still lived at home after completion of the program. By contrast, recent experimental studies have shown that many children from the control group stayed home as well (see reviews Bath, 1994; Wells & Whittington, 1993). Therefore, the results suggest that the effects are mixed.

Families First of Michigan (FFM) provides families with intensive, short-term crisis intervention and family education services for families in their homes for a period of between four to six weeks. The families are provided with 24 hour support and the workers spend a significant time in the family home working with the parents and ensuring that the children are safe. The workers have only three families on their caseload at any one time so that they can spend a significant amount of time with each of the families. The Families First workers use family assessment to assist families by teaching, modelling and reinforcing positive parenting. The Families First workers undergo extensive training. There are 18 separate trainings, ranging from a core training series to specialised topics such as solution-focused interventions, working with substance abuse affected families, domestic violence, and cultural awareness. A unique feature of the program is that the end of intervention does not mean the end of support for the family. The Homebuilders model requires that the family be linked to less intensive support after the intervention to maintain its gains. Furthermore, the end of the intervention does not mean the end of support for the family. The Homebuilders model requires that the family be linked to less intensive support after the intervention to maintain the gains made by the family. Family preservation workers help families find day care and job

training and get whatever special educational help the children may require. They teach practical skills and help with financial problems.

Schuerman, Rzepnicki and Littell (1994) conducted a large scale evaluation of a Families First program in Illinois. The study provided an in-depth description of the families served, the problems they experienced, the services provided for them, and the outcomes of those services. The results of the evaluation indicated that the program did not prevent the placement of children in substitute care, nor were services delivered to those families for which they were intended. However, the negative findings from this evaluation need to be treated with caution as other researchers have criticised its methodology. The Audit Report from the Office of the Auditor General (State of Michigan, July 1998) concluded that the Program was effective in providing a safe alternative to the out-of-home placement of children that are at imminent risk of being removed from the home. The most recent evaluation conducted by Walters, Blythe and Ivanoff (2006), used a randomised control group design with a sample of 202 subjects. The findings indicated that the Families First program met its primary goal of preventing unnecessary placement of children in out-of-home care. Children in the Families First condition had an average of 0.3 placements, compared with 1.2 placements for children in the foster care condition. When out-of-home placement was required, Families First subjects spent fewer days in such placements. Children in the experimental group were significantly less likely to receive a subsequent substantiated abuse or neglect report than were children in the control group. The authors concluded that the results support recent policy and practice trends toward working to preserve families in order to serve the best interests of children. Other researchers have also found similar positive outcomes when the program was implemented outside of the United States (it is currently operating in many States across America (see Fraser, Walton, Lewis, Pecora, & Walton, 1996; Walton, Fraser, Lewis, Pecora, & Walton, 1993), in the Netherlands (see Veerman, de Kemp, Tjeerd ten Brink, Wim Slot, & Scholte, 2003). The program is also currently being run in New South Wales, Australia.

3.3.1.9 Triple P – Positive Parenting Program

Triple P is a parenting and family support strategy program that is based on social learning, cognitive-behavioural and developmental theory. Triple P was

developed in Australia by Professor Matthew Sanders and his colleagues from the Parenting and Family Support Centre in the School of Psychology at the University of Queensland. It uses a multi-level framework to tailor information, advice, and professional support to the needs of individual families. Sanders et al. assert that "the self-regulation of parental skills is a central construct in the program" (p.1). Triple P offers five levels of intervention of increasing strength, ranging from basic tip sheets and videos, to brief targeted interventions, to more intensive parent training in positive parenting that targets broader family issues such as parental depression, anger and stress and to prevent severe emotional, behavioural and developmental problems in children (Sanders, Markie-Dadds, & Turner, 2003). According to Sanders et al,. the aims of Triple P are:

1. To promote the independence and health of families by enhancing parents' knowledge, skills and confidence.
2. To promote the development of non-violent, protective and nurturing environments for children.
3. To promote the development, growth, health and social competencies of young children.
4. To reduce the incidence of child abuse, mental illness, behavioural problems, delinquency and homelessness.
5. To enhance the competence, resourcefulness, and self-sufficiency of parents in raising their preadolescent children (p. 3).

The program aims to use the minimally sufficient intervention a parent requires, working from level 1 up to level 5, to prevent the child from developing more serious problems. The program targets five different developmental periods: infants, toddlers, preschoolers, primary schoolers, teenagers within each developmental period, the intervention is very flexible and tailored to the specific needs of the individual. The program also uses a variety of flexible delivery modalities, including individual, face-to-face, group, telephone-assisted and self-directed programs.

The five core positive parenting principles that form the basis of Triple P include ensuring a safe and engaging environment; creating a positive learning environment; using assertive discipline; having realistic expectations; and, taking

care of oneself as a parent. The distinguishing features of Triple P that distinguish the program from other family interventions include its principle of program sufficiency; its flexibility to tailor interventions to identified risk and protective factors; its varied delivery modalities; its wide potential reach; its multi-disciplinary approach; and its contextual approach.

Triple P has a twenty-five year history of implementation and research evidence and is considered to be evidenced-based family intervention. Many of the studies conducted by Sanders and his colleagues (see Sanders et al., 2003, for a comprehensive list of outcome studies) reported very positive changes in child behaviour problems, reductions in aversive parenting practices and parenting conflict, and improvements in relationship satisfaction and communication.

3.3.1.10 Elmira Nurse Home Visitation program

The Elmira Nurse Home Visitation program is an example of an early intervention program for families and their children at risk of placement into out-of-home care. The Elmira nurse home visitation program is designed to address three major risk factors: adverse maternal health-related behaviours during pregnancy that are associated with neuropsychological impairment in children, child abuse and neglect, and a troubled maternal life course. First, according to the developers of the program, children who exhibit antisocial behaviours early in life are more likely than other children to have impaired neurological functioning, such as poor motor functioning, attention deficits, hyperactivity, impulsivity, and impaired language and cognitive functioning. In many cases, the malfunctioning can be traced to poor prenatal health conditions that interfere with the development of the foetal nervous system (see Olds, 1997). The Elmira program attempts to address such risk factors by, for example, helping pregnant women improve their diets and reduce their smoking and use of alcohol or illegal drugs. The developers of the program also acknowledge the role of abuse and neglect and its effects on the developmental pathways of children. The Elmira clinical trial has reduced rates of abuse and neglect by helping young parents deal with depression, anger, impulsiveness and substance abuse programs. The program also teaches the new parents about normal child development, gets them to reflect on their own experiences of being parented and helps them develop skills to ‘read’ their baby’s signals (Olds et al., 1997). The third

risk factor addressed by the Elmira program is the mother's personal development and life course. It is well established that young women who become parents as adolescents and have recent welfare experience are more likely to have children who engage in a variety of antisocial and delinquent behaviours. The Elmira program therefore helps young parents to achieve goals such as completing their education, finding employment and avoiding unplanned subsequent pregnancies (Olds et al., 1997).

Brown et al. note that interventions, such as the Elmira nurse home visitation programs, developed by Olds, Eckenrode, Henderson, Kitzman, Powers, and Cole (1997), may reduce not only the rate of child abuse and neglect but also its mental health consequences. The authors conducted a 15 year follow-up study of the program to assess its long-term effects on children's criminal and antisocial behaviour and found that it had a substantial positive effect (Olds et al., 1997; 1998). For example, the authors found that adolescents whose mothers received nurse home visitation services over a decade earlier were 60 percent less likely than adolescents whose mothers had not received a nurse home visitor to have run away, 55 percent less likely to have been arrested, and 80 percent less likely to have been convicted of a crime. The study also noted that the adolescents whose mothers had received the intervention (nurse home visitation) smoked fewer cigarettes per day, consumed less alcohol in the previous six months, and had exhibited fewer behavioural problems related to alcohol and drug use (Olds et al., 1998).

3.3.1.11 Wraparound

The use of the terms 'wraparound' or 'wraparound process' is relatively new to out-of-home care literature. According to Burns, Schoenwald, Burchard, Faw and Santos (2000):

> wraparound is a philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports that are individualised for the child and family to achieve a positive set of outcomes (p. 295).

Wraparound originated in the early 1980s with the Kaleidoscope program in Illinios that had set up group homes for troubled youths. As the term denotes, the wraparound process 'wraps' services around children within their families, schools and communities. Wraparound was developed to keep youth with their families and out of institutional settings. Furthermore, like MST, the wraparound process is community-based, individualised, family-centred and culturally competent. Such program elements correspond to the Child and Adolescent Services System Program values that have been a part of American federal policy for over ten years (Stroul & Friedman, 1986). However, unlike MST which was derived from a research tradition, wraparound was derived from a need to improve service delivery. The intervention strategy of wraparound is the coordination of a variety of interventions and is different from treatment modalities discussed above that focus on the provision of a direct applied, theoretically-based clinical treatment. The wrapround process is designed to provide long-term care by a team that coordinates both the professional clinical services that are provided by multiple agencies and informal support services in the community (Burns et al., 2000). The wraparound process is a team-driven process that relies on the effective coordination and utilisation of community-based natural supports and existing services. Moreover, wraparound differs from the majority of other treatment models in a very distinct way. The majority of treatment models are designed to provide a short-term intensive intervention, whereas wraparound has an unconditional commitment to provide services and supports for as long as they are needed. Thus there is a 'no reject, no eject' policy. Wraparound also does not use one specific clinical intervention but rather coordinates the use of an intervention that the treatment team deems the most appropriate to meet the needs of the child and the family.

According to Burns et al. (2000), the theory of environmental ecology (Munger, 1998) is most closely related to wraparound. The theory assumes, as stated by Burns et al., (2000), "that a child will function at their best when the larger service system surrounding them coordinates most efficiently with the microsystem of his immediate home and family environment" (p. 296). Due to the systemic design of wraparound, it has been easily adapted for children served in a range of fields systems including mental health, education, and juvenile justice.

The developers of wraparound recently documented the overriding values, elements and practice requirements of the intervention (Goldman, 1999). The program places an emphasis on families, attempts to incorporate the child and family's view point at all times and tries to ensure that the services are provided in a compassionate manner. They also identified ten essential elements of wraparound. They are as follows:

1. Wraparound efforts must be based in the community.
2. Services and supports must be individualised, build on strengths, and meet the needs of children and families across life domains in order to promote success, safety, and permanency in home, school and community.
3. The process must be culturally competent.
4. Families must be full and active partners in every level of the wraparound process.
5. The wraparound process must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualised service plan.
6. Wraparound teams must have flexible approaches with adequate and flexible funding
7. Wraparound plans must include a balance of formal services and informal community and family resources.
8. The community agencies and teams must make an unconditional commitment to serve their children and families.
9. A service/support plan should be developed and implemented based on an interagency, community-neighbourhood collaborative process.
10. Outcomes must be determined and measured for each goal established with the child and family as well as for those goals established at the program and systems levels (Goldman, 1999, p. 11).

Goldman (1999) also documents the ten elements that are essential at the community level and includes organisational and structural issues that assist the functioning of the wraparound child and family teams.

As with MST, a crucial element of wraparound is that the families must be full and active partners at all levels of the wraparound process. However, as

mentioned previously, this may not always be possible for children in out-of-home care and this is where the application of the program for foster and adoptive partners is important.

Research has documented the effectiveness of the wraparound process. A randomised clinical trial conducted in Florida (Clark et al., 1998) compared outcomes for youths randomly assigned to either standard practice foster care or to a wraparound program – the Fostering Individualised Assistance Program (FIAP). Both groups of youth received standard foster care services, but the group in the FIAP received additional services including case management and flexible funds. The data were collected at base-line and then at six monthly intervals for a period of 3.5 years. The results demonstrated that both groups improved; however, the youth in the FIAP program experienced greater improvement. For example, for the youth in FIAP, there was a reduction in the number of placement changes and number of days absent from school. Significantly lower delinquency rates and fewer externalising behaviours were observed in those youth than those in the standard foster care group. The older youth in the FIAP group also achieved significantly more permanency placements (i.e., living with relatives or on their own) than did the older youth in standard foster care. Three other pre-post design studies have documented positive outcomes for youth and family as result of the wraparound program. The pre-post design measures program outcomes by comparing outcomes at the end of the program (post) to some baseline, usually the same elements measured at prior to the start of the program (pre). The studies all noted decreases in the youth's negative behaviours and restrictiveness of living environment after the program and also improvements in home adjustment (Bruns, Burchard, & Yoe, 1995; Clarke, Schaefer, Burchard, & Welkowitz, 1992; Yoe, Santarcangelo, Atkins, & Burchard, 1996).

Wraparound appears to be gaining acceptance, as it is utilised by many agencies and organisations throughout America, Canada and the UK. It appears to be a more affordable option for many Child Welfare agencies as is it does not require the level of training or ongoing in-house training that MST requires, nor does the agency need to pay for the initial set-up, ongoing training or evaluations that are provided only by MST services. However, wraparound also relies on the availability of community resources and these differ dramatically from one community to the

next. Yet, unlike MST, wraparound is only now introducing fidelity measures and not all wraparound programs are using the same measures. This is an obvious limitation of the model that makes it difficult to compare data across programs.

3.4 Summary

This Chapter has presented descriptive details on many types of psychological interventions that could serve as possible solutions to the many and varied issues of the children and their families identified in the national profile study. The next Chapter (4) is a research project-based study of the literature and an internet search of placement arrangements for children with high support needs. This next Chapter will present descriptive examples of possible international and national service and intervention solutions that are operating around the world for children with emotional and behavioural disorders.

Chapter 4
A Study of International Program Designs

4.1 Overview

The purpose of this study was to obtain an overview of the range of placement services available to assist children and young people in out-of-home care both in Australia and internationally. Although there is potentially an endless multitude of services that could be included under this category, this study focused only on programs meeting two specific selection criteria: those which were specifically designed to meet the needs of young people in out-of-home care, and which assisted children with significant emotional or behavioural disorders. The primary sources of information for this research was an extensive review of the published academic literature, government reports (from Australia, North America and Europe), the Internet, information supplied by email contact, and primary data drawn from programs visited by the researcher.

North America was chosen as the principal focus for the empirical investigation for both strategic and practical reasons. Strategically, North America contains the largest concentration of intensive therapeutic services in the world and is therefore the best area in which to obtain sufficient data to profile different program designs. From a practical perspective, North America proved to be the only part of the world that was amenable to rapid collation of information via the Internet and on-site because of the greater coverage of service information online (very little is available online from the United Kingdom and tends to be more confined to archived reports, journal publications and books produced by peak bodies such as the British Association for Adoption and Fostering), and where research support was available to conduct site visits (some assistance in identifying programs was received from the University of Toronto). In addition, the lack of translators and limited number of English-language sites available in other countries meant that it was not practical to provide detailed analysis of non-English speaking countries.

Ideally, it would have been desirable to have conducted a systematic audit of programs with identical information collected directly from different agencies so as to achieve greater detail and consistency in the information collected. However,

given the many thousands of programs and services available in North America and the lack of any consistent records of what is generally available, the aim of this project was therefore more modest; namely, to profile and describe the different service options available internationally, and how these compared with the range of services currently available in Australia. For each program type, a summary table is provided to describe its prevalence in America and, in some instances, Canada, the types of children served, as well as the types of intervention and services provided. Several representative case examples are then provided to describe some of the better established programs currently in operation. It would have also been desirable to present only those placement options that have been shown to have given rise to reliable improvements in children's well-being as compared with best available alternatives, but unfortunately such evidence is almost non-existent. As pointed out by Bloom (2005), "there are no manuals or formal training programs for specific programmatic approaches". As one obsever has said, "few centers can now provide a substantive (much less a theory-based) written account of their program" and they still lack criteria "that rationally link diagnosis, etiology, prognosis, and (sic) criteria for specific forms of residential treatment" (Wells, 1991, cited in Bloom, 2005, p. 3). Although some manuals are now available for some specific intervention types, such information is rarely found and perhaps difficult to compile when one looks more generally at placement types.

Accordingly, as a result of the varying quality and availability of evaluative data, a standards of evidence approach was adopted (see Barber & Gilbertson, 2001). Where it was possible to present empirically validated examples, this was done, followed by propositions for which there was at least of moderate degree of empirical support. Where such information was not available, the reporting is confined to general case descriptions with some discussion as to whether such models might be considered and formally evaluated in Australia in the absence of similar information elsewhere. Such findings and the summaries are therefore best treated as indicative of the situation prevailing in these other countries and are perhaps best seen as reflective of the range and scope of the models and broad differences identified rather than a true prevalence study of different program types and their components.

After a summary of different North American program types, a comparative summary is then provided of the broad service and placement option trends in the United Kingdom, Europe and Australia (with specific examples).

4.2 Procedure

4.2.1 Literature search strategy

As indicated in the previous chapter, a detailed search was undertaken in 2003-2004 to identify the location and nature of currently operating services and programs. Early reviews of the literature on treatment programs revealed that 'treatment foster care' was a general term used to describe a wide-ranging therapeutic process or program for children that involved some form of treatment or therapy. Further investigation revealed that many others terms were used to describe similar practice. Such terms included therapeutic foster care, specialised foster care, intensive foster care and medical foster care. Therefore, it was decided that each of the terms would be used when searching the databases. The main aim was to locate any reviews or evaluations that may have been conducted on the success of 'treatment foster care' and other intensive or therapeutic programs for children with high support needs in out of home care. The electronic journal article databases were searched using the same five description terms and were searched back as early as 1950 to current. The search databases that were accessed included PsycINFO, Science Direct, Academic Search Elite, Expanded Academic Index, Kluwer Online, and APAIS (Australian Public Affairs Information Service).

4.2.2 Internet search strategy

The online search engine that was utilised for the extensive Internet search was google™. The search engine was used to search for treatment programs throughout Australia, the United States of America, and Canada. The same search method was used systematically for each country. Each of the five search terms was entered separately with the appropriate location. For example, the terms "Treatment" and "Foster care" would be entered along with "New York", with subsequent searches using "therapeutic foster care" and "New York", followed by "Specialized foster care" and "New York" and so on. This same method was followed for each State or major city.

Each time the search was executed the search engine would produce hundreds to thousands of 'hits'. After initially accessing all of the hits it was decided that the maximum number of hits to access would be 300 after initial searches indicated that this was the point when saturation was reached (i.e., the majority of hits after that were repeating the same information). Approximately 220,000 Internet sites were accessed during the search yielding extensive information on the nature and success of treatment programs throughout Australia, the United States of America, and Canada. This search strategy was unlikely to be exhaustive because it is very likely that not all treatment programs have web pages so that the search it unlikely to have captured all of the operating treatment programs in those countries. For example, residential care was only included to the extent that it provided therapeutic services to children in out-of-home care. Nevertheless, the fact that all Canadian provinces and American States were sampled suggests that the search has been generally successful in identifying the vast majority of well-established programs and different program types, as well as the range of services and interventions that are employed.

Information on all treatment programs was collected using a template (see Appendix C) and systematically categorised separately by two researchers into an SPSS database. Only those programs that provided information concerning the type of services provided were included in the analysis.

4.2.3 Program Variables Recorded

It had been hoped that all programs could be profiled according to each of three clusters of variables; physical arrangement; service type and living environment; and staffing arrangements. However, because of the variability in the information obtained, only a subset of variables was considered. In addition, it was found that some characteristics (e.g., physical location), while useful in describing differences between services, were not useful in classifying services. For example, because almost all residential placements were located on campuses, whereas all other arrangements were in the general community, any cross-tabulation of the general type of arrangement and this characteristic would be redundant.

(a) Identification type

Each program was allocated an identification type code which was based on broad descriptive information noted by the agency's website. From inspection of these descriptions, it was clear that services or programs fell into six identifiable types: (1) Treatment foster care, (2) Group homes, (3) Residential or facility-based care, (4) Crisis, Transition and Assessment houses, (5) Community villages, and (6) Day treatment centres.

(b) Origin and State/ Province

The country of origin and state of each program was recorded so as to ascertain the distribution of different program types in different areas.

(c) Type of psychological intervention

The type of psychological intervention promoted by each service was also recorded. The list of interventions included behavioural management training / token economy, milieu therapy / therapeutic community, attachment therapy, grief / loss / PTSD / trauma therapy, cognitive-behavioural techniques, anger management, abuse/victim counselling, relapse prevention, post-abuse counselling, and psychotherapy,. The programs were also classified on the type of social based interventions they employed as part of their treatment service to the children and young people. The social based interventions included self-assertiveness training, self-esteem training, play therapy, general social skills training, mentoring, adventure / outdoor / team building activities, peer support models, general communication skill training, sex education, conflict resolution and any other service that fitted into this category.

(d) General services

Other services that were promoted as being available to the children and young people were also noted wherever possible. Such services included; educational support or tutoring services, special curriculum design, parent skills training (biological parents), 24 hour crisis support, wraparound services, multisystemic therapy (MST), independent living skills training, vocational guidance services, phone counselling for biological or foster parents, periodic home visits to biological parents, support group for foster carers, community service opportunities for children

and young people, family therapy (biological or foster parents), group therapy and individual therapy.

(e) Other descriptive program information

Information on the referral source and main reasons for referral to the program was collected. Other information included the minimum and maximum age of the children and young people that the programs served and whether the program served both male and female children together, or separately.

(f) Staffing Arrangements

Information was also collected on whether children and young people lived with carers or only came into contact with casual or rostered staff.

Based on this information, it was therefore possible to describe programs both in terms of their general description or name (a) and the other more specific characteristics (b) to (f).

4.3 Results of Internet Search

Table 4.1 summarises the results for the North American searches. As indicated, a very large number of services was identified in the United States, including over 300 treatment foster care programs, 134 residential units that reported providing treatment for foster children, and 243 group homes. A relatively smaller number of programs were located in Canada. Caution must be applied in comparing the relative proportion of different types of program because the focus of the study was on treatment alternatives for foster children, so many residential units have been omitted. However, it appears reasonable to conclude that group homes are relatively less common in Canada than in the United States, and that Canada appears to place a strong emphasis on day treatment services.

Table 4.1 Principal program types in North America

	United States (N = 725) N (%)	Canada (N = 52) N (%)
Program type		
1. Treatment foster care	326 (45.0)	17 (32.7)
2. Large residential Units	133 (18.3)	12 (23.1)
3. Smaller residential Units	213 (29.4)	1 (2.0)
4. Group homes (in community)	29 (4.0)	3 (5.8)
5. Crisis / Assessment Houses	21 (2.9)	2 (3.8)
6. Day treatment centres	*	16 (30.8)

* Many day treatment centres were identified but these were typically run from residential units or via other services, rather than as independent programs.

4.3.1 Overview - Treatment foster care

Professional foster care is one of the latest trends in the evolution of the care system, as child-placing agencies are experiencing great difficulties in recruiting carers. Meadowcroft (1989) observed that the rapid proliferation of such treatment programs for children with severe emotional disturbance began in the early 1980s and continues today, due to the high need for such programs. Also during the 1980s, a huge cognitive shift occurred in the care system when it was realised that countless children needed more than just care. For many years, the primary need for the majority of children in the foster system was care, but today such care-focused models are no longer adequate for children with intensive support needs. Such treatment programs are referred to in the literature by many titles, including therapeutic foster care, specialised foster care, foster family-based treatment, foster family-based residential treatment and medical foster care. Although treatment foster care has been referred to by many titles, according to Reddy and Pfeiffer (1997) “the literature can be roughly divided into two general approaches: “specialised foster care” and/or “treatment foster care” (p. 581). The main difference between the two approaches is that parents in specialised foster care are provided with training and carry out the interventions under the supervision of mental health professionals. By contrast, in treatment foster care, treatment parents are viewed as the primary change agents and, as such, mental health professionals are accessed as consultants rather

than provided directly in the program. Nevertheless, both approaches, regardless of title, offer "therapy and intensive family-centred community-based services to the children who require out-of-home placement" (Reddy & Pfeiffer, 1997, p. 582).

Farmer, Burns, Dubs and Thompson (2002) contend that treatment foster care is a term used to cover all treatment programs that share some or all of the following features:

- A focus on youth with special needs (Chamberlain & Weinrott, 1990a; Luginbill & Spiegler, 1989),
- focused recruitment of treatment foster parents,
- extended pre-service training and in-service supervision/support for treatment parents,
- placement of children in treatment parents' own homes and parent stipends that are substantially higher than those of traditional foster care (Chamberlain, Moreland & Reid, 1992), and
- planned treatment that combines technologies from more restrictive settings with an emphasis on daily interactions with treatment parents and others as opportunities for treatment and development (Meadowcroft, Thomlison, & Chamberlain, 1994, p. 214).

At present, treatment foster care has become one of the fastest growing treatment programs for children (Hudson, Nutter, & Galaway, 1992; Hudson et al., 1994). Treatment foster care was originally conceptualised as a "transition program" to move children from residential care back into the community (Waskowitz, 1954). Since then, it has increasingly been viewed as a viable alternative to residential or hospital care and can therefore treat many different children, from children infected with AIDS (Dennis, 1992) to children suffering from behavioural, emotional or physically disabling conditions (Szymanski & Seppala, 1995). According to Webb (1988) the definition of specialised or treatment foster care rests on three basic assumptions. First, the foster parents are viewed as paraprofessionals, who undergo extensive training (preservice and/or inservice) and who establish a therapeutic environment within their own homes. Second, the program professionals direct and monitor the therapeutic regime for a limited number of children and, finally, agencies

determine the driving therapeutic philosophy of the program. Furthermore, the programs are designed to provide the most treatment intensive but least restrictive normalised living environment that is close to "normal" in an out-of-home placement.

A small number of reviews in the area of treatment foster care have affirmed that, in comparison to residential or hospital care, treatment foster care is a more cost effective and less restrictive treatment setting. Treatment foster care has also been found to produce behavioural improvements that are comparable to residential forms of care (Hudson et al., 1994; Meadowcroft et al., 1994). Meadowcroft, Thomlison and Chamberlain (1994) noted that "most children served in treatment foster care successfully complete the program largely as planned at placement, indicating that treatment foster care can provide residential family stability for children with histories of instability" (p. 569). Such a finding is particularly important in a time when placement instability is so ubiquitous in the care system.

4.3.2 Treatment Foster Care

A program was classified as a treatment foster care program if it provided a treatment foster service, was non-residential and community-based. The mean number of children and young people per dwelling for treatment foster care program type was 1.66 (*SD* = 0.73) with a range of 1 to 4 in each home. Most of the agencies (98.4%) served both male and female children and young people, only one agency (0.3%) served just male children and 4 agencies (1.3%) served male and female children separately. Almost all programs reported receiving referrals from within the care system (99.1%). Other referral sources included juvenile justice systems (6.6%), mental health services (6.3%), educational services (1.3%) and community services (1.3%). The average minimum age for this program type was 3.28 (*SD* = 4.11, range 0 -13 years) and the average maximum age was 17.65 (*SD* = 2.37, range of 6 – 22 years).

The main reasons for referral included behavioural problems (86.6%), socialisation/peer problems (45.3%), grief and loss issues (7.8%), emotional problems (80.9%), sexual offending or sexually at-risk behaviours (3.8%), offending (6.3%), disability (11.6%) and developmental delay (17.8%). The mean duration for

this program type was just under 12 months (*M* = 54.45 weeks, *SD* = 29.13), with a range of 0 -104 weeks. Furthermore, all but two programs had live-in foster parents (98.1%); the other two programs had rostered full-time staff.

As can be seen in Table 4.2, almost all the services in the United States advertised individual therapies, with almost a third offering group counselling, and a fifth family counselling. In the United States, psychological interventions are predominantly behavioural, with just over half of the treatment foster care programs reporting that their interventions were based on this theoretical approach. Other theoretical approaches included psychotherapy, milieu therapy, and attachment therapy. In terms of specific interventions and service supports, it was found that approximately half provided 24-hour support for carers, home visits, and carer support groups. However, there was considerable variation in the types of specific interventions provided, ranging from social skills training to self-esteem building and vocational guidance. Just under half employed vaguely described counselling techniques and interventions that could not be classified into any more specific categories. Interestingly, only two agencies were found to refer to multi-systemic therapy by name, whereas Wraparound was reported by over a dozen agencies.

It is more difficult to profile Canadian treatment foster care programs because of the relatively small number of programs identified via the search methodology. However, a number of trends were observed. Compared with the US, few programs appear to use behavioural methods and there appears to be a greater emphasis on parent skills training rather than the provision of general support services for carers. Canadian programs also appear less likely to advertise the use of individualised therapies. Canadian programs had smaller proportion of live-in foster carers and were more likely to have rostered professional staff.

Table 4.2 Treatment foster care dimensions of care

	United States (*N* = 326)	Canada (*N* = 17)
Staffing arrangement		
Live-in foster carers	98.1	77.8
Rostered staff	1.9	22.2
Therapeutic Approach		
Behavioural/ Token Economy	51.8	23.1
Psychotherapy	7.5	23.1
Play therapy	5.9	6.3
Milieu therapy	2.2	23.1
Attachment therapy (non-holding)	1.6	5.9
Attachment (holding)	0.0	0.0
Therapy Type		
Individual	98.1	64.7
Group	21.9	5.9
Family	30.3	17.6
Specific Interventions/ Services		
24-hour support services	55.0	23.5
General/ unspecified interventions	46.3	20.0
Support groups for carers	41.9	11.8
Periodic home visits	37.5	5.9
Special tutoring	23.8	23.4
Social skills training	19.1	25.0
Independent living skills training	15.3	35.3
Adventure-based activities	13.4	11.8
Special curriculum	12.5	17.6
Vocational guidance	11.9	5.9
Parent Skills training	10.6	41.2
Self-esteem building	6.6	7.7
Community service activities	5.9	17.6
Wraparound	5.0	5.9
Mentoring	4.7	11.8
Anger management counselling	2.8	7.7
General communication skills	2.5	5.9
Grief/loss/PTSD/trauma	2.5	0.0
Self-assertiveness training	2.2	6.8
Peer support models	2.2	0.0

Note: Due to missing data, the *N*'s vary across the different items so that percentages are based on different denominators.

4.3.3 Examples of treatment foster care programs in the United States

According to Chamberlain (1998), the treatment foster care model is appealing because it is cost-effective, it places the child in the least restrictive setting

possible and it reduces the influence of peers with similar problems (Chamberlain, 1998). Close to 500 'treatment foster care' programs were identified right through America. However, only 326 programs had sufficient information to be able to be classified. The term treatment foster care refers to a family-based home in the community whereby children are provided treatment primarily by trained foster parents. Two examples of agency-operated treatment foster care will now be discussed. These examples provided extensive information on their programs and clearly demonstrate the typical structure of this type of treatment program.

Case study: Youth Villages – Mississippi (USA)

Youth Villages is a child welfare agency that provides care and treatment to children in over 33 locations throughout Tennessee, Mississippi, Arkansas, Alabama and Texas. Youth Villages also employs more than 1,100 counsellors, teachers, and support staff who provide services to more than 5000 emotionally troubled children and their families. Youth Villages receives donations and grants to assist in the administration and operation of the agency. Their treatment foster care program is relatively cost-effective, with an approximate cost of US$2,691 per month for each child. They run a range of comprehensive programs, such as home-based counselling; residential treatment; therapeutic/treatment foster care; adoption; community-based services; transitional living services and family-based care for children with developmental disabilities and crisis services.

The treatment foster care program was designed to address the emotional and behavioural problems of children through treatment in a stable home. The children are provided treatment by trained foster parents. The foster parents are supplied with guidance, structure and 24 hour, seven day a week support. Youth Villages also supplies the children and foster parents with direct access to counsellors and behavioural specialists. The children who are referred to Youth Villages have been identified as emotionally troubled and/or behaviourally disturbed and in need of mental health services. The children reside in the community-based homes of the foster parents and generally attend the local school. The foster parents undergo extensive pre-service and in-service training based on the Multidimensional Treatment Foster Care (MTFC) model developed by Patricia Chamberlain at the Oregon Social Learning Center (OSLC). The treatment model is also based on

Nicholas Hobbs' Re-ED philosophy of re-educating troubled young children. The Re-Ed model is described as both ecological and psychoeducational and has a strong emphasis on children's strengths, health, and joy rather than on the deviance and pathology of children. In Hobbs' book, *'The Troubled and Troubling Child'* (Hobbs, 1982), he argued that most emotional disturbance is not a symptom of individual pathology but, rather, a sign of malfunctioning human ecosystems.

The foster carers work as an integral part of the treatment team and implement a daily treatment plan for the child. Generally, only one child is placed in each treatment home to reduce the influence of deviant peers. The plan is based on the child's behaviours and their relationships with parents, peers and teachers. The Oregon Social Learning Center emphasises the importance of 'attacking all fronts' to ensure that all aspects of the child's life are addressed. Therefore, the model was designed to provide interventions for both the home and school settings. According to Patricia Chamberlain, the developer of the multidimensional treatment foster care model, "the model emphasises the importance of using significant adults, such as parents and teachers, to act as agents of change or interventionists for the child" (Chamberlain, 1998). Furthermore she states that for the model to be effective, these adults must be carefully trained to react systematically to the child's problems and behaviours. Chamberlain refers to such reactions as 'therapeutic reactions'. 'Therapeutic reactions' are reactions to the child that are consistent, contingent and generally supportive. The foster carers are trained to react in this way and to actively work at deceasing overt and covert forms of antisocial behaviour and increasing the child's appropriate behaviours and prosocial skills. The foster carers also use non-violent discipline methods. The main objective of the program is to make systematic changes to the child's social environment so as to control antisocial behaviour and to encourage the development of appropriate prosocial behaviour and academic skills. The daily treatment plan is also supplemented through the provision of individual therapy for the child and family therapy for the child's parents. A program is also set up with the school and parole or probation officers if required. Typically the placement lasts six to nine months. The family therapy sessions concentrate on improving the supervision, discipline and encouragement skills of the child's biological parents. Either Functional Family Therapy or Structural Family Therapy is utilised in conjunction with the behaviour management strategies to create a

structured treatment environment in the home of the natural parents when the children return. The program aims to teach the parents how to set appropriate limits and provide good supervision so that the child returns to an environment that will support the child's development and maintenance of appropriate social skills and behaviours (Chamberlain, 1998). Youth Villages conducts continued research by contacting families and other information sources at 6, 12, 18, and 24 months to monitor the long-term impact of all of their programs on placement stability, school success, and legal status. During the last fiscal year, outcomes for more than 2,000 children were tracked up to the 24 month mark. For those continuum clients that were enrolled in a number of services during June 2000 to 2005, the report shows that 78% (N = 1317) were discharged to their homes. After twenty-four months, 74% were still residing in their homes or a home-like environment (i.e. foster home, adoptive home). After twenty-four months, 74% of the young people enrolled in school, had graduated from high school or were in GED classes. After the same period of time (24 months), only 13% of the young people had had an out of-home placement in either a residential treatment centre, psychiatric hospital or detention/corrections centre (Youth Villages Report, 2005).Youth Villages is about to embark on a collaborative project with Professor Richard Barth from the Jordan Institute for Families at the University of North Carolina Chapel Hill. He will be conducting an extensive review of the process and will recommend improvements in the system. The Youth Villages approach has been proven successful in helping troubled children in clinical trials and has been endorsed by both the U.S. Surgeon General and the National Institutes of Health.

Case-study: Pressley Ridge Youth Development Extension (PRYDE) – Maryland (USA)

Another example of treatment foster care is the Pressley Ridge Youth Development Extension (PRYDE) program run by the Pressley Ridge Child Welfare agency. Pressley Ridge is a 170-year old non-profit agency that provides an array of services for troubled children and their families. Pressley Ridge operates from the philosophy that children belong with families. Their treatment foster care program is specifically designed to serve seriously emotionally disturbed children by providing them with a highly structured treatment foster home. The program was developed to provide an alternative to placing troubled children in residential or institutional

placements. The program serves children experiencing emotional and behavioural problems and children with mental health diagnoses in need of out-of-home care. The children referred to the PRYDE program range in age from infancy to 18 years. Most of the youths have a history of institutional and special education placements. Over 70% of the youth are referred for problems of aggression, and 30% have a history of psychiatric hospitalisation. Nearly every PRYDE child has had a minimum of one prior placement outside of his or her family, with an average of four previous placements. Pressley Ridge states that the children served are the most difficult children, often labelled treatment-resistant. The children are referred through local departments of social services, the juvenile justice system, and the department of mental health.

The PRYDE treatment program is provided to troubled children within the homes of professional parents. The program focuses on the importance of permanency and individualised treatment. The PRYDE treatment parents are carefully screened, selected and trained. Each parent undergoes 42 hours of specialised pre-service training. The parents also receive extensive feedback and support by the PRYDE staff and monthly reviews are also provided along with weekly face-to-face meetings. PRYDE also conducts semi-annual and annual performance appraisals. At this time professionally developed plans for the following year are determined and form a basis for merit increase in parents' per diem payments.

PRYDE operates from the position that each child is different and unique and therefore has unique needs. As such, the intensity of their services can be adjusted to suit the child, which allows the child to remain within the same family setting as his or her situation improves. The professional parents are viewed as the main agents of change for the child and therefore are part of the child's treatment team. The treatment team develops individualised plans for each child. The majority of PRYDE homes have only one child placed; however, approximately 20% of the homes have more than one child, sibling groups and adolescent mothers and their children. The treatment parents are required not only to provide treatment to the child but also to address issues that may arise in the community, from peer interactions, in school settings, and within the child's biological family.

The main purpose of the PRYDE program is to provide individualised service plans and treatment for each child in the home of professional parents. Pressley Ridge aims to achieve stability, safety and permanence for each child. The program achieves this by providing the opportunity for the development of important, supportive relationships and by the pursuit of adoption if the child is unable to return home.

As with Youth Villages, all of Pressley Ridge services are guided by a common treatment philosophy called Re-education. Based on Nicholas Hobbs' Re-education theory (Hobbs, 1994), Re-ED focuses on the strengths of each child and family with the belief that it is possible to teach competence, that change is possible, and that the most significant factor in turning around the lives of seriously troubled children is the development of trusting relationships with caring, committed adults. The staff and professional foster parents are well trained and supportively supervised. Every day they work towards doing their best for troubled children and their families.

Pressley Ridge has been conducting ongoing research over the last two decades on the outcomes for children in all of their programs. Current research projects include fidelity measures for Re-ED, quality outcomes, and research in Autism Spectrum disorders**.** A five year study has been conducted on the "therapeutic alliance": which is the working relationship between a child and a therapist. The study helped to inform the development of a curriculum on how to form positive relationships and observation tools for supervision and skill development. A recent report released by Pressley Ridge reported that most children received services for nine months or less, and close to 65% of children are discharged in less than nine months. It was also reported that 95% of the young people are happy to very happy with life in general, their living environment and school since being discharged from the program.

Case study: DEVEREUX (USA)

Devereux is a not-for-profit organisation that provides services for children, adolescents and adults in many states across America. Their continuum of care ranges from residential and day treatment programs, community-based group homes,

respite care programs, hospital inpatient and outpatient settings, transitional living arrangements, supervised apartments, and special education day schools. Devereux also provides several types of foster care, including treatment foster care. As part of their services, Devereux offers family therapy, preventive and post-discharge services, after care programs and vocational and pre-vocational training.

Devereux's treatment foster care service is a managed care model for children aged 5 to 17 years of age. The model is designed to provide individualised treatment to children and adolescents suffering from mental health, behavioural, development and/or adjustment problems or difficulties. The treatment foster care services are provided in highly structured home-based settings in the community on a one to one or a one to two staff to client ratio. The service is designed to serve as an alternative to institutionalisation or hospitalisation as well as a step-down level of care following residential treatment. The foster carers are specially trained and supported by a treatment team of psychiatrists, therapists, behavioural analysts and case managers. Therapeutic visits are done in the foster home on at least a weekly basis, and the foster parents are specifically trained to manage the challenging behaviours. The foster parents bring the children to the office for monthly psychiatric visits, medication management and treatment team meetings.

Devereux is very committed to providing high quality services to children, adults and families with special needs. The agency utilises several clinical accountability tools, including eTRACS™, a web-based information tracking and charting system; e-Cet - an electronic clinical record; Devereux Scales - clinical assessment tools (LeBuffe & Pfeiffer, 1996); and a compliance system. Numerous research projects have been undertaken by Devereux staff and all of the publications are listed on their web-site.

4.3.4 Examples of treatment foster care programs in Canada

Case study - Algoma Family Services, Ontario

A Canadian example of a treatment foster care program is run by Macdonald Algoma Family Services. This program is aimed at children and young people who exhibit emotional, behavioural and delinquency difficulties. Only one child is placed per home with treatment foster parents who have undergone extensive pre-service

and in-service training. The program utilises a behavioural Points and Levels system whereby children earn points through the completion of specified tasks and routines. The points are then totalled and the child is located to services based according to these scores. The model is based on the Oregon Multidimensional Treatment Foster Care (MTFC) model developed by Patricia Chamberlain (Chamberlain, 1998), as described earlier. The model integrates multiple intervention modes (individual and family therapy, and social skills training) in multiple domains (family homes, school, and peer groups). The routines include wake up routines and house chores, and children can earn points to maintain their level as well as extra points for rewards and incentives. The foster parents are trained to use encouragement and praise to teach and reinforce appropriate behaviours. The children also attend community-based local schools.

The treatment foster care program utilises a team approach consisting of a coordinator who works closely with the foster family, family therapists working with the natural parents, individual therapists and skill trainers to teach the child social skills. Algoma also uses the Therapeutic Crisis Intervention for family care providers. Foster parents are provided with training in this approach and learn to understand and identify where problem behaviours originate and appropriate intervention techniques to deal with them. A key feature of the program is to insulate young people from contact with other delinquents and to promote activities that will bring them into relationship with less troubled youths. As indicated earlier, the Oregon MTFC model used by Algoma Family Services is considered an efficacious treatment intervention for young people with high support needs (Chamberlain & Reid, 1991; 1998).

Case study - New Directions Bridges

Another Canadian example of treatment foster care is the Bridges program run by New Directions. Bridges provides professional parent and specialised foster placements for children and young people with mental health and behavioural issues. The children in the Bridges program are aged 6 to 18 years and are generally referred to the program by a Child and Family agency or one of the Manitoba Services offices. The objectives of the program are to provide support to individuals so that they can achieve independence, community involvement, safety and stability in the

community. Bridges develops a person centred plan in consultation with the family, referring agency, school and day program personnel. The needs of the children create the team that works for them, therefore, the program is highly individualised and there is no standardised routine of activities for the children. The foster parents are provided with parent skills training and guidance by case managers and given access to respite services. The children typically stay in the program until adulthood and may maintain contact with the agency once independent. The program does not appear to adhere to any specific theoretically-based intervention of the nature employed in the Algoma program described above. However, New Directions appears to offer a promising placement option for children and young people with mental health and behaviour problems and is worthy of further investigation.

4.4 Residential Programs

The therapeutic residential care model is not a new development in the field of children's mental health. However, it is an important treatment option for children who are unable to cope or safely reside in a less structured setting. In the past, residential care has been considered the last resort for children who were difficult to place in the care system now, in North America, it is considered to be a crucial service for children with significant behavioural and emotional disturbances. Traditionally, residential facilities did not include treatment or therapy and were instead primarily a care and housing option for large groups of children. Although it is true that such placement arrangements have generally not been family-based or family-like and are therefore often considered less desirable from a child welfare perspective, such arrangements are nonetheless seen as an effective way to provide very intensive and structured treatment at residential campuses, and often with an emphasis on creating more family-like environments.

4.4.1 Larger residential units

As indicated in Table 4.1, 133 (18.3%) a number of residential campus-based programs were identified via the Internet search as providing treatment services for children who might otherwise be placed in foster care. The mean number of children served by individual residential programs served was 46.89 (*SD* = 25.29) with a range of 4 -128. The majority of the programs served both male and female clients at the same campus (65.7%), 15.7% served just males, 11.9% served just females and

6.7% of the agencies served male and female clients separately on the same campus. The programs served mainly adolescents or older children (the mean minimum age was 9.16, *SD* = 4.22) and the mean maximum age was 16.85 (*SD* = 2.74). The main source of referrals was from the care system (97.8%); 15.7% came from mental health departments and juvenile justice systems; 3.7% from the education department/services; and 3.7% came from community/private sector. The main reasons for referral to the program included behavioural problems (83.6%), emotional problems (73.8%), and social/peer problems (52.2%). Grief and loss problems were identified as a reason for referral in 14.2% of the programs and sexualised behaviours/offending in 11.2% of the programs. The average duration of service for this particular program type was close to one year (49.92 weeks, *SD* = 30.02), with a range of 2 to 104 weeks. The majority of programs employed rostered staff to provide care and treatment for children and young people. Only 3.7% (5) of the programs were identified as having live-in carers/parents.

Table 4.3 Larger Residential Facilities: Dimensions of care

	United States (*N* = 133)	Canada (*N* = 12)
Staffing arrangement		
Live-in foster carers	3.7	8.3
Rostered staff	96.3	91.7
Therapeutic Approach		
Behavioural/ Token Economy	44.0	20.0
Psychotherapy	19.5	16.7
Play therapy	14.2	18.2
Milieu therapy	17.2	40.0
Attachment therapy (non-holding)	0.7	0.0
Attachment (holding)	0.7	25.0
Therapy Type		
Individual	94.0	45.5
Group	84.0	45.5
Family	46.3	41.7
Specific Interventions/ Services		
24-hour support services	44.0	27.3
General/ unspecified interventions	70.1	9.1
Support groups for carers	2.2	9.1
Periodic visits to parents	35.8	0.0
Special tutoring	57.2	36.4
Social skills training	30.1	36.4
Independent living skills training	26.1	45.5
Adventure-based activities	43.3	36.4
Special curriculum	40.3	36.4
Vocational guidance	21.6	9.1
Parent Skills training	8.2	0.0
Self-esteem building	9.0	40.0
Community service activities	9.7	9.1
Wraparound	3.0	9.1
Mentoring	4.5	0.0
Anger management counselling	9.0	20.0
General communication skills	4.5	9.1
Grief/loss/PTSD/trauma	3.7	0.0
Self-assertiveness training	2.2	0.0
Peer support models	8.2	9.1

Note: Due to missing data, the *N*'s vary across the different items so that percentages are based on different denominators.

As can be seen from Table 4.3, behavioural management/token economies (44.0%) are the common treatment intervention used in this particular program type in the United States. Psychotherapy (19.4%) was also another common treatment

intervention employed. Close to 30% of the programs also used social skills training and 43.3% reported employing some form of adventure-based therapeutic activity such as camping, equine therapy or ropes courses. Over half of the programs offered educational supports/tutors to the children and young people, and 40.3% of the programs had specially designed curriculum. Just over a quarter of the programs also offered vocational guidance assistance. Over a third of the programs offered periodic home visits for the children and young people, and 46.3% offered family therapy as part of the program. Nearly all of the programs offered individual therapy of some kind, and group therapy was available to the children and young people in 85.0% of the programs.

Very few Canadian programs were identified, so great caution needs to be applied in interpreting these data. However, similar trends to what was observed for treatment foster care were also noted. Very few Canadian residential programs use behavioural techniques, few advocate individual therapy, and few advertise outreach services to parents (e.g., periodic visits). However, the range of specific services appears to be very similar to the United States.

4.4.2 Examples of larger residential units in America

Two promising examples of this treatment program classification type identified via our internet search are the Mercy Home for Boys and Girls in Illinois and the Laurel Health System in Pennsylvania.

Case study - Mercy Home for Boys and Girls – Illinois

Mercy Home for Boys and Girls is an example of a therapeutic residential centre for troubled young people experiencing learning disabilities, poor academic achievement, gang affiliation, substance abuse, and/or court involvement. Many of the children have been abused, abandoned or neglected. The Home provides care for approximately 100 children and accepts children referred from both private families and from the Department of Children and Family Services. The Home receives the majority (99.2%) of its funding from private donations.

The Home is offered for youths aged 11-21 years and provides 24 hour supervision by rostered staff. Private education is available for youth along with

tutoring and educational counselling. A behavioural-oriented intervention is used as the main form of treatment during individual therapy. Children also participate in family therapy. The youth have access to mentors and an employment assistance program. Children in the program can attend either local public or alternative schools and the Home develops individual education plans for each child. Mercy Home also has an aftercare program for graduates of the program to assist and support their transition from the program to independent living or reunification with their families. No evaluative data at the time of the review were located, but the program model appears to be a promising care option that is worthy of further investigation.

Case study- Laurel Health System – Pennsylvania

Laurel Health System offers a residential treatment program for youth aged 12 to 18 years presenting with problems such as arson, assault, sexual assault, theft, truancy, running away and a variety of clinical diagnoses. The long-term residential centre serves up to 32 youths for a period of six to twelve months. The youth receive 24 hour supervision and the client to staff ratio is 4 to 1. The staff consists of a team of professionals, including psychologists, educational specialists, and psychiatrists. The youth are provided with individual, group, family and recreational therapy.

The treatment milieu is based on basic child care practices such as routines and limits, feedback, team building and positive peer-guided interactions and treatment. The principles of the treatment program utilise elements from cognitive behavioural therapy, reality therapy, positive discipline and Balanced and Restorative Justice (BARJ). The BARJ program assists youth in developing the competencies and skills they require for adulthood. These include anger management, problem solving skills, and conflict resolution. A treatment plan is developed for each youth in collaboration with the youth, their family, the referring agency and the treatment team. The treatment plan is reviewed regularly, and in some cases, revised on a monthly basis. The plan is utilised to monitor the youth's progress based on the program's level system, whereby more privileges and responsibility are awarded as they advance through the program.

The youth's education is provided in an alternative on-grounds classroom provided by the Southern Tioga School District and approved by the Department of

Education. The residents may also have the opportunity for vocational and work experiences. Youths are mainstreamed on a part-time or full-time basis in the public school when they are academically and socially ready.

At the time of the review no evaluation data were located, but Laurel Health Services residential treatment model also appears to be worthy of further investigation as a possible treatment model for young people with similar needs in Australia.

Case study - Andrus Children's Center – New York

Andrus Children's Center is a large provider of programs and services for children and families in New York. The Center provides services for approximately 2500 children and families each year, with a broad array of preventive and restorative services for children from birth through to adolescence. One of their programs is a large residential treatment service that serves sixty children aged 5 to 14 years of age. The children reside in Tudor-style cottages under the full-time guidance of trained staff members. The main goal of the Residential Treatment program is to help children and families plan and meet treatment goals that will ultimately allow them to live together at the completion of the program. Nearly 90% of the programs graduates reunify with their families.

The therapeutic model utilised by all of Andrus' program is the Sanctuary Model developed by Sandra Bloom (Bloom, 1997). It is a trauma-informed model for creating or changing an organisational culture. Originally developed in a short-term, acute inpatient psychiatric setting for adults who were traumatised as children, the model has been adapted for residential treatment settings for children, public schools, domestic violence shelters, group homes, substance abuse program and parenting support programs. The Sanctuary Model is not an intervention but rather a 'full system approach'. The model is based on the premise that the therapeutic environment is a critical determinant in facilitating the recovery process. Within the context of a safe, predictable therapeutic community, "a trauma recovery treatment framework is used to teach youths effective adaptation and coping skills to replace nonadaptive cognitive, social and behavioural strategies that may have emerged earlier to deal with traumatic life experiences" (Rivard et al., 2003, p. 139). The aims

of the model are to guide an organisation in the development of a culture with seven dominant characteristics. The seven characteristics serve goals related to a sound treatment environment and are as follows (Bloom, 1997):

1) Culture of Non-violence – building and modelling safety skills and a commitment to higher goals
2) Culture of Emotional Intelligence – teaching and modelling affect management skills
3) Culture of Inquiry & Social Learning – building and modelling cognitive skills
4) Culture of Shared Governance – creating and modelling civic skills of self-control, self-discipline, and administration of healthy authority
5) Culture of Open Communication – overcoming barriers to healthy communication, reduce acting-out, enhance self-protective and self-correcting skills, teach healthy boundaries
6) Culture of Social Responsibility – rebuilding social connection skills, establish healthy attachment relationships
7) Culture of Growth and Change – restoring hope, meaning, purpose

Furthermore, according to Bloom, the impact of creating a trauma-informed culture should be observable and measurable. As such, all of the programs are extensively researched to ensure that a trauma-informed culture has been created.

All of the children enrolled in Andrus' campus-based programs attend the on-site Orchard School. The school has a maximum of 1:4 staff to student ratio so that students receive highly specialised instructional services. The school uses the Sanctuary Model of treatment, where community is treatment. The Orchard School provides a welcoming environment in which children feel safe, can address affective issues and acquire academic skills. The school also integrates neurodevelopmental psychology with classroom instruction and related service provision. A multidisciplinary instructional team improves the staff members ability to continuously assess student functioning. The school ensures that the students receive plenty of opportunity for artistic and athletic exploration, such as adventure-based counselling program, chorus, dance and the National Youth Program Using Minibikes (NYPUM).

The Sanctuary Model used at Andrus' Children Center appears to be a very promising model for working with traumatised children in a residential setting. It is considered an evidence-based, trauma-informed, organisation and clinical model (see Bloom, 2005).

4.4.3 Examples of smaller residential units in America

Campus-based group care or smaller residential units comprised 29.4% (213) of all of the American programs identified by the international audit (see Table 4.4). A program was classified as a smaller residential program if it served children and young people in smaller groups on a campus-based residential facility. Only 10.7% of this program type was identified as having live-in parents as the main carer for the children and young people. The mean number of children the programs served was 14.98 (*SD* = 16.90). The majority of programs served both male and female clients together (63.1%), 16.4% served males only, 9.3% served females only, and 11.2% of the programs served males and females separately. The mean minimum age the programs served was 9.53 (*SD* = 3.75) and the mean maximum age was 17.29 (*SD* = 2.56). The referral sources included care system departments (98.6%), educational services (3.3%), community/private sector services (3.7%), juvenile justice services (9.8%) and mental health services (10.7%). The main reasons for referral to this type of program included; behavioural problems (82.2%), social/peer problems (52.3%), emotional problems (75.7%), grief and loss issues (7.9%), sexualised behaviours/offending (5.1%), developmental delay (5.1%), and physical or intellectual disability (16.4%).

Table 4.4 Smaller residential units in America

Group care (campus-based) (%), *N* = 213 (29.4%)	
Location	
Community-based	0.0
Campus-based	100.0
Staffing arrangement	
Live-in carers/parents	10.7
Rostered staff	89.3
Treatment intervention services	
Behavioural /token economy	48.6
Milieu therapy	14.5
Attachment (holding)	0.5
Attachment (general)	1.4
Grief/loss/PT*SD*/trauma	3.3
Cognitive-behavioural	7.0
Anger management	6.1
Abuse counselling	2.3
Relapse prevention	2.3
Post-abuse counselling	0.5
Psychotherapy	17.8
Self-esteem	13.6
Self-assertiveness	6.1
Play therapy	12.6
Social skills	33.7
General communication skills	6.7
Sex education	4.7
Conflict resolution	2.8
Other	63.1

As can be seen in Table 4.4, behavioural training/token economies and social skills training were again featured as a common treatment intervention for the children and young people. Psychotherapy was offered in 17.8% of the programs, and self-esteem training was offered in 13.6% of the programs. Adventure-based therapy was also another common form of treatment intervention offered to children and young people in campus-based group care. Close to sixty percent of the programs offered educational supports/tutors, and just under half had specially designed curriculum available to the children and young people. Twenty-hour crisis intervention was another service commonly offered in this program. Close to thirty percent of children and young people in this program type were offered vocational guidance and independent living skills training. Half of the programs offered

periodic home visits and family therapy to the children and their birth families. Individual and group therapy was available to the majority of children and young people in campus-based group care programs.

Smaller residential units in America

The example of smaller residential units or campus-based group treatment have live-in carers/parents that provide 24 hour care and treatment to children and young people and are often referred to as cottage style care: The Children's Home Of Easton in Pennsylvania (two other examples can be found in Appendix D: The Harbor House for Teens in Oklahoma and The Florida Sheriffs Youth Ranches Incorporated). The other two examples are campus-based group treatment models that have rostered staff that provide the 24 hour care and treatment: the Intermountain Children's Home and Services in Montana and the Baby Fold in Illinois (see Appendix D for description).

Case study- The Children's Home of Easton – Pennsylvania

The Children's Home of Easton in Pennsylvania is an illustration of the cottage style treatment model. The home is a private, non-profit agency that provides treatment for up to 50 troubled children aged 9 to 18 years. The agency states that they provide services to children in need in a home environment, not an institutional environment. The children live in cottages and function as a family. Each of the four cottages has live-in house parents that provide treatment to the children. The children attend public, private and parochial schools whilst participating in the program. When children are admitted to the program, the staff assesses their educational level and establishes their placement in the correct grade level. Until the children are placed in school, the Children's Home of Easton provides interim schooling on campus. The Home also provides additional educational services such as evening tutoring, GED tutoring and a Summer Enrichment Program. The Home also ensures that the children are prepared for independent living through a formal program. The independent living program covers such topics as job hunting, money management and daily living skills. For the children who attend college, the Home provides both financial and moral support during the child's time in college. Furthermore, the children receive vocational training at area vocational schools.

The children live in cottages with up to four other children and receive treatment and support from the trained house parents. The house parents receive pre-service and ongoing in-service training and provide the homelike environment for troubled children. The programs at the Home are individually designed for each student and assist the children to return to the community as responsible citizens. In addition, the program provides counselling services to the children and their families. At the on-site Family Enrichment Center, the children and their parents participate in individual and group therapy, psychiatric and psychological evaluations and art therapy. The staff at the Home consists of 115 members including case-workers, teachers, nurses, physicians, a chaplain, house parents and administrative and support personnel.

At the time of the review, no psychological data was available on the children and young people. However, the Children's Home of Easton's Annual Report (2004) provided some basic information on the location and number of children discharged from their programs and the number of children currently at school or who had graduated from school. The program appears to be a promising model of residential group service for young people that is worthy of further investigation.

Case study- Intermountain Children's Home and Services – Montana

Intermountain Children's Home and Services is a non-profit organisation that provides treatment program to children suffering from moderate to severe emotional disturbances. One of their residential treatment programs is a Therapeutic Youth Group Home for children aged 4 to 11 years who are emotionally disturbed and have attachment disturbances. The Home is an example of a group residential treatment model. The children live in groups of eight in one of the four on-site cottages that are operated by rostered workers. The children are supervised 24 hours a day. During the day, there is a child to staff ratio of 1 to 4 and an overnight staff to child ratio of 1 to 8. Directors and Program Leaders provide on-call crisis support.

The children referred to the Home have a variety of diagnoses. Some of the most prevalent diagnoses are Reactive Attachment Disorder, Post Traumatic Stress Syndrome, and other affective disorders. The Home serves children and families from Montana and all of the United States. The program serves children who are in

the care of their birth parents, have a temporary legal custody status with the state, children in permanent care of the state, or are adopted.

Upon entry to the program, children undergo extensive assessment and consultations with the members of their treatment team. All of the children are psychologically tested, psychiatrically consulted and educationally assessed. The program also provides other services if there is a need, such as speech therapy, occupational therapy, psychiatry services and medical services. Furthermore, the Home has an on-site Registered Nurse who coordinates the medical care for the children. The program uses medication conservatively, and a group of professionals and clinicians work in consultation with the treatment team to determine if medication is needed to assist the child in their treatment process. The Registered Nurse, Clinical Director and Consulting Psychiatrist meet with each team's medication representative and therapist on a weekly basis to assess and discuss medication needs of children. All members of the child's treatment team work with both the child and family to develop an individualised treatment plan.

The program also has special education teachers that have extensive experience teaching children with disabilities. The teachers guide the children through the development of positive self-esteem and a sound self-concept. Furthermore, at the Intermountain Children's Home, the Chaplain attends to the spiritual needs of children in the residential program. The Home has a long history with the Christian faith; however, children are provided opportunities to follow the faith of their choice.

The treatment philosophy of the Intermountain Children's Home is based on the attachment model of therapy. The staff members at the Home believe that children cannot resolve psychological issues underlying disturbed behaviour until they have successfully formed a relationship with a significant adult. When children enter the program, they are provided with structure, control and emotional containment so that they are able to express their intense feelings within a close relationship with the adult who is treating them. The containment is provided through the structure of the milieu, through various interventions such as rocking, playing, soothing and confrontation, and may also involve holding the child during displays

of emotional distress. The attachment model encourages the expression of all emotions, even in their rawest forms. The treatment milieu retains two basic rules for the children. First, the children will experience increased freedom once trust has been established between the child and an adult. Second, the children will only be able to participate in emotional work once they feel safe and cared for by adults in the Home.

The length of treatment is generally 18 months to two years and is designed to help the child internalise the changes made, generalise the trust of adult care and leave treatment. The Home considers that each child moves through predictable stages of treatment, and specific treatment interventions are dependent upon the stage of treatment. The first stage is 'engagement', whereby the child learns to trust the safety of care and control. This generally takes place in the first several months of treatment. The second stage is referred to as 'working through'. During this stage, the child has formed an attachment with significant staff on campus and begins to tolerate more anxiety and expresses feelings in more direct ways. The child begins to recognise that current life is different and safer than past experiences. The third stage is 'adaptation/separation'. The child continues to work through difficulties in therapy and in the milieu, but they are more able to express themselves directly, and use therapy and relationships to contain pain. In addition to the therapeutic milieu and attachment therapy, the children receive individual, group and family therapy. Each child has a therapist on their treatment team that coordinates and oversees the clinical work of each child and family. The Home also offers case management services in order to coordinate the care and treatment of the children. Case mangers attend to the administration and operation of the program. They also keep a focus on the child's discharge plan and help families acquire the services needed in their home communities. The Home views case management service as critical to its ability to achieve the goal of permanency for children.

The Intermountain Children's Home and Services tracks children for two years following discharge from their Therapeutic Youth Group Home program. The Home defines treatment success as the child remaining relatively stable in post-discharge placement and requiring only out-patient or community-based services to achieve this stability in their placement. Therefore, the child needs to remain in the

placement without high levels of intervention. At the time of the review, the Home was reviewing follow up studies to provide information on the children's functioning after they leave treatment. The placement model appears to be a promising residential group care approach for emotionally disturbed children and young people.

4.4.4 Examples of smaller residential units in Canada

Case study- Wood's Homes Programs and Services Residential treatment service

An example of a smaller residential program in Canada is run by an agency named Wood's Homes. Wood's Homes offer 25 programs and services to young people aged 11 to 18 years. Wood's Homes serves young people who present with problems such as externalising behaviour problems, maltreatment issues, attachment problems, violence, school difficulties and placement breakdown. The agency operates short-term and long-term small group homes that teach young people basic living skills. The treatment approach of the group homes is a wraparound treatment model.

As part of the daily routines of the group homes, children may participate in a number of group activities, such as journal work, quiet time, chores, and nightly reflections. The daily routines also vary depending on the time of the year. During the school year, the children carry out school routines, whereas during the summer the young people participate in campus recreation activities such as camping and horse back riding.

The staff at Wood's Homes includes social workers, child and youth workers, nurses and psychiatrists. All of the programs also have full-time therapists that deal with individual, family and group work. Woods' Homes also provides specialised group programs to a number of young people dealing with serious issues, such as adolescent sex offenders, Aboriginal youth with solvent/substance abuse, and youth involved in prostitution. Educational programs at Wood's Homes consist of therapeutic/educational services in the community, partnered with the Calgary Board of Education and the Calgary Catholic School District. Regional programs are services outside the Calgary area. No evaluation data were available at the time of

the review but this model appears to be a promising care option that is worthy of further investigation.

Case study- Macdonald Youth Services Specialized Individual Treatment Program

Another example of a small residential program in Canada is MacDonald's Youth Services Specialised Individual Treatment program. The program serves young people aged 10 to 17 years of age exhibiting high behavioural and emotional needs such as physical aggression, ADHD, and mental health problems. MacDonald Youth Services provides ongoing healing and individual treatment plans for the youth placed in the program. Each young person receives close 1:1 supervision with staff, and the children do not have free time. The agency runs three group homes that serve male and female young people separately. The majority of the children attend specialised classes and the program staff is able to accompany children in the classroom. Older youth who do not attend school have access to job skills and training provided through external agencies.

MacDonald Youth Services develops daily chores and recreational activities that are based on the children and young people's interests and abilities. The children and young people also partake in groups and workshops targeting a number of areas, including anger management, relationship building and grief and loss. Staff are trained in non-violent crisis intervention, suicide intervention, and counselling techniques. Intervention plans attempt to address developmental, emotional, relationship, and life skills needs. Adolescents are assisted with personal safety planning such as social skills, positive family contact, anger management, and daily problem solving. The agency is guided by a Strengths perspective, in which emphasis is placed on listening to youth, celebrating successes, and relationship development. There is also an Individual Treatment and Support Program (ITS) targeting youth 16 to 18 who need supports to become established in the community. The programs aim to enable youth to make positive choices, to foster self-worth and dignity. Again, no evaluation data were available at the time of the review but the model appears to be a promising care option that is worthy of further investigation.

Case study- Project DARE Therapeutic Adventure Residential Program

Project DARE in Canada provides a small residential program for young males aged 11 to 17 years who present with challenging behaviours such as drug abuse, truancy, and anger management issues. The provincially funded program has been in operation for over 30 years and has a therapeutic adventure approach which serves up to 20 youth. The program places youth into a "crew" of 10 youth who provide the context for therapy and community. Project DARE places the youth into groups of 10 and because it believes that group size allows for natural conflict as well as constructive resolution. There are four levels, representing the developmental stages that the youth will pass through with increasing levels of autonomy and choice. The crew spend time in dealing with practical challenges involving menu planning and care of personal gear for activities such as rock climbing and rappelling. The daily routine followed by the young people in the facility begins with a 6:45 wake-up, morning chores, then breakfast at 8 followed by kitchen clean-up and morning activity from 9:30 to 12. Lunch and cleanup take place at 12.15, afternoon program from 1:30 to 4:45 and supper and cleanup at 5:15. Evening program from 6:45 to 9 is followed by an hour for phone calls to family, letter writing, reading and homework before dorm lights are out at 10 and bunk lights are out at 10:30. The experience at DARE includes community service work and earning school credits, as there is an integrated academic curriculum. The program supervisor consults with instructors, a teacher, and clinical support/supervision through a local counselling service.

An evaluation conducted on 57 young people in Project DARE (Russell, August 2004) concluded that it appears to be an effective intervention to help improve anger management and social skills of young offenders. Significant improvements were not observed in their emotional and behavioural well-being, but their discharge scores reflected the fact that the young people were still in need of treatment and further aftercare.

Case study- Maples Adolescent Treatment Centre, British Columbia

Maples is a short-term residential treatment service for young people aged 11 to 17 years. The Centre operates a four week residential assessment service (two twelve bed units and six respite beds) and a three month residential treatment

program (The Orinoco program). The service uses attachment theory for young people diagnosed with conduct disorder. The young people reside on-campus and attend the on-site school. After discharge, the outreach team provides ongoing support to carers and other people from the young person's network, including community agencies. The treatment team at the Centre is multi-disciplinary and is drawn from psychiatry, psychology, social work, education, nursing/child care and youth work. The assessment program uses attachment theory and social ecological theory to treat young people diagnosed with conduct disorder. Social ecological theory was proposed by Brofenbrenner (1979) and the theory defines complex "layers" of environment with each layer having an effect on the child's development. Therefore, the focus of treatment is addressing unresolved attachment and affiliation issues that are situated in the layers of the child's environment. This theoretical approach to treatment also informs multisystemic theory (MST), described in the previous chapter.

The Orinoco C.A.R.E. (Caregiver, Adolescent Resource Enhancement) Program provides medium-term treatment in addition to assessment. The program is run during the week with young people returning home on weekends. The program works with both young persons and caregivers. The Orinoco program also uses attachment therapy along with family therapy, therapeutic home based care, parent training, social, cognitive and school interventions, and vocational training. Treatment is conducted primarily via a relationship with a key worker, who has the responsibility for the treatment of two young people. The treatment is conducted both on an individual and group basis, and the young people spend a considerable amount of time with the key worker outside the unit. An evaluation of the program demonstrated a reduction of problem behaviour and emotional difficulties reported by the young people and their caregivers over an 18-month follow up period (Moretti et al., 1994, cited in Morton, Clark & Pead, 1999).

4.5 Group homes in the Community

Community-based group homes was identified as a stand alone category of care and treatment. In many States of Australia, such arrangements would be considered forms of residential care, even if they had only one child, if the staffing did not include any person designated as a "foster carer". However, if one defines residential

care in terms of its physical characteristics and general living environment rather than its staffing, then group homes can clearly be differentiated from the larger or small cottage style arrangements described above. Group homes or congregate care have often been criticised because they have the potential for negative associations and relationships with other peers living in the home (Barber & Delfabbro, 2004; Sallnas, Sallnas, Vinnerljung, & Westermark, 2004). However, some current forms of group care have many advantages. First, they are able to provide care and treatment in the community so that children and young people can attend local schools, use local resources, and feel less restricted in their daily lives. Second, the children and young people can still receive the same level of intensity of treatment and services as residential placements.

Community-based group care programs only comprised 4% of the total number of programs identified by the internet search in America. Programs were classified as this type if they served children and young people in a small group in the community as opposed to a campus-based facility. Half of the examples of this program type were identified as having live-in or “house” parents as the main carers of the children and young people in the program. The mean number of children and young people this type of program served was 8.14 (*SD* = 4.00), with a range of 3 - 16. The majority (77.3%) of the community-based group care programs served both male and female clients together, 9.1% served females only, 4.5% served males only, and 9.1% served males and females separately in different locations. The mean minimum age was 11.5 years (*SD* = 4.83) and the mean maximum age was 18.5 (*SD* = 2.32), with a range of 14 – 22 years. The main referral source was from the care system (100%), and 4.5% of referrals came from either juvenile justice system or the mental health system. The main reasons for referral included behavioural problems (81.8%), emotional problems (59.1%), and social/peer problems (54.5%). Sexualised behaviours or sexual offending issues were identified as a reason for referral in 4.5% of the programs. Only one of the programs identified the duration of service as being approximately one year.

Table 4.5 Community-based group care dimensions of care, *N* = 29 (4.0%)

Location	USA
Community-based	100.0
Campus-based	0.0
Staffing arrangement	
Live-in carers/parents	50.0
Rostered staff	50.0
Behavioural /token economy	27.3
Milieu therapy	4.5
Grief/loss/PTSD/trauma	4.5
Cog-behavioural	4.5
Anger management	4.5
Psychotherapy	22.7
Play therapy	13.6
Social skills	27.3
Adventure-based activities	22.7
Peer support models	4.5
Other	36.4

Inspection of Table 4.5 demonstrates that the main types of treatment intervention included behaviour management training/token economies, psychotherapy, social skills training and adventure-based therapy. Close to thirty percent of the programs offered educational supports/ tutors, and 13.6% had specially designed curricula available to the children and young people. Close to seventy percent of the programs had 24-hour crisis intervention available to the staff or carers caring for the children and young people. Approximately half of the programs offered vocational guidance and independent living skills training. Less than thirty percent of the programs also had periodic home visits and family therapy available to the children and families in the program. All of the programs offered individual therapy, and 90.9% offered group therapy to the children and young people.

Community-based group homes were not a common treatment model utilised in Canada, although one example run by New Directions in Manitoba will be described below.

4.5.1 Examples of staffed community-based group care programs in America

The first two examples of community-based group care programs employ rostered staff to provide care and treatment to the children and young people. Boys

Republic in California and Stanford Home for Children in California, whereas the last two examples have live-in carers/parents as opposed to rostered staff: Hearthstone of Minnesota (HOM) and the Charlee Program in Florida. Such programs are often referred to in the literature as Supported Community type programs. The Supported Community model is slightly different from many of the other models operating for children with behavioural and emotional disturbances. Placements tend to be located in the community and involve small groups of children being cared for and treated by trained house parents. In addition, several homes are commonly clustered together. The location and positioning of the homes replicates a family-like environment, with a close support network of other children and trained staff. The close proximity of the other children and house parents is intended to replicate the situation that might prevail in the general community, in which families live in close proximity to other relatives. These other house parents can act like aunties and uncles to the other group home children and are available for both support and respite services. In this sense, the arrangement combines the characteristics of treatment foster care, and some of the elements of some residential care programs, in that multiple carers and support services are available in the same location.

Case study- Boys Republic - California

Boys Republic is a private non-profit, non-sectarian school and treatment provider for troubled youth in California. Boys Republic, along with its companion program, Girls Republic, has served more than 23,000 at-risk teenagers since it was founded in 1907. The organisation runs many residential and community-based programs. Their satellite community-based programs are good examples of a staffed community-based group treatment model. The children reside in homes in the community and receive 24-hour supervision and treatment, whilst living in the smaller, less-restrictive family-type setting. Each of the Boys Republic homes accommodates between 10-20 boys, whereas each Girls Republic home serves up to 8 girls. The children attend local public high schools or the on-grounds public school at the Boys Republic campus. All children receive psychiatric and psychological assessment and therapy, including individual professional counselling. The children also participate in group and multi-family counselling. Educational, vocational and substance abuse counselling is offered to the students as part of the program,

including a vocational training module. All of the youth complete work experience and employment training. Boys Republic also provides aftercare services for all graduates and a transitional housing program.

The Boys and Girls Republic 2003 Annual Report (Boys Republic, 2003) stated that close to 700 young people (N= 679) were served in residential and day treatment programs in the last financial year. Of those children served, approximately 80% of incoming students were in other placements, and more than 60% of the boys treated had histories of physical and sexual abuse. Approximately 80% of the girls treated in the residential programs had been physically or sexually abused. Nearly all (95%) were referred to the programs with emotional and/or behavioural problems. Additionally, nearly three out of four students referred to Boys Republic were below academic grade level. Boys Republic reported that the average length of treatment for students in the residential programs was 9 months. It was also reported that 100% of the student body earned school credit, including a significant number of students who advanced one full year or more academically. Furthermore, upon graduation, more than 80% of the residential students returned home. The rest of the residential students either returned to the home of another relative or were emancipated through the Independent Living Program and utilised the program's aftercare services to live on their own.

In addition to the above mentioned outcome measures, Boys Republic also reviews youth as part of their aftercare follow-up program. The evaluation occurs at regularly scheduled intervals, over a one-year period following the youth's graduation. The outcomes for those children and young people specifically residing in community-based group homes were very positive. It was found that 85% of the graduates of the community residences program were considered law-abiding citizens based on the fact that they were free from arrest in the previous 12 months. Additionally, none of the graduates from that program were on Welfare, and most were attending college, were working or were enrolled in the Military. Moreover, all of the community residences graduates were residing in acceptable living arrangements. As a final point, the results indicated that in comparison to the outcomes of residents of other programs, the community residences graduates fared considerably better (Boys Republic, 2003).

Case study - Stanford Home for Children - California

Another example of a staffed community-based home model is the Stanford Home for Children in California. The Stanford Home for Children is a non-profit, non-sectarian organisation providing services for vulnerable children and their families. Standford Home for Children provides treatment programs for emotionally disturbed troubled teens aged 12-18 years. The children are generally referred through social services departments, probation or mental health services. Stanford Homes has four community-based treatment homes with rostered staff that provide 24 hour care supervision and treatment. The staff consists of child care counsellors, social workers and case managers. The children receive a psychiatric assessment, psychopharmacological assessment and treatment, medical services, and case management services upon entry to the program. All the children have individual treatment plans tailored by the staff to meet their specific needs. The children participate in individual, group and family therapy that involves behavioural modification, milieu therapy and life skills development. The program also offers therapeutic recreation and vocational training.

Stanford Homes also has a day treatment program that provides a special education treatment program with individual education plans. The Jane Lathrop Special Education Private School operates the day treatment program. The school program is designed to meet the needs of children exhibiting severe emotional, behavioural and learning difficulties. Therapeutic services are targeted at helping the children transition back to a community school, graduate from high school, and ultimately to earn a GED. A professional academic and treatment team staffs the school. The team consists of special education teachers, consulting psychologists, art therapists, speech therapists, therapists, behaviour management specialists, and a vocational counsellor. In addition, the school offers individual group and family therapy, crisis intervention, psychiatric consultation, speech therapy, enrichment curriculum, interscholastic athletics, vocational services, tutoring and GED preparation.

The vocational program at Stanford Homes is called Stanford Works, It is an intensive program designed to teach high-risk youth the pre-vocational and vocational skills they require to function in the community. StanfordWorks assesses

and matches teenagers with appropriate employment that suits their interests and level of skill. The students may work at the Stanford Home administrative office, StanfordWorks career centre, Stanford Home's School, or at a job in the community. The students earn minimum wage and are expected to meet all job requirements and to demonstrate a good attitude toward work. A job coach is utilised as a liaison between the student and the employer to ensure appropriate work behaviours on the job. The program also offers training in resume writing and prospective future job placements.

The treatment services at the Stanford Home for Children are outcome-driven, as they are designed to assist the children to achieve one of three long-term goals, namely returning home to live with one's family, living with a foster family, or living independently in the community when they reach 18 years of age. However, at the time of the review, no outcome data were located on the outcomes for the children in the program, but this appears to be a promising model worthy of further investigation.

4.6 Community-based group care – with live-in carers/ foster parents

A very similar model of community based group care is referred to as the supported community model. Unlike in the other group home models described above, carers are specifically referred to as foster carers rather than just house parents or live-in workers. This model is not new in that the worldwide organisation, SOS villages, has utilised this type of model for several decades. Essentially, the model is designed to build upon the strengths and advantages of foster care and bring in the added benefits of a campus-based model whilst still in the community. The foster care homes are situated in the suburbs in a cluster and generally have a main or core home that houses staff and clinical specialists. The foster homes are clustered together so that foster parents can gain support from one another, provide respite services, and furnish a relative-type relationship (i.e. aunty or uncle) to the foster children in the other homes.

4.6.1 Examples of community-based group care with foster parents in America

Case study- Hearthstone of Minnesota (HOM)

An example of a community-based group care model is run by Hearthstone of Minnesota (HOM), which is a private non-profit organisation designed to provide care and treatment for males aged 6 to 18 years with emotional and behavioural disturbances. HOM has 8 group homes situated in the community. The foster group home program is based on a family model with live-in carers who offer a therapeutic setting in which youth can experience a nurturing and stable family environment. The model is designed to develop the young people's ability to live successfully in a family, in the community and in society. The program aims to improve the youth's ability to trust adult role models, to function in the home, school, and community and to achieve satisfactory self-confidence. Each child receives an individual treatment plans upon entry to the program. All children are referred to HOM either by their local social service agency or by private agency or individual referral.

Family care and treatment are provided 24 hours per day by live-in family care parents who have the skills to care effectively for this group of youth. Family care parents are supported by the treatment staff who provide ongoing support, consultation, and coordination of each child's individual treatment plan. Family care parents also have the support of a treatment staff that consists of a director of program operations, a program supervisor for each home and a recreation therapist. The treatment staff also coordinates the child's treatment with other service providers working with the child, the school and the county.

The program utilises community resources and networks to assist in the child's development during their time at the group home. The model is an alternative to residential treatment for those youth whose needs can be safely and effectively addressed within a family group home setting. The length of stay in the home is determined on an individual basis. HOM's primary focus is to provide the children with a sense of permanency and stability.

No evaluation data were available at the time of the review but the community-based foster treatment model utilised by HOM appears to be worthy of further investigation.

Case study- The Charlee Program – Florida

The CHARLEE program in Florida is another example of a foster community-based group treatment model. The CHARLEE program runs six community-based family care group homes. The homes were developed in order to provide high-quality long-term therapeutic foster care for adjudicated dependent children between the ages of ten and seventeen. The children referred to the program have had significant histories of abuse and neglect and have experienced multiple placements within the current child care system. The children accepted into the program are children who have been considered in the past as "hard-to-place". The program accepts referrals to the program from social service agencies the Case Review Committee, the Court, and the Family Service Planning Team (FSPT). Ideally, the CHARLEE programs aims to provide care and treatment to these children until they reach the age of majority and are able to live independently.

The CHARLEE Program operates five family care homes, housing six children per house, in a family style living arrangement. The family care parents are seen as the primary agents of change for the children. Case managers, psychological staff, program aides, secretaries, fiscal personnel and the program director provide support to the family care parents but they are considered the child's principal treatment provider. In addition, therapist, counsellors and other professionals take a secondary role to the family care parents in the child's treatment. The program staff develop individual treatment plans for each child which addresses their educational, vocational, recreational and therapeutic needs of each child. The family care parents are provided pre-service and in-service training on such topics as sexual abuse, separation and loss, behaviour management techniques and specific topics geared for the child entering the foster care system. The children also participate in individual, group and family therapy. A nurse on staff assesses the client's entire medical, dental and vision needs upon admission.

The Charlee program is another example of an innovative community-based care option for young people with emotional and behavioural disturbance that is worthy of further investigation. According to the CEO of the program, the high quality of the CHARLEE program was validated when they were selected by the Florida Legislature to launch the "Model Foster Care Project" in January 2002. However, no outcome data were located at the time of the review.

4.6.2 Examples of community-based group homes in Canada

Case study- New Directions, Community Treatment Centres

The New Directions' Community Treatment Centres are residences for emotionally challenged children and youth. The centres are designed to help young people re-integrate into their community. Two centres are for males aged 6 to 10 and 11 to 13 years of age, while one centre serves both males (ages 8 to 11) and females (aged 13 to 16). The philosophy behind the centres is that children and their families can learn to enhance their strengths and meet challenges and this is achieved through individualised goal setting. The goals of the treatment centres is to promote positive family relationships, build coping skills, self-esteem and responsibility, and develop interpersonal and social skills. There is also a focus on group/daily living, reviewing goals, accessing other New Directions program, and providing individual/family therapy and psychiatric consultation as needed. The treatment centre staff is responsible for daily appointments, community based activities, and liaisons between children, families, schools, and probation services.

4.7 Crisis/Assessment/Transition programs

This particular category of care and treatment is often referred to by many names, including crisis or assessment houses, or transition programs. The model of care is generally for older children who are experiencing high levels of transience and instability and is designed to provide crisis or emergency assistance, and provide a more planned transition to a more appropriate placement. On the other hand, many agencies employ transition programs for older youth who are transitioning from a more restrictive placement such as a residential unit and need to acquire the independent living skills and training before leaving care. Two types of transition programs will be discussed: campus-based and community based.

Community-based transition programs (2.9%) comprised only a small percentage of the total number of programs identified by the internet search. The program served mainly adolescents (mean minimum age = 14.86, *SD* = 4.72, mean maximum age = 21, *SD* = 11.73) transitioning from one program (generally considered more restrictive) to another less restrictive program. The programs served on average 12.33 (*SD* = 5.67) young people, with a range of 2- 44 clients. The majority of programs provided services to both male and female young people together (86.7%), and 6.7% of the programs served only male or female clients separately. Often transition houses are referred to as independent living houses or apartments for young people transitioning from other programs or transitioning out of the care system to independence. Just over 13% of the programs identified having live-in parents as the main carer of the young people, often acting as role models or mentors to the young people. The main referral sources to the program were from the care system (100%) or from community/private sector services. The reasons for referral to the program included behavioural problems (73.3%), social/peer problems (66.7%), grief and loss issues (6.7%), and emotional issues (6.7%).

Table 4.6 Community–based transition house dimensions of care in America, *N* = 21 (2.9%)

Transition house (community) (%)	
Location	
Community-based	100.0
Campus-based	0.0
Staffing arrangement	
Live-in carers/parents	13.3
Rostered staff	86.7
Treatment intervention services	
Behavioural /token economy	46.7
Psychotherapy	6.7
Play therapy	10.0
Social skills	33.3
General communication skills	25.0
Other	53.3

Again, behavioural management/token economies and social skills training were common treatment modalities employed by the programs (see Table 4.6). Play therapy was offered by 10% of the programs and 6.7% offered general communication skills training. A further 26.7% of the programs offered educational

supports/tutors to the young people and 13.3% offered community service opportunities for the young people to become involved in such as volunteering.

Statistics for the Canadian program will not be presented as there were only a few examples of this type of program; however, a few examples that were identified will be described in detail below.

4.7.1 Examples of transition houses in the United States

Many treatment programs throughout America offered supported independent living in combination with other residential and/or community-based programs, but relatively few were offered as a separate treatment models. It should be noted here, that the model is quite flexible and was offered in a variety of settings and structures.

Case study- Chaddock – Illinois

Chaddock in Illinois is a non-profit child welfare agency for at-risk youth including those with severe emotional and behavioural problems. Chaddock operates many residential and community-based services including an independent living program for male and female youth aged 16-21 years. Chaddock receives financial support from public and private funding sources. Fee-for-service monies from state, county, and insurance entities account for approximately 67% of the agency's annual operation income. Approximately 3% of Chaddock's funding is from service agreement and the other 30% comes from private charitable funding accounts.

Chaddock operates an independent living program that has two components: a supervised on-campus program and a community program in off-campus apartments. The programs are designed to prepare youth for self-sufficiency in moving to independence. In the off-campus program, the youth reside in an apartment and are supervised by 24 hour awake rostered staff. The youth participate in weekly individual and group therapy that focuses on independent living skills, behaviour modification treatment, and personal development. Young people are also provided with training in money management, employment and time management. The youth progress through the program in three phases. The first phase involves the identification of goals and objectives with the help of the case manager. These goals

and objectives are then developed into an individualised plan for the youth and the plan may address employment, education, recreation, community services, personal development or like skills training. In the final phase, the client and case-worker develop a plan to transition to complete self-sufficiency and independence.

Chaddock's treatment philosophy for the youth is based on the application of Reality Therapy/Choice Therapy. This form of therapy is established on the principle that individuals are responsible for their behaviour and every behaviour is an attempt to meet one of five basic needs: survival, power, belonging, freedom and fun. The therapy addresses personal strengths and assists individuals in coping with the stresses and problems of life. Effectively implementing this philosophy is dependent on two major factors: creating an environment that is supportive and conducive to allow people to change; and approaching relationships with the following steps that lead to change by allowing people to take more effective control of their lives. Chaddock offers specialised behavioural health treatment for youth through the use of Individual Treatment Plans that are developed by a Core Treatment Team of professionals. The Core Treatment Team consists of the client's therapist, village manager of the cottage where the client resides, school teacher, client services coordinator, and the associate director of clinical services, who supervises the team. Individual Treatment Plans are used by the team for assessment, planning, implementation and evaluation of the client's treatment needs and progress.

In regards to the educational needs of the youth, Chaddock runs its own on-campus private school for youth with behaviour problems. The school is operated by certified special education teachers with a low teacher-student ratio. The school services youth living on Chaddock's campus as well as youth residing off-campus in the community programs. As students progress they may gradually be placed back into mainstream schools.

The young people also participate in outdoor experiential education for example; participating in adventure treks, high ropes courses, backpacking and other outdoor activities. Chaddock is also a faith-based agency and therefore all youth are taught the importance of spiritual awareness and development. In addition Chaddock encourages the youth to be involved in community service. For example, young

people participate in the community by delivering groceries to elderly or visiting the elderly at nursing homes.

Again, no evaluation data were located at the time of the review but the Chaddock model appears to be a promising approach for at-risk young people transitioning from care.

Case study- Devereux – Florida

Another example of the Supported independent living model is Devereux's Transitional Living Centre. The Centre provides children aged 15 to 17 years the opportunity to live in an unlocked, open community, voluntary residential program. The children referred to the Centre suffer from emotional disturbance and the program prepares the youth for independence through the provision of clinical, vocational and life skills training. All the young people attend public school and trained staff provide tutoring when special attention is required. The Centre is a five-bedroom home located in the Florida community. The youth are supervised 24-hours a day by trained staff and receive individual, group, and family therapy. Psychiatric and nursing services are also offered as part of the program. The program differs from the therapeutic community house model in that the youth are older and are being prepared specifically for independent living.

As stated previously, Devereux is very committed to providing high quality services to children, adults and families with special needs. The agency utilises several clinical accountability tools, including eTRACS™ a web-based information tracking and charting system; e-Cet - an electronic clinical record; Devereux Scales - clinical assessment tools (LeBuffe & Pfeiffer, 1996); and a compliance system. Numerous research projects have been undertaken by Devereux staff and all of the publications are listed on their web-site.

4.7.2 Transition houses – campus-based

Campus-based transition houses comprised only 0.5% of the total number of programs identified via the internet search. There was insufficient information to yield a result as to the mean number of children the program type serves. However, the program type was identified as mainly serving adolescents with a mean age of

16.0 (*SD* = 1.41) and a maximum age of 20.0 (*SD* = 1.41). The main referral sources were from care sector (100.0%), juvenile justice systems (25.0%) and private sectors (25.0%). The main reasons for referral were intellectual/physical disabilities (75%), behavioural (50.0%) and social/peer problems (50.0%). The average duration of service was just under one year (50 weeks). This program type is generally used by residential campus-based facilities as a transition program for adolescents who are not ready to reside in a community-based program but are at the age when they need to receive independent living skills training and vocation guidance.

As noted in Table 4.7, behavioural/token economies, cognitive-behavioural therapy, anger management, abuse counselling and relapse prevention were the most commonly employed treatment services used by the programs. Self-esteem and self-assertiveness training were also common treatments which were identified. Social skills training and play therapy were also commonly offered to children and young people in this program type, along with general communication skills training, sex education and 'other' services such as religious/spiritual services.

Table 4.7 Campus-based transition house dimensions of care

Transition house (campus) (%)	
Location	
Community-based	0.0
Campus-based	100.0
Staffing arrangement	
Live-in carers/parents	0.0
Rostered staff	100.0
Treatment intervention services	
Behavioural /token economy	25.0
Cog-behavioural	25.0
Anger management	25.0
Abuse counselling	50.0
Relapse prevention	25.0
Self-esteem	25.0
Self-assertiveness	25.0
Play therapy	25.0
Social skills	75.0
General communication skills	25.0
Sex education	25.0
Other	50.0

The main services offered to young people in campus-based transition houses were independent living skills training (100.0%) and vocational guidance (75.0%) and individual (100.0%) and group therapy (75.0%). The campus-based transition houses also offered a variety of general supports to the young people including educational supports/tutoring (75.0%) and specially designed curriculum (25.0%). Half of the programs made periodic home visits available to the young people and their families.

An American example of a campus-based transition house is New Directions of Three Springs. The Chaddock agency of Illinois, described previously, also runs a campus-based transition house for adolescents.

Three Springs Incorporated in Alabama offers residential treatment programs for adolescents with severe behavioural and emotional disturbance. Their Transitional Living Program, New Directions is an example of the supported independent living treatment model. The Transitional Living Program at Three Springs helps male children aged 15 to 19 years make the “transition” back into normal life by learning acceptable modes of behaviour and social skills. Three Springs also offers a similar program, called Turning Point, for female adolescents aged 14 to 19 years. Many of the children referred to the program are exhibiting at-risk behaviour, sexual promiscuity and juvenile delinquency. Some of the diagnoses of the children referred include, attention deficit disorder (ADD), oppositional defiance disorder (ODD), depressive disorders, conduct disorders and adjustment disorders. Additionally, the children may have a secondary diagnosis of substance abuse and learning difficulties. The children are often transitioning from a more restrictive environment so that the program is seen as a necessary step before returning home or to total independence. The cost of the program is generally paid for by the parents of the child through insurance; however, Three Springs also offers a loan repayment system. In addition the school is provided educational funding from the State Government.

The youth reside on campus in a home-like environment with live-in staff. In this setting the adolescents acquire independent living skills aimed at promoting self-reliance and self-discipline. The Residents receive counselling from licensed

professional counsellors and attend an accredited school on campus. The treatment philosophy of the program is based on positive peer culture whereby the children learn respect, individual responsibility and how to interact with others in a community setting. Within a positive peer culture, each child is challenged to learn responsible thinking and behaviour. The children are viewed as the most critical component in the process because of their ability to influence one another. The positive peer culture works towards eliminating inappropriate behaviours, and developing pro-social values in addition to accepting full responsibility for behaviour and gaining a sense of mastery and control in their lives. Residents accomplish these goals through daily schedules that are established by the Three Springs staff that are designed to develop the child's respect for authority, self-control, self-discipline and establishment of a work ethic. The daily program is designed so that children are a part of a group of peers and that same group works towards group goals and personal goals. The daily interaction whereby individuals receive immediate feedback is referred to as the Group Process Model and is the foundation of the therapeutic process.

The program staff consists of Direct Care Counsellors who work with the children on a daily basis and Family Service Workers who focus on the needs of the whole family. The program also includes consultant psychologists and psychiatrists. The children also participate in weekly abuse victim's treatment, eating disorder education and substance abuse education. Many of the residents attend Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) meetings in conjunction with the substance abuse education module. Behavioural counselling services are also offered to the children via individual and group therapy sessions. Furthermore the program includes an outdoor education program, vocational and community service projects.

The accredited on-campus private school attends to the individual educational needs of the children and incorporates their education as part of their treatment process. The special education school has highly qualified teachers with a low teacher-to-student ratio and works towards preparing the students for college. Some children may attend local public schools or a local community college. Students at

New Directions also have the opportunity to obtain a part-time job to learn the basics of money management, workplace responsibility and work ethics.

Three Springs encourages family involvement for successfully treating at-risk youth. The parents are invited to attend frequent family conference and receive telephone and letter progress updates. The staff also encourages parents to have periodic overnight stays on campus and they also provide monthly support and education sessions for the parents.

New Directions provides a structured aftercare service for both the resident and their families. Assistance is made available to ensure the successful placement of the child back into the home and reunification of the family. Staff are available via telephone conferences for crisis situations.

Since 1985, Three Springs has helped thousands of troubled teens and families. Three Springs asserts that the positive peer culture is one of the most effective methods in the facilitation of change for at-risk youth. The anticipated length of treatment is three to six months depending of the individual needs of the youth.

Three Springs conducted a review of 167 teens' and parents' level of program satisfaction and success. They found that 90% of teens and parents agreed that the program helped them achieve better family conflict and resolution management. Close to 90% of teens and 73% of parents stated that they had an improved awareness of appropriate behaviour. The teens (88%) and parents (76%) interviewed also felt that they required no further treatment for the original problems. 76% of teens and 77% of parents affirmed that the family relationship had improved. In addition close to two-thirds of the teens (61%) and 48% of the parents felt that the child's academic performance had improved. Finally 96% of the adolescents and parents stated that they were hopeful and positive about the future.

4.7.3 Examples of transition houses in Canada

Case study- Macdonald Youth Services Community Service Program

MacDonald Youth Services operate a transition houses for young people aged 12 to 20 years. The service provides youth with the opportunity to become positively involved in the community through community service involvement, education/employment preparation and life skill development. Volunteer Mentors support the program and youth and receive specific training. Mentors and staff work alongside youth at work centres acting as a role model and support. Several programs are offered by the community service program. For example the Support Towards Education/Employment Participation (STEP) is a training program for individuals with the goal of returning to school or finding employment. The STEP program targets youth looking to gain work experience and be positively involved in the community. Another program is the Community Alternatives to Detention (CAD) program that provides a service for youth and assists them to access employment counselling, life skills clinics, recreation activities, and support in dealing with legal or probation issues.

No evaluation data were located at the time of the review but the model appears to be a promising care option that is worthy of further investigation.

Case study - Katlin House Child and Family Centre

Katlin House Child and Family Centre offers services for children in need of stabilisation, in cycles of repeated breakdowns, in crises, and those with no placement available. Children aged 6 to 12 years are eligible for the program. The goal of the agency is to assess, develop treatment plans, assist in transitions for children to go to TFC or return to their biological family, stabilise children in safe environments, provide clinical treatment, and recommend resources. A typical stay for a child begins with obtaining a history and background, determining a purpose for admission, settling in, deciding on treatment goals, school placement, medication review, transition plan, and transition/follow-up. Work with the biological family involves teaching in the home setting with children who have demonstrated success. School interventions are also available as an integrated plan is set up to reach the goal of mainstream classroom without suspensions.

Again, no evaluation data were located at the time of the review but the model appears to be a promising care option that is worthy of further investigation.

4.8 Day treatment centres

Day treatment centres in America are a common treatment approach utilised by many agencies as part of their continuum of care. It is generally not a treatment model that is provided on its own but rather in conjunction with other services and programs. For example, a day treatment centre will operate in conjunction with a treatment foster care program or a residential unit. Two examples of day treatment centres are operated by Morrison Center Child and Family Services in Oregon and The Child Centre in Oregon.

4.8.1 Examples of day treatment centres in America

Case study- The Morrison Center Child and Family Services

The Morrison Center provides therapeutic foster care services for children and youth enrolled in Morrison's day treatment program called the Proctor Care Program. The Proctor care program is unique to many other day treatment centres as it considers the day centre to be the main source of treatment and the other program where the children and young people reside is considered to be the support program. The Proctor program works in conjunction with many other programs including the Breakthrough program. This particular program offers a blend of alcohol/drug abuse treatment, mental health treatment, alternative education and competency-based skill development for chemically-dependent adolescents. The program offers a recovering lifestyle model to chemically-dependent youth, teaches social and living skills and provides individual and family recreation.

The Hand-in-Hand Day Treatment program is another Proctor care program that serves pre-school children aged three to six years who have been severely abused and neglected and are exhibiting emotional and behavioral problems. The Hand-in-Hand proctor parents offer the child a role model of a nurturing two-parent family, and provide therapeutic treatment in the course of daily family life in conjunction with treatment in the classroom.

Another Proctor Care program is the Counterpoint Residential/Day Treatment program that serves adolescent males, ages 12 - 18 years, who are acting out, suffering from severe emotional or behavioral problems, and displaying inappropriate sexual behavior. The Counterpoint Proctor parents offer a role model for effective family functioning and problem-solving, teach social and living skills, especially anger management and appropriate sexuality and provide individual and family recreation.

A review was conducted of the Hand-in-Hand Proctor care program who observed positive results for the combination of a day treatment program with a treatment foster care placement. Whitemore, Ford and Sack (Whitemore, Ford, & Sack, 2003) evaluated the immediate and long-term outcomes for 77 boys and 52 girls who had completed the program which combined day treatment, case management, individual and family therapy. Also, 60% of these clients were placed in proctor care homes which are short-term family placements providing in-home treatment. Whitemore et al., showed that there was increased stabilisation in family placements, with 67% of participants still living in a permanent family placement at the 4-year follow-up. They also noted that 69% of participants transitioned to a less-restrictive academic placement and remained in regular classroom placements at follow-up. The children in the program also showed significant behavioural improvement at discharge and follow-up on the Child Behaviour Checklist. Participants also showed significant developmental improvement on the Battelle Developmental Inventory and the Expressive One Word Vocabulary Test. The authors concluded that the results suggest that this treatment modality is effective in maintaining these children in the community and in producing positive long-term outcomes.

Case study- The Child Centre in Oregon Intensive Day Treatment (ITS)

The Child Center's Intensive day treatment program provides intensive psychiatric day treatment and special education services to 29 children between the ages of 3 and 12 years. The ITS program is for children whose primary handicapping condition, at the time of admission, is characterised by severe mental, emotional and behavioural disorder as determined by a individualised comprehensive assessment. The Child Centre will only accept the referral if the disturbance has advanced to a

degree and complexity where no other less restrictive program in the community can adequately meet the special needs of the child and family.

All children accepted into the Intensive Day Treatment Program have or will meet criteria for a DSM IV axis 1 diagnosis and a child Global Assessment Score (CGAS) of less than 40. Many children accepted to the program have multiple diagnoses and all have experienced a significant disruption in level of functioning compared with peers. Most of the children have experienced mental/emotional or behavioural disturbances for at least one year.

Day treatment services are provided to a variety of children and families, such as children who live at home with their parents, in single parent households, in foster care, with relatives (e.g. aunts, uncles, grandparents), in blended step families, or in other arrangements. Many of the children will have already come to the attention of one or more agencies before being referred for treatment. These agencies are often those who provide health care, education, juvenile justice, protective services (CWP), early education (i.e. Head Start) and prevention services (Relief Nursery).

The program accepts both male and female children and considers family participation and adult services as a crucial component of the overall treatment program. Children not accepted into The Child Centre's day treatment program include children aged thirteen and older, children younger than three years of age, children whose primary handicapping condition is severe mental retardation, moderate to severe forms of autism, and those children who, in the judgment of the intake committee, would not be suitable for the program.

Case study - Intensive School Based Day Treatment (ISBDT)

The Child Centre also operates an Intensive School Based Day Treatment Program that provides a specialised and individualised set of in-home and community based mental health services that are delivered in the most normative and least restrictive setting, the child's home and at a public school. The intensive program offers an integrated treatment and education program geared towards elementary aged children, ages 6 to 10 years who have severe mental, emotional and behavioural disorders. The program provides individual therapy, group therapy and

an individualised academic program which are all provided on campus at the Springfield School District Moffit Elementary School. The program also provides the family with a full array of medically appropriate services as identified in their plan of care including but not limited to crisis prevention and intervention including safety/crisis plans, care coordination, case management, individual, group and family therapy, psychiatric services, skills training, family support services, respite care and team driven service coordination planning. The two day treatment models operated by the Child Centre appear to be promising care options for children and young people with psychological disturbance and are both worthy of further investigation.

4.8.2 Examples of day treatment centres in Canada

Day Treatment Centres in Canada are a very common form of treatment for children and adolescents with behavioural and emotional disorders therefore descriptive statistics will be provided. Sixteen day centres were identified via the internet search and a few examples will be discussed in detail below. The majority of day treatment programs in Canada served children and young people in community-based centres or schools. The mean minimum age the programs served was 6.53 (*SD* = 6.17) and the mean maximum age was 12.20 (*SD* = 8.79). The main referral sources to such programs included the care system (37.5%), community services (31.3%), education system (18.8%), juvenile justice (18.8%) and mental health system (12.5%). On average, each of the day treatment programs served 5.00 (*SD* = 10.12) children and young people at a time for a mean time period of 3.31 (*SD* = 7.36) weeks with a range of 2 weeks to 22 weeks. The day programs received referrals for children and young people suffering from a variety of issues including; socialisation/peer problems (68.8%), emotional problems (62.5%), behavioural problems (43.8%), developmental delay (18.8%), offending (18.8%), grief and loss (6.3%), sexualised behaviours (6.3%), and intellectual and physical disability (6.3%). The day programs frequently served both male and females together (87.5%), whereas one of the programs served the male and female children separately.

Table 4.8 Day Treatment programs in Canada

	Canada (N = 16)
Staffing arrangement	
Rostered staff	100.0
Therapeutic Approach	
Behavioural/ Token Economy	12.5
Psychotherapy	12.5
Play therapy	12.5
Milieu therapy	6.3
Therapy Type	
Individual	25.0
Group	56.3
Family	43.8
Specific Interventions/ Services	
24-hour support services	6.3
Periodic visits to parents	12.5
Special tutoring	62.5
Social skills training	50.0
Independent living skills training	37.5
Adventure-based activities	12.5
Special curriculum	62.5
Vocational guidance	25.0
Parent Skills training	25.0
Self-esteem building	12.5
Community service activities	18.8
MST	6.3
Mentoring	12.5
Anger management counselling	16.3
General communication skills	18.8
Grief/loss/PTSD/trauma	12.5
Peer support models	6.3

As can be observed in Table 4.8, the majority of programs offered treatment to children and young people through rostered staff. The main therapeutic approach was focused more so on educational services such as specialised curricula and tutoring. Many of the programs also offered social skills training and independent living skills training. A few of the programs also focused on the children's family and offered parent skills training, periodic home visits, and family therapy. Multi-systemic therapy was also provided as part of the service in one of the day treatment programs to improve the chances of reunification and assist with the transition from out-of-home care back to the family home. Over half the programs provided group

therapy to the children and young people and a variety of other specific interventions such as anger management counselling and general communication skills training.

Case study- Horsham and Simpson Day Treatment Program

The Horsham Day Treatment program is provided to children aged 8 to 12 years who live in foster homes or in the community who have borderline to normal intelligence and demonstrate socio-emotional difficulties. The Horsham program has capacity for eight students, while the Simpson program can treat six students. Children are referred to the program by their protection worker and if there is space in the classroom, documentation is requested (any assessments on file). An intake screening meeting is arranged and attended by the worker, guardian, child and program staff, and teacher. When children are ready to re-integrate into the regular school system, evening programs are recommended to support the child and family during the transition. The evening programs include social, life skills programming, recreation, and arts and crafts. Children demonstrating problems at home such as mealtime behaviour issues, homework difficulties or inappropriate interactions with peers may be referred to this program alone.

The children attending the Simpson Day treatment program participate in a modified school day. Each child has an individualised program while belonging to a class of similar aged peers. The classroom consists of a teacher and Child and Youth worker with 6 students. There is a focus on social skills and anger management. The children receive one lengthened recess in the morning. The goal of this program is to reintegrate the child, provide support to the child and family, and provide counselling necessary for successful re-integration to community schools. The average duration of the program is one to two years.

No formal evaluation has been conducted; however, the agency sends parent's evaluation feedback forms to gauge the quality and their satisfaction with the available services. Weekly staff meetings are held to review the progress of the child and the individualised plan created for them.

Case study- Centre for Addiction and Mental Health Day treatment service

The Centre for Addiction and Mental Health operates a day treatment service for children struggling in special education and who are being suspended regularly. The intake committee at the Centre assesses from which program the family and child would most benefit. Programs include parenting groups and after-school social skills groups. The Classroom Assessment and Treatment for Children's Health (CATCH) classroom team offers on-site day treatment for 19 weeks. It serves eight children aged six to eight with disruptive behaviour disorders and their families. The CATCH classroom has both treatment and research goals to offer brief, evidence-based day treatment and to evaluate the outcome of the treatment. The program has therapeutic and academic components: it follows the academic guidelines and curriculum set by the Ontario Ministry of Education, and it offers individual and group therapy to children focusing on their positive and adaptive behaviour. The classroom is taught by a special education teacher and two Child and Youth workers. A consulting psychiatrist is part of the team as well as social worker who works with the family. The therapy applies principles of Errorless Remediation (that is, offering praise and encouragement for succeeding at gradually more difficult tasks) and a supportive and structured environment. The program is run 4.5 days a week during school hours.

Research has been conducted on Errorless remediation by a behaviourist. This approach entails graduated expectations from the child. The child begins with a high level of support with low expectations. As the child succeeds in reaching the expectations, the level of support is lowered. Children are audio visual taped daily in both individual and group levels. The tapes are coded at baseline and during treatment to determine behaviour change. The model appears to be promising care option service that is worthy of further investigation in Australia.

Case study- Hincks-Dellcrest Voluntary Day Treatment

Hincks-Dellcrest's day treatment services are offered to children and youth experiencing mental health problems interfering with functioning in community school settings. The program works in collaboration with the Toronto District School Board (TDSB) and other community partners. The day treatment provides clients

with integrated programs consisting of strategies including but not limited to clinical assessment, therapeutic classroom milieu, educational programming, parent groups, and family/individual therapy. Services to support transition back to community school setting and to assist family maintain and enhance gains are offered. Follow-through services are provided after a child leaves the placement by connecting families with community resources to maintain or enhance gains.

Hincks-Dellcrest's services undertake ongoing research into all of their programs and services and their day treatment service appears to be a model worthy of further investigation.

4.9 Summary

The results of this review show that current North American approaches to out-of-care care are very diverse and range from day treatment programs and treatment foster care to intensive residential treatment facilities, sometimes containing several hundreds of children. In both Canada and the United States, there appears to be a full continuum of services, many of which are provided within the same corporate structure, although, as indicated, few of these programs have been properly evaluated. It is clear that many of the programs in North America are theoretically-derived interventions that have been developed on established principles of behavioural and development psychology, as well as sociological theory. In contrast to the programs available in Australia and the United Kingdom (reviewed in the next chapter), it appears that psychologists play a critical role in the development, coordination, and evaluation of programs in America and tend to work in direct partnership with social workers in the same program. Although the terms best practice and evidence-based practice are widely used in America, it appears that very few agencies have conducted systematic, independent and publically available evaluations of their programs and their outcomes. Thus, despite the number of program models and examples identified in the search, it is difficult to assess the effectiveness of specific programs or services without further empirical evidence.

Despite this, the information reported here provides Australian researchers, practitioners and policy makers with an extensive profile of services and interventions for children and young people with significant emotional and

behavioural disorders. The profile of treatment services also enables researchers, practitioners and policy makers with the ability to 'pick and choose' between those programs and services that may or may not be suitable for the Australian foster care system and then evaluate their effectiveness, perhaps through pilot investigations.

4.10 Broad European and United Kingdom trends in treatment services for children in out-of-home care

The previous sections provided extensive information on current treatment services in North America. As mentioned previously, one important reason why North America was chosen was because of the great accessibility of information concerning programs. Nevertheless, it is important to also provide a brief overview of how intensive out-of-home care services are delivered in other first world countries; in particular, in the United Kingdom, Europe and Australia. Although reviews of this nature must always be treated with some caution because of a lack of information concerning the full range of services in these parts of the world, it is nevertheless possible to identify some of the broad factors that differentiate the care systems of different countries.

4.10.1 Trends in United Kingdom

The UK fostering system is similar in many ways to the US and Australian systems. For example, in both Scotland and England, foster care is now the main form of substitute care offered to children looked after away from home (Triseliotis, Borland, & Hill, 2000). Furthermore, Triseliotis et al. comment that "most of those looked after children in foster care now would have been in residential care 20 years ago, and those in foster care then are now looked after in their own homes" (p. 2). They assert that the implementation of the each of the Children Acts in England and Wales, Scotland and Northern Ireland, with more stringent conditions under which children can be placed away from home, is likely to be resulting in the placement of fewer but more problematic children (i.e., children with emotional and behavioural disturbance, juvenile offenders, disabilities, HIV positive). However, one major difference between the UK and US is that the UK system mandates that case workers use the well-documented Looking After Children (LAC) package involving the detailed profiling and monitoring of care-giving practices as part of their case-work. The LAC package has also been implemented in several States across Australia.

Anglin (2002) comments that beginning in the 1960s, Europe and North America both experienced a 'deinstitutionalisation' movement resulting in a move toward community-based care in foster families or other small groups. In much the same way, residential care in UK has also shifted over time, from custodial protection and care to treatment. Nevertheless, the numbers of children in residential care in UK, even though they are hard to determine, is still lower than in the United States. According to Little, Kohm and Thompson (2005), England has a much greater proportion of children in boarding schools and a much lower ratio of children in child welfare settings than in USA. Also, Rushton & Minnis (2002), assert that it has become extremely rare for English children with mental health problems to be placed in a residential context.

A major trend in UK fostering in the last ten years has been the rise in the number of independent fostering organisations. Although the majority of organisations provide "conventional" fostering services (emergency, short-term and long-term placements), a minority also provide specialist fostering services (Walker, Hill, & Triseliotis, 2002). In the UK, the earliest specialist fostering schemes catered for adolescents and also for children with disabilities. Walker et al. (2000b) comment that one of the best known early fostering schemes in the UK was the Kent Families Project for serious young offenders. The project adopted a contractual and behavioural therapeutic approach and carers underwent extended preparation and training. During the 1990s, specialist fostering schemes continued to proliferate but the distinction between specialist and traditional fostering began to blur. According to Walker et al., a number of local authorities treated all of their carers as "specialised" carers and they all received higher pay, more intensive support and careful contracting. This resulted from carers dislike of the two-tiered system and resentment from non-specialist carers who felt they were often caring for difficult children anyway.

In recent years, the development of specialist fostering schemes has extended further with the professionalisation of fostering. For example, in the UK, some of the most innovative work has involved enhancing the skills and supports available to foster carers. In the UK, Open University courses are available for foster carers who obtain greater expertise in working with children, and there are specialised programs

such as the Community Alternatives to Placement (CAPS) in Scotland in which foster carers' remuneration is linked to their level of qualification, and where more collaborative relationships are formed between agency staff and carers in order to achieve more effective outcome for children with significant behavioural problems (Butcher, 2004). CAPS was set up by NCH (National Children's Homes) Action for Children (Scotland) in 1997 to provide placements for young people who would otherwise be placed in secure care. Core elements of the service include:

- carer payments equivalent to a reasonable salary
- intensive support to carers, available 24 hours
- specialist training
- time-limited placements
- automatic entitlement to respite care
- individualised placements
- educational support (Walker et al., 2002, p. 6)

The scheme differs from other 'specialist' foster schemes that have been in existence for many than 20 years both in terms of the level of payments and the level of support provided to carers (Walker et al., 2002). Furthermore, the design of the scheme is to make fostering a 'job' and therefore foster carers are part of the treatment team. The extensive review of the scheme conducted by Walker et al. found that a considerable number of young people who would otherwise have been placed in secure care could be placed in foster care and can achieve better outcomes. The review also recommended that the scheme was more likely to be successful:

> if young people were motivated to join a family, were subject to few demands in the initial stages of the placement and were helped by the social worker and carer to address the issues which fuelled their anxiety and caused them to run (Walker et al., 2002, p. 145).

Many of the findings from small-scale studies of professional foster care programs in England have also been positive. The studies have confirmed that carer recruitment and retention rates were much better. Such findings in England are similar to programs utilising professional carers in both Scotland and the United

States (Berridge, 1997; Johnstone, 2001b; National Conference of State Legislatures, NCSL, 2002).

Another innovative program being piloted in England, designed at reducing the number of placements for children in care, is the 'concurrent' placement scheme. The scheme involves placing young children with approved adoptive families who initially work with social workers to determine if restoration is possible. If restoration is not possible, then they proceed with adoption and this process avoids an additional placement. The 'concurrent' placement scheme, for appropriate cases, may have the potential to reduce the harm from changes in placement and delayed placement (Thoburn, March 2000). In a consultation response, the British Association for Adoption and Fostering (BAAF, May 2005) reported that:

> 90% of concurrent planning placements in the UK today to date have led to adoption orders and that this has given vulnerable infants far greater security than more traditional placements (i.e. moves between foster carers and adopters) would have allowed (p. 3).

A small scale study (Monck, Reynolds, & Wigfall, 2004) of 24 young children in three concurrent planning (CP) projects and 44 from two 'traditional' adoption teams found some encouraging results for the scheme. The study reported that the CP children had fewer placements, spent shorter periods in impermanent care and were younger when their legal status was resolved. Only two of the CP children out of the 24 returned to birth families. The results from the study are promising but should be read with caution due to the small number of participants. Further research is necessary before generalisations about the effectiveness of the scheme could be made.

Other innovative models of foster care are currently being developed in certain regions in the UK and relate to developments in respite care and support care. Currently, there are 16 support fostering projects in the UK. The children in the support fostering schemes go to trained carers on a regular basis for short periods giving the birth families time off. This model affords the families respite so that they can resolve their problems and the children ultimately remain in the family home.

Other advantages of this model are the number of children entering local authority care is reduced and local authorities are able to retain experienced carers who regard respite fostering as an alternative to conventional models of fostering. According to Clough, Bullock, Ward, Colton, Pithouse, Roberts, and Ward (2004), such support schemes also do not have the stigma commonly associated with Social Services care.

4.10.2 European Trends

In continental Europe, the nature of out-of-home care differs dramatically depending on the country. In Eastern Europe, out-of-home care very much resembles Australian foster care in the 1970s and earlier, with most placements being either in family foster care or larger residential units. In Scandinavia and other northern countries, a very strong emphasis is placed on keeping children with their biological families, so there is a general reluctance to place children into care unless it is absolutely necessary. Generally, this means that children come into care much older than in Australia and North America, and unsurprisingly many of these children tend to be those with significant emotional and behavioural difficulties that have only been amplified by the relatively longer time spent at home. Although there has been some trend towards adopting some of the intensive out-of-home models developed in America, a more favoured option has been to use Intensive Family Preservation Programs or IFPPs, which involve intensive visitation and social work counselling with biological families to prevent children from entering care. Even though some major review studies involving randomised control groups have been generally pessimistic about the effectiveness of these programs (e.g., Rossi, 1994), the approach continues to remain popular in Europe. For example, the Michigan based Families First package (discussed in previous Chapter) has recently been trialled in the Netherlands with some positive results, although (as has often been the case with earlier US evaluations of this program) it was trialled without any adequate control group to determine what would have happened without the intervention.

Another difference between European countries and other parts of the world has been the very rapid growth in privatised care. In Sweden, it has been estimated that out-of-home care is provided by several hundred different providers (Vinnerljung, 2005, personal communication). Many of these are small residential homes with 5 to 10 children run by private home-owners who have space available to

house children and who have received the necessary accreditation to sign on as carers. This would appear to be a very positive development; but, as Sallnas, Vinnerljung and Westermark (2004) have shown, the downside is that the placement breakdown rates for these arrangements tend to be very high, and only the more behaviourally settled children tend to be accommodated for any length of time.

Other research has highlighted that countries such as Sweden, Denmark and France perceive long-term foster care as a positive form of care. Long-term foster care is seen as a form of care that can provide psychological security together with ongoing relationships with birth families, co-placement with siblings, support with health and disability issues and, in Denmark, ongoing support up to 22 years of age. George and van Oudenhoven (2002) assert that in these European countries, many children end up advantaged, with two families for life. They describe this as "a composite family characterised by connectedness, permeable boundaries and complementary care" (p. 23). In Hungary and Germany, fostering is also seen as offering an alternative family through the provision of long-term placements to promote child security. In the Irish Republic, fostering is a distinctive service provided by non-relatives, whereas, in Poland, the term foster care can refer to care by next of kin, appointed care-givers or guardians by court order (Clough et al., 2004). Also in Poland, there have been attempts to develop different types of foster care to meet different or specific child needs. For example, the different types of foster care may include emergency care, assessment care, therapy, rehabilitation care, preparation for moving home, or preparation for adoption. Developments in Italy have focused upon a more integrated use of day-time foster care and residential services. By contrast, in Finland, there is an emphasis upon child rearing support needs of birth parents, and as a result of this child health clinics have expanded, family training has diversified and co-operation with families is much more strongly emphasised by policy (Clough et al., 2004).

The differences in developments of services in many of the different countries reflect the different philosophies and policies and legislation of each of the countries. However, many of the services are not based on empirical evidence or sound research. For example Clough et al. (2004) comment that "the fostering

literature generally (and this review) tends to reveal a more descriptive case-study discourse than an applied discipline based on tested and established theory" (p. 173).

4.11 Treatment services for children and young people in Australian out-of-home care

4.11.1 Changes in Residential Care

Many of the same trends observed in the UK are similarly observed in Australia. There has been a substantial growth in the development of large private providers of out-of-home care services, particular in the eastern States, and there are a small number of agencies that developed intensive services for children already in care, or at risk of being placed into out-of-home care. For example, an increase in treatment foster care services (TrACK) and therapeutic family preservation services, for example MST, TAKE TWO (Victoria) and Families First, are currently operating in a few States in Australia. Australia has, on the other hand, in contrast to the United States, very few large-scale training programs for foster carers, standardised treatment packages, or larger residential treatment facilities (Bath, 1998).

As with the UK, Australia has witnessed similar reductions in the provision and usage of residential facilities for children in care. For example, a recent review of residential care in New South Wales documented that this general trend is continuing, with only about 4% children or young people in care being in residential care placements in Australia at 30 June 2004 (Flynn, Ludowici, Scott, & Spence, November 2005). Many researchers have attributed the reductions in residential care to the three basic assumptions associated with residential facilities: first, that they are considered the last resort for children who have been unable to find stability in family-based placements; second, that they are restrictive and do not provide a 'normalised' living environment for children; and finally, that they cannot provide the same quality of care as a family-based environment. Flynn et al. also draw attention to the higher costs of residential care as well as the much publicised cases of abuse in large institutions as related to the decline in residential care options. Nevertheless, as discussed in Section A of this thesis, in recent years governments around the world and in Australia are now recognising the potential role that residential care might still play as part of a 'continuum of care' (Victorian Department of Human Services, June 2003). Many governments have realised that

residential care may be suitable for a small subpopulation of children who cannot otherwise reside in family-based settings because of their behaviours or their inability to experience the level of emotional intimacy present in a family-based setting. For these reasons, residential care is now seen as a realistic care option for those children and young people that need the level of routine and treatment that can be provided by a residential facility. However, there have been several improvements in the provision of residential care today as opposed to the large 'boarding homes' or orphanages run by agencies in Australia in the past. For example, now many agencies (as will be discussed below with examples of specific services) offer residential care on a much smaller scale such as in group homes for three to six children with full-time house parents who have undergone extensive training. These homes can be situated on a campus with staff that visit the home on a daily basis and the children generally attend school on campus also (Parkerville Children's Home in Western Australia), or they can be situated in the community so that professionals can visit the homes and the children can attend local schools (Belmont Program in Western Australia).

The next section of this Chapter will present examples of possible treatment options from other States in Australia that may be appropriate for the population of high support needs children profiled in Chapter 2. The Chapter will conclude with comments and suggestions for the future provision of foster care services for these children, young people and their families.

4.11.2 Treatment foster care models

Several treatment foster care models are available in Australia. One example of these programs is Westcare and Salvation Army's One-to-One program. The program is run by the Salvation Army in collaboration with Westcare's Intensive Case Management Service (ICMS). The program provides supportive home-based care placements for young people with challenging behaviour and multiple complex needs. The program provides training and support to the volunteer caregivers and young people in placement. Another example is Mercy Children's Services which provides foster care, specialised home based care and residential care for children aged 0 to 17 years in Western Australia. Their specialised home based care is an expansion of the foster care program and is targeted to high needs clients that require

therapeutic placements to meet their needs. Mercy Children's Services places great focus on the individual needs of children and the importance of families. Home Based Care is able to provide safe, nurturing and stable care whilst it is necessary for a child and their family. Essential to all home based care is provision of a high quality service that ensures that the child's social, emotional and physical needs are met and that children are provided with experiences that give them the best opportunity to meet and achieve age appropriate skills and competencies. Mercy's Group residential care is a medium to long term program for children aged between 8 to 17 years. The care and treatment is provided in family style houses in the community for up to four young people at a time. The experienced program staff help children who have experienced trauma.

Another more recently established program is Berry Street Victoria, which provides Specialised Home-Based Care for children and adolescents who have special needs which preclude them from traditional Foster Care. This service also provides caregivers with additional training and support. In addition, Berry Street also offers One-to-One Home-Based Care. This service is for high-risk adolescents in need of out-of-home care, but who need more intensive support than is available in traditional home-based care. The service provides a home-based placement and case management for young people identified by Child Protection as 'High Risk Adolescents' (aged 13 to 17 years). The program offers 24 hour support for young people and their caregivers. The young people are placed in the home of individually matched volunteer caregivers. The treatment model is based on behaviour modification techniques and provides individual and family therapy.

TrACK is another therapeutic Foster Care program run by Anglicare Eastern Region in Victoria in conjunction with the Australian Childhood Foundation (ACF) that receive funding by the Department of Human Services (Eastern Region). A full description of this particular program is provided in Chapter 5 along with the current outcome from a pilot evaluation conducted by the researcher.

4.11.3 Intensive family preservation models

Intensive family preservation models in Australia, as described by Ainsworth (1997a), vary from each other both in their philosophy and design and even though

many models use the term ‘family preservation’, many have not altered their established practice. Even still, the models are designed to prevent placement into the alternative care system and the current models appear to be very innovative. Berry Street Victoria and Austin CAMHS TAKE TWO program is a unique intensive therapeutic service and the first of its kind in Australia. The program provides counselling and therapy for children and young people who have suffered profound abuse or neglect. It assists families and carers who undertake quality support and training. The service provides a safe environment for children and young people and provides ongoing supportive relationships as they work through the complex emotional and behavioural issues which are the result of severe abuse and neglect. The treatment model is based on attachment and trauma theory and is designed to prevent the placement of children and young people into the care system and also help reunify those children that have already entered care.

4.11.4 Small residential treatment models

Parkerville Children’s Home in Western Australia is a provider of residential treatment for vulnerable children that have histories of multiple abuse and display a range of trauma-related behaviours. The Home has several programs including a Cottage program, the Belmont program, Jenny House and Community Care. The Cottage Home is an example of a small residential unit. It is situated on a large campus with several cottages that house between three to six children and young people. Youth workers live in the cottages on a rostered basis. A staff facility is based on campus that houses the administration staff, the therapists and the CEO of the program. A school is also situated on the campus. The program provides a range of therapeutic services such as structured play therapy, body work, art therapy, dance and movement, drama therapy and the use of metaphor and visualisation. The program also has a strong commitment to families and always aims for reunification wherever possible.

The Belmont program is an example of a small residential unit in the community. It is a medium term program that provides 24 hour care by qualified professionals. Jenny House is a supported accommodation program for at risk and vulnerable young women with or without young dependents. The community care program is a ‘foster-type’ service in which carers are trained to provide specialist

therapeutic care. Parkerville Children's Home also provides an early education program known as PREPARE. It is a structured program with Education Officers that work with the young residents of the residential programs to help them develop the skills they need to achieve at school. Individual education plans are developed for each of the children along with in-school and after-school support and tuition time.

Marist Youth Care Limited runs two residential treatment programs in New South Wales; the Catalyst program (three separate units) and the Compass program (eight separate units). The Catalyst program serves six young people aged 12 to 16 years with moderate to high support needs who are homeless or likely to become homeless or are experiencing problems in relationships with family. The program has a focus on family restoration and/or transition to semi-independent or independent living. The Compass program serves young people with high and complex needs. The therapeutic approach of both programs is based on a model of skills development. It is a strengths-focused model that works towards developing and strengthening resilience. The young people and their families are also provided with conjoint family therapy that is undertaken in the St Vincent's restoration program. The agency prefers to not use the term 'therapeutic' or 'treatment' as it gives the impression of the young person being a passive recipient of services. The intended outcomes of both programs is community integration with aftercare support, if needed. The average length of placement is six months in Catalyst and 12 months in Compass program. Catalyst is one of the few restoration focused residential care programs.

Wesley Dalmar of the Wesley Mission is a non-government agency in New South Wales that provides two out-of-home Care Residential facilities (Gateway Cottage and Carlisle Cottage) for children and young people aged 8 to 15 years of age and 10 to 16 years of age, respectively. The residential cottages provide short term or crisis care and all referrals come through the Department of Community Services. Children and young people can reside at Gateway cottages for up to three months and at Carlisle for up to eight months. The cottages are staffed by trained personnel and during the day there are one or two staff present and one staff member sleeps over each night. Twenty-four hour telephone after hours support is also provided for staff.

The two cottages provide treatment for the children and young people including anger management and social skills training. The cottages also using Therapeutic Crisis Intervention strategies to address aggressive or distressing behaviour so as to provide the children with opportunities to gain new insight and understanding of their behaviour so they can regain control. The children and young people are expected to attend school or have an alternative daytime program in place during school term time and a special activity program is offered during school holidays.

The Stretch-a-Family program is an Adolescent Fostering and Community Placement program which is run by a non-government, non-denominational community organisation. The S.A.F. House at Stanmore accommodates a maximum of six young people between 12 to 16 years who are waiting to be fostered, restored to their families, or to find some other type of suitable long-term accommodation. The average length of stay in the program is approximately 12 months. The programs staff consists of youth workers, case-workers, foster carers, administrative staff and the Chief Executive Officer.

The Caseworkers at Stanmore are also foster care workers. The foster carers' allowance is determined by the individual needs based assessment. The assessment is based both on the needs of the young person and on the foster carers ability to engage in paid work outside the home while fostering. The services provided at the S.A.F. Stanmore House includes: preparation for fostering; preparation for family restoration whenever possible; counselling and friendship; recreational activities; and living skills: cooking, housework, budgeting and personal hygiene. The staff at Stanmore House also work on personal development skills, such as assertiveness, self-esteem, sexuality, and drug and alcohol issues. Behaviour problems are also addressed.

For the Children Limited operates a staffed group home in New South Wales for young people aged between 8 to 15 years with high needs. The For the Children Limited group homes closely resemble the 'Sanctuary Model' by Dr. Bloom (see Andrus Children's Services, New York, described earlier in this Chapter). The intended outcome of the program is to equip children with the skills to move to

permanent long term care. The average length of placement is between six to seven months. The program has a capacity for six young people. The staff are rostered on short shifts (7 to 10 hours) and there is one male and one female staff member on each sleepover shift.

Mackillop Family Services in Melbourne provides a Youth Services/Transitional Integrated Education and Residential Service (TIERS). The TIERS program is a program designed to meet the needs of children and young people requiring out-of-home care and an educational response. TIERS is operated by Rice Youth Services and St Vincent's Education and Training. The TIERS project aims to provide the appropriate environment to enhance the social and learning skills and help them with the opportunity to have a better quality of life and cope with the demand of living in the general community.

TIERS' provides an integrated accommodation and education service to boys aged 9 to13 years upon admittance for a period of 6 months to 2 years. This state wide service caters for young people who cannot be maintained in their own region because their own families and local services are unable to manage their behaviour, including risk of serious harm to themselves and others, significant damage to property. The activities of the TIERS program are aimed towards providing a safe and secure living and learning environment that will provide transition to: reunification with family where possible; investigating and locating less intrusive accommodation options within young person's region; or transition to a mainstream education program within the young person's region.

The TIERS program operates the Pathways Plan, which is a designed by the Pathway Team consisting of the young person, home room teacher, social worker, residential care worker/carer/parents. All of the team members develop an individualised plan which outlines a young person's goals in the areas of education, recreation, health, family, relationships and accommodation. The program staff includes; social workers (2); manager program -TIERS (1); manager program - school (1); co-ordinator residential care (1); teachers (6); integration officer (1); teacher aide (1). In addition, there are 12 residential care workers (9 full time, 3 part-time) and supervisors of units (3).

4.11.5 Stabilisation, Assessment and Transition models

Amongst non-government agencies in Australia, a variety of other treatment programs for children and young people have been developed to serve as an alternative to traditional family-based foster care. For example, in recent years Baptist Community Services (BCS) and Life Without Barriers (LWB) have developed several programs for children and young people with severe behavioural and emotional problems. BCS offer a program called "X-Streams" which is a Stabilisation and Transitions service (SATs) that is designed to stabilise the young people, and transition them into a more appropriate placement so that they do not undergo further placement instability. BCS and LWB also offer wraparound services, called "X-Alt" and "Individual Packages", respectively, that provide individual packages of care to children and young people with extreme levels of behavioural and emotional disturbance and who have experienced severe levels of placement instability (see Chapter 5 for a review of the program).

4.11.6 Supported Independent living models

Barnados in Canberra offers a transition program for homeless youth aged between 15-21 years. They offer a Head-leased Accommodation referred to as Lead Tenant arrangement. A lead tenant arrangement is designed so that the young person is the head leaser of the property who reside with a full-time youth worker. The arrangement is designed in this way so that if the placement breaks down, the youth worker leaves the property as opposed to the young person. Another example of this is referred to as the Special Youth Carer program offered by Anglicare in South Australia. A review conducted by Gilbertson, Richardson and Barber (2005) compared the Special Youth Carer program with a treatment foster care program and found promising results from this type of arrangement. In this pilot study, all subjects had a history of placement instability and at-risk behaviours. The subjects were randomly allocated to either the TFC (N = 10) or the SYC (N = 8) condition. Post-intervention, the number of placements was lower than pre-intervention for the SYC group but not for the TFC group, although behavioural gains were noted for subjects in both conditions.

Berry Street Victoria also runs a Lead Tenant Program that offers housing for young people in a group situation with a 'lead tenant' role model. The young person

is the lead tenant leasing the rental accommodation. This program also assists young people to develop skills allowing them to move on to independent housing.

4.12 Summary

In summary, therefore, it is possible to identify several principal international trends in the nature of placement options:

- *The Professionalisation of Foster Care*: Formal training and accreditation of foster carers achieved via the completion of tertiary qualifications, where remuneration levels are matched to the level of expertise and qualifications

- *Intensive Family Preservation Services*: Intensive services involving support, training and visits to biological families to prevent children coming into care wherever possible (i.e. MST and Families First discussed in previous Chapter)

- *Privatisation of out-of-home care*: The expansion of placement options via the engagement of larger private organisations or smaller operators.

- *Intensive Therapeutic Services*: The development of a continuum of services that includes residential care, and in which treatments are theoretically driven and empirically evaluated.

On the whole, the range of services currently available in Australia is relatively poor compared with many other first world countries. First, although Australia has to some extent implemented treatment foster care as part of its treatment options for young people in out-of-home care, this has not occurred to anywhere the extent as in America or Britain. Australia also has not professionalised foster care in any sense of the word. Intensive family preservation program have been introduced into several States, and some capital cities (Perth and Brisbane) are implementing MST. Despite this, the programs have not been nationally implemented even though the research has provided some promising results.

Second, although the privatisation of out-of-home care as mentioned above is becoming a reality in Australia, this still has many associated problems, including less de-regulation of the system and greater State-by-State differences. Moreover, much of this is State funded and may not be sustainable in the longer-term. Australia does not have the number of philanthropic trusts present in the United States and therefore the possibility of setting up large residential treatment facilities is unlikely without more substantial financial input from State or Federal governments.

Finally, intensive therapeutic services and the development of a continuum of services which are theoretically driven and empirically evaluated still only remain in their early stages. Many State governments in Australia are recognising the need and the importance of developing empirically validated models of care and treatment, but there is still a long way to go before all children and families in need are receiving the most timely and appropriate treatment services. One way in which this might be enhanced is through the greater role of multidisciplinary teams including clinical psychologists with specialist training in trauma theory, behavioural and emotional disorders, attachment theory, sexualised behaviours, and substance abuse. Furthermore, pre-service and in-service training for foster carers and unit staff is also important. In the US literature, training for foster carers has proven effective in the recruitment and retention of carers and in the overall success of children in foster placements (Clough et al., 2004). Specialised training for foster carers has also been shown to play a significant role in increasing the involvement of foster parents in maintaining biological parent-child contact (Sanchirico & Jablonka, 2000).

Another issue relates to the use of residential care. As Fonagy (2002) clearly states, “there is no empirical evidence either for or against the use of residential and day treatment facilities. However, there is clinical consensus that the severity and complexity of some disorders… may require access to inpatient and day patient treatment units (p. 389). This position is further argued by Ainsworth (1998, quoted in Bath, 1998), who asserts that:

> the service system has to include residential education or residential treatment programs. What is required is a sufficiently powerful re-education and re-socialisation experience aimed at positively changing difficult behaviours and this can only be provided by 24 hour per day residential programs (p. 23).

However, as documented in a recent review of residential care in NSW, residential care in some States in Australia is still declining (Flynn et al., November 2005). Nevertheless, the report also noted that in some States, particularly New South Wales, there have been moves to increase residential placements.

In terms of identifying the principal service gaps in the care system, Morton, Clark and Pead (1999) made the following recommendations based on their observations of Victoria, but noted that similar points could be raised for all systems across the country:

- Multi-sectoral, multi-disciplinary assessment and case planning
- Early identification of children and adolescents, entering the care of the Department, who have suffered severe abuse and/or neglect and who manifest high levels of emotional disturbance;
- Consultation, training and intensive support for kith and kin, carers, or staff providing specialist placements for young people with extreme levels of disturbance;
- Intensive specialist therapeutic interventions for young people in care who manifest severe emotional and behavioural disturbance;
- Specialist therapeutic outreach services in rural regions;
- Therapeutic residential group care for young people with extreme levels of disturbance;
- Specialist intensive therapeutic residential or day programs;
- Alternative educational programming for young people not able to be supported in mainstream schools; and
- Mandatory community-based intensive therapeutic options as an alternative to custody, or as an enhancement of community-based

> correctional orders, for young people with extreme levels of disturbance convicted of violent crimes or drug offences. (p. 43)

Although some States have taken steps to extend their range of placement options or are, at least, attempting to respond to many of the developments occurring overseas, this has so far only occurred to a relatively limited scope. Thus, there is a danger that children with high support needs will continue to impose considerable burdens on the existing care system. Another important consideration is that attempts are made to use more intensive placement support services in an appropriate and effective way. As Yelton (1993) stresses,

> the foster care system has not been able to respond to the increasing number of children and their needs, resulting in frequent crises and multiple placements. By the time a child is placed in residential care for treatment purposes, one could question whether the foster care experience was the primary reason for treatment rather than the original reason for removal (p.185).

Yelton's argument clearly highlights the need for timely, appropriate, intensive treatment services before it is too late and these children, already subject to considerable trauma when they enter care, only have these difficulties compounded by the inability of the system to provide timely and appropriate therapeutic services. Thus, as Stroul and Friedman (1986) and Ainsworth and Small (1994) have pointed out, even when one has an appropriate range of services it is important to use them flexibly. Although some residential care or more intensive options might be considered to be undesirable unless other family-based options have been tried first, it may be important to utilise more intensive options as soon as they are necessary, so that problems are not allowed to continue. In other words, a flexible use of a continuum of services would involve matching children's needs to the intensity of the service rather than allowing children with significant problems to be maintained in less supported placements for long periods of time. Within this sort of flexible arrangement, there is no assumption that children who need more intensive options should stay in such arrangements for long periods. An effective system is one where intensive options can be used interchangeably with family-based options to create a

balance of behavioural management and stabilisation while maintaining a normalised family environment, where this is appropriate for the particular child or young person. Several agencies such as Youth Villages, Devereux, Pressley Ridge and Andrus' Children's Center, provide good examples of how such flexibility can be provided within the same agency, and that there can be a capacity to move young people between placement arrangements based on their level of need (even if one does not agree with every aspect of the treatment philosophy or types of intervention provided). These agencies appear to offer a quite a different service in comparison to many of the Australian agencies. In Australia, often due to limited funding, agencies generally only offer one or two intensive services rather than a continuum of services that can be matched to the child's level of need. These examples could provide a model for how Australian services might be adapted to better serve the children and young people in out-of-home care.

Another important implication of the above summary and review is that there is a need to be able to provide appropriate services and placement models that have the capacity of being evaluated (Jackson, December 2005). The use of fidelity measures or implementation checks and the development of training and practice manuals are very important in this regard. Clearly, at the moment, many of the interventions and services described above do not meet even the lowest level of research standards and can only really be considered in very broad descriptive terms rather than in terms of models with a known capacity to generate reliable and clinically significant improvements in child and adolescent well-being.

SECTION D

Chapter 5

Small pilot evaluations in SA and Victoria

5.1 Overview

As discussed in Chapter 1, it is well established that foster care systems in Australia and around the world are dealing with a population of children and young people suffering from a range of increasingly complex emotional and behavioural problems. Several studies (Barber & Delfabbro, 2004; Victorian Department of Human Services, June 2003) have identified that young people with mental health or behavioural problems are least likely to achieve placement stability or to display improved psychological adjustment while in care. Most importantly, these studies have demonstrated that these individuals do not appear to be suitable for placement in traditional forms of family-based care and thus require innovative solutions to meet their needs.

5.1.1 Study aims

As stated in Chapter 1, one of the principal aims of the national study was to produce a clear statement and summary of the magnitude of the problems faced by the alternative care system, specifically in relation to the challenge of finding stable permanent placements for children with 'high-support needs'. In response to these concerns, a number of small-scale innovative programs have been developed to assist children in this specific population. However, relatively little information is available concerning the effectiveness of these programs, or how long they would need to be run in order to bring about clinically significant improvements in children's well-being.

According to the American Psychological Society (Jackson, December 2005), a program can only be said to be clinically effective if;

I. *"At least two good between-group experiments demonstrating efficacy in one or more of the following ways:*
   A. Superior to pill or psychological placebo or to another treatment
   B. Equivalent to an already established treatment in experiments with

adequate statistical power

OR

II. A large series of single case design experiments (n > 9) demonstrating efficacy. These experiments must have:

A. Used good experimental designs and

B. Compared the intervention to another treatment as in I.A.

Further criteria for both I and II:

III. Experiments must be conducted with treatment manuals

IV. Characteristics of the client samples must be clearly defined

V. Effects must have been demonstrated by at least two different investigators or investigatory teams" (Table 1, p. 15).

In other words, research needs to adhere to such guidelines to give it a strong grounding in the best-practice principles of psychological evaluation before a treatment can be considered 'effective' or 'well-established'. In the current context, it would be desirable that the program brings about changes that are superior to the best available alternative, namely the conventional alternative care system in South Australia and Victoria.

Two innovative intervention strategies used in two Australian States are the individual packages of care (IPC) currently being run by the South Australian Department for Families and Communities (DFC) and the TrACK program being run by Anglicare Victoria. An opportunity arose during the national comparative study to collaborate with these partners to evaluate these two programs. The purpose of this chapter is to summarise the results of the short-term evaluation of these programs, in the hope that the findings might provide evidence to other Australia States faced with similar populations of challenging children. The first part of the Chapter summarises the outcomes from the evaluation of the IPC program as compared with 'control' groups comprising children with similar needs placed into conventional care: either 'residential' or foster care. The second part of the chapter summarises the results for the TrACK program. The final section provides a brief summary of the differences and similarities between the two programs.

5.2 Intensive Support Services – Individual Packages of Care (SA)

The Individual Packages of Care or IPCs were developed by the Department for Families and Communities (DFC) in the State of South Australia. The packages of care were individually designed and tailored to meet the specific needs of each child and young person and involved a time-limited, contracted service provided by external agencies outside the conventional Government system. Children and young people eligible for an IPC were identified by the Central Alternative Care Unit (CACU) and then each case was presented to the Placement Consulting Group (PCG). The PCG comprised a number of individuals drawn from across the sector including CAMHS (Child and Adolescent Mental Health Service), CYFS (Child, Youth and Family Services), CRC (Community Residential Care) and DSO (Disability Services Office) and a departmental Aboriginal advisor. Each case was discussed by the PCG, with the child's case-worker present, and then assigned an appropriate Level of Care rating. The IPCs were provided to children through the Department for Families and Communities and the principles of the program were "based on relevant legislation, the Social Welfare Framework, the CREATE "Commitments in Care Charter", the Alternative Care Review Discussion Paper, the Joint Venture Project, DFC policy regarding procurement and probity and research and best practice principles from South Australia and around the world" (Department of Human Services, April, 2002 p.4).

The service principles outlined in the Department for Families and Communities "Guidelines for Individual Packages of Care" (Department of Human Services, April, 2002) include:

- cultural inclusiveness;
- individually tailored services;
- youth participation;
- strengthening links with families and significant others;
- stability and continuity of care;
- increasing capacity of young people to enable them to reach their potential;
- supporting transition between placements and into independent living;
- respect of privacy and confidentiality of young people;
- timely, flexible and responsive services;

- carer matching; and,
- evaluation of service delivery.

Currently, the IPCs are operated through two non-government agencies: Life Without Barriers ("Individual Packages") and Baptist Community Services ("X-Alt"). Both agencies provide the service on behalf of DFC and serve the children and young people directly in line with the guiding principles described above. The agencies provide the appropriate level of care, placement and required contracted services, including psychological intervention, mentors, tutors, cultural support workers, and aftercare services.

5.2.1 Evaluation methodology

The children that were enrolled in the IPC program were selected as part of the national comparative South Australia sample. The national comparative study involved an extensive case-file reading (conducted by a paid employee of DFC) and a face-to-face interview (lasting approximately 30-45 minutes) with the child's case-worker (conducted by the Principal investigator, Alexandra Osborn). The children who were included in the study were selected using the same selection criteria as the national study, that is, based on an empirically-derived and objective criterion of placement disruption. Children were selected if they had been referred for emergency, short-term, or long-term placements were aged 4 to 17 years of age, had had two or more placement breakdowns in the previous two years due to their behaviour, and were currently enrolled in the IPC program. All data were collected via a combination of case-file reading and interviews with case-workers at the baseline point, and then through repeated interviews thereafter (at six and twelve months). Variables and measures included in the evaluation were the same as in the national study as described in Chapter 2.

5.3 Results

5.3.1 Sample characteristics

A total of 30 young people were enrolled in an IPC at the commencement of the study, but only 18 young people were included in the study because the other 12 were nearing the completion of the program. Close to two thirds of the sample were

male (61.1%), with a mean age of 14 years (*SD* = 2.77). The majority of the sample were identified as non-Indigenous (77.8%), 11.1% were Aboriginal, and 11.1% had another ethnicity.

Two comparison groups (randomly drawn from the national comparative study South Australian sample) were identified, based on the two most commonly available or conventional alternatives to these newly developed specialist programs. The first comprised 22 young people who remained in the conventional South Australian foster care system. Of these 22, 40.9% were male, with a mean age of 12.95 (*SD* = 1.84) years. Again, the majority of the sample was identified as non-Indigenous (77.3%), with 22.7% identified as Aboriginal. A second comparison group comprised 18 young people placed into residential care units in South Australia for the same period. These young people had a mean age of 13.89 (*SD* = 1.94) years and had a similar demographic composition to the other comparison group: 44.4% were male, 72.2% were identified as non-Indigenous (72.2%), 16.7% were identified as Aboriginal, and 11.1% as possessing another ethnicity.

No significant differences were found between the three groups in relation to age, gender, or ethnicity.

5.3.2 Factors Contributing to Placement

Across the three groups, several factors were identified as contributing to the placement of the child into the care system. Some of the more common factors included: physical abuse (88.9%), sexual abuse (66.7%), neglect (55.6%), financial problems (50%), homeless or no adequate housing (38.9%), domestic violence (72.2%), parents involved in substance abuse (61.1%), and/or mental health issues of the parents (50%). The primary reasons for entry into care identified via the case-file reading were either that the parents were unable to cope with the child (61.1%), or had mental health problems, or other factors that made it difficult for them to provide adequate care. There were no significant differences between the groups in relation to the factors that contributed to them being placed into the care system.

The mean age for first entry into care for the IPC sample was 8.13 years (*SD* = 3.01), *M* = 7.33 (*SD* = 3.88) for the residential group and 5.40 (*SD* = 4.24) for the

foster care control group. An independent samples t-test revealed the IPC group were significantly older when they entered care (t (2) = 2.29, $p < 0.05$) as compared with the other groups. The mean number of years spent in care for the IPC group was 6.36 years (SD = 4.14), 5.85 (SD = 4.23) years for the residential group and 7.07 (SD = 4.58) years for the foster care control group. No significant differences were found between the three groups in terms of the length of time in care.

The average number of foster placements prior to entering the current program or placement for the IPC group was 17.36 placements (SD = 15.50) with a range of 2 to 55 placements. The residential group had experienced an average (mean) number of 19.06 (SD = 13.91) previous foster placements, with a range of 4 - 39, and the foster care control group had experienced 13.77 (SD = 9.32) previous foster placements with a range of 3-55. No significant differences in the number of previous foster placements were found between the groups.

An analysis of the previous placement experiences of the three groups indicated that the majority of children enrolled in the IPC program had previously been placed into residential care (83.3%), and only 16.7% had previously been placed in relative care. The entire residential group had been placed into residential care previously, but only 4.5% of the group had been previously placed in relative care. In the foster care control group, only 18.2% had been previously placed in residential care and only 13.6% had been previously placed in relative care. These results indicate that relative care does not appear to have been a widely used or successful placement option for children within this population.

OUTCOMES

5.3.3 Education

At the baseline assessment, just over half 10 (55.6%) of the IPC group young people were attending school or TAFE. At the six month assessment, this percentage remained stable. Also, at the final twelve month review, 55.6% were currently attending school or were enrolled in a special educational program (including TAFE).

At the baseline assessment, 95.5% of the foster care control group were attending school or TAFE, but this figure had decreased to only 72.7% by the 12-month review. In contrast, the residential group commenced with a much lower level of educational participation (38.9% at baseline), but this number had almost doubled to 66.7% by the time of the 12-month review. Although McNemar change tests indicated that the proportion of children at school in each group had not significantly changed over time, this lack of significance is very likely due to the lack of statistical power of the analysis. The results therefore provided little evidence that school participation was in any was enhanced by the IPC program.

5.3.4 Family contact

As can be seen in Table 5.1, the most common forms of family contact for the IPC group were monthly or weekly phone visits or unsupervised direct (face-to-face) visits with the biological mother. The findings from the six and twelve month reviews revealed similar levels of family contact across the three forms of family contact (phone, direct supervised and direct unsupervised). The only significant difference noted was a reduction in the frequency of phone contact with the biological mother from the six to twelve month assessment (t (1) = 2.38, $p < 0.05$). Nevertheless, the frequency of family contact remained relatively stable over the twelve month period, suggesting that the IPC program had not greatly influenced the frequency of contact.

No significant differences were noted across time between the three groups in relation to the frequency of family contact. This suggests that the level of family contact remained stable over this time period for all the young people in the IPC, residential care and control groups.

Table 5.1 Frequency of contact with biological mother and father at baseline, 6 and 12 month reviews

Contact (%)	Never	< 1 week	Weekly or more often
Mother – Phone			
Baseline	50.0	27.8	22.2
6 months	33.3	27.8	38.9
12 months	55.6	16.7	27.8
Mother- Direct supervised (face-to-face)			
Baseline	88.9	11.1	0.0
6 months	83.3	16.7	0.0
12 months	88.9	11.1	0.0
Mother –Direct unsupervised (face-to-face and overnight stays)			
Baseline	44.4	33.3	22.2
6 months	55.6	27.8	16.7
12 months	61.1	22.2	16.7
Father- Phone			
Baseline	88.9	0.0	11.1
6 months	83.3	11.1	5.6
12 months	88.9	0.0	11.1
Father- Direct supervised (face-to-face)			
Baseline	94.4	5.6	0.0
6 months	100	0.0	0.0
12 months	100	0.0	0.0
Father – Direct unsupervised (face-to-face and overnight stays)			
Baseline	61.1	33.3	5.6
6 months	77.8	11.1	11.1
12 months	77.7	11.1	11.1

5.3.5 Type and frequency of intervention(s)

All but one child was identified by their case-worker as based on psychological and/or psychiatric assessments as having psychological health problems that required attention in the previous six months at the baseline assessment. The psychological health problems included attachment disorder (33.4%), post-traumatic stress disorder (22.2%), trauma (16.7%), sexualized behaviours (27.9%), behavioural issues/conduct disorder (27.8%), depression/anxiety (5.6%), emotional issues (27.8%), substance abuse (11.1%) and other issues (61.2%).

The types of psychological attention the children and young people were receiving included private psychological sessions (27.8%) and intervention provided through CYFS (16.8%), CAMHS (22.3%), NADA (22.2%), Women's and Children's Hospital (26.7%), or other services (44.4%). The majority of children (77.8%) were also identified as receiving attention for physical health problems in the previous six months such as dental, optical, allergies, pregnancy and general check-up needs. The services they received included dental (22.2%), general check-up (27.8%), and specialist services (5.6%).

At the six monthly follow-up assessments, again all but one child was identified as having psychological health problems that required attention. Again, the psychological health problems receiving attention were similar to the above identified at the baseline assessment. At the final twelve month review, 88.9% of the sample or 16 out of the 18 individuals were identified as having a psychological health problem. As indicated in the previous assessment, the case-workers identified similar psychological health problems that were receiving some form of intervention.

No significant difference was found between the three groups in relation to identified psychological problems at baseline or at twelve month review. However, a significant groups-by-time effect was noted between the three groups in relation to the number of identified health problems at baseline and at the twelve month assessment (F (1,54) = 6.23, $p < 0.05$). A paired samples t-test revealed that the foster care control group had experienced a significant increase in identified health problems over time (t (2) = 2.12, $p < 0.05$), whereas no further increases were observed in the other two groups.

5.3.6 Strengths and Difficulties Questionnaire (SDQ)

The SDQ (Goodman, 1997) is a clinical instrument used to measure behavioural and emotional functioning in the child and is generally administered to a parent, teacher, or, in cases of foster children, their case-worker. The instrument has been found to be a very reliable and valid tool (Mathai, Anderson, & Bourne, 2002) and has also shown to be sensitive in detecting any changes across six month time periods and is the measure included in the national longitudinal study of children. The instrument consists of four sub-scales: Conduct problems, Emotional symptoms,

Hyperactivity/inattention and Peer relationship problems. Each subscale has questions relating to the child's functioning in respect to the four domains. For example, conduct problems items include; "often has temper tantrums or hot tempers" or "often lies or cheats" or in respect to emotional problems, "often complains of headaches or, stomach-aches or sickness". The parent, teacher, or case-worker is asked to respond to each of the statements as either "not true", "somewhat true" or "certainly true". The child's case-worker was interviewed at the beginning of the study and then at six months and twelve months.

An initial t-test comparison of the scores of this group with others in the national study of children with high support needs revealed no significant differences, suggesting that the IPC sample was representative of other 'hard to place' children elsewhere in the country.

Table 5.2 Baseline, six and twelve month assessment results from the Strengths and Difficulties Questionnaire (SDQ), *M* (*SD*) for IPC, Foster care control and Residential care groups

	Conduct problems	Emotional Symptoms	Hyper-activity	Peer Problems	Total difficulties
IPC group					
Baseline	5.72 (2.82)	4.44 (2.53)	7.00 (2.37)	5.89 (2.45)	23.06 (5.23)
6 months	4.82 (2.60)	5.06 (2.77)	6.06 (3.27)	5.47 (2.24)	21.41 (8.50)
12 months	5.44 (2.68)	5.33 (2.38)	6.59 (2.67)	5.22 (1.99)	23.00 (5.86)
F-value	< 1	3.19	1.38	< 1	< 1
Cohen's *d**	-0.10	+0.36	-0.16	-0.30	-0.01
Foster care control					
Baseline	5.19 (2.60)	4.14 (2.95)	6.33 (2.39)	6.05 (2.33)	22.20 (6.83)
12 months	5.29 (2.88)	4.86 (2.03)	6.38 (2.62)	3.86 (2.37)	20.38 (6.29)
F-value	< 1	< 1	1.09	10.74***	< 1
Cohen's *d**	-0.04	+0.28	-0.02	-0.93	-0.28
Residential care group					
Baseline	6.47 (2.32)	4.41 (3.06)	6.12 (2.26)	4.94 (1.91)	21.94 (4.81)
12 months	5.13 (2.68)	4.81 (2.17)	6.69 (2.06)	4.38 (2.78)	21.00 (6.32)
F-value	9.64**	< 1	< 1	< 1	< 1
Cohen's *d**	-0.54	+0.15	+0.26	-0.24	-0.17

* Cohen's *d* based on the comparison of baseline and 12 month scores, ** $p < 0.05$, ***$p < 0.01$

The differences observed between baseline and 12 months have been expressed as a standardised effect size. Signs have been added to indicate the direction of effect, with positive changes indicating an increase in symptomology over time. As can be observed in Table 5.2, the results do not provide any clear indication of the relative advantages of IPCs over conventional care in terms of their effects on psychological and social functioning. None of the small improvements in subscale scores for the IPC group were significant, whereas they experienced a significant deterioration in emotional functioning. By contrast, those in the foster care control group experienced a large improvement in peer functioning, and the

residential group a moderate improvement in conduct problems. These findings are surprising considering the young people in the foster care and residential care groups were not enrolled in a therapeutic program. It should be noted the young people in the IPC group may not have shown improvements because their case-workers may have been more aware of their difficulties. The greater the knowledge of the child and perhaps the greater engagement of the child with the intervention, the more the child might have to come to terms with repressed memories of traumatic experiences.

Reliable change analyses of the conduct problems scale, as it was the only scale observed to have a significant difference for the residential group, were conducted to determine the extent to which the change shown by an individual falls beyond the range which could be attributed to the measurement variability of the instrument itself (Evans, Margison, & Barkham, 1998). The measurement variability is referred to as Reliable Change (RC) Index and is based on a variation on the standard error (SE) of measurement which takes into account the before and after treatment measurements. Evans et al. refer to this in their paper as the SE of the difference. The formula for the SE of measurement of a difference is: $SE_{diff} = SD_1\sqrt{2}\sqrt{1-r}$. SD_1 is the standard deviation of the baseline observations and r is the reliability of the measure. Change that exceeds 1.96 times this SE is considered to be unlikely to occur more than 5% of the time by unreliability of the measure alone. For example, the SE_{diff} for the conduct problems SDQ sub-scale for residential group was found to be 1.70. Therefore any change that exceeds 1.96 X 1.70 = 3.33 can be considered to be a reliable change (see Table 5.3 below). The same calculations were conducted for each SDQ sub-scale for each of the three groups.

Table 5.3 Proportion of children, *N* (%) with reliable change from baseline to twelve month review for SDQ for three groups

	IPC (*N* = 18)	Residential Care (*N* = 17)	Foster Care (*N* = 21)
Conduct problems	0 (0.0)	3 (18.7)	8 (40.0)
Emotional problems	4 (22.2)	5 (27.8)	6 (28.6)
Hyperactivity	1 (5.0)	7 (41.2)	2 (9.5)
Peer problems	2 (11.1)	4 (23.5)	8 (40.0)

As can be observed in table (5.3) above, four of the participants in the IPC group were observed to have a reliable deterioration in their emotional problems score over time. Only two participants were noted to have a reliable change (one was observed to improve and one was observed to deteriorate over time) for the peer problems sub-scales, but one participant showed a reliable improvement in their hyperactivity score for the IPC group.

Table 5.3 demonstrates that 3 of the 16 (18.7%) participants in the residential group showed reliable improvement in their conduct problems score. Five of the young people in the residential group were observed to have a reliable change (two were observed to improve and three were observed to deteriorate over time) in their emotional problems but seven of the participants were found to have a reliable change (three were observed to improve and three were observed to deteriorate) in their hyperactivity scores over the same time period. Four of the young people in the residential group also displayed a reliable change (two were observed to improve and two were observed to deteriorate) in their peer problems score from baseline to twelve month review.

Reliable change analyses were also conducted for the SDQ sub-scales for the foster care group (see Table 5.3). Eight of the foster care group participants showed reliable improvement in their peer problems score from baseline to twelve month review. However, eight of the participants were also observed to have a reliable change (four were observed to have an improvement in their scores and four were observed to have a deterioration in their score) in their conduct problems score over

time. Six of the young people in the foster care control group were observed to have a reliable change (four were observed to have deteriorated over time and two were observed to have improved over time) in their emotional problems score and two of the young people for the hyperactivity score over the same time period.

Table 5.4 Social adjustment and attachment-related problem behaviours, *M* (*SD*)

	Social functioning	Attachment-related problem behaviours
IPC		
Baseline	20.19 (3.27)	27.17 (5.39)
Six months	19.38 (3.03)	25.47 (5.77)
12 months	19.94 (2.63)	26.33 (4.43)
F-value	< 1	< 1
Cohen's *d**	0.08	0.17
Foster care control group		
Baseline	19.10 (3.75)	25.76 (4.81)
12 months	18.76 (3.42)	25.55 (4.89)
F-value	< 1	< 1
Cohen's *d**	0.09	0.04
Residential care group		
Baseline	20.18 (3.40)	26.76 (4.29)
12 months	18.13 (3.12)	24.13 (4.37)
F-value	7.05**	10.57**
Cohen's *d**	0.63	0.61

* Cohen's *d* based on the comparison of baseline and 12 month scores, **$p < 0.05$

As can be observed in Table 5.4, improvements were also noted in the social functioning and attachment-related problem behaviours of the IPC participants from the baseline review to the six month reviews and twelve month assessments (a slight deterioration is noted between the six and twelve month assessments) but were not found to be statistically significant. The same was true for the young people in the foster care control group. However, in stark contrast to what might be expected, the residential care group showed significant improvements in both their social functioning (F (1, 15) = 10.57, $p < 0.05$) and level of attachment-related problem

behaviours (F (1, 15) = 7.05, $p < 0.05$). Again this finding is interesting considering that anecdotally young people in residential group care are generally considered to receive a relatively poor standard of care in South Australia (as indicated in earlier chapters).

5.3.7 Placement stability or instability

At the initial baseline assessment the average number of unplanned placement terminations the young person in the IPC group had experienced in the previous two years was just over seven terminations (M = 7.41, SD = 9.25). At the six monthly review, the findings indicated that the young people had experienced a dramatic decrease in the number of unplanned placement terminations. The majority (83.3%) of young people had experienced no unplanned moves and only one individual had experienced one unplanned move and two other individuals had experienced two unplanned placement terminations. Again, at the annual review, the findings were similar and indicated that the majority of individuals (83.3%) had remained stable over the previous six month period. Only three individuals had experienced one unplanned placement termination during that time period of six months. These findings are particularly impressive considering the placement instability the young people had experienced prior to entering the IPC program.

Further analyses were conducted to evaluate the baseline and twelve month assessment findings of the IPC group in comparison to the residential and control groups. To compare the findings of the number of placement disruptions in the past two years to the number in the past 12 months a new variable was calculated. The new variable involved dividing the mean number of placement disruptions in the last two years by two to get a comparable number with the mean number of the last twelve months (see Table 5.5).

Table 5.5 Mean number of placement disruptions as baseline (previous 12 months) and at twelve month assessment, *M (SD)*

	IPC	Residential	Foster care
Baseline placement disruptions in previous 12 months	3.70 (4.63)	2.44 (1.22)	1.91 (1.64)
Annual review placement disruptions	0.18 (0.38)	0.47 (1.20)	1.36 (2.74)

Statistical analysis was undertaken to examine placement stability over time. A repeated analysis of variance revealed a significant Time effect (F (1, 53) = 21.94, $p < 0.001$) and a significant Group x Time interaction (F (2, 53) = 4.19, $p < 0.05$). Paired sample t-tests were then used to examine which group(s) experienced a significant change in the number of placement breakdowns over the twelve month period. No significant change was noted for the control group but a significant reduction was noted for the IPC group (t (2) = 3.08, $p < 0.01$) and the residential-care group (t (2) = 4.68, $p < 0.001$). This finding again highlights that the IPC group was very stable at the twelve month follow-up when compared to a control group with similar age, gender and ethnicity and that had experienced similar levels of previous placement instability. This result could also suggest that residential care does provide stability for young people in care with extreme levels of placement disruption and indicates the superiority of the IPC as compared with conventional foster care for providing placement stability.

Further analysis was therefore undertaken to understand the placement history of the residential group. Closer analysis of the placement moves of the residential care group showed that the residential care group had experienced a significant reduction in the number of unplanned placement terminations over the assessment period, but that the young people had still experienced a number of planned placement moves. Many of the young people in the residential care group had experienced several respite and emergency placements and several placements with family and friends, and in motels and caravan parks. In South Australia, residential care is usually treated as a last option for children who cannot be placed elsewhere, so that stability in care does not necessarily indicate that a successful placement has been obtained. Nevertheless, the young people in residential care did

show significant improvements in their social functioning, level of conduct problems and attachment-related problem behaviours and further research into why this is so and what types of young people are most likely to benefit from this form of care is necessary.

5.4 Conclusion

The fundamental purpose of the study was to ascertain whether the innovative programs that are designed to meet the challenging needs of children and young, (in this case, the IPCs) are in fact doing so. As the results indicate, the IPCs appear to be providing stability for young people with histories of extreme placement instability as compared with conventional foster care and without any obviously detrimental effects on the level of family contact. In this sense, the results are very promising when viewed in light of the sheer number of placements the young people had previously experienced. The results also revealed very limited changes in the social functioning and attachment-related problem behaviours of the young people and some improvement in some areas of their behavioural functioning. However, a significant deterioration was noted in their emotional functioning but this may be related to the fact that a greater awareness of young people's personal difficulties may result in signs of deteriorations in the short-term. Nevertheless, it is also clear that more intensive and specialised interventions are very likely to be required to give rise to significant improvements in psychological well-being. The IPC sample by its very nature includes only those young people with the most extreme difficulties and so it is to be expected that considerable time and resources are probably needed to assist this group and those improvements in psychosocial functioning are unlikely to occur unless these young people receive very intensive therapeutic interventions. In Barber and Delfabbro's (2004) summary of 1998-2001 longitudinal study it was found that this group were very poorly served by the conventional system. Not only did they experience unacceptable levels of placement disruption, but their psychosocial development (most noticeably their emotional and social adjustment) tended to decline over time. In comparison, young people in the IPCs do not appear to be experiencing similar deteriorations in their functioning, very likely because of the greater placement stability that has been achieved. It must be noted here, that the IPCs are not therapeutic interventions but rather managed models of care (i.e. similar to wraparound services in America) which provide

therapeutic interventions by external providers. In this connection, it should be emphasised that the two agencies could provide more therapeutic interventions to further improve the psychosocial functioning of the young people. For these reasons, the provision of more supports for programs of this nature should be an important priority for the State government in future alternative care policies and initiatives. However this requires not only funding but acknowledgement by the State government of the importance of these programs.

5.5 TrACK: Anglicare Victoria's Intensive Program

TrACK is a Therapeutic Foster Care program run by Anglicare Eastern Region in Victoria in conjunction with the Australian Childhood Foundation (ACF) that receive funding by the Victorian Department of Human Services (Eastern Region). TrACK evolved in July 2003 from a program (CATALYST) that was specifically designed for children with sexualised behaviours and has extended its target group to include children with both sexualised and challenging behaviours. The target group for TrACK is generally children under 13 years of age who live in the Eastern Region (Melbourne Metro), who exhibit a range of challenging behaviours and who are identified as requiring a more specialised and therapeutic form of home based care than what they would receive in general Foster Care i.e. a professional foster care service. As such, the intention of service is similar to that of the South Australian IPCs in that it is specifically designed for children and young people that require more or are not suitable for traditional family-based foster care. A further requirement of entry into TrACK is the child still must be assessed as being suitable for home based care with the capacity to develop and maintain relationships within a family environment. The program is designed to improve outcomes for children through intensive case management services, individual and group carer support, liaising with parents and family and individual work with the children.

TrACK is currently funded to provide placements for 12 children. At the time of the review, there were 11 children in the program and the pilot evaluation includes the review of all 11 of the children at baseline (i.e. within three month of entering the program), after six months in the program and of ten children at the 12 month review time point as one child left the program.

The role of Anglicare Victorian workers is to recruit and train specialist caregivers. Each of the caregivers undertake 18 hours of general Foster Care training and the general Foster Care accreditation and then they are assessed to determine whether they are suitable to be a TrACK caregiver (relating to family composition, childcare skills, attitude and aptitude). If the caregivers are identified as fitting the criteria they then undertake additional training and assessment and receive a higher reimbursement. Anglicare workers also provide intensive support services to caregivers along with intensive casework and case management services. ACF also provides training, secondary consultation and supervision to caregivers and other stakeholders in the program. The therapeutic interventions and services and group programs for caregivers and children are coordinated by ACF.

Recent reviews

A recent evaluation of TrACK (Szirom, McDougall, & Mitchell, August 2005) reviewed the outcomes of seven children and their carers who had been in the program for a minium of six months. The review identified a number of positive outcomes and improvements in children's: self-esteem; sleeping patterns; ability to verbalise fears; eating issues and disorders; ability to establish and maintain relationships and to express affection; ability to accept limits and routines, and to participate in family tasks; connection to school; violent behaviours, vandalism, property damage and absconding; and inappropriate sexualised behaviours. However, all of these improvements were assessed using rating scales that only allowed responses in a positive direction, and there was no baseline assessment or follow-up assessment that allowed the comparison of scores obtained using the same measures.

5.5.1 Sample characteristics

A total of 11 children were enrolled in TrACK program at the commencement of the study and all children were included in the study. All of the children in the program were non-Indigenous with a mean age of 11.45 (*SD* = 3.01). The majority of children were male (*N* = 9, 18.2%) under Guardianship of the Minister orders (*N* = 8, 72.7%). One participant was under a care and protection order and 1 participant was under a voluntary court application (VCA). The length of the orders varied: three participants were under 12 month orders (27.3%); two

participants were under guardianship orders until 18 years of age (18.2%); and six participants were under 'other' length orders (54.6%).

5.5.2 Care history

The mean age of entry into care was 3.73 (*SD* = 3.27) with a range of 0 to 10 years of age. The primary reasons for entry into care included: neglect (*N* = 3, 27.3%), abuse (*N* = 1, 9.1%), parental mental health problems (*N* = 1, 9.1%), parents unable to cope (*N* = 1, 9.1%) and a variety of 'other' reasons (*N* = 4, 36.4%) such as voluntary placement of the child by the parents or self referral by the child. On average, the TrACK participants had been in the care system for 5.82 (*SD* = 3.61) years. During that time in care they had experienced on average 12.09 (*SD* = 12.91) placements prior to their placement in the TrACK program. The mean number of reunification attempts was 3.45 (*SD* = 5.89) with a range of 0 to 15 previous attempts and the mean duration of the longest reunification attempt was 19.58 (*SD* = 26.95) months with a range of 2 weeks to 60 months. The majority of the participants had previously been placed into residential care (*N* = 9, 81.8%) and 4 (36.4%) of the participants had previously been placed in relative care.

5.5.3 Social and family background

All of the TrACK participants had social and family backgrounds characterised by a number of issues that contributed to their placement in the care system including: financial problems (72.7%), homelessness or no adequate housing (63.6%), domestic violence (90.9%), parental imprisonment (45.5%), parental mental health problems (72.7), parental substance abuse (54.5%), sexual abuse (45.5%), physical abuse (90.9%), neglect (81.8%) and parental physical illness and/or disability (27.3%).

5.5.4 Family contact

On average, the participants were having contact with their biological mother on a relatively infrequent basis: two participants (18.2%) were having monthly or less often telephone contact, seven participants (63.6%) were having monthly or less often supervised face-to-face contact, and three participants (27.3%) were having monthly or less often unsupervised contact and two participants (18.2%) were having weekly overnight stays. None of the participants were having contact with their

biological father. Two participants (18.2%) were having monthly to weekly telephone con tact with relatives (siblings) Only one participant was having monthly supervised face-to-face contact with a relatives and four participants (36.4%) were having monthly unsupervised face-to-face contact and overnight stays with relatives.

5.5.5 Health and psychological health issues

The majority of the participants were noted as falling within the healthy weight range (N = 7, 63.6%) according to their case-worker, three of the participants (27.3%) were noted as 'slightly underweight' and one participant (9.1%) was noted as very underweight. The physical coordination of the children was described by their case-workers as 'average for age' for five participants (45.5%) and 'slightly better than normal' to 'very good' for the other five participants (45.5%) and one participant was noted as having very much better than average physical coordination (9.1%).

All participants had experienced some form of health problem that required attention in the previous six months including; dental/orthodontic reasons and a variety of other general health problems that were treated by a general practitioner. All of the participants had been identified as exhibiting psychological health problems that required attention in the last six months. Such health problems included; conduct disorder/behavioural problems (81.9%), attachment disorder (45.5%), anxiety (27.3%), depression (18.2%), post-traumatic stress disorder (9.1%), trauma (9.1%), emotional problems (9.1%) and a variety of other problems including enuresis and encopresis and sexualised behaviours (36.4%). Three of the participants had received treatment by a private psychologist, one participant had received psychotropic medication for Reactive Attachment Disorder, and one participant had received attention from a general practitioner.

5.5.6 Education

At the time of the baseline review all the participants were attending school with children enrolled in grade 1 to grade 8. During the previous six months, prior to review, 4 of the participants (36.4%) had been suspended from school with a mean number of suspensions was 0.88 (SD = 1.23) with a range of 1 to 3 suspensions. Three of the participants (27.3%) had been excluded from school in the previous six

months with a mean number of 4.80 (*SD* = 9.45) and a range of 1 to 25 exclusions during that time period. At the six month review follow-up all participants were all still attending school, but five participants (45.5%) had been suspended from school and three participants (27.3%) had been excluded during the previous six months. At the twelve month review all of the ten children in the program were still attending school. Two of the children had been suspended (*M* = 0.30, *SD* = 0.67) and three children had been excluded (*M* = 2.60, *SD* = 4.33) from school during the previous six months.

5.5.7 Placement history

Information was collected concerning the number and reason for placement breakdowns in the previous two years. The mean number of placement breakdowns in the previous two years, reflected as the baseline measure, was 2.18 (*SD* = 4.07) with a range of no breakdowns to 14 breakdowns during that time period (see Table 5.6).

Table 5.6 Frequency of placement breakdowns at baseline, 6 and 12 month reviews, *N* (%)

No. breakdowns	Baseline*	6 months	12 months
Mean (*SD*)	2.18 (4.07)	1.00 (1.25)	0.60 (0.84)
0	4 (36.4)	4 (36.4)	6 (54.5)
1 - 2	4 (36.4)	5 (45.5)	4 (36.4)
3 - 4	2 (18.2)	1 (9.1)	0 (0.0)
> 10	1 (9.1)	0 (0.0)	0 (0.0)

* This breakdown rate is the number of breakdowns in the two years prior to review

As can be observed (Table 5.6) at the baseline measure the mean number of breakdowns was higher than the other two assessment points (Cohen's *d* = 0.64). A Wilcoxin two related samples non-parametric test revealed a significant difference between the baseline and 12 month review, $Z = 2.06$, $p < 0.05$**.** At the twelve month assessment, the majority of children had remained stable and only four children had experienced an unplanned placement breakdown since the previous assessment. Therefore, it appears that children who had a prolonged history of placement

disruption, only experience one or two placement changes during their time in the program.

5.5.8 Psychosocial adjustment

A number of psychosocial measures were collected including social functioning, attachment-related problem behaviours, and behavioural and emotional measures (i.e. Boyle's CBC and Goodman's SDQ,). As can be observed in Table 5.7, the mean social functioning score of the participants at baseline was 18.82 (*SD* = 3.66). At the six month review, the social functioning score was lower, reflecting an improvement in their functioning. A further decrease in the score at 12 month review indicated an overall improvement in the children's social functioning to indicate the magnitude of the effect. However, due to the lack of statistical power in the analysis, this improvement was not identified as statistically significant. Cohen's *d* was calculated to determine the effect size, a large positive effect was noted between the baseline and twelve month assessment (*d* = 0.61) for the social functioning of the participants.

Table 5.7 Social functioning and attachment-related problem behaviours at baseline, six month and twelve month reviews, *M* (*SD*)

	Baseline	6 month	12 month
Social functioning	18.82 (3.66)	18.30 (4.24)	16.50 (3.98)
Attachment-related problem behaviours	22.80 (5.33)	25.00 (6.02)	20.30 (4.97)

The mean attachment-related problem behaviours score at baseline was slightly lower than at the six month review. The high score at six month reflects a reduction in positive attachment behaviours and an increase in negative attachment behaviours (see Table 5.7). A paired samples t-test found that the change in attachment scores was significant, t (9) = 2.43, $p < 0.05$). However, at the twelve month review the score was lower than the baseline and six month review time points indicating an improvement in attachment-related problem behaviours. A paired samples t-test revealed that the change in score from six to 12 month review was significant (t (9) = 3.15, $p < 0.05$). Cohen's *d* was calculated to determine the

effect size. A moderate negative effect was noted between the baseline to six month review but a very large effect was noted between the six month and twelve month assessment and the baseline and twelve month assessment. This finding may suggest that at the twelve month review point the changes were large enough to be able to be detected by the attachment checklist or it may suggest that the improvements in attachment behaviours because of the longer time spent in the program.

Table 5.8 Mean (SD) Baseline, 6 and 12 month SDQ scores

	Baseline	6 month	d^1	12 month	d^2
Conduct problems	5.70 (2.79)	4.60 (2.37)	0.35	4.30 (1.77)	0.61
Hyperactivity	5.30 (2.41)	5.70 (3.13)	-0.14	5.80 (1.99)	-0.26
Emotionality	5.40 (3.50)	4.40 (3.31)	0.29	4.50 (2.76)	0.29
Peer functioning	4.90 (2.64)	4.80 (1.40)	0.01	4.40 (2.80)	0.18
Total difficulties	21.30 (9.07)	19.50 (6.15)	0.24	19.00 (6.99)	0.29

1 = Baseline and 6 month comparison, 2 = Baseline and 12 month comparison

The SDQ baseline, six and twelve month review comparisons are summarised in Table 5.8. Improvements were noted in three sub-scales and in the overall total difficulties score but not in the hyperactivity sub-scale at both time points. A slight increase was also noted in the emotional symptoms sub-scale at the twelve month review. Paired samples t-tests were conducted to determine whether the improvements were statistically significant. The improvement in the conduct problems sub-scale was found to be statistically significant (t (9) = 3.16, $p < 0.05$), but the difference between baseline and the six and twelve month review for the other 3 sub-scales and the Total Difficulties score was not significant. The table also shows Cohen's *d* for each of the sub-scales and Total difficulties score for the comparison of baseline and six months and baseline and twelve month assessments. A large positive effect was noted for the conduct problems sub-scale and a small positive effect for the emotionality and peer functioning sub-scales. Cohen's *d* for the hyperactivity sub-scale shows a small negative effect for this measure.

The improvement noted for the conduct problems is promising as the program is specifically designed for those children with very challenging behaviours

and it appears that the behavioural treatment component of the program is effective. However, less evidence was found for improvements in emotional, social and attentional problems.

Reliable change analyses of the SDQ sub-scales were conducted to determine the extent to which the change shown by an individual falls beyond the range which could be attributed to the measurement variability of the instrument itself (Evans et al., 1998). Change that exceeds 1.96 times this SE is considered to be unlikely to occur more than 5% of the time by unreliability of the measure alone. For example, the SE_{diff} for the conduct problems SDQ sub-scale was found to be 2.05. Therefore any change that exceeds 1.96 X 2.05 = 4.01 can be considered to be a reliable change (see Table 5.9 below). The same calculations were conducted for all of the SDQ sub-scales.

Table 5.9 Proportion of young people with reliable change for TrACK SDQ sub-scales from baseline to twelve month review

	Reliable change *N* (%)
Conduct problems	2 (20.0)
Emotional problems	0 (0.0)
Hyperactivity	1 (10.0)
Peer problems	1 (10.0)

Of those participants where baseline and 12 month data were available only 2 out of the 10 participants showed reliable improvement in their conduct scores over time. One participant was observed to reliably deteriorate in their hyperactivity score and their peer problems score over time. No reliable change in the emotional problems sub-scale was observed.

5.6 Conclusion

Overall, the findings provide some limited evidence for the benefits of a family-based treatment foster care program for children with high support needs. Over the six month period and the overall twelve month review period a significant improvement was noted in the conduct related behaviours of the children and a small

improvement in the social and emotional functioning of the participants. A significant improvement was also noted in the children's attachment-related behaviours at the twelve month review which is also very promising, after observing a decline in the attachment-related behaviours at the six month review. As mentioned before, the decline at the six month review may be related to the fact that attachment-related behaviours are generally more well-established than behavioural patterns and may take longer to show improvements and children may show signs of initial regression due to the introduction of new caregivers (i.e. TrACK foster carers) and changes to their surroundings. Furthermore, the improvement noted at the twelve month review may provide evidence that the longer period of time spent in the program (i.e. a further six months) provides the amount of time needed to reduce problematic attachment-related behaviours.

Placement stability appeared to improve as noted between the baseline and the other two assessment points. On average, the number of placement breakdowns had decreased over this time period, with many participants not experiencing any breakdowns at all. This finding is positive considering that the TrACK program is specifically designed for children and young people that require more or are not suitable for traditional family-based foster care due to challenging behaviours and placement instability. However, some children had still experienced some placement instability whilst in the program and this clearly would need to be addressed. As mentioned previously, arrangements (in the form of education or greater awareness) could be made with the children's school and classroom teachers to reduce the number of suspensions and exclusions so that the children do not experience any more disruptions to their education. Furthermore, it would also be beneficial if treatment were more focused on the children's emotional and social functioning (for example; social skills training, mentoring, group play activities).

5.7 Comparisons of IPC and TrACK programs

As mentioned previously, the IPC and TrACK programs have many similarities and differences in their design and purpose however they both attempt to address the issue of placement instability. The table (5.10) below documents the similarities and differences in outcomes for children enrolled in each of the programs.

First, the primary difference between the IPCs and the TrACK programs is that the IPCs are essentially a managed model of care or could be considered a ‘wraparound’ model of coordinated care. In contrast the TrACK program is a therapeutic or treatment foster care program that provides treatment as part of the program by staff employed by the program as opposed to hiring or tendering out services to another supplier. Both of the programs are specifically designed to meet the needs of those children and young people that are not being met by current foster care services; namely to prevent further placement disruptions. The programs are also designed to address the many complex needs of the children and young people. Programs can be differentiated on many levels according to the staffing arrangements, status of carers, professional staff and intervention type (see Delfabbro et al., 2005). Programs can also be differentiated according to their physical arrangement for example; community-based or residential. Both of the programs are considered community-based programs that provide home-based care and treatment (TrACK and IPC) or managed care and treatment in a residential group care facility (IPC only). The individual packages of care provide a holistic model of care that is individually tailored to the specific needs of the child. In contrast, the TrACK program is a more therapeutic model based on the neurobiology of abuse and related trauma with an emphasis on therapeutic parenting. Furthermore attachment theory informs all care and intervention provided by the program. Both programs provide psychological therapy and the IPCs also provide any extra services that are deemed appropriate and necessary. The IPCs are considered a time-limited contracted service, but often the service is re-contracted after a certain period where necessary.

Table 5.10 Comparisons of IPC and TrACK programs

	IPC	TrACK
Staffing arrangements	Contracted providers	Program staff Contracted providers
Status of carers	Foster carers/Residential carers – no specialist training	Professional/treatment carers
Type of treatment intervention(s)	Psychological intervention, mentors, tutors, cultural support workers, aftercare services	Attachment theory informs all care and intervention provided in program Individual, group, sibling and foster and biological family therapy
Model of care	Managed care model Individually designed service	Treatment foster care model Case management
Current capacity	*N* = 30	*N* = 12
Age limit	18 years	13 years
Program duration	Time-limited contracted service	Not specified

Although quite different, both programs appear to be achieving modest success in meeting many of the complex needs and challenging behaviour of the children and young people. Interestingly, the IPCs appeared to achieve a better level of placement stability than the TrACK program; however, greater improvements were noted in the emotional, behavioural, social and attachment-related behaviour patterns of the children in the TrACK program. Ideally a program that combines the design and theoretical underpinnings of both programs is most likely to be effective in meeting all not just some of the children's needs.

5.8 Overall conclusions

As discussed in Chapter 4, a small number of reviews in the area of treatment foster care have demonstrated that, in comparison to residential or hospital care, treatment foster care is a more cost effective and less 'restrictive' treatment setting. Treatment foster care has also been found to produce behavioural improvements that are comparable to residential forms of care (Hudson et al., 1994; Meadowcroft et al., 1994). The outcomes of the TrACK program are in line with these previous findings. It is clear than treatment foster care is a less restrictive option whereby children are placed in 'family' homes in the community. TFC programs have also been shown to be less expensive than other residential care facilities (see Szirom et al., 2005). In relation to behavioural improvements in TFC populations being comparable to

residential forms of care it is still difficult to determine as unfortunately so few evaluation studies have been conducted on TFC and residential care, especially in Australia. The findings from the two pilot studies suggest that TFC (TrACK) programs do produce significant behavioural improvements in the children, as well as improvements in their attachment-related behaviours. However, in line with APA guidelines, further evaluation of this service with an appropriate control group comparison is necessary before one can conclude that this program is better than the best available alternative in the State of Victoria.

As discussed in Chapter 3, the outcomes for children in TFC in America have been very positive (i.e. Chamberlain, 1998). The findings from the pilot study of TrACK appeared to have achieved similar outcomes. For example, the study conducted by Chamberlain and Reid (1991) that compared children in TFC or Group Care (GC) over a seven month period. They found that TFC participants in comparison to the control group reported significantly fewer psychiatric symptoms, had better school adjustment and rated their lives as happier compared to boys in Group Care. The TrACK group, as previously stated, showed significant improvement in the behavioural and emotional functioning and their attachment-related problem behaviours over a twelve month time period. Therefore the findings suggest that the Victorian TFC program is similarly successful in treating young people with high support needs.

As mentioned above, the IPCs could be considered as a ‘wraparound’ model of care. The findings from the pilot study are consistent with previous research and evaluation of wraparound. For example, Clark (1998) conducted a randomised trial of youth randomly assigned to either wraparound model of care or to standard practice foster care in Florida. Both groups of youth received standard foster care services, but the group in the FIAP received additional services including case management and flexible funds. Clark demonstrated that both groups improved, but that the youth in the FIAP program experienced greater improvements. For example, the youth in FIAP displayed a reduction in the number of placement changes and number of days absent from school. They also showed significantly lower delinquency rates and better externalising adjustment than the youth in the standard foster care group. The outcomes for the youths in the IPC program appear to be

similar to the youths in Clark's study; namely improvements were noted in the levels of placement stability, stability in family relationships and retention in schooling. However, no significant improvements were noted in the emotional, social or behavioural functioning of the IPC participants. A difference was that Clark's study tracked the young people for a period of 3.5 years whereas the current study was for only twelve months. As recommended earlier, a greater focus on the longer term psychosocial functioning of the participants as part of the therapeutic component of the IPC's appears to be necessary.

In conclusion, further research is needed to determine what types of children and young people (i.e. age, gender etc) are most likely to benefit from particular service options. In addition, the 'active' components of treatment service options that improve the psychosocial functioning need to be investigated so that those components are identified. For example, if the individual therapy component is proven successful to the emotional and behavioural functioning of the children and young people as opposed to the mentoring component it is important that this component be retained in the program. The converse, of course, applies if a component is found not successful that it is then removed from the program.

As Bath (1998) points out there are a limited number of programs operating in Australia that involve any sort of theoretical underpinning. The majority of treatment programs for children and young people have developed as a response to a need or crisis but without the necessary theory and evaluation that is required. In other words, many programs could be described as a 'grab bag' of supports as opposed to a theoretically driven structured program with proven efficacy. Bath (2001) has therefore encouraged a focus on treatment (along with care) that incorporates the attendant implications for program development, case management, funding, staff qualifications and specialist training; for example, the implementation of a range of specialist foster care services, expanded intensive support models based on a mixture of support and brokerage and a range of treatment residential group care options. It appears that an increasing number of programs are attempting to do this, for example the TrACK program in Victoria. It is not sufficient for one small program to try to treat the population of high support needs children (approximately 15-20% of children in care). There needs to be, at the bare minimum, a State-wide

implementation of appropriate and effective treatment services and interventions for this sub-group of children and young people.

As a final comment, it is important to recognise certain problems and difficulties encountered in previous evaluative research. First, Curtis, Alexander and Lunghofer (2001) state that the "variability in program characteristics and inadequate description and standardisation of treatment protocols limit the generalisability of research findings (p. 387). This is especially true when attempting to generalise research findings to Australian foster care systems. In addition, small sample sizes continue to be the norm in out-of-home care research and very few studies have utilised control or comparison groups. Curtis et al. also argue that the lack of standardised measures have made it hard to isolate potentially important variables and to replicate previous findings. In addition, as discussed earlier, the authors conclude that little attention has been paid to the importance of mediating variables, which may affect treatment efficacy. Finally, longitudinal research is a must to ensure that the program participants are maintaining positive and enduring post-discharge outcomes. Therefore, it is paramount that researchers make reasonable attempts to follow the above-mentioned guidelines for evaluation research wherever this is possible. The current two pilot evaluations attempted to address many of the stipulated guidelines and criteria including: using a control group (IPC study), two points of evaluation (longitudinal in design); using standardised assessment tools (i.e. Strengths and Difficulties Questionnaire) and also measuring relevant outcomes (i.e. level of family contact, education and social functioning). However, it would important to determine the extent to which outcomes are maintained over time and in reference to new samples of children with similar characteristics to be in a position to make a stronger statement about the benefits of the program that is generalisable to more than one sample.

Chapter 6
Overview and Conclusions

6.1 Overview

As indicated in the first section of this thesis, this project was predicated on the findings of a number of published studies and reviews that have identified many significant problems in existing out-of-home care services in both Australia and in other Westernised countries. It was pointed out that some of the principal concerns are the very high rates of placement breakdown and multiple placements, and the psychological effects of these experiences. From the relevant evidence obtained from the recent Australian studies it was concluded that the principal reasons for the considerable placement disruption evident in current services is: (a) The increasing prevalence of children with significant emotional and behavioural disorders in the care system, and (b) The lack of suitable therapeutic and placement services capable of dealing with the problems experienced by this population of children. The principal aim of this thesis, therefore, was to undertake the first multi-State or national review of the psychosocial adjustment and placement history of children with high-support needs in Australia, and what services and interventions might be developed to assist this population of children. This project builds upon the findings of recent longitudinal research undertaken by Barber and Delfabbro (2004) as well as a review by Morton et al. (1999) that addressed similar issues, although using only a very small qualitative investigation involving ten children in care.

In Barber and Delfabbro's (2004) previous research it had been shown that there are approximately 15-20% of children in out-of-home care for whom it is very difficult to achieve stable placements. Such children have significant emotional and behavioural problems which were found to give them only a 5% chance of being in a stable placement after two years in care. The aim of the national profile study therefore was to extend this work conducting a more detailed national study of the needs, social background, and service responses to children who met the empirically derived criteria across four different Australian States. A second aim was to examine and place a greater emphasis on the utilisation of services for both children and families before they enter care and during their time in care. A third aim was to provide a national reference point for evaluations of intervention strategies

conducted in different States. The objective for obtaining national data, using standardised measures, is to provide a means by which to compare the needs of children in different jurisdictions so that treatment options that prove effective in one State can be replicated or considered by others faced with children with similar profiles. A final aim was to develop a national profile of these children to strengthen national awareness and facilitate debate concerning these problems, and the need to address them in a unified way across the country. As described previously, this research was conducted using multiple methods, including an extensive case-file audit, inspection of computerised records and detailed interviews of case-workers, who were found to have quite frequent contact with the children and their foster families.

The findings of this study provided a grim, but clear, picture of this sub-group of children who are subjected to extremely high levels of placement instability. As compared with the Australian out-of-home population in general (AIHW, 2005), this group contained an over-representation of boys (60% vs. 50%), and an under-representation of Indigenous children (17% vs. 24% in the general out-of-home care population), suggesting that non-Indigenous boys are the group in Australia most likely to be at risk of significant ongoing placement disruption. Almost all of the children had been subjected to traumatic, abusive, and highly unstable family backgrounds. In every State, domestic violence, physical abuse and substance abuse were the three most prevalent problems, with parental mental health problems and neglect also observed in at least half of the sample. Over half of the sample had experienced four or more family background problems and this included 15% of the sample who had experienced very close to all of the problems identified. Specific analysis of children who had been subjected to abuse showed that one third of children had been exposed to every type of abuse: physical, sexual and neglect. Contrary to expectations, there was no clear evidence that children fell into any distinct clusters based on their social backgrounds. Instead, so similar and high was the prevalence and nature of background problems that children could almost be said to belong to one cluster. Many similarities were also observed in the analysis of data on psychosocial measures. The vast majority of the population had clinical levels of conduct disorder, significant depression and anxiety, problems with peer relations, and significant difficulties to adjusting to educational and social environments.

Scores on these measures of psychological adjustment were moderately to highly correlated, although not correlated so highly that it would be possible to differentiate young people in terms of particular areas of vulnerability or dysfunction which could assist in the targeting of services.

Comparisons of different Australian States showed some differences in the profiles of children in each of the different States, but showed that the children were generally well matched in terms of their psychosocial adjustment. Thus, it appears that if one were to use similar selection criteria (two or more placement breakdowns due to behaviour) in the recruitment of children into different services or placements in different States, then one could be reasonably confident that those services were dealing with a population of children that is reasonably similar both socially and psychologically. Encouragingly, the results also revealed that the children were generally very similar to the children identified as 'hard to place' in Barber and Delfabbro's (2004) longitudinal study, so that one can be reasonably confident of the likely long-term trajectory of these children over the coming 2-3 years.

The results of the study also confirmed several commonly advanced beliefs prevalent in out-of-home care research. First, it was found that children with more disrupted backgrounds also tend to have poorer overall psychological functioning. Second, children with more complex family backgrounds also have poorer psychosocial functioning on a range of measures. Third, children with greater needs or poorer functioning also tend to receive a greater range of services, consistent with the view that greater amounts of resources tend to be directed towards the most difficult cases. This finding again confirms the difficulties associated with trying to identify positive associations between the intensity of service interventions and outcome success. If more difficult cases get more services, it may be difficult on occasions to show how increasing service support enhances child outcomes.

Following the review of the characteristics of the children, the thesis examined the range of therapeutic interventions and placement options that might be suitable to address the range of problems that had been developed. This section involved a literature review of published literature and an extensive internet search and review of program documents where available. The review highlighted the range

of treatment and placement options available, particularly in North America. The review of therapeutic interventions examined both child-focused and family-focused interventions for children with high support needs. It appears that very few of the interventions currently operating can be considered efficacious but several do appear to be quite promising and could be considered examples of best practice. For example, the Chadwick report (2004) concluded that Abuse-focused CBT, Trauma-focused CBT and Parent-Child Interaction Therapy (PCIT) could be considered examples of best practice in the field of child abuse treatment. Other promising initiatives included professionalised fostering schemes (i.e. CAPS) in the United Kingdom and intensive family preservation programs (PCIT, Triple P, Families First, MST, The Incredible Years). None of these have been appropriately and fully investigated in Australia as potentially useful models for certain groups of children in care.

In terms of what programs would be most suitable for addressing the many and varied problems of the children and young people described in this research, a number of programs can be recommended. To begin with, one of the most commonly identified problems were behavioural or conduct disorder issues and those relating to peer relations, although it was acknowledged that such externalised behaviours usually had a clear history in early traumatic and abusive histories and may relate more broadly to fundamental disruptions to early attachments. Therefore, it is recommended that programs need to not only stabilise and manage current behavioural problems and symptoms but also address the early traumatic and abusive life histories of the children and their attachment problem related behaviours.

Programs or interventions that employ cognitive behavioural therapy are most likely to be successful in addressing these issues; for example: Trauma-focused CBT and Abuse-focused CBT. Both of these interventions attempt to address not only the previous abuse and/or trauma but also the negative attributions and responses associated with the early abuse and trauma. Several of the family-focused interventions also included behavioural management techniques for the parents and foster parents such as: MST, PCIT, Parent Management Training and Triple P. The Incredible Years program series have also been found to be successful in treating conduct problems in children aged 2 -10 years. Similarly, trauma-related issues and

problematic behaviours relating to attachment could also be assisted by specialised approaches such as Trauma-focused CBT and Abuse-focused CBT, EMDR, Parent Child Interaction Therapy (PCIT), The Incredible Years; Play therapies (Trauma-focused play therapy), Cognitive Processing therapy (CPT), general trauma counselling and trauma-focused attachment therapies (e.g., as practised by Daniel Hughes in the U.S.). Other problems such as social and peer functioning problems in older children could be potentially enhanced through further developments in individual and group therapy approaches including personal and social skills training, perhaps including elements of role-playing, peer support, and mentoring. On the other hand, for younger children who still have contact with their parents, it might be useful to consider the role of interventions such as PCIT, a family-focused intervention, based on both social learning and attachment therapies which is designed to facilitate the development of a more authoritative style of parenting. PCIT teaches parents how to interact with their children in a more socially appropriate and non-abusive way.

One of the evident trends of the population of children in the national study was the occurrence of multiple and complex problems. For example, the case studies in Chapter 2 clearly highlight the troubled early life histories of the children that are followed by the very troubling current life histories. Many interventions discussed in Section C attempt to address all of the problems that commonly affect the children and their families that enter the care system. Multisystemic therapy (MST) is one of the few examples of a program that attempts to not only deal with the behavioural symptoms but also the ‘systems’ that the child and family are located in. MST views individuals as being nested within a complex network of interconnected systems that include individual, family and extra-familial (i.e. peer, school and neighbourhood) factors. MST is a family preservation model that attempts to prevent children entering the care system but if the child has entered the system the therapist works with families to get the child back home as soon as possible. As previously stated, the ultimate goal of MST is to empower parents with the skills and resources needed to address the difficulties that may arise in the home with the youth and also enable the youth to cope with the family, peer, school, and neighbourhood problems. As opposed to traditional services that removed youth from their environment and in many cases placed them with other youths that had similar problems, MST helps the

family to function more successfully in their immediate environment (Burns et al., 2000). MST is provided to families using a home-based model of services delivery. The reason for this type of service delivery model is to help overcome barriers to service access, increase family retention in treatment and allows for the provision of intensive services and it enhances the maintenance of treatment gains. However, it is recognised that MST is a very expensive program with large fees paid for training, licensing and program establishment, so that it may only be possible to provide this service to a relatively small proportion of children in Australia.

In relation to the types of placement services that are the best approach in dealing with this population of high support needs children, it appears that a continuum of intensive services is most likely to be able to appropriately and effectively serve this population of children. Thus, a continuum of intensive services for children and young people with high support needs could include the following range of services:

1. Intensive parent management training and family support models
2. Intensive family preservation services
3. Day treatment centres
4. Family-based treatment foster care models (including professional fostering schemes)
5. Community-based small group treatment homes with either live-in trained house/foster parents or rostered staff
6. Campus-based cottage-style small group homes with either live-in trained house/foster parents or rostered staff
7. Supported or semi-supported independent living or transition models

The provision of a continuum of intensive services could be implemented in each State and could be used flexibly depending on the age of the child and the extent of their problems. The continuum of services should not be used so that as the children's problems worsen the greater the intensity of services is supplied rather the child receives the most appropriate service from the outset. For example, as indicated in Chapter 4, if a child is assessed as requiring a very intensive service when they enter care instead of the child being placed into other placement options that have

clearly not worked in the past for children with similar profiles they enter the most appropriate service immediately. This is something that has failed to be achieved by fostering systems around the world, but may be related to the lack of appropriate placement services rather than from the lack of planning.

A major obstacle to this area of research, that came apparent during the review of interventions and programs, was the lack of empirical data and evaluative research available on many the programs. This finding is very concerning on many levels. First, without empirical support it is unknown whether the resources, time and effort placed into developing such programs in Australia is fully justified by the limited available empirical evidence. Second, it is still unclear whether the programs operating internationally are serving the right population of children and young people. For example, a treatment foster care program may be more suited to children up to the age of twelve whereas a group treatment home may be more suitable for adolescents. This is an area of research that needs a lot more attention. Third, as identified in the previous Chapter, more research is needed in understanding the critical components or aspects of a service or intervention that are the most clinically significant and important in successfully treating the problems and achieving the desired outcomes.

A final section of the thesis involved two small-scale reviews of two representative programs recently developed in Australia to assist this population of children; the Individual packages of care (IPC) and TrACK. As indicated previously, both of these programs are designed to meet the needs of those children and young people that are not being met by current foster care services; namely to prevent further placement disruptions. The IPCs provide a holistic model of care that is individually tailored to the specific needs of the child. In contrast, the TrACK program is a more therapeutic foster care model based on the neurobiology of abuse and related trauma with an emphasis on therapeutic parenting. Furthermore attachment theory informs all care and intervention provided by the TrACK program. Both programs provide psychological therapy and the IPCs also provide any extra services that are deemed appropriate and necessary.

The pilot evaluation of the Individual Packages of Care (IPC) provided evidence that the young people in the IPCs were achieving stability that they would otherwise not be receiving in traditional forms of alternative care. However, as discussed previously, there were no apparent psychological gains noted by the young people in the packages and therefore it is strongly suggested that greater therapeutic resources are provided to these young people to improve their psychological functioning and development. On the other hand, the TrACK program did demonstrate gains in behavioural, emotional and social functioning and a reduction in problematic attachment behaviours.

6.2 Limitations and future research

Limitations of National profile study

Although data collection methodology used in this study was thorough and was successful in obtaining detailed information about children's social history, it is important to recognise several limitations. The findings here can only be generalised to four Australian States and the findings relate solely to children in metropolitan areas, so the relevance of these findings for rural children needs to be treated with caution. In addition, it is important to acknowledge that there may have been omissions and inaccuracies in case-file and case-worker reports used as the basis for this study. Not all relevant psychiatric, medical or child protection paperwork may always be filed, so that it is possible that the figures reported here understate the true prevalence of problems within this sample. However, in support of this methodology, previous research by Femina et al. (1990) has suggested that using objective administrative records may be a more accurate method than child self-report in obtaining details of abuse because of the danger of distortions, omissions and repression of early traumatic experiences, many of which might have occurred before the age of three. Another potential strength of the data collection was that placement data could, in most cases, be verified from one date to the next against computerised payment records for individual carers. Thus, it is highly likely that the data provides a very accurate depiction of the level of placement instability affecting this sample.

The findings on the provision of services to children and families demonstrates that those children with the highest level of problems appear to be the most likely to receive services and interventions. Several State differences in service

provision were observed; specifically the Victorian sample received a significantly higher number of family services and interventions. However, it is important to recognise that the observed State differences in the frequency of service provision may not be a true reflection because of the variations in the quality of records collected from different States. The State differences in service provision could also be attributed to differences in the children and families themselves. For example, the Victorian sample was observed to have a significantly higher proportion of males and to have had their first contact with the department at a significantly older age than the other three States. As a result, the children may have entered care with more behavioural problems and hence received more behavioural intervention services. The families of the Victorian sample were also observed to have received a higher proportion of services and interventions and the South Australian sample was also observed to have received a significantly higher number of child psychological services. However, this may only reflect differences in the demand for, and availability of services, in each of the four States. Nevertheless, the findings demonstrate that nationally the children and families are currently receiving or had previously received a wide variety of services and interventions, but that there was a need for a greater integration of services, and more focus on ensuring an ongoing commitment to addressing the entrenched psychological and social difficulties contributing to placement instability.

Important future research could possibly investigate further the number of children and families not receiving services; this data was not collected in this particular study.

Limitations of the review of International designs

As previously stated, the purpose of the review of international designs was to obtain an overview of interventions, services, placement and treatment options for high support needs children. The review was not intended to be an audit. A limitation of the methodology employed for the search was that not all organisations and agencies have internet sites or available outcome literature for the review to be considered exhaustive. Nevertheless, the review has identified a number of interventions, services and placement options that many Australian practitioners and researchers may not necessarily be aware of. The case studies may provide an

important ‘starting-point’ for other researchers who may want to investigate any of the services identified or who may be interested in implementing similar programs here in Australia.

Limitations of the pilot program evaluations

The pilot program evaluations were intended to provide outcome data on two treatment programs operating in Australia. This aim was achieved. However, a limitation of the evaluations was that, due to time constraints, only twelve month outcome data was collected. It is recommended that the organisations continue the evaluations over a longer period of time, possibly up to a minimum of two years post-discharge so that longer-term outcomes can also be assessed. The pilot program evaluations do provide other agencies, who wish to conduct program evaluations, a guideline on methodology for conducting this type of research but unfortunately it is unclear what aspects of each of these programs were successful. For example, it is not exactly clear which aspects (i.e. which particular services, individuals etc.) of the IPC had the greatest effect on achieving stability and which aspects of the TrACK program were most successful in achieving psychological gains in social and emotional functioning (i.e. individual therapy, the foster carer training, the attachment therapy model). Further research is required to identify which aspects are the most clinically significant in achieving the desired outcomes. Nevertheless, the findings do provide a starting point for future longitudinal research, but control groups (i.e. children not receiving any services, children receiving just individual therapy etc.) are necessary for comparisons to be made. In addition, the review of international program designs identified the lack of empirical data that is available on program outcomes. It is crucial that agencies and organisations conduct or continue to conduct ongoing empirical research on programs.

6.3 Thesis conclusion

Drawing on all of the findings from this thesis, it is possible to make some important practice and policy recommendations. First, the Australian foster care system is plagued with similar problems when compared with other systems around the world. The national study highlighted that each of the States were quite similar in the level of problems, with only subtle differences (see Chapter 2). The young people in the sample were generally very similar in their characteristics, suggesting that it is

possible to adopt a national perspective when discussing policies and services suitable to meet the needs of this population. The national study demonstrated that this population of children do not appear to fall into neat subgroups or clusters as might be expected based on the range of different background variables. Instead, children within this population appear to form one single cluster based upon very common family experiences; namely, the combined effects of domestic violence, substance abuse, physical violence and neglect. Such findings suggest very strongly that out-of-home care policy cannot, and should not, be considered in isolation from other important areas of social policy and public health. Any policies which are successful in reducing levels of substance abuse, domestic violence and the problems of adult mental health are likely to have significant impacts upon out-of-home care systems, juvenile justice systems and adult prison systems.

This thesis has also highlighted the need for a greater integration of services, and a greater focus on ensuring an ongoing commitment to addressing the entrenched psychological and social difficulties contributing to placement instability. The need for a re-structuring and re-thinking of the continuum of care services available to children in out-of-home care including the possible development of professional foster care services, and an increased use and availability of treatment group residential care options. As previously stated, a more flexible approach to the use of the continuum of care and the provision of services is desperately needed. It is essential that children receive the most appropriate and effective services when they are needed, not after many failed attempts at placement services that clearly are not suitable and have not worked for children with similar profiles in the past. We now know that children with high support needs profiled in Chapter 2 do not appear to be suitable for traditional family-based foster services and require a range of more intensive placement options (including residential care options) and this is something that needs to be addressed immediately by State governments.

In conclusion, one of the main findings of this thesis is that out-of-home care policy should not be considered in isolation from other important areas of social policy and public health. To address this requires major structural and philosophical changes to the structure of State and Federal government community services. For example, at the very minimum women who receive domestic violence services or

substance abuse services also should receive family support services. Families that come to the attention of adult mental services also need to receive family support services and possibly parent management training services. The families that come to the attention of child protection for abuse and neglect reasons also need to receive family support, parent training and/or preservation services from the first notification not three years later after a multitude of notifications and further abuse and trauma suffered by the children. Basically, State and Federal governments need to acknowledge that these are not separate services or problems but closely linked services and co-morbid familial and social problems. The Layton Review (2003) recommended that a service agreement is developed by leading hospitals, Drug and Alcohol Services, Family and Youth Services (now Child and Youth and Family Services CYFS) and Child and Youth Health to ensure the coordination of the provision of services and case management of babies and infants affected by substance abuse and their parents/carers (p. 2.7). It was also recommended in the review that services such as CYFS, SAPOL (South Australian Police), health and domestic violence services coordinate their services when responding to child protection when women and children are experiencing domestic violence (p. 2.91). Ultimately, community services need to be structured in a way that all family and social services (domestic violence, mental health, substance abuse services, health services, education services, support services and child protection) that involve parents and children are linked both logistically and philosophically. For example; when a domestic violence issue is identified a computerised system contacts family support services such as nurse, outreach or community visitation services to provide support and protection to parents who have children who might be exposed to the domestic violence. In a philosophical sense, State and Federal governments need to accept that resolving many of the current difficulties in the out-of-home care system requires a much stronger understanding of the fundamental links between this system and other areas. It is only by addressing the factors that contribute to abuse and neglect as well as family violence that one can slow down the increasing numbers of children entering the care system, and this requires a major shift in how governments in Australia understand the links between developments in different service systems.

List of Appendices

APPENDIX A: National Comparative Case-file Audit and Interview Questions for Children with High Support Needs

A: CHILD'S CHARACTERISTICS, NEEDS AND BACKGROUND

Demographics:

Gender:	
Child's age:	
Ethnicity:	
Type of order:	
Duration of Order	

Biological family / social background

	Tick if mentioned	Details
Financial problems		
Homeless/ no adequate housing		
Domestic violence		
Parents imprisoned		
Parents involved in substance abuse		
Sexually abusive		
Physically abusive		
Parents mental health issues		
Parents physical illness		
Parents physical disability		
Parents intellectual disability		
Severe neglect		
Number of siblings under 18		
Number of siblings also in the placement		
Number of siblings still with biological parents/ guardian		
Other		
Other		

CRITICAL EVENTS:

What circumstances contributed to the family or child's first contact with the Department? [Extend text if necessary]

What circumstances appeared to contribute to the child first being placed into care? [Extend text if necessary]

Care history

Age at first entry to care	
Primary reason for entry to care	
Number of foster placements prior to entering current program or placement	
Years spent in care	
Number of previous reunifications with family	
Has the child previously been placed in residential care?	
Has the child previously been placed in relative care?	
Duration of longest reunification	
Reason(s) for re-entry to care	

Description/ Comments

B: CHILD'S NEEDS

High support needs identified

	Tick if on file	Details
Conduct disorder [Also complete B2]		
Hyperactivity		
Depression / Anxiety		
ADHD		
Personality disorder/ Mental Illness		
Physical disability		
Intellectual disability/ developmental delay		

Any other comments

_____
_____
_____
_____
_____
_____

Conduct disorder issues identified

	Tick if on file	**Details**
Damaging or destroying property		
Offending		
Substance abuse		
Temper tantrums		
Lying and cheating		
Fighting with, or physically Attacking, others		
Persistent disobedience		
Severe school problems		
School refusal		
Running away		
Harm to self		
Inappropriate sexualised behaviours towards others		
Sexually at-risk behaviour		
Interpersonal conflict		
Attachment disorder		

Any other comments

_____
_____
_____
_____
_____

School / Education-based interventions before or since contact with Department

School involvement

	Response
Was the child attending school at the time of the 1st placement into care? [YES/ NO]	
Is the child currently at school? [YES / NO]	
What year level is the child studying?	

CHECKLIST OF POSSIBLE SERVICE SUPPORTS

	Tick	**Details**
Periodic meetings between teachers and carer (s)		
Individually tailored curriculum		
Private tutor (at school)		
Private tutor (at home)		
General education support worker at location		
Other …….		

Specific therapies / interventions provided to CHILDREN since or before they came into contact with the department.

CHECKLIST

	Tick	**B = Before D = During time in care**	**To where were they referred?**
Assertion training			
Self-esteem building			
Psychiatrist			
Psychologist			
Treatment for mental health issues please specify…….. ……			
Anger management			
Social skills training			
Dealing with grief and loss			
Behaviour management			
Employment training/ apprenticeship			
Independent living /Short periods away from home			
Substance abuse treatment			
Safe sex practices			
Family mediation			
Mentor			
Other……..			
Other……			

Summary of service supports for child before 1st placements into care [extend as necessary]

Summary of service supports for child since 1st placement into care [Extend as necessary]

Specific therapies / interventions provided to BIOLOGICAL FAMILIES since or before they came into contact with the department.

CHECKLIST OF POSSIBLE SUPPORTS

	Tick	**B = Before D = During time in care**	**To where were they referred ?**
Assertiveness training			
Self-esteem building			
Treatment for mental health issues please specify…….. ……			
Anger management			
Psychiatrist			
Psychologist			
Social skills training			
Dealing with grief and loss			
Behaviour management			
Employment training/ apprenticeship			
Independent living /Short periods away from home			
Substance abuse treatment			
Family mediation			
Family support worker visits			
Other……..			
Other……			

Summary of service supports for BIRTH FAMILY before 1st placements into care [extend as necessary]. What agencies were involved? What did they do? How long were they involved?

Summary of service supports for BIRTH FAMILY since 1st placement into care [Extend as necessary] What agencies were involved? What did they do? How long were they involved?

PSYCHOSOCIAL ASSESSMENT: INTERVIEW WITH CASE-WORKER

Boyle et al.'s Child Behaviour Checklist
For each item, tick 1 column (refer to the previous 6 months)

CONDUCT

	Never	Sometimes	Often
Damaged school property or other property			
Destroyed things belonging to others			
Disobedient at school			
Lied and cheated			
Stole things from outside the home			
Physically attacked some-one			

HYPERACTIVITY

	Never	Sometimes	Often
Could not concentrate or pay attention for long			
Couldn't sit still, restless or hyperactive			
Distractible, had trouble sticking to things			

EMOTIONALITY

	Never	Sometimes	Often
Unhappy, sad or depressed			
Nervous, highly strung, or tense			
Not as happy as other children			
Too fearful or anxious			
Worried a lot			

2. Strengths and Difficulties Questionnaire (SDQ)

1= Not true, 2 = Somewhat true, 3= Certainly true (*refer to the previous 6 months*)

CONDUCT DISORDER

	Not true	Somewhat true	Certainly true
Often has temper tantrums or hot tempers			
Generally obedient, usually does what adults request			
Often fights with other children or bullies them			
Often lies or cheats			
Steals from home, school or elsewhere			

HYPERACTIVITY

	Not true	Somewhat true	Certainly true
Restless, overactive, cannot sit still for long			
Constantly fidgeting or squirming			
Easily distracted, concentration wanders			
Thinks things out before acting			
Sees tasks through to the end, good attention span			

EMOTIONALITY

	Not true	Somewhat true	Certainly true
Often complains of headaches, stomachaches or sickness			
Many worries, often seems worried			
Often unhappy, downhearted or tearful			
Nervous or clingy in new situations, easily loses confidence			
Many fears, easily scared			

PEER FUNCTIONING SCALE

	Not true	Somewhat true	Certainly true
Shares readily with other children, e.g., toys, treats, pencils			
Rather solitary, tends to play alone			
Has at least one good friend			
Generally liked by other children			
Gets on better with adults than with other children			

SOCIAL ADJUSTMENT

1= Often, 2 = Sometimes, 3 = Rarely, 4 = Never (*refer to previous 6 months*)

	Never	Rarely	Sometimes	Often
Has been getting along well with people				
Has resented people telling him/ her what to do				
Has felt persecuted or picked on				
Has blamed others for his / her mistakes				
Has looked forward to mixing with others				
Has been willing to talk and express his/ her feelings				
Has been inconsiderate of other people's needs or feelings				

EDUCATIONAL ADJUSTMENT

a. Is the young person attending school? …….

b. What grade level? ……

c. How many times during the previous 6 months has the young person:

How many times during the previous 6 months has the young person:

	Number of times
Been suspended	
Been excluded	

GENERAL HEALTH ISSUES

Is the child's weight appropriate for his or her age?

	Tick
Very under-weight	
Slightly underweight	
Normal healthy weight	
Slightly overweight	
Very overweight	

Is the child's physical co-ordination appropriate for his or her age?

	Tick
Very much below average	
Slightly below average	
Average for age	
Slightly better than normal	
Very good	

Does the child have any physical health problems (including dental) requiring attention (i.e., that have been attended to during the previous 6 months)?

List physical ailments	Action taken?

Does the child have any psychological health problems requiring attention?

List psychological difficulties	Action taken?

ATTACHMENT DISORDER CHECKLIST

	Never	Rarely	Sometimes	Often
Makes very little eye contact				
Shows little guilt or remorse for actions				
Has been indiscriminately affectionate towards strangers				
Deliberately provokes anger in others				
Produces theatrical displays of emotion				
Has been able to give and receive affection				
Has produced incessant nonsense speech				
Has been willing to seek comfort from others when frightened or hurt				
Is able to trust others				
Has been excessively demanding or bossy				

FAMILY CONTACT

How often has the child had contact with family members during the previous 6 months?

0 = Never
1 = Monthly or less often
2 = 2-3 Times per month
3 = Once per week
4= 2-6 times per week
5 =Daily or more often

	Mother	**Father**	**Relatives**
Telephone			
Face to face: supervised			
Face to face: unsupervised			
Overnight stays			

PLACEMENT HISTORY

a. How many unplanned placement terminations has the young person had in the last 2 years?

_____

_____

b. What were the primary reasons for the last three moves?

_____

_____

_____

c. How many of these moves were requested by the carer because of the young person's behaviour?

_____

_____

_____

d. What behaviours have been the primary cause of these breakdowns?

_____

_____

_____

e. Can you describe some critical incidents in recent placement breakdowns?

_____

_____

_____

f. What factors make it most difficult for the child to return to his/ her biological parents?

_____

_____

_____

APPENDIX B: Sample Information Sheet

Foster Care Study
Information for FAYS Staff

The University of Adelaide and Flinders University are undertaking a national and International research project into foster care. This project builds upon previous research undertaken in South Australia and is designed to enhance national knowledge concerning the most appropriate strategies to reduce placement instability amongst children with high support needs in out-of-home care. One component of this study (currently underway) is a detailed international review of projects and programs designed to provide assistance to children and young people who experience severe placement instability in out-of-home care. Hundreds of programs located in Australia, Canada and North America have been identified and reviewed with the aim of producing (within the next 2 years) a highly accessible summary for Australian practitioners and policy-makers.

A second component of this research (with which we need your assistance) is to develop a national database of case-profiles of children identified as experiencing significant placement instability in different jurisdictions. Although information like this is available from previous studies, there is little or no work that has examined this issue nationally, and this is necessary in order for concerns about the challenges faced by child protection agencies to be more accessible and relevant to policy-makers at a federal level. Currently, we have the support of both State Governments and/or agencies located in SA, WA, Qld, and Victoria. The principal aim of this part of the research is to obtain a brief assessment of young people's social background and previous care experiences and/or service history. This information will assist in the understanding of the typical pathways into care around the country and the opportunities that exist for early intervention strategies (i.e., what services are needed) to prevent children having to be placed into long-term care. The research will identify what has worked or not worked in the past; what other services are needed, and allow comparisons to be made between different jurisdictions. For

example, if a particular policy or strategy works in another State, we cannot be confident that it might work here in SA until we are confident that the needs of the children are similar.

To complete this work requires relatively little time commitment on behalf of case workers; in nearly all cases, only a 20 minute interview with one of our research staff at your district centre office. Other information will be obtained by qualified and approved research staff reading the relevant case-file at the office. Your child or young person has been identified by CACU staff as having experienced placement instability and suitable for inclusion in the study. Interviews will be conducted either by Ms. Alexandra Osborn (University of Adelaide) or Ms. Mignon Borgas, (FAYS). Only Mignon is authorised to read the case-files and access computerised client records. Alex will conduct interviews identifying the young person only by his or her first-name and client number to ensure that anonymity is maintained. All data will be de-identified in both analysis and reporting.

This research has been approved by the Ethics Committee of the Department of Human Services, Mr. Jim Birch, Chief Executive (DHS) and also Ms. Learne Durrington, Director of Community Services, Social Justice and Country Division. Staff at CACU (Annie Paton or Chi-Sing Wong) can also be contacted to confirm the ongoing status of the project. If you have general questions concerning the research project, please feel free to contact me on 8303 5744 or email: paul.delfabbro@adelaide.edu.au. Both Mignon and Alexandra can provide approval letters from the Department to confirm the Department's support for, and approval of, the project.

Thank you very much for your assistance with the project. I hope that I will have the opportunity to catch up and discuss the project with many of you in the coming year, and say thank you again to everyone who provided such generous support to our previous longitudinal project.

Dr. Paul Delfabbro
Senior Lecturer in Psychology
University of Adelaide

APPENDIX C

Template For

Profiling

Treatment Foster Care

Outcome Evaluation Studies

COMPONENTS OF ANALYSIS

A. Child characteristics
B. High support needs identified
C. Details of interventions
D. Outcomes and evaluation

Author (s) + Publication Year	**Title of document/ Program**

Information source

	Tick
Refereed journal article	
Published report (refereed)	
Published report (unrefereed)	
Unpublished report	
Book	
Student thesis	
Internet site	
Interview with program manager/ worker	
Other……..	

CHILD'S CHARACTERISTICS, NEEDS AND BACKGROUND

Children's demographics:

Number in intervention	
Female (%)	
Minority race (%)	
Mean age	

Biological family / social background

	Tick as appropriate	% affected
Financial problems		
Homeless/ no adequate housing		
Domestic violence		
Parents imprisoned		
Parents involved in substance abuse		
Sexually abusive		
Physically abusive		
Parents mental health issues		
Parents physical illness		
Parents physical disability		
Parents intellectual disability		
Severe neglect		
Number of siblings placed into same placement		
Number of siblings still with biological parents/ guardian		
Other……		
Other……		

Care history

Estimated number of previous placements	
Years spent in care	

CHILD'S NEEDS

High support needs identified

	Tick if mentioned	% with problem
Conduct disorder		
Hyperactivity		
Depression / Anxiety		
ADHD		
Personality disorder/ Mental Illness		
Physical disability		
Intellectual disability/ developmental delay		

Conduct disorder issues identified

	Tick if mentioned	% with problem
Damaging or destroying property		
Offending		
Substance abuse		
Temper tantrums		
Lying and cheating		
Fighting with, or physically Attacking, others		
Persistent disobedience		
Truancy/ severe school problems		
Running away		
Harm to self		
Sexualised behaviours		
Interpersonal conflict		

DETAILS OF INTERVENTION

Service framework (referring agency)

	Tick which applies
Alternative / out-of-home care	
Residential care unit	
Juvenile justice	
Mental health providers	
Hospital/Psychiatric ward	
School	
Other ……	
Other ……	

Living arrangements

	Tick as appropriate	1 Number of children per house or residential unit	2 Number of children at treatment location*
Single house in suburbs			
Institutional: single building, multiple living spaces			
Cottage style: single location, detached living spaces			
Other……..			
Other……..			

Cohabitation issues

	Tick if appropriate	Number of children
Biological children present in same living space		
Siblings placed in same location		
Siblings placed in same living space (e.g., in same cottage)		

Child-carer allocation

Note: The term carer refers to some-one who tends to the needs of the children on an ongoing basis, rather than being some-one to whom they are referred if a problem arises, e.g., doctor, etc.

	Tick if applies	Consistent (C) or Rostered (R) Inconsistent (I)
Single carer per child		
Single carer per single house or cottage with multiple children		
Multiple carers per child with different function (e.g., psychologist, social worker)		

Professional training of the support workers

	Tick as appropriate
Foster carer	
Treatment foster carer	
Social worker	
Clinical psychologist	
Other……..	

C6: Format of the training provided

	Tick as appropriate
No training	
Pre-program training	
Within program training	
Other ……..	

Type of training program provided to carers

	Tick as appropriate
General behavioural management	
Anger management in young people	
Building self-esteem in young people	
Carer roles and responsibilities	
Legal responsibilities of caring	
Child development	
Modelling appropriate behaviours	
How to live with adolescents	
Assertiveness training	
Social skills training	
Counselling for grief and loss	
Trauma counselling	
Cognitive behaviour therapy	
Other …….	

Service supports available

	Tick as appropriate
Extra payments to carers ……..	
Outside social worker assistance	
Mentor	
Psychologist	
On-call help	
Psychiatrist	
Medical or dental care	
Crisis intervention	
Whole family care (family members live in with child)	
Whole family activities (family members brought together for activities)	
Respite care for carer	
Flexible service dollars	
Foster parent advocates and/ or support group	
Ongoing funding for program	

Family contact (birth family)

	Tick as appropriate
Regular telephone contact	
Supervised contact	
Unsupervised contact	

School / Education-based interventions

	Tick as appropriate
Periodic meetings with teachers by carer others	
Individually tailored curriculum	
Private tutor (at school)	
Private tutor (at home)	
General education support worker at location	
Other …….	

Mean duration of program

	In months
Mean duration	

Many papers and reports will have a variety of ways of describing their programs and interventions. Some will do it in terms of a particular theoretical framework. Others will describe particular types of theory without a theoretical context. The following items will catch these different ways in which the programs are described.

Theoretically based programs or interventions used

	Tick as appropriate
Behavioural	
Cognitive	
Social learning	
Psychotherapy	
Narrative	
Other……..	

Specific therapy types

	Tick as appropriate
Reality Therapy	
Eclectic / mixed	
Milieu therapy	
Person centred	
Issue-focused treatment	

Social context of therapies used

	Tick as appropriate
Individual therapy	
Group therapy	
Family therapy	
Joint sibling therapy	
Other …….	

Broader service category

	Tick as appropriate
Wrap-around	
Multi-systemic	
Treatment foster care	
Other…….	

Other specific therapies / interventions provided to children

	Tick as appropriate
Assertion training	
Self-esteem building	
Treatment for mental health issues please specify…….. ……	
Anger management	
Social skills training	
Dealing with grief and loss	
Behaviour management	
Employment training/ apprenticeship	
Independent living /Short periods away from home	
Family mediation services or family therapy to resolve conflict and breakdowns in communication	
Other……..	

OUTCOME EVALUATION

Type of design

Design	Specify length of follow-up analyses if presented
Randomised with control group	
Waiting-list control group	
Longitudinal with baseline analyses	
After-only (X-0) design	
Retrospective longitudinal	
Cross-sectional comparison with outcomes for other children in care	

Data source for outcome measures listed below (use this legend for D2 and D3)

Interviews with children	1
Interviews with workers	2
Structured observation by relevant workers	3
Case files	4
Computerised placement records	5
School records or reports	6
Interview with teachers	7
Formal clinical assessments	8

D2	**Tick**	**Insert numbers using legend**
Psychosocial		
Self-esteem/ Confidence		
Independent living skills		
Conduct/ behaviour		
Depression/ anxiety		
Criminal offending		
Interpersonal skills		
Structural		
Placement rate per year		
Employment outcomes		
School grades/ report quality		
Other……..		
Other……..		

Service outcomes

	Tick as appropriate	**Data source**
Program non-completion rates		
Discharge to less restrictive foster placement		
Adopted by family		
Independent living		
More restrictive		
Mental / psychiatric ward		
Alcohol / drug treatment		
Temporary shelter		
Other …….		

D3: System outcomes achieved (percentages)
The control group will only be relevant for some studies

	Tick as appropriate	**% treatment group**	**% control group**
Program non-completion rates			
Discharge to less restrictive foster placement			
Adopted by family			
Independent living			
More restrictive			
Mental / psychiatric ward			
Alcohol / drug treatment			
Temporary shelter			
Other …….			

Outcomes (longitudinal designs)
This should be used for the <u>treatment</u> group at baseline vs. the most appropriate follow-up point. Different columns have been included for different data qualities. Some will only indicate improvement (tick), others will say that X% improved. The best ones will provide means and SDs.

	Tick	Tick if improved	Mean (SD) before	Mean (SD) After	% treatment group who improved	Mean test statistic with (df)	Proportion test statistic with (df)
Psychosocial							
Self-esteem/ Confidence							
Independent living skills							
Conduct/ behaviour							
Depression/ anxiety							
Criminal offending							
Interpersonal skills							
Structural							
Placement rates per year							
Employment outcomes							
School reports or grades							
Other…… …….							
Other…… ……..							

Outcomes (comparison group design)

This should be used to compare the results of the control group and treatment group after the intervention. This could be used at the final follow-up point for a control group longitudinal study, or to compare a treatment group with a comparison group at any point in time.

	Tick	Tick if Improved	Mean (SD) Treat	Mean (SD) Control	% in treatment group who improved	Mean test statistic with df	Proportion test statistic with (df)
Psychosocial							
Self-esteem/ Confidence							
Independent living skills							
Conduct/ behaviour							
Depression/ anxiety							
Criminal offending							
Interpersonal skills							
Structural							
Placement rate per year							
Employment outcomes							
School outcomes							
Other…… ……..							
Other…… ……..							
Other…… …….							
Other…… …….							

What is the interval between baseline and the follow-up data used

Period	Tick as appropriate
3 months	D6.1
6 months	D6.2
12 months	D6.3
Other please specify……. ……. ……..	D6.4

Funding source for program …….

Other notes or details

_____

_____

_____

APPENDIX D

Examples of campus-based group treatment with live-in carers/parents

Case study - The Harbor House for Teens in Oklahoma

An example of this particular program type is The Harbor House Home for Teens in Oklahoma. The Harbor House provides residential group treatment for male children aged 12 to 18 years diagnosed with attention deficit disorder (ADD) and attention deficit hyperactive disorder (ADHD). The Harbor House specialises in academics, anger management and social development. Admission is on an open-ended and voluntary basis. However there is a minimum ten months length of stay in the program, generally youth stay for a period of ten to twenty-four months. The program serves up to 65 children, with 3 children residing in each home with a set of trained house parents. The residential facility is made up of four wings each housing 12 rooms. Up to three students can share a room. The house parents provide 24 hour supervision and care for the children and implement a behavioural levels treatment program. The house parents have extensive experience with struggling teens, pastoral care and situational counselling. The program is offered in conjunction with anger management, substance abuse treatment and social skills training. The children have access to offsite clinical counselling for an additional cost. Additional program staff provides 24 hour supervision for the students. The staff consists of child care staff, night security and a director of student services.

The Harbor House also has an on-site school called Harbor Academy that runs its own individual academic program. Harbor Academy's academic program for youth is based on the Accelerated Christian Education (ACE) and Alpha Omega programs. The students learn in a class ratio of one teacher to 7-10 students. The program enables the children to work at their own pace based on their level of academic function. In addition, if the student is behind academically, they begin with individual paces using the ACE program. As the student progresses they are moved on to the computer-based programs with Alpha and Omega. The teachers at Harbor Academy monitor each student and evaluate their progress by filling in weekly progress reports for each student.

The cost for the program for each youth is approximately US$2000 per month. Harbor House receives the majority of its financial support from monthly donations from businesses and churches across America. There is a US$200 non-refundable registration fee for each student placement and the parents are not charged a fee for the program but are asked to make a donation if possible.

Case study - Florida Sheriffs Youth Ranches Incorporated - Boys Ranch

A further illustration of the cottage style arrangement identified is the Boys Ranch run by the Florida Sheriffs Youth Ranches organisation. Florida Sheriffs Youth Ranches, Inc. is the parent non-profit, charitable organisation of four residential programs and two camping programs. The Boys Ranch is one of the four residential programs. It is a cottage style treatment program for troubled, neglected and unsupervised boys aged 8 to 18 years of age. The average age of the youth in the residence is 15 years and 5 months (Florida Sheriffs Youth Ranches Incorporated, 2003). The boy's legal guardians request their placement in the program and the boys need to agree to the placement and make a commitment to work on the goals set for them. The children admitted to the program must have average or above average intelligence and must not be a serious or habitual juvenile offender, including no alcohol or drug dependency. The Ranch also requests that the boys agree to receive religious instruction and participate in an academic program.

The Ranch accommodates up to 80 boys in 8 cottages whereby children are provided care, guidance and treatment by 'cottage parents'. Each cottage houses 8-10 boys and the cottages are divided up into "Units" for the purpose of supervision and management. Each unit has a director, a therapist and a secretary, together with the cottage parents that makes up the boys treatment team. The boys attend school on campus or the local public school system in the Live Oak community. If the boys' academic functioning is behind they receive an individual education plan implemented at the Beck Learning Centre. The learning centre also provides the boys with behaviour modification and operates a vocational education program. In addition, the boys are encouraged to participate in recreational activities such as swimming, baseball, volleyball, canoeing, horse riding, farm activities and arts and crafts. Each boy also participates in a structured work program at the Ranch. Each of the boys has a job with regular working hours and is paid for the work. The boys go

through a formal job interview and are able to earn raises through job performance evaluations conducted monthly by their supervisors. Some of the older boys are employed part-time in the local community. The Boys Ranch also has its own All-Faiths Chapel and the boys are asked weekly to attend either a church in town or the non-denominational services in the Ranch Chapel.

Generally the average length of stay at the Boys Ranch is one year. The Boys Ranch works intensely at reuniting the boys with their families where possible. If there is no family or they are unable to find a suitable alternative for the child then the child remains at the ranch until they are ready for independent living.

The majority of funding for Florida Sheriffs Youth Ranches comes from donations, wills, bequeaths and trusts (29.9%). General gifts account for 26.3% of funding and a further 14.7% of monies is from productive enterprises. Reimbursements, Medicaid and fees account for 11.8% of the financial contribution and 12.7% is from income generated by Ranch investments. Less than 5% of money comes from Government contracts and grants (Florida Sheriffs Youth Ranches Incorporated, 2003).

Examples of campus-based group treatment model

Case study- The Baby Fold – Illinois

The Baby Fold's Residential Treatment Centre is another example of a smaller residential treatment model. The Centre is situated in Illinois and serves children aged three to thirteen years with behavioural problems, psychiatric disorders, learning disabilities and/or victims of trauma. The program is available for children who cannot be successfully treated in a less structured setting. Children reside in a home-like setting whereby the children are still closely supervised 24 hours a day by rostered staff. The Centre is divided into four-separate living units, each of which has six bedrooms, a living room, dining room, computer/quiet activity room, bathrooms, and staff offices. The Centre is equipped with therapy rooms, family visiting rooms, a skate room, and playgrounds. Typically the children are referred from the Illinois Department of Children and Family Services, Private agency case-workers, mental health agencies, individual care grant recipients, parents or school districts.

The Centre provides a specialised mental health treatment program for up to 24 children in conjunction with residential school services. The children's treatment is funded through a variety of sources including the Illinois Department of Children and Family Services and the Department of Human Services and local school districts. Each child in the program has an individualised treatment plan designed to assist the child in developing appropriate behaviours so that then can return to a home setting. Generally the children stay at the Centre for a period of 12 months. During their stay, they receive a combination of structure, nurture, and individual and group therapy. The treatment staff focus on treating a variety of behavioural and/or emotional problems, such as aggressive behaviours, self-harm behaviours, destructive behaviours, attachment issues, non-compliance, social skills and relationship building, sexually problematic behaviours, anger control and self-esteem building. The main therapeutic intervention is behavioural modification and cognitive problem solving, in conjunction with daily living skills training, therapeutic recreation, community skills training, art therapy and educational services through Hammitt School or through public schools the children may be attending. The Centre also supplies the children with religious values and education as part of the treatment program and abides to the religious choice of the children and family.

The staff at the Baby Fold Residential Treatment Centre consists of licensed social workers, a clinical psychologist, a developmental paediatrician, registered nursing staff, case managers, and certified teaching staff. Licensed social workers who oversee each child's treatment plans, therapeutic interventions and case management services. The daytime ratio is 1 staff to 2 children and at night there is a ratio of 1 staff to 6 children. In addition the staff encourage and supervise family and sibling visitation. They also offer parent training and family therapy to the child's family. Transition and aftercare services are also supplied to the children and families once they have completed the program.

APPENDIX E
PUBLICATION LIST

Journal articles

Delfabbro, P.H., Osborn, A., & Barber, J.G. (2005). Beyond the continuum: New perspectives on the future of out-of-home care research in Australia. *Children Australia,* 30, 11-18.

Osborn, A. & Delfabbro, P.H. (2006). An analysis of the social background and placement history of children with multiple and complex needs in Australian out-of-home care. *Children, Communities and Families Australia,* 1, 33-42.

Conference papers

Osborn, A. & Delfabbro, P.H. (2005) Children with high support needs in Australian out-of-home care: A national comparative study. *Paper presented at the 9th Australian Institute of Family Studies Conference.* Melbourne, Victoria.

Osborn, A. & Delfabbro, P.H. (2005) Children with high support needs in Australian out-of-home care: A National Comparative Study. Preliminary Findings. *Paper presented at CROCCS International Conference,* Mackay Queensland.

Osborn, A. & Delfabbro, P.H. (2005) Children with high support needs in Australian out-of-home care: a national profile study. *Paper presented at the Centre for Excellence in Child and Family Welfare and CAFWAA 2005 National Symposium*, Melbourne,Victoria.

Delfabbro, P.H. & Osborn, A. (2005) Beyond the continuum: international service and intervention models for children with significant emotional and behavioural problems. *Paper presented at the Centre for Excellence in Child and Family Welfare and CAFWAA 2005 National Symposium,* Melbourne, Victoria.

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